



ACTING ON THE WARNING SIGNS EVALUATION

FINAL REPORT

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An Advocacy Health Alliance to
address family violence through
a multi-disciplinary approach



Legal Services **BOARD**
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Funding was originally applied for and received by North Melbourne Legal Service (NMLS). During the Project, NMLS became Inner Melbourne Community Legal (IMCL) to better reflect the community they serve and the location of their programs and partners.

The Women's 'Women's Social Support Service' (WSSS) also underwent a name change during the Project and is now referred to as Social Work.

For the purposes of this report, we will use both current names of IMCL and Social Work.

Acronyms

AOWS	Acting on the warning signs
CASA	Centre Against Sexual Assault
CLSIS	Community Legal Services Information System
The Evaluation	The evaluation of the Project
IMCL	Inner Melbourne Community Legal
The Project	Acting on the Warning Signs: Addressing violence through the hospital setting (original name) Acting on the Warning Signs: An Advocacy-Health Alliance to address family violence through a multi-disciplinary approach (new name)
UOM	The University of Melbourne
The Women's	The Royal Women's Hospital
WSSS	Social Work (formerly The Women's Social Support Service)

Executive Summary

Background

Acting on the Warning Signs (the Project) is a Legal Advocacy-Health Alliance between Inner Melbourne Community Legal (IMCL) (formerly North Melbourne Legal Service) and The Royal Women's Hospital (The Women's) aimed at addressing family violence through a multi-disciplinary approach. The Project was developed by Helena Maher (Strategic Advisor, Strategy and Planning, The Women's) and Khoi Cao-Lam (former Executive Officer, IMCL) and managed by Linda Gyorki (IMCL). The Project was developed to complement family violence training for staff at The Women's and the ad-hoc legal outreach service that IMCL started to deliver at The Women's in 2009. The Legal Advocacy Health Alliance consisted of training of health professionals, early intervention through identification by health professionals and referral, and outreach legal assistance.

The aims of the Project were to:

- build capacity and willingness of health professionals to identify signs of family violence and provide information on referral pathways for women, in particular train 70 health professionals;
- empower patients from low socio-economic, and multi-cultural backgrounds who are experiencing, or at risk of experiencing, family violence to obtain legal and non-legal assistance by using health professionals as educators and information sources;
- provide patients with legal assistance as part of a multifaceted response, in particular provide 25 instances of legal advice to patients and open 10 ongoing casework files;
- develop and evaluate a model for a multidisciplinary approach to addressing family violence in the hospital context that can be introduced into other Victorian hospitals.

The Evaluation

An evaluation (the Evaluation) of the Project was conducted by The University of Melbourne. The Evaluation has undertaken the five activities specified.

Activity 1 Developed and administered a behaviour change survey before and after training

- Undertook a brief literature review of training methods to inform the training program.
- Evaluated the AOWS training by analysing evaluation questionnaires given immediately post training to health professionals attending the workshop (completed in part by 99 health professionals of the 123 registered for training).
- Administered and analysed two questionnaires sent to the 123 health professionals, at baseline prior to training and at 3-month follow-up (67 health professionals completed both).
- Recruited and facilitated two focus groups and two telephone interviews to obtain qualitative data from health professionals (seven in total), and undertook thematic analysis.

Activity 2 Evaluated the IMCL Outreach clinic

- Undertook a brief literature review of access to justice within a hospital setting for women who were victims of violence.
- Collected and analysed hard and soft copy, de-identified, referral data from IMCL's appointment sheets and Community Legal Services Information System (CLSIS) database.

Activity 3 Evaluated the impact of health information on women's knowledge and behaviour - particularly whether women who are referred to legal or non-legal support services at the Women's have increased knowledge of the law and their options in relation to family violence

- Collected data through questionnaires from 22 women attending Social Work and IMCL outreach service.
- Conducted nine in depth interviews with women attending Social Work and IMCL outreach service clients and undertook thematic analysis.
- This activity was limited by lack of data on source of and reasons for referral and reliance on hospital staff to recruit for the surveys.
- Fact sheets were delayed in development so this aspect was not examined.

Activity 4 Evaluated the referral pathway

- Collated and analysed de-identified referral data in hard copy format from Social Work.
- Collated and analysed de-identified referral data both hard and soft copy from IMCL's appointment sheets and CLSIS database.
- This activity was limited by the data available, which included lack of systematically recording type of attendance (repeat visit for ongoing advice or new client); and not all data fields were mandatory which did not enable systematic identification of violence against women indicators.

Activity 5 Documented and evaluated the Legal Advocacy Health Alliance model

- Facilitated two Stakeholder Workshops at The Women's.
- Reviewed reflective journal of the Project Manager.
- Reviewed client satisfaction among a small group of users.

Key Findings

The key findings of the Evaluation are summarised below.

1. Training outcomes

- ❖ AOWS training numbers (123) exceeded the 70 health professionals outlined in the objectives.
- ❖ Of the 99/123 health professionals who filled out the evaluation survey, the vast majority agreed that the workshop was well coordinated and presented in a clear, stimulating manner (97%), training resources assisted learning (95%), participation was worthwhile and the workshop made connections between the learning and the workplace (98%).
- ❖ Of the 84/123 health professionals who filled out this part of the evaluation survey, the vast majority rated the training very good or excellent (86%), felt it was a positive learning experience (98%) and that they would recommend it to colleagues (91%).
- ❖ 67/123 health professionals filled out the baseline and 3 month follow up survey and two thirds of these respondents were nurses or midwives.
- ❖ AOWS training significantly¹ improved health professional's self-reported general knowledge of family violence and the common presenting symptoms of family violence. There was also a significant improvement in their self reported confidence in having sufficient knowledge and skills to respond to women experiencing family violence and to refer.

¹ Significantly is used in this report as a statistical term. Statistical significance refers to whether any differences observed before and after are "real" or whether they are simply due to chance.

- ❖ After attending the workshop, all of the 67 health professionals responding felt they were able to help or knew what to do if they had a patient with family violence.
- ❖ Health professionals after the training felt significantly more comfortable asking about family violence (20% very comfortable prior and 40% very comfortable post training), although one in five health professionals still felt overwhelmed when responding to such a sensitive issue.
- ❖ Health professionals post training had a significantly greater understanding of:
 - the role of lawyers in a hospital setting (66% prior and 90% post training);
 - intervention orders; and how an intervention order can be tailored to the woman's circumstances and needs.
- ❖ AOWS training significantly increased the proportion of health professionals who felt that they should refer their patients to the IMCL outreach service (55% prior and 85% post), and there was an increase in self reported referrals rarely or occasionally to IMCL post training (6% to 19%) (i.e. those who never referred decreased from 94% to 81%).
- ❖ AOWS training significantly increased health professionals use of the Clinical Practice Guideline with an extra one in five health professionals referring to it in the three months post training.
- ❖ Although health professional's confidence increased to make referrals, health professional's self-reported referral rates in a three month period are low compared to all services. Only one in five health professionals refer regularly or often to Social Work, one in ten to Women's Alcohol and Drug Service, around half referring rarely or occasionally to both services and around 25% to 30% never referring to Social Work or Women's Alcohol and Drug Service respectively.
- ❖ To further enhance the training, participants wanted even more case studies and further strategies on how to deal with family violence within consultations. There also needs to be a further emphasis on the current lack of evidence for routinely screening all patients.

2. *IMCL outreach clinic referrals*

- ❖ During the 12 month evaluation period (January – December 2013), IMCL outreach clinic at The Women's received 56 referrals, 33 of these were for women with family violence related issues.
- ❖ Of the 56 clients recorded in the IMCL outreach, 38 were recorded as on-going clients, thereby exceeding the project target of 10 new, on-going clients². All 56 clients received advice, thereby also exceeding the project target to provide 25 instances of advice.
- ❖ During the 12 month evaluation period there were 122 appointments and 83 attendances in the outreach clinic, a 68% attendance rate³.
- ❖ There has been a notable increase in total referrals to IMCL outreach in 2013 (n=56) compared with 2012 (n= 39) and 2011 (n=26), including both family violence and non-family violence related clients.
- ❖ Within two comparative CLSIS sample periods (2012 and 2013) clients with family violence issues could be identified as more complex cases having an average of 4.4 legal problems compared with non-family violence clients recording an average of 2.7 legal problems.

² 'On-going' client refers to an action performed beyond advice and may not indicate on-going client interaction over time. Definition of client type and activities are provided in Part 2 of this report.

³ Data represents appointments and attendances rather than individual clients. That is, women attending multiple sessions have been counted multiple times.

3. *Women's Knowledge and Satisfaction*

- ❖ The number of women involved in this part of the evaluation was small (22 surveys and nine interviews) due to delays in ethics committee processes and difficulties in recruitment.
- ❖ Accessing information about responses to violence within a women specific healthcare setting was seen as helpful and empowering mainly by advising women on their options.
- ❖ Hospital staff members were appropriate in their questions and discussion about possible violence in the relationship among these patients participating in this evaluation.
- ❖ The eight women accessing the IMCL outreach and participating in the evaluation were generally positive about all aspects of the service they received.

4. *Referral pathway*

- ❖ During the evaluation period Social Work received an average of 21 violence related referrals per month (ranging from 15 in March 2013 to 28 in October 2013). Referrals fluctuate widely each month and *may appear* to be trending toward an increase over time. A longer time analysis is required to determine whether the increase is an anomaly or sustained.
- ❖ Patterns of increased referrals into Social Work for violence related issues could not be identified in the months directly following AOWS training; referrals from clinical staff were largely into Social Work rather than directly into IMCL outreach (nearly all referrals into IMCL were from Social Workers); information is not recorded identifying if the person referring into Social Work had attended AOWS training.
- ❖ Small numbers, manual and inconsistent data recording of referrals and appointments means that changes in referral patterns are difficult to measure and complex to examine with potentially large margins of error.
- ❖ The referral pathway, as it currently exists, did service clients from a wide range of language groups. By definition this will incorporate a number of cultural groups however the range of cultural groups is unknown. Analysis of women's cultural diversity could not be undertaken due to the format of data provided to the researchers.
- ❖ Those clients who agreed to contribute to the evaluation found that the referral pathway was successful and appropriate for them.
- ❖ The evaluation was unable to ascertain either the views of women who were referred but did not attend Social Work or IMCL services, or the views of women dissatisfied with services related to their referrals.

5. *Documented and evaluated the Model*

The Legal Advocacy-Health Alliance aimed to provide health professional education, early intervention and outreach legal assistance. This model involved the following features:

- ❖ a hospital setting which has previously established clinical guidelines and referral pathway for violence against women;
- ❖ identification of an executive sponsor within The Women's (in this case it was the Director for Clinical Operations);
- ❖ establishment of an internal project working group and external reference group;
- ❖ engagement and promotion activities within the hospital by the legal project manager including regular attendance at committee and unit meetings (approximately 53 meetings with staff of The Women's between Aug 2012 and June 2014);

- ❖ physical space provided for the legal outreach to operate within Social Work, with regular and consistent presence of a lawyer;
- ❖ 123 health professionals trained (largest number in one year at The Women's);
- ❖ training was informed by existing best practice evidence and involved
 - consultation with domestic violence experts and the reference group
 - tailoring the sessions to different professional groups
 - multidisciplinary presenters
 - use of survivor voices
 - use of case studies
 - community resources and knowledge of legal system
 - promotion of those trained to become family violence champions;
- ❖ outreach legal assistance was offered one session per week and 83 appointments could be identified to have been attended in the 12 month period.

Recommendations for future models

Training

- Given the prevalence of family violence and its impact on health, family violence training should be mandatory, recurrent and ongoing for all staff at The Women's and other similar hospitals.
- A funded clinical lead from the hospital, together with the legal project manager would further enhance the training and assist to sustain the relevance of the training.
- To maximise attendance, delivery of training needs to continue to be flexible and responsive, utilising a variety of formats such as workshop based, audio visual, online and delivered across several sessions or in-service.
- Any future training provided at The Women's could be enhanced by coordination with any other existing training programmes on violence against women e.g. sexual assault.

Early intervention requires greater system changes within the hospital

- Sustained system changes within a large hospital such as The Women's would require more staff to be trained and more than a part time designated manager. The current program trained almost 10% of clinical staff, however a larger critical mass of trained and sensitised staff are needed to sustain changes.
- For training to be even more effective in the future, it needs to be further embedded in the Women's strategic plan to systematically change the culture of the hospital in the area of family violence and violence against women. This could include ongoing organisational and management support, and recurrent communication of flexible training opportunities associated with violence against women in the hospital.
- For AOWS to make an ongoing greater impact on referrals;
 - health professionals need to perceive a greater need to ask about family violence through the support of a hospital wide campaign on family violence;
 - it needs to be associated with other system changes that assist women to access help e.g. posters, warm referrals (women supported and accompanied to the legal clinic);
 - Effective, good quality databases/recording systems are required to capture and track referrals within The Women's, including demographics and reasons for presentation.

Outreach legal service

The co-location of a regular and consistent legal practitioner within Social Work appears to be the mechanism that led to increased awareness and accessibility for social workers to refer women to this service. Analysis of referrals into the legal outreach pre-AOWS and during the evaluation period suggests that this co-location is the clearest explanation for increased referrals in the current model.

The main reasons for this include:

- ❖ maintaining regular and consistent hours of IMCL outreach ensured regular referrals;
- ❖ the consistent presence of a primary lawyer with a special interest built strong relationships with Social Work and enabled trust in stability of the program and advice being offered; and
- ❖ the co-location of IMCL outreach within Social Work enabled social workers to make appointments on behalf of their clients, even on the same day.

This part of the model could be strengthened by:

- better signage to the IMCL outreach service for clients and staff;
- freely available information sheets, especially outside of Social Work operating hours or to encourage women to self-refer without accessing Social Work (this has been enacted in 2014);
- increased availability of the IMCL outreach service (an extra half day began in January 2014, post-evaluation).

Conclusion

This innovative Legal Advocacy Health Alliance of engagement and training of over 100 health professionals has built capacity, confidence and willingness of health professionals to identify signs of family violence. Health professionals clearly increased their knowledge of legal options.

Appropriate legal assistance from the outreach service has also been provided alongside other services as part of a multifaceted response within the hospital. Over the five year development of the legal clinic at The Women's there has been a steady increase in referrals reported by IMCL. Greater referrals from health professionals might be visible with better data capture of referrals and may occur with greater availability of the IMCL outreach service.

The legal partnership with The Women's builds on a strong organisational foundation to address violence against women. The Women's Clinical Practice Guideline, on-going staff training, and leadership within senior management at the hospital have been consistent for more than a decade. The AOWS project exemplifies the strengthening of this response. The implementation has involved not only the once a week legal clinic, but also staff training and extensive relationship building between IMCL and The Women's to strengthen the Legal Advocacy-Health Alliance. It is difficult to assess what the effect of implementation of the model in other health settings would be, particularly if strong organisational support for violence against women activities is absent.

The further development of the model in the next phase to increase the number of legal assistance sessions, on-going (and possibly mandatory) family violence training, stronger, practical support for women to access the legal clinic, and experimenting with whether legal support can be provided directly without the intermediary social work support service provide promising extensions for the future development of the legal service within the hospital.

Overview

This is the final report for the Evaluation of *Acting on the Warning Signs: Addressing violence through the hospital setting* (the Project)⁴. The Project is a Legal Advocacy-Health Alliance between Inner Melbourne Community Legal (IMCL) (formerly North Melbourne Legal Service) and the Royal Women's Hospital (The Women's) aimed at addressing family violence through a multi-disciplinary approach.

The Project was developed by Helena Maher (Strategic Advisor, Strategy and Planning, The Women's) and Khoi Cao-Lam (former Executive Officer, IMCL) and managed by Linda Gyorki (Project Manager and Lawyer, IMCL).

The Project was developed to complement family violence training for staff at The Women's and the ad-hoc legal outreach service that IMCL started to deliver at The Women's in 2009. It brings together pathways to justice and health sector training. The aims of the Project were:

- build capacity and willingness of 70 health professionals to identify signs of family violence and provide information on referral pathways;
- empower patients from low socio-economic and multi-cultural backgrounds who are experiencing, or at risk of experiencing, family violence to obtain legal and non-legal assistance by using health professionals as educators and information sources;
- provide patients with legal assistance alongside other services as part of a multifaceted response; and
- develop and evaluate a model for a multidisciplinary approach to addressing family violence in the hospital context that can be introduced into other hospitals around Victoria.

Training workshops were delivered in five waves over the period of 9 months (AOWS Workshops) to a range of health professionals including nurses, midwives, doctors and any other health professionals that would come into contact with patients at The Women's. Two models for the AOWS Workshops were developed. The primary model was a one-day session comprising a range of presenters speaking on clinical warning signs, emotional warning signs and appropriate responses, legal aspects of family violence and the multidisciplinary approach, mandatory reporting and appropriate documentation, cultural sensitivity for Aboriginal and Torres Strait Islander patients, and support for staff and self-care (see Appendix 1). The second model was targeted at doctors and was developed to maximise participation by taking into account scheduling difficulties. Doctors were offered the option of attending a 90 minute training session that focused on short presentations from a general practitioner in the maternity and peri-natal mental health sectors, corporate counsel, social work and the Project Manager (see Appendix 2). A multi-disciplinary panel answered questions following the presentations.

⁴ The name of the program has been recently changed to *Acting on the Warning Signs: An advocacy health alliance to address family violence through a multi-disciplinary approach*.

Context Setting

The Legal Advocacy-Health Alliance developing between the Women's and IMCL builds on strong organisational foundation to address violence against women at the hospital. The Women's Clinical Practice Guideline (CPG) for the management of violence against women, on-going staff training, and leadership within senior management at the hospital has been consistent for more than a decade and marks The Women's out as a leader in Victoria, if not nationally, in the attention to violence against women in a hospital setting. The AOWS project exemplifies the strengthening of the response to violence against women at the hospital. The implementation of the model has involved not only the once a week legal clinic, but also staff training and extensive relationship building between IMCL and The Women's to strengthen the Legal Advocacy-Health Alliance. It is noteworthy that the legal advocate attended approximately 53 meetings with staff of The Women's between August 2012 and June 2014 (excluding the project working group).

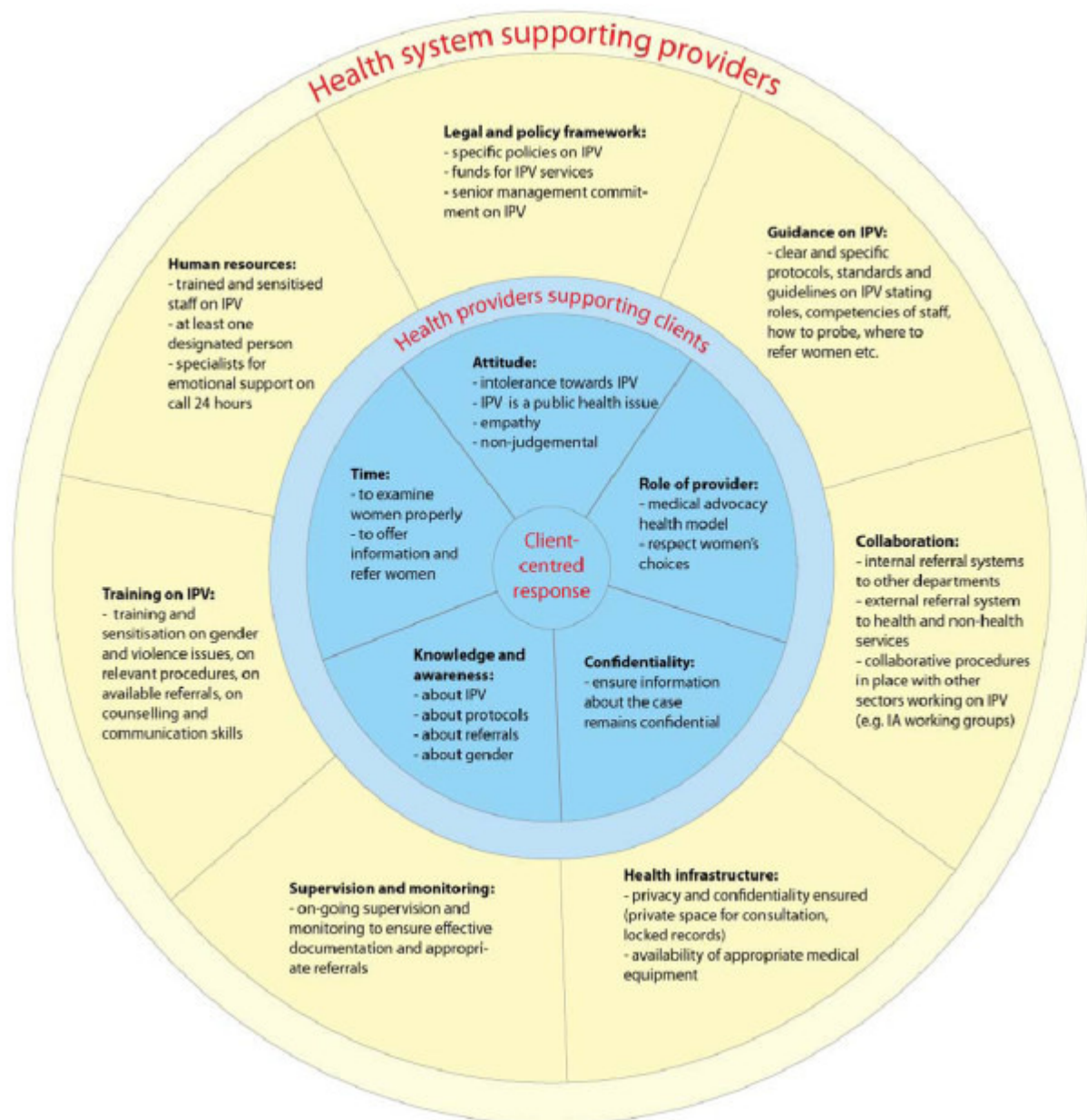
A comparison between the current Legal Advocacy-Health Alliance with the recently published health systems wheel by Colombini et al, 2012 (see Figure 1)(4), shows that this model contains many of the system features that are required to enact changes towards an effective program for family violence or intimate partner violence (IPV) in a complex health system. These include:

- legal and policy framework;
- collaboration;
- guidance;
- health infrastructure;
- training; and
- human resources (partially).

However, there are further steps which could be taken to strengthen the human resources funded within the current model. Sustained system changes within a large hospital such as The Women's would require more staff to be trained and more than a part time designated person. Currently there are around 1500 clinical staff at The Women's, so although the current program trained almost 10% of these, a larger critical mass of trained and sensitised staff are needed to sustain changes. Knowledge and awareness of health professionals about IPV changed with this program, but there needs to be ongoing training to ensure this knowledge and awareness is across a higher proportion of health professionals to enact sustained referrals.

Using the Realistic Evaluation Model, we can see that the *context* at The Women's of an existing Violence Against Women strategy, including hospital champions was vital to the implementation of the Advocacy- Health model. Further, the *mechanisms* that operated that were key to the successful outcomes were the engagement by the dedicated project manager with the wider hospital, the collaborative training and the co-location of the legal project manager within Social Work.

Figure 1 Health systems wheel(4)



The Evaluation

An evaluation had formed a part of the Project's original funding application in which health professionals would be surveyed before and after training, female patients would be interviewed and data would be collected from IMCL and The Women's regarding referrals. The Evaluation proposal was conducted by a research and evaluation team from University of Melbourne with extensive experience in research and evaluation in the area of violence against women.

The evaluation approach that was proposed was based on Pawson and Tilley's *Realistic Evaluation* model (1997). This approach argues that interventions need to be understood in terms of the interactions between program mechanisms (the processes that generate change) and contexts (the physical and institutional environment within which a program takes place, as well as the norms, values and relationships of those involved as providers or participants). The goal was to provide a more complete understanding of how the Project works within the context of the legal and health systems. In this way the evaluation documents the processes that generate intended and unintended outcomes, and identifies resources and other factors that act as limiting or facilitating factors. This approach enables further refinement of the Project model, and how it may be adapted or translated to other contexts.(5)

Evaluation Activities

The activities of the Evaluation were as follows:

- develop and administer a behaviour change survey before and after training;
- evaluate the IMCL outreach clinic;
- evaluate the impact of health information on women's knowledge and behaviour - in particular whether women who are referred to the legal or non-legal support services at The Women's have increased knowledge of the law and their options in relation to family violence;
- evaluate the referral pathway;
- document and evaluate the legal-medical partnership model.

Methods

The Evaluation drew on the Realistic Evaluation model in two key ways. The first part of the Evaluation involved a half one day workshop with a range of stakeholders designed to test and elaborate the Project, focusing on identifying the processes that were intended to generate desired outcomes for participants, and the contextual factors that would shape how the Project worked. This process in turn provided the basis for the design of the survey and interview schedules for the main data collection stage of the Evaluation. Alongside the stakeholder workshop, a literature review on training methods was conducted to inform the Project team regarding optimal training methods. At the other end of the evaluation process, there was a second workshop to review the activities, contextual factors and practice principles identified as productive of, or barriers to, desired Project outcomes. The goal of the review was to engage key stakeholders in decision making about the future development of the Project.

The second part of the evaluation was to explore client satisfaction with the referral pathway from hospital clinical staff identifying violence and referring on to Social Work through to a legal outreach service if appropriate. A short literature review was also conducted to inform The Women's and IMCL of both the potential benefits of this service, and comparable systems. In particular, the literature review identifies the degree to which whole system change may be required to implement a best practice model.

In practice, the Evaluation formed two parts. The first part focused on evaluating training received by health professionals through the AOWS Workshops at The Women's as part of the Project ('Part 1'). The second part focussed on referral pathways and client satisfaction ('Part 2').

Evaluation Part 1

Part 1 involved the following:

- a. literature review of training methods;
- b. stakeholder workshop (Appendix 3);
- c. the design and dissemination of baseline (Appendix 4) and 3-month follow-up (Appendix 5) surveys that were given to health practitioners (HPs) who registered for the AOWS Workshops ('HP Surveys');
- d. the recruitment and facilitation of two focus groups and telephone interviews with health professionals who both had and had not attended an AOWS Workshop (Appendix 7).

The HP Surveys measured knowledge, skills and attitudes of HPs towards identification, response and referral in relation to family violence, whilst the Evaluation Survey gathered data on the training as perceived by those attending.

The focus groups provided qualitative data around providing training at The Women's and feedback on the AOWS Workshops.

Evaluation Part 2

Part 2 involved the following:

- a. a baseline client satisfaction survey ('Client Survey'), which was given to clients attending Social Work and/or the IMCL outreach service at The Women's where a case worker was aware the client had experienced violence, regardless of whether she disclosed, and in circumstances the case worker felt was suitable to be asked (i.e. not in a crisis) (Appendix 8 and Appendix 9);
- b. in depth interviews with Social Work and IMCL outreach service clients (Appendix 10);
- c. collation and analysis of referral data from Social Work and IMCL outreach service (Appendix 11 and Appendix 12)
- d. a second stakeholder workshop (Appendix 13)

Ethics

The ethical process for the evaluation was complex and lengthy. Ethical clearance was provided by the RWH Human Research Ethics Committee.

Part 1: Evaluating AOWS Training Programme

Literature Review of Training Methods

A literature review was conducted to inform the Project regarding optimal training methods. Thus Training was informed by this existing best practice evidence and involved:

- consultation with domestic violence experts and reference group;
- tailoring the sessions to different professional groups;
- multidisciplinary presenters;
- use of survivor voices;
- use of case studies;
- community resources and knowledge of legal system;
- promotion of those trained to become family violence champions.

Intimate Partner Violence Focused Education Interventions

A systematic review of the literature (2005) regarding identification of Intimate Partner Violence (IPV) found that didactic training with support aids given to healthcare professionals in healthcare settings improve referral rates to support agencies in the short term.(6) However, in order to sustain referral rates, reinforcement of training was required.(6) The recommendations arising from the review suggested team training on partner violence in health care settings needs to be implemented with regular enforcement and training should include close collaboration with community based advocacy services. A more recent intervention undertaken in a paediatric setting found that training that familiarizes paediatricians with the risk and impact of IPV on children and families along with practice supports that make incorporating screening for IPV as easy as possible can increase identification and referrals to support agencies(7). This included putting in place a 'champion' of the intervention, also recommended by Scalzi et al. (2006) in changing organisational culture.(8)

More recently, a training and support programme targeted at primary care clinicians and administrative staff improved referral to specialist domestic violence agencies and recorded identification of women experiencing domestic violence.(9) This training programme included 2 sessions of multidisciplinary training, incorporating case studies and practice in asking about violence and responding appropriately. Training was delivered by a DV advocate educator and either a clinical psychologist or academic family doctor with backgrounds in DV training research and training. Presentations and interactive sessions were standardised and every practice given a handbook with additional materials. The DV advocate educator was central, with not only a training role but in also providing practice support and advocacy to women referred from the practices.

Taking account of barriers

Warshaw et al., commented that "in order for health professionals to develop and sustain appropriate responses to Intimate Partner Abuse, they must have the support of the institutions in which they practice".(10) Studies up to 2006 underscored challenges in changing teaching strategies and overcoming barriers encountered by health professionals. Such studies also highlighted difficulties providers have integrating knowledge about IPV into practice unless broader issues, including social, are addressed.(10)

Cabana et al., (1999) found there were a number of barriers to overcome if physicians were to adhere to guidelines, including lack of awareness, lack of familiarity, lack of agreement, lack of self-efficacy, lack of outcome expectancy, the inertia of previous practice, and external barriers.(11) For interventions to be successful, and for physician behaviours to change, such barriers need to be considered and addressed.(11-13) In terms of changing provider behaviour, Grimshaw et al.'s systematic review found that passive education (mailing educational materials to targeted clinicians) is generally ineffective and is unlikely to result in behaviour change when used alone, although it might be useful to raise awareness of the desired behaviour change. Active approaches are more likely to be effective.(14-16)

Active rather than passive learning for behaviour change

Education models have been more effective at improving knowledge and confidence than at changing actual practice.(10) Traditional (didactic, knowledge-focused) continuing medical education (CME) does not consistently lead to sustained improvements in practice (13) and dissemination strategies alone have little to no effect on health professional behaviour change.(17) A Cochrane systematic review (2009) of continuing education meetings and workshops effect on practice found that educational meetings alone or combined with other interventions, can improve professional practice and healthcare outcomes for the patients. The effect is most likely to be small and similar to other types of continuing medical education, such as audit and feedback, and educational outreach visits. Strategies to increase attendance at educational meetings, using mixed interactive and didactic formats, and focusing on outcomes that are likely to be perceived as serious may increase the effectiveness of educational meetings. Educational meetings alone are not likely to be effective for changing complex behaviours.(18) These findings were reinforced by a review of education interventions that found complex, multi-modal educational strategies combining predisposing, enabling and reinforcing factors achieved better results than where strategies used only one or two of these components.(19) Predisposing factors included disseminating information, communication and didactic teaching. Enabling factors facilitate the desired change in performance by using protocols, guidelines and providing resources. Reinforcement factors consolidate learning through reminders and feedback from peers and experts.(20)

Components of IPV education for health professionals

Training content and institutional changes need to address obstacles practitioners face in responding to IPV particularly as health professionals may be faced with the frustrations of working within increasingly rigid time constraints, the realities of limited community resources, and an inadequate criminal justice system.(10, 21-23) Knowledge of the legal system, community resources, and strategies to protect women's safety are essential components of a framework for teaching about IPV.(10) Any education model must address the conditions that shape clinicians' interactions with both IPV victims and abusive patients as well as acknowledge the need to transform conditions that limit health professionals' abilities to respond.(10) Lack of attention to provider issues, lack of institutional reinforcement can all have impact on training effectiveness.(10) Furthermore the tutors' own attitudes and preparedness can affect learning outcomes.(24)

Warshaw et al., (10) suggest that any core principles or training should include: immediate and long-term safety of the patient; routine enquiry in a confidential, non-judgemental, and compassionate manner is an essential skill that needs to become part of routine care; understanding dynamics of

abuse, respecting choice and holding perpetrators accountable are critical to appropriate intervention; education should include information on the legal protections available and reporting requirements; professionals need to understand the rationale and develop the skills to work as part of a multidisciplinary team (including working with advocacy groups and linking to community resources). Health professionals need to develop awareness of own responses and behaviours and how these can affect clinical care; interventions and responses should reflect an understanding of the cultural background, needs and preferences of patients.(10) Warshaw et al. also suggest that curricular learning objectives and skill-based competencies should include: problem awareness; dynamics of IPA and social context; IPA across diverse communities; issues of safety, privacy, confidentiality, validation, and empowerment; identification, assessment and diagnosis; intervention and treatment; documentation; legal protections and responses; community resources and referrals; additional clinical issues; controversial issues; provider issues, responses and concerns; prevention, collaboration, advocacy and social change.(10)

Other suggested strategies include learning from survivors either in person or by use of DVDs; simulated patients; relational skill-building activities and learning from empowerment models through use of role plays, modelling by educators and advocates, video and in-person observation, conversations with survivors; modelling respectful community collaboration that provides a support network and understanding for health professionals who are helping patients deal with complex situations for example teaching the health professional what happens when referrals are made; providing health professionals with information on supports available if they experience vicarious traumatisation.(10)

Content of an education model needs to include interactive teaching activities as interpersonal skills are an important component of responding to IPV. Standard didactic education does not allow space to consider the emotional response of health professionals and their subsequent ability to provide appropriate care. Educators therefore need to create safe environments so cultural and personal responses to abuse can be explored and individual, professional and institutional concerns discussed. Ongoing feedback and support are necessary to develop and sustain provider response (rather than one-time trainings).(10) As some of the health professionals may have direct or indirect experience of IPV, acknowledging the likelihood of personal experience and offering recognition and support is a useful starting point in training.(10)

First stakeholder workshop

The first stage of the project involved a half one day workshop with a range of stakeholders designed

- ❖ to test and elaborate the program model;
- ❖ identify the processes that are intended to generate desired outcomes for participants; and
- ❖ the contextual factors that will shape how the program works.

It was also used to review some elements of the proposed data collections (in particular, the content and delivery methods for the training survey). The programme is attached at Appendix 3.

The workshop was held on 28 September 2012. Twenty-nine staff from The Women's attended covering all levels from Director through to Managers, Nurses, Allied Health and Midwives from Women's Health, Maternity Services, Neonatal Services, Gynaecology, Women's Cancer and Perioperative as well as key Administrative and Education staff. Details about the AOWS Project were provided by Linda Gyorki and the Stakeholders were asked to comment on various aspects of the Training and Evaluation through breakout sessions.

Feedback received from the Stakeholders is summarised in Table 1.

Table 1: Key feedback arising from the Stakeholder Workshop

Program Logic Model & Engaging Health Professionals	<ul style="list-style-type: none">▪ Top level support required to engage staff▪ Training to be practical: culturally appropriate, team specific case study format, taking into account practical environmental issues▪ Legal information needs to be well resourced and supported if staff being asked to do something that is beyond their role▪ Support needs to be given to staff
Engaging HPs in Training and Surveys	<ul style="list-style-type: none">▪ Workshop length depends on health professional: full day suitable for nurses but not for medical staff▪ Junior medical staff turnover needs to be taken into consideration▪ Need to target the audience during training▪ Need to be clear on health impacts of family violence – it is important to all clients, it is not just an added extra▪ Online survey suitable but needs to be short, 1–15 minutes in length▪ Survey format: tick boxes preferred over text boxes▪ Email invitation also needs to be short▪ Email reminders regularly, every couple of days otherwise they will get lost in staff's inbox
Engaging Clients for the Client Survey & Interviews	<ul style="list-style-type: none">▪ 'Impact and Experience' not 'Satisfaction Survey'▪ Pilot survey with existing consumer groups▪ Need an empathic approach▪ Ensure diversity in group being interviewed
Sustainability	<ul style="list-style-type: none">▪ Take into consideration the impact on staff: safety & protocols▪ Training needs to be relevant to current work protocols and aligned with current practices around documentation▪ Middle-management and supervisor support▪ Seek support from Government around training programmes for health professionals

Workshop Evaluation Survey

An evaluation survey (Evaluation Survey) was prepared by the Evaluation Team, in conjunction with the Project Team, to ensure relevancy with the AOWS Training. These were provided to the Project Team in hard copy prior to the AOWS Training for dissemination to and collation from participants.

As there were some health professionals who registered to attend but missed the workshop and some who did not register but attended, these responses may not be by the same health professionals as completed both baseline and follow-up surveys. They were also completely anonymous with no identifying information provided.

Methods

An Evaluation Survey was provided to each AOWS Workshop participant in hard copy format to complete before leaving at the conclusion of training. They were collated by the Project Team and mailed to the Evaluation Team following each AOWS Workshop for data entry and analysis.

Survey questions asked AOWS Workshop participants what they thought of the training they had received, both content and delivery, with responses following a Likert scale. Participants were also given the opportunity to provide open text responses on what they felt were the most useful and least useful aspects of the AOWS Workshop. The participants were finally requested to provide an overall rating for the training and whether they would recommend it to colleagues.

Descriptive analysis was undertaken, the results of which are shown below.

Results

A total of 99 health professionals attended the workshop and completed an evaluation survey (see Table 2), however not all those who completed a survey completed all responses. Denominators may vary.

Table 2 Response rates to AOWS Evaluation Survey by wave

	WAVES					Total
	A	B	C	D	E	
Registered for AOWS workshop	33	13	27	13	37	123
Attended & completed evaluation survey	23	15	15	11	35	99

The AOWS workshops were very well received, with 86% (n=72) of those attending rating the training very good or excellent (see Figure 2). Furthermore the majority of those who completed the evaluation surveys also felt the workshop was a positive learning experience (n=82, 98%) and would recommend it to their colleagues (n=81, 96%) (see Figure 3).

Figure 2 Overall workshop rating (n=84)

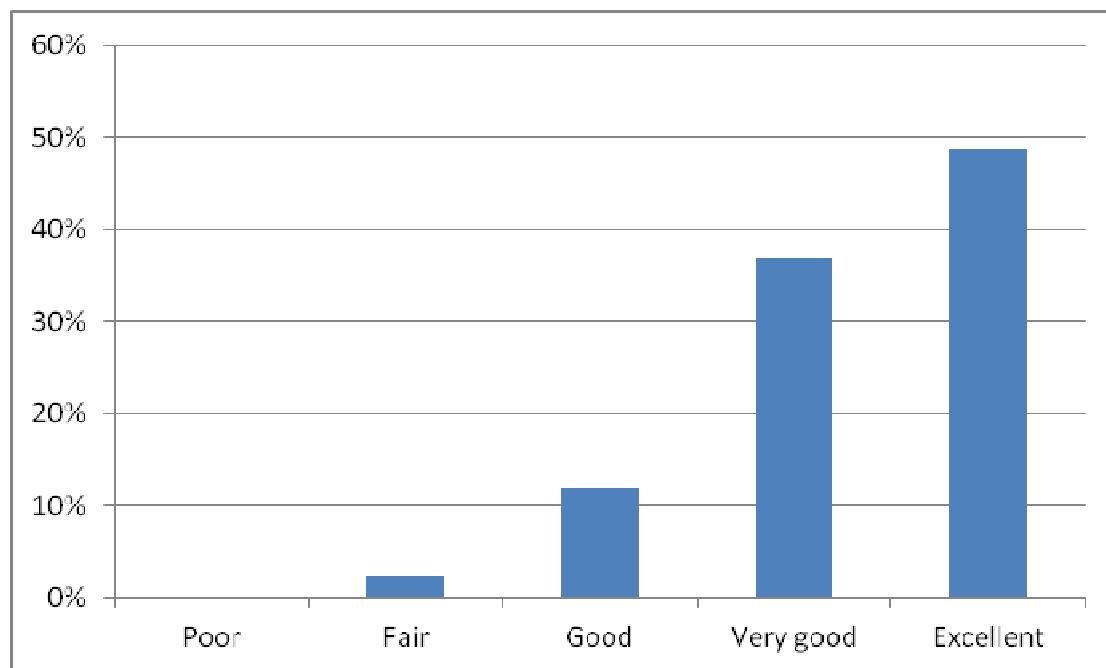


Figure 3 Workshop ratings (n=84)

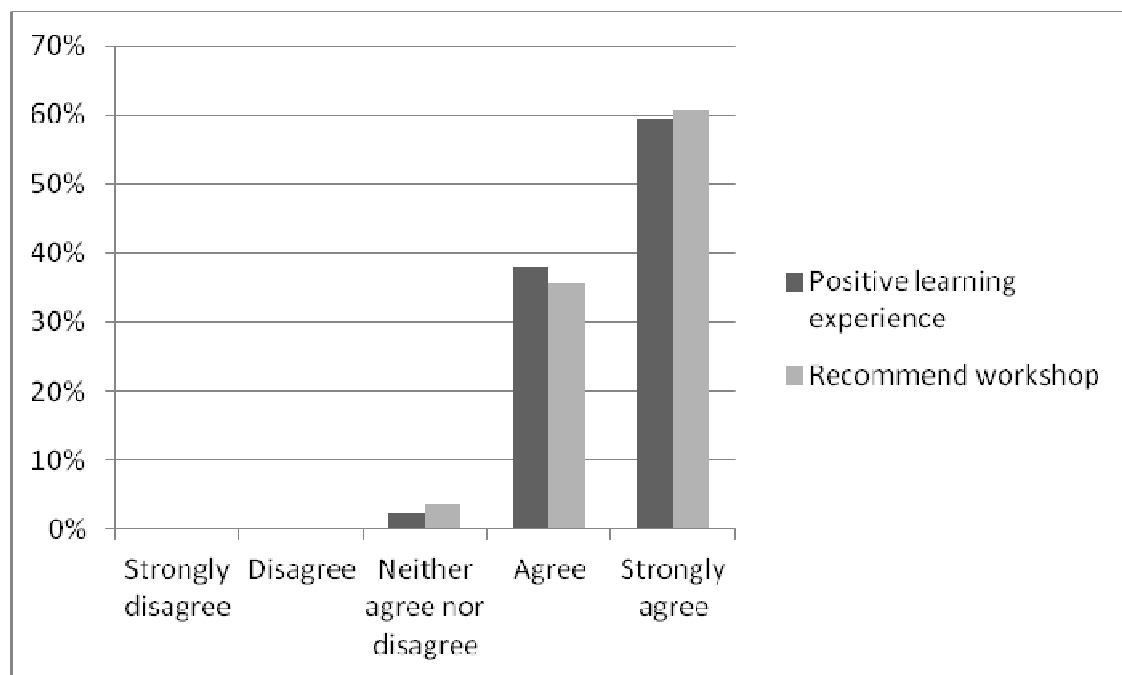


Table 3 Aspects of the Workshop

	Strongly disagree		Disagree		Neither agree nor disagree		Agree		Strongly agree	
	no.	%	no.	%	no.	%	no.	%	no.	%
The workshop was well coordinated	0	0.0%	1	1.0%	2	2.0%	48	49.0%	47	48.0%
Communication about the workshop was clear, and timely	0	0.0%	0	0.0%	1	1.0%	51	52.0%	46	46.9%
The workshop fitted in well around my other responsibilities	0	0.0%	3	3.0%	6	6.1%	59	59.6%	31	31.3%
The way the workshop was delivered supported my learning	0	0.0%	0	0.0%	1	1.0%	58	59.2%	39	39.8%
The depth and breadth of the workshop content was right for me	0	0.0%	2	2.0%	7	7.1%	55	56.1%	34	34.7%
Training resources and materials assisted my learning during the workshop	1	1.0%	1	1.0%	3	3.1%	50	51.0%	43	43.9%
Participation in the workshop was a worthwhile experience	0	0.0%	0	0.0%	2	2.0%	39	39.8%	57	58.2%

*denominators vary from 98-99

Table 4 Facilitators

	Strongly disagree		Disagree		Neither agree nor disagree		Agree		Strongly agree	
	no.	%	no.	%	no.	%	no.	%	no.	%
They were well prepared for the workshop	0	0.0%	0	0.0%	1	1.0%	48	48.5%	50	50.5%
They made connections between the learning materials and activities, and my workplace	0	0.0%	0	0.0%	2	2.0%	49	49.5%	48	48.5%
They demonstrated a sound knowledge and understanding of the workshop content	0	0.0%	0	0.0%	1	1.0%	45	45.5%	53	53.5%
They presented in a clear and stimulating manner	0	0.0%	0	0.0%	2	2.0%	46	46.5%	51	51.5%

Below we summarise what participants considered to be the most useful and least useful aspects of the AOWS workshop.

The most useful aspects of the workshop

- Information provided about family violence indicators and health impacts
- Information regarding HP's role in family violence and their resources to support women
- Provision of practical advice, for example how to ask patients about family violence
- Definition of family violence
- Mandatory reporting
- Background information
- Legal information
- Access to legal advice within The Women's
- Information on the services to support women
- Referral pathways
- Discussions around family violence within Aboriginal and Torres Strait Islander families
- Interactive training methods, particularly the use of case studies
- Using multidisciplinary presenters

Areas where the workshops could be improved

- Irrelevance of certain information: legal and depth of information regarding EAP
- Too much background on family violence at the expense of referral discussions
- Too many discussion breakouts
- Too much information
- Repetitive
- Length of the workshop –too long/too short for the information being provided
- Intensive
- Responding 'refer to social work' to many of the issues raised
- Need more practical discussion regarding mandatory reporting
- Need more real stories
- Not enough on different cultural perspectives
- More active learning required

As with any evaluation, opinions were sometimes polarised regarding certain aspects of the training. Whilst some participants felt legal information was useful, others did not.

Participants also provided additional feedback as to what they would suggest to improve the AOWS workshop. These suggestions included providing even more case studies to continue to get the information across in a practice and relevant manner; providing more information on cultural diversity and specific case studies relating to these communities; using role plays; providing more strategies with how to deal with family violence within conversations with patients and delivering the workshop in multiple sessions or over two days. The latter suggestion is useful for ongoing development of the workshops, which had initially been restricted to a one-day format to enable ease of evaluation.

The next section outlines the results of the health professional surveys.

Health Professional Surveys

The training of health professionals, completed in five waves across a period of 9 months, was assessed via two surveys: prior to training (Baseline Survey); and at three-month follow-up (Follow-up Survey).

The survey was developed by the Evaluation Team with input from the Project Team and in consideration of the insights provided by the Stakeholder Workshop.

Aim

The aim of the health professional surveys was to assess behavioural change amongst those health professionals who registered and attended the AOWS workshops. The surveys aimed to measure knowledge, skills, and attitudes of health professionals towards identification, response and referral in relation to family violence.

Research questions

- Do health professionals who attend AOWS workshops self-report increase in skills and confidence in identifying, responding and referring in relation to family violence three months after receiving training?
- Does health professionals' knowledge of the role of lawyers improve following attendance of the AOWS workshops?
- Do health professionals who attend AOWS workshops self-report increase in referrals to Social Work and IMCL?

Methods

Following the Stakeholder Workshop and in liaison with Bridget O'Brien of The Women's Human Resources (HR), it was agreed that the Baseline and Follow-up surveys would be developed online using SurveyMonkey® and disseminated via The Women's HR team direct to those staff that had registered to attend an AOWS Workshop.

Anonymity was assured by the Evaluation Team transferring the final draft of the survey to The Women's SurveyMonkey® account prior to dissemination. On receipt of data, The Women's HR de-identified responses before transferring the data to the Evaluation Team. The Women's HR also sent reminder emails on dates agreed with the Evaluation Team.

Approximately two weeks prior to an AOWS Workshop and at the point where registrations for attendance had closed, the Evaluation Team would send the online survey template to The Women's HR for dissemination. Text for three reminder emails was also sent at agreed intervals with The Women's HR (taking into account activities within The Women's that may prevent staff from responding to their emails). To maximise responses to baseline surveys, contact telephone numbers were provided to the Evaluation Team to call those who were yet to complete the surveys.

The dissemination of Follow-up Surveys followed the same process as the Baseline Surveys. However, to maximise response rates (see Table 5) to the follow-up surveys, the Evaluation Team and Women's HR team translated the online SurveyMonkey® survey into hard copy format. Following the final reminder being sent via email, hard copy surveys were placed in the non-responding participating health professionals' pigeon holes within The Women's.

Analysis

De-identified data was transferred from The Women's SurveyMonkey® account to the Evaluation Team in excel format. Variables were assigned and a codebook developed for both Baseline and Follow-up Surveys. Data was analysed by Jodie Valpied at the Department of General Practice, UOM using SPSS. Significantly used in this report refers to a statistical term. Statistical significance refers to whether any differences observed before and after are "real" or whether they are simply due to chance.

Results of Health Professional Surveys

A total of 123 health professionals participated in the AOWS workshops across nine months, exceeding the 70 health professionals outlined in the objectives, with 96 completing a baseline survey and 67 completing both baseline and follow-up surveys (see Table 5). Overall response rate for those who participated in an AOWS workshop and completed both a baseline and follow-up survey was 54% (67/123). Response rate for those completing a follow-up survey following the baseline survey was 70% (67/96).

Table 5 Health Professional Survey Response Rates

	WAVES					Total
	A	B	C	D	E	
Attended AOWS	33	13	27	13	37	123
Baseline	31	10	17	11	27	96
Follow-up	23	7	12	8	17	67
Response rate	74%	70%	71%	73%	63%	70%

Demographics

The majority of participants were female (89%, n=58) and were permanent staff at The Women's, split almost equally across full time and part time status. Of those who worked part time, almost half worked between 28 - 37.9 hours and 25% worked 18 - 27.9 hours per week. Two-thirds of the participants were midwives or nurses, with almost half of the participants coming from the maternity sector.

There was no difference in the characteristics of those who only participated at baseline and attended training and those who participated at both baseline, training and follow-up (see Table 6).

We will report only on those participants who completed both the baseline and follow-up surveys (n=67).

Table 6 Participant demographics

	All baseline respondents		Baseline & Follow-up respondents	
	mean	SD	mean	SD
Age (mean:SD)	42.0	11.5	43.1	11.4
	n	%*	n	%*
Female	83	91.2	58	89.2
English is first language	74	81.3	54	83.1
Employment status				
Casual / locum	5	5.6	4	6.1
Full time - Fixed term	10	11.2	8	12.1
Full time - Permanent / ongoing	33	37.1	25	37.9
Part time - Fixed term	4	4.5	3	4.5
Part time - Permanent / ongoing	37	41.6	25	37.9
Clinical sector				
Emergency Care	3	3.1	3	4.5
Gynaecology, Women's Cancer & Perioperative	11	11.5	7	10.6
Maternity	41	42.7	31	47.0
Mental Health	2	2.1	2	3.0
Neonatal Services	13	13.5	6	9.1
Non-clinical	5	5.2	4	6.1
Reproductive Services	2	2.1	2	3.0
Women's Health	13	13.5	9	13.6
Other (please specify)	5	5.2	2	3.0
Profession				
Allied Health	5	5.2	4	6.1
Consultant	7	7.3	5	7.6
HMO	2	2.1	1	1.5
Medical Officer (Registrars, Consultants, HMOs)	1	1	1	1.5
Midwifery	30	31.3	21	31.8
Nursing	31	32.3	21	31.8
Resident	1	1	1	1.5
Sessional Medical Officer	4	4.2	3	4.5
Social Work	8	8.3	4	6.1
Unit Head	1	1	1	1.5
Other (please specify)	5	5.2	4	6.1

* denominators may vary: all baseline respondents (n=89-96); baseline and follow-up respondents (n=64-66)

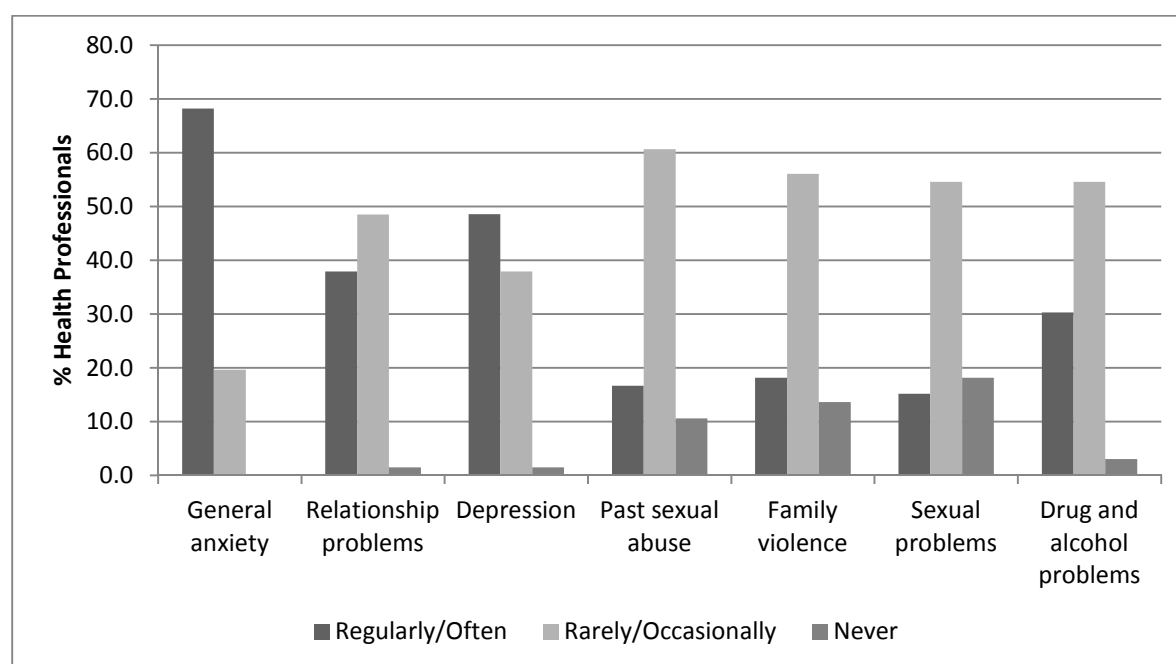
Training experience

Half of the participants had received prior training in family violence (48.5%, n=32), with the most prevalent form of training being a one-off work-shop external to The Women's (28.8%, n=19), followed by self-taught (27.2%, n=18).

Common presentations

From a list of common psychosocial issues, health professionals who had seen patients in the last 3 months (n=58, 87.9%) self-reported that the most common presentations they saw often or regularly were general anxiety (n=45, 68.2%), depression (n=32, 48.5%) and relationship problems (n=25, 37.9%). However, only 18.2% (n=12) of health professionals self-reported that they had seen family violence.

Figure 4 Proportion of Health professionals seeing the following presentations ‘regularly’ or ‘often’ over the previous 3 months (n=58)



Understanding of family violence

Overall the participants had a good understanding of family violence however there were several aspects which continued to be misunderstood. Only just under half of participants (n=30, 45.5%) understood that women are at greater risk of injury when they leave a relationship. The number of participants who understand this did not significantly change following training (n=34, 54%). There was an increase in the belief that alcohol consumption is the greatest single predictor of the likelihood of family violence from 36.4% (n=24) to 47.6% (n=30). Whilst only a quarter of participants believed men who abuse partners cannot control their anger (n=17, 25.8%), there was no change in this belief following training (n=16, 25.4%). Future training could further work to correct such misunderstanding.

Presenting symptoms

One of the biggest impacts of the AOWS workshop was the significant changes in what health professionals saw as presenting symptoms that would prompt them to suspect family violence. This was mirrored in the health professional focus groups, which is discussed below. Figure 5 shows that by follow-up all symptoms were significantly ($p \leq 0.002$) more likely to be thought of as potential indicators of family violence. Injuries was the only symptom that shows no significant change, but almost all health professionals (n=61, 93.8%) recognised this as an indicator at baseline so increase was only marginal:

Figure 5 Presenting symptoms prompting suspicion of family violence (n=63)

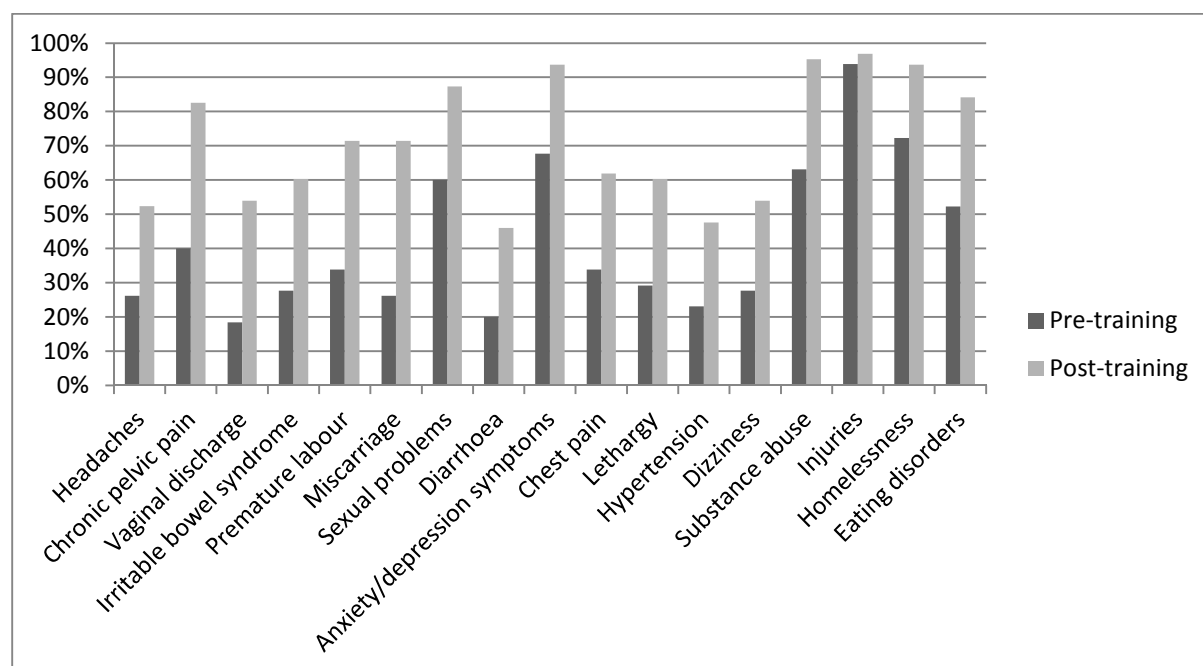


Table 7: Presenting symptoms prompting health professionals to suspect family violence (n=63)

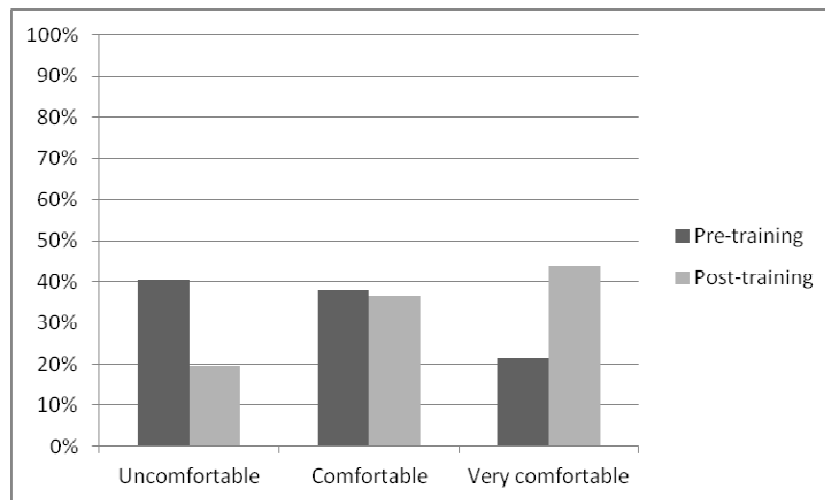
Symptoms	Pre-training		Post-training	
	n	%	n	%
Anxiety/depression symptoms	44	67.7%	59	93.7%
Substance abuse	41	63.1%	60	95.2%
Eating disorders	34	52.3%	53	84.1%
Chronic pelvic pain	26	40.0%	52	82.5%
Premature labour	22	33.8%	45	71.4%
Lethargy	19	29.2%	38	60.3%
Irritable bowel syndrome	18	27.7%	38	60.3%
Miscarriage	17	26.2%	45	71.4%
Vaginal discharge	12	18.5%	34	54.0%

Asking about family violence

In terms of comfort to ask about family violence, it was a positive sign to see that there was a significant improvement ($p=0.007$)⁵ after health professionals had attended the workshop (see Figure 6).

⁵ Using Wilcoxon signed-rank test

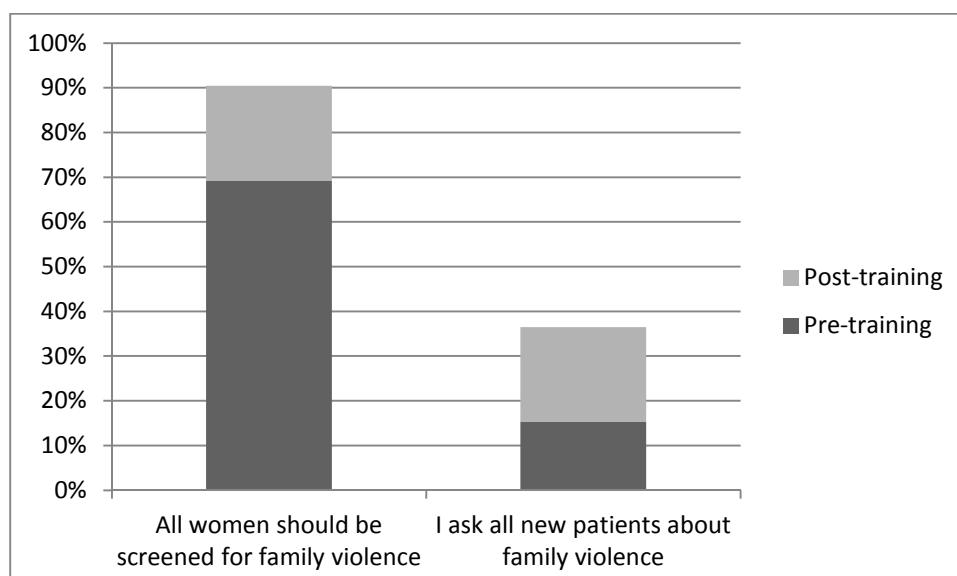
Figure 6 Comfort to ask about family violence (of those who saw patients; Baseline n=58; Follow-up n=52)



Whilst The Women's nor the AOWS Workshop advocated for screening for family violence, over two-thirds of health professionals (n=45, 69.2%) believed that all women should be screened before attending the AOWS training and this figure significantly increased ($p=0.003$) at follow-up to 90.5% (n=57). There is insufficient evidence for screening in clinical settings(25, 26) and the World Health Organisation advise that health professionals should ask about exposure to family violence when patients present with conditions that may be caused or complicated by such violence(25). However, screening has been advised in ante-natal care.(26) Despite this, a significant increase ($p=0.002$) was found in the number of health professionals reporting that they asked all new patients about family violence, overall numbers were still quite low at one third (n=23, 36.5%) (see Figure 7). These may have been from an ante-natal setting.

In future workshops, even greater emphasis may need to be placed on the need for case-finding or clinical enquiry for patients who present with 'warning signs' of potential family violence, as opposed to screening.

Figure 7 Asking about family violence (n=62)

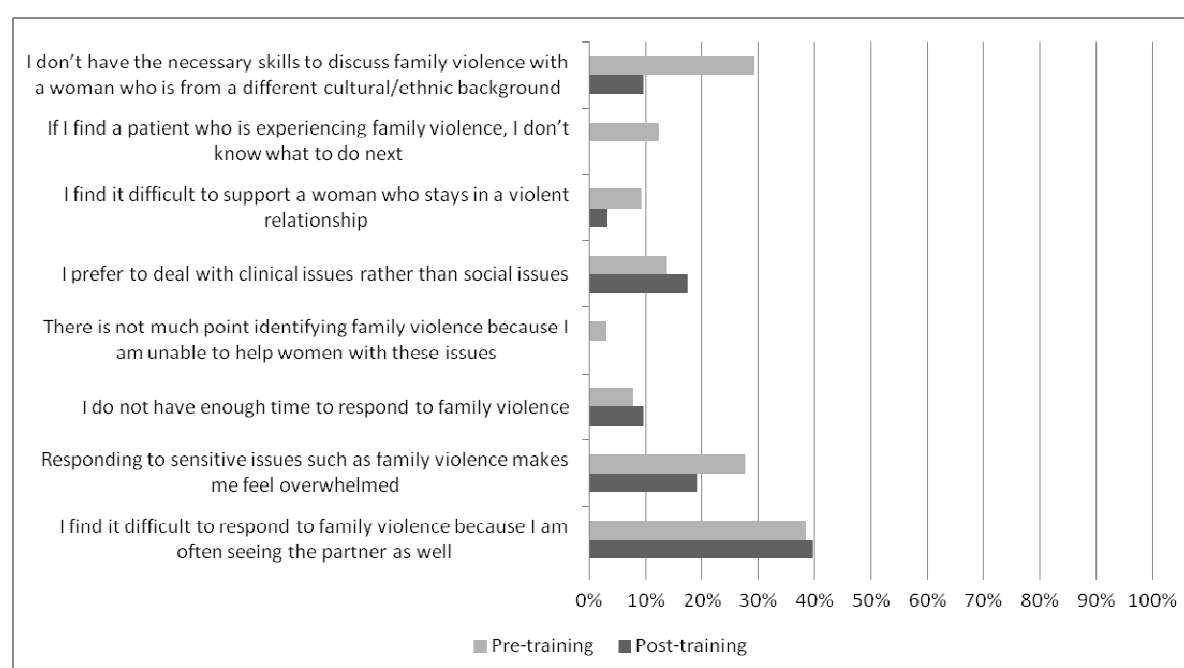


Few health professionals believed that it is not important to ask a woman about safety at the first visit (n=12, 18.5%) and that asking about family violence is likely to offend patients (n=6, 9.2%). However, there was no significant change in the number of health professionals who believed this following the AOWS workshop. There is still scope within future workshops to increase such belief so that safety is explored without fear of offending patients (27).

Responding to family violence

No changes between pre and post training responses were significant for statements about how the health professionals felt they may respond to a woman experiencing family violence. Whilst no statistical significance was found, no health professional attending the workshop felt they were unable to help or did not know what to do if they had a patient who was experiencing family violence and there was a slight decrease (from 29.2%, n=19 to 9.5%, n=6) in health professionals feeling that they did not have the skills to discuss family violence with women from a different cultural background. However, 19% (n=12) still felt overwhelmed when responding to such sensitive issues (see Figure 8).

Figure 8 Health professionals agreement with statements relating to potential response to women experiencing family violence (n=62)



However, when considering how to respond to family violence, there was a significant increase in health professionals feeling they had the skills and knowledge to carry out almost all the potential responses posed (see Table 8 below):

Table 8 Confidence in having sufficient knowledge and skills to carry out responses (n=61)

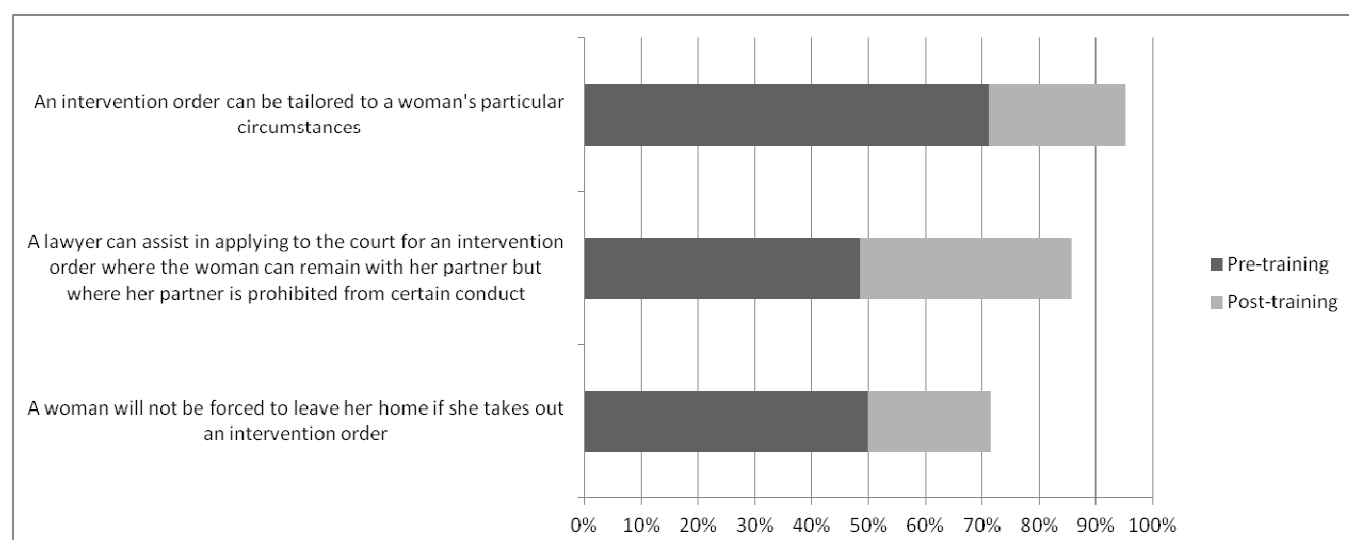
Health professional responses to a woman experiencing family violence	pre-training		post-training		p-value
	n	%	n	%	
I should encourage a woman to talk about things that might be on her mind	51	78.5%	58	93.5%	0.039
There are services that I can access for myself if I become distressed responding to a woman experiencing family violence	43	66.2%	59	95.2%	0.000
I should identify women who may be experiencing family violence	34	52.3%	54	87.1%	0.000
I should consider whether the children of a woman experiencing family violence are at risk of harm	32	49.2%	49	79.0%	0.000
I should provide her with family violence patient education or resource materials	31	47.7%	51	82.3%	0.000
I should explore the options open to her	26	40.0%	48	77.4%	0.000
I should offer to contact the police	24	36.9%	35	56.5%	0.004
I should give advice on legal options including referrals	18	27.7%	41	66.1%	0.000

The role of lawyers

Understanding of the assistance a lawyer can provide women was already high amongst health professionals before they attended a AOWS workshop with almost all (91-94%) understanding that a lawyer can assist a woman to protect her rights regarding her children (93.9%), help her understand her rights and entitlements (93.9%) and that those women experiencing family violence can be assisted by the legal system (90.9%).

Furthermore it appears that following training, participants significantly ($p \leq 0.004$) improved their understanding of intervention orders (particularly regarding how an intervention order can be tailored to the woman's circumstances and needs) ($p=0.000$).

Figure 9 Health professionals understanding of intervention orders (n=63)



The workshops appeared to have been successful in changing the perceptions of health professionals views of potential medico-legal partnerships: there was a significant increase in the number of health professionals who believed it was a good idea to have a lawyer in a hospital (see

Figure 10) (66%-90%) and that they should refer their patients to the IMCL outreach service (see Figure 11) (55%-85%).

Figure 10 'It is a good idea to have a lawyer in a hospital' (n=62)

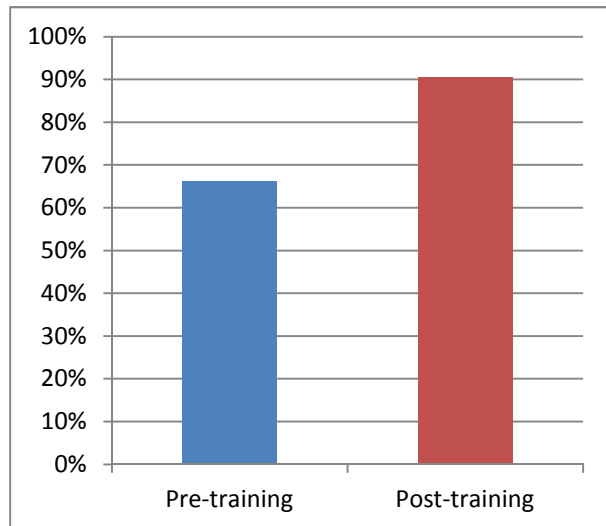
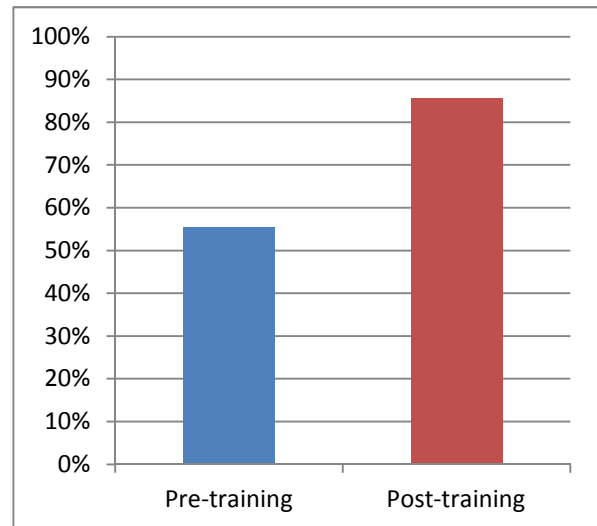


Figure 11 'I should provide my patient with a referral to IMCL Service' (n=61)

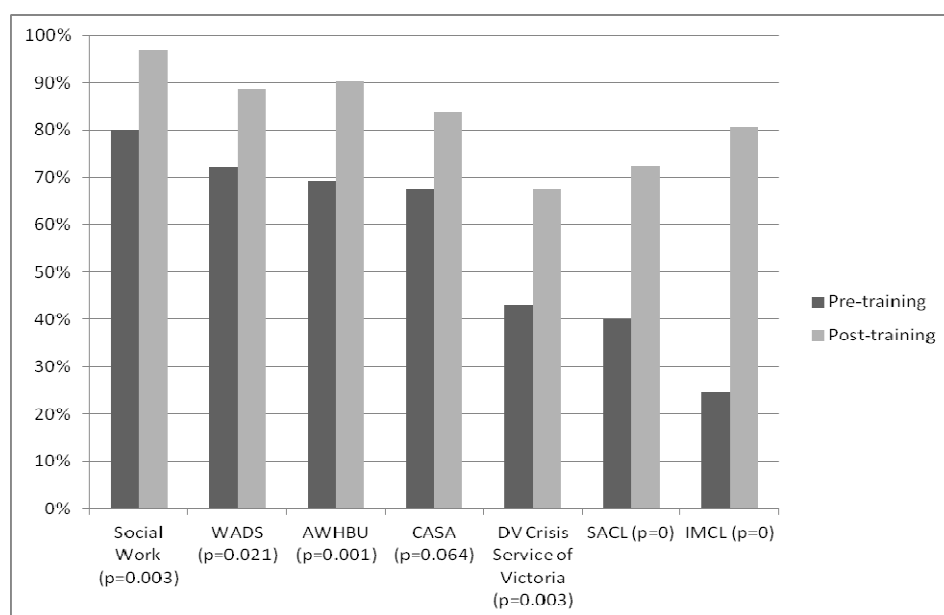


Making referrals

Health professionals' confidence in having sufficient knowledge and skills to carry out referrals significantly improved (see Figure 12).

Significant increases (6%-19%) were shown in the frequency of self-reported referrals being made to the IMCL service (either through Social Work or directly). However, these increases were only regarding referrals being made 'rarely or occasionally' as no referrals were made 'regularly' or 'often' and the numbers making such referrals were very low. Most of the health professionals attending the AOWS workshops already felt they should be making referrals to services such as Social Work (WSSS), Centre Against Sexual Assault (CASA), the Aboriginal Women's Health Business Unit (AWHBU) and The Women's Alcohol and Drug Service (WADS) and this improved.

Figure 12 Confidence in having the skills and knowledge to carry out referrals (n=61)



Whilst health professionals' confidence increased, the frequency of referrals did not. Table 9 below shows there was little, if any, change in the frequency of self-reported referrals made from health professionals to a range of services at The Women's except for two areas highlighted. Recourse to The Women's clinical practice guidelines for abuse and violence and referral to the IMCL service did show significant increase in frequency. Unsurprisingly, as the concept of and provision of a legal outreach service within a hospital is relatively new, referrals to the IMCL service were amongst the lowest made to any service.

Table 9 Frequency of self-reported referrals

	Never		Rarely/occasionally		Regularly/often	
	Pre-training	Post-training	Pre-training	Post-training	Pre-training	Post-training
The Women's Social Support Service (WSSS)	27.7%	24.6%	55.4%	55.4%	16.9%	20.0%
The Women's Alcohol and Drug Service (WADS)	36.9%	35.4%	52.3%	56.9%	10.8%	7.7%
The Women's on-call social worker (weekends)	55.4%	56.9%	43.1%	40.0%	1.5%	3.1%
Aboriginal Women's Health Business Unit (AWHBU)	55.4%	50.8%	43.1%	47.7%	1.5%	1.5%
Centre Against Sexual Assault (CASA)	58.5%	53.8%	40.0%	41.5%	1.5%	4.6%
The Women's Clinical Practice Guideline "violence against women: management and referral options"	55.4%	35.4%	40.0%	61.5%	4.6%	3.1%
Maternity team care meetings or case meetings	53.8%	52.3%	38.5%	36.9%	7.7%	10.8%
Centre for Women's Mental Health	49.2%	49.2%	36.9%	35.4%	13.8%	15.4%
Police	78.5%	80.0%	21.5%	20.0%	0.0%	0.0%
Sexual Assault Crisis Line	81.5%	80.0%	16.9%	20.0%	1.5%	0.0%
Domestic Violence Crisis Service of Victoria	80.0%	72.3%	16.9%	26.2%	3.1%	1.5%
Another lawyer or legal service	89.2%	87.7%	10.8%	12.3%	0.0%	0.0%
Other	89.2%	90.8%	6.2%	9.2%	4.6%	0.0%
North Melbourne Legal Service (either through WSSS or directly)	93.8%	81.5%	6.2%	18.5%	0.0%	0.0%

Health Professional Focus Groups

Two focus groups with health professionals were held to evaluate the AOWS training received and to explore:

- ❖ staff perceptions of AOWS;
- ❖ use of the referral pathways;
- ❖ experiences of outcomes achieved.

Numbers attending the focus groups were low despite extensive recruitment practices which included emails to AOWS participants, flyers, attendance at unit meetings and notice in inform. A total of five health professionals attended the focus groups (three had attended AOWS workshops and two had not). Telephone interviews were offered to those who could not attend on the dates selected for the focus groups and subsequently two additional health professionals who had attended an AOWS workshop were interviewed.

Those attending the focus groups/ interviewed covered such roles as clinical educators/co-ordinators, midwives and unit managers.

Informing staff and increasing attendance

Being informed about AOWS

Those who had not attended an AOWS workshop explained that they had not been informed about it. One focus group participant explained that she had not been working within The Women's much during 2012-2013 and one thought that she may have missed information about it as there were so many other things going on at the time.

Those who had attended the AOWS workshops had been informed or recommended to attend by their team leaders.

Why attend the AOWS workshops

When asked why they had attended the AOWS workshop, the key reasons were:

- to improve skills
- to assist in educating student health professional
- to support other staff

Those who had not attended an AOWS workshop advised promoting the workshops as multidisciplinary and provide CPD points in order to encourage health professionals to attend.

Perceptions of the AOWS workshops

Relevance and breadth of the AOWS workshops

Focus group participants resoundingly asserted that all staff at The Women's should attend AOWS workshops and that it should remain multidisciplinary. One participant explained:

I just think you can't ever know when a woman is going to choose to disclose and everyone needs to just be armed with the capacity to deal with it when that times comes because it's such a narrow window of opportunity and if it's not dealt with she may never disclose again [FG2, Participant E].

The pre-training survey itself had been useful in alerting AOWS workshop participants to the warning signs of family violence and provided a primer to the training. However, participants explained that staff at The Women's do not often complete surveys because they receive so many.

For one of the interviewed AOWS participants, the training had actually reaffirmed what she already knew [Interviewee 1]. This she viewed positively.

Increased awareness of family violence and its 'warning signs'

Increased awareness of family violence and its warning signs was the most noticeable outcome of the AOWS workshops with both focus groups reflecting upon this as key:

it was the warning signs. A lot of the warning signs I'd not have even considered... For me before the course it was well, they're scared of the process, they've had no antenatal, not antenatal care, but no childbirth education, they haven't done any reading on their own, they're unaware that what they are going through is actually normal so for me the best place for you is at home. So after the course it's well, why don't you want to go home? Is it more than just all of those things? [FG1, Participant B]

Increased confidence in asking about family violence

The participants expressed an increased confidence in asking about family violence and those who hadn't attended also reiterated how phrases that could be used when talking to women would be useful.

there were phrases of how to ask, and that's important to keep because you get stressed thinking how do I approach this question and also how to ask the question when they've got their partner with them, strategies for getting the partner out of the room like um saying 'I'm just going to look at, just some women's talk (FG2, Participant D)

Referral pathways

All focus group participants and interviewees were very clear that any woman who disclosed family violence would be referred to Social Work.

The first port of call would always be social work because they would then know where else to filter and it gets tough if they don't want it [FG1, Participant B]

me I immediately think of social work and social work will work out where the woman needs to go and because social work is a very reliable and consistent point of contact (FG2, Participant E)

However two participants, one from the second focus group and one of the interviewees, brought up the difficulty of out of hours disclosures when social work is not available:

social work 9-5 Monday to Friday when we actually offer a 24 hour service. It's an issue across the board and it's always perplexed me for 30 years why social workers don't work shift work [FG2, Participant E]

usually there's a crisis worker and if it's, usually she comes in on a weekend. Usually there's not much on a Friday night so we just tend to have to do what we can. If that means bringing

the lady in and making sure she's safe um as an elective admission, then we do [Interviewee 2]

If the patient does not want to be referred to social work, the participants provided information on what other options they may have or use e.g. fill in referral but say the patient does not want to be seen; social workers may work with the team in the background; letting the unit manager know; or reinforce contact options for patient both within and outside the hospital.

If participants suspect family violence but the patient does not disclose they explained they may still refer to social work or make a note that suspicions have been raised so that at the next appointment more questions can be asked.

In terms of other referral pathways, some individuals appeared to refer to a psychologist (and the internal mental health team); pastoral care; and Aboriginal and Torres Strait Islander support (both FG1 and 2). One participant remarked in terms of her usual patient population:

depends on their history and depend on what the women want if the women don't want to link with the social worker because many of the young women I am seeing already have um history with DHS or community workers and they don't want another worker in their life anymore and they may feel ok with a psychologist [FG2, Participant C]

Both focus groups referred to external referrals for women which included Lifeline, 000, women's information and referral service (WIRE), CASA, 1800RESPECT and the patient's GP. However further detail on such services was desired, particularly so that they can tell their patients what to expect when contacting them:

I guess I feel like I've got a handle on where I could refer women but again to have up to date resources and actually an idea of what they actually can do so it's not theoretical or nebulous in that oh you ring them and they'll help you. So I can say 'you ring them, they actually will be able to find you a house within 3 months or they can actually help prepare an AVO or they are nothing more than a place to go to share your feelings, whatever. That's the kind of thing I like in training (FG2, Participant E)

The IMCL Service

There was an awareness of the IMCL service for those who had attended the AOWS workshops but it was rarely at the forefront of discussions during the focus groups. Only one referred to it in any great detail and for other participants, when asked about the legal aspects of the training, they could not remember any detail other than it was a service available in the hospital:

that's probably a little bit hazy from the course now so I don't remember. I just remember the North Melbourne Legal service, I can contact them and they can cope with that if it is anything that I am concerned about, I can call the police as well. Um but social work they're my, yeah [FG1, Participant B].

However Interviewee 1 did believe the training around legal services changed how she would approach her clinical practice:

that would be the part of it that did raise issues for me... I suppose the context that the legal service that comes to the hospital can offer women in this situation and we have links and clients to the legal service and they have been brilliant in helping address a number of issues... I was aware that it was available... widening I suppose the expertise that was offered that I hadn't thought of linked to family violence. I thought of the basic stuff like intervention orders and things like that but it was looking at other perspectives of the legal availability that was just really helpful for the women [Interviewee 1]

When using the term 'legal' in the focus groups, the majority of participants said what they took away from the workshops was that the police could be called, or they would encourage the patient to call, if the situation is particularly bad.

just that they come and they're available and they can help. I probably would have liked more about the law and how it can help and maybe some case studies and just show us what they can do. Very interesting people to listen to. One of the police came from north Melbourne and they were very interesting [Interviewee 2]

System changes

Discussions within the focus groups and with interviewees suggested that system changes would be required in order for training to be effectively implemented. In particular participants explained more time was required with patients in the form of longer appointments. The training they had received had related to engagement with patients and building trust but time pressures experienced in practice often meant such trust building was rarely enabled. New models that required continuity of care may be preferred.

There was a general feeling that AOWS training should be compulsory. Staff are not charged for compulsory training which could improve attendance rates. Another suggestion was made that the training could tie in with mental health training which often included reference to family violence. However it was acknowledged that not everyone wants to learn about mental health. Other options raised were using in-service training and management involvement.

Many of the focus groups participants worked with patients from ethnic minorities. They felt more was needed in managing the wide variety of cultural differences.

Part 2: Client impact and satisfaction with referral for violence

This section of the Evaluation explored the existing referral pathway (from the hospital, to social work through to the IMCL outreach service) to examine whether the AOWS training has resulted in any measurable increase in referrals and client satisfaction with this pathway. For the purposes of reporting, this combination of AOWS services is referred to as ‘the Project’.

The Evaluation Part 2 covers the following:

- Overview of the theory and methodology informing this stage of the evaluation, as well as the limitations of the study;
- Short literature review relevant only to this evaluation;
- The results address:
 - the referral pathway;
 - profile of clients referred from The Women’s and using the IMCL service;
 - satisfaction with the services received from Social Work and the IMCL outreach by a small group of women;
 - the impact of receiving legal advice and information on the health and behavior among women who have experienced violence.

Overview

Part 2 of the Evaluation was based on Pawson and Tilley’s Realistic Evaluation model (5) which identifies that interventions need to be understood in terms of the interactions between program implementation and contexts (the physical and institutional environment within which a program takes place, as well as the norms, values and relationships of those involved as providers or participants). This part of the Evaluation took place between November 2012 and November 2013.

The goal of our approach was to provide a more complete understanding of how the Project works within the context of the legal and health systems. In this way the Evaluation has documented the processes to generate intended and unintended outcomes. We have also identified limiting or facilitating factors to both the Project and its evaluation.

This approach has provided a basis for further refinement of the Project model, which should assist to adapt or translate the model to other contexts. The pilot nature of AOWS⁶ means that the program is evolving and the number of clients flowing through will be limited in the initial stages. The data obtained will therefore be descriptive rather than able to provide statistical power. Realistic evaluation lends itself to this sort of program where a detailed understanding of a relatively small program can provide evidence.

⁶ As stated above, the pilot nature of the project refers to the combined AOWS program including hospital engagement, clinical training (with emphasis on warning signs of violence against women) legal information and referral pathways. Clinical education, Social Work and the legal outreach service existed prior to the AOWS project.

Literature Review

Exploring access to justice for victims of violence and responses to violence against women within a hospital setting

A plethora of literature exists substantiating the complex needs of women experiencing violence, including both acute and long-term health issues (28, 29) as well as the importance of access to legal services (30-33) for both violence and non-violence related issues. This literature review will not explore these complex needs but rather accept this as a well-established basis for piloting the AOWS project, a Legal Advocacy Health Alliance. It is the specific combination of women's access to justice for issues of violence within a healthcare setting which is the subject of this short literature review.

Women who experience violence routinely report mixed views of interaction with the justice system ranging from barriers to access, fear of child protection involvement, safety concerns during the process, as well as both disappointment and satisfaction with outcomes.(31, 34-36) Research into justice system access more widely also validates these findings. Herman's review of the literature (37) identified serious psychological barriers to entering the legal system, and for those who attempt to enter the system there are negative mental health impacts both with involvement and also with inability to be involved. There has been a call for on-going research to understand the long-term health impact of justice access issues.

Research into the access and impacts of justice system involvement among women experiencing violence and especially evaluations within a health care setting are extremely limited. One study measuring depression and post-traumatic stress symptoms (PTSD) of women who obtained a court directed intervention order (IO) and those who did not. The women in the study who obtained the IO did demonstrate lower PTSD symptoms and lower recurrence of some forms of physical violence.(38) These results are limited to the study of a court outcome; not access to legal advice or the legal process. One small qualitative study in Australia identified that women needed to detach emotionally from their relationship before they could make a decision to enter the legal process for an IO and suggests that many women may undergo a process of grieving the loss of their relationship in connection with a legal process, thus reinforcing negative psychological impact.(39, 40) These findings support the international trend for integrated and coordinated responses to interpersonal violence (41-44) inclusive of legal, psychological and medical assistance to improve women's mental health.(45-47)

A majority of the evaluation research into the impact of the justice system among women experiencing violence has focused on intersections between court processes and outcomes rather than legal advice and consultation.(30, 31, 48-50) There is clear connection between court processes and outcomes as being either empowering, if experienced positively, or re-traumatising and increasing risks to safety if experienced negatively.

Hunter's feminist analysis of the law, the Australian legal system and women's experience of it examined specific interconnections, including applications for IOs.(51) In relation to IOs, Hunter observed that magistrates adopted a different manner when women were legally represented:

They were more likely to be 'good natured' - courteous, respectful, concerned for the woman's safety, helpful in referring her to other support services, taking her claim seriously - if the applicant had a lawyer, but more likely to be bureaucratic towards unrepresented applicants. (51:272)

This observation is important as fewer women are represented in an application for an IO as compared to their partners (the defendants) ((31, 51)⁷. An associated limitation faced by women is the consistency of legal representation. Fewer women, as compared with their male partners, can afford private representation and are subsequently reliant on legal aid. This means women may not have consistent representation and often spend a large portion of their time re-briefing lawyers rather than building the case.(31)

Most recent peer reviewed studies examining women's access to justice have been within the context of broad gender equity rights in non-western countries, among indigenous populations; post-conflict, or among particularly disenfranchised populations within a westernised context such as trafficked women, sex workers and asylum seekers or for specific issues such as reproductive rights (52-54). Within the recent literature it appears to be assumed that systems have been set up allowing most women and men in western countries to have equal access to justice systems. However the experiences of sub-populations of women throw this assumption into question, and women experiencing violence is one such group.(31, 55)

The AOWS program is one attempt to fill this gap with a non-traditional pathway to justice for a group of women experiencing violence. The AOWS project is a Legal Advocacy-Health Alliance model approach to delivering legal advice and consultation for women experiencing violence and who present within a large metropolitan hospital. This evaluation varies from evaluations of other medical-legal partnerships which are primarily targeted toward low-income and vulnerable populations but not any one specific client group (i.e. women experiencing violence).(56)

Most medical-legal partnerships exist in the US and provide legal advice to patients. They have been designed to address the inequity of access to health within a highly individualised and privatised health care sector where access to health care is often limited by systems and structure (57, 58) and full access often requires legal intervention.(56) Thus, while a medical-legal partnership may be function as a model of holistic healthcare practice, the origins are a result of the inequitable access to healthcare in the US through privatisation of the hospital and healthcare system managed primarily through health management organisations (HMOs) and employer medical insurance plans. The variation between healthcare systems in Australia and the US makes it very difficult to compare medical-legal program evaluations. However, with the increasing presence of privatised healthcare in Australia comparisons may become increasingly relevant. The longevity of these partnership programs makes them useful resources to explore the range of services and issues on which legal advice has been sought.

An examination of the types of issues frequently consulted on in US based medical-legal partnership show that they are primarily related to health insurance claims. However, other issues include: access to health care, also include negotiation with employers and government provision of income support, public benefits, health insurance, education rights, orders of protection and divorce for intimate partner violence, immigration, guardianship, and powers of attorney. A review of the breadth of issues dealt with in a medical-legal partnership support recommendations to expand partnerships to include social workers. A more complex partnership promotes comprehensive, legal and non-legal problem solving as well as a multi-pronged, systematic approach to address complex

⁷ In Victoria, Australia there have been recent changes to make attorneys available at all courts specifically to support intervention order applicants however the program had not been evaluated at the time of reporting these results.

needs as is the case with many current medical-legal partnerships supporting health equity among disadvantaged populations.(59)

International evaluations of legal advocacy-health alliances and their impact on women specifically are limited. Those which could be identified do list expansive benefits. A Romanian study identified benefits to women including: access to legal consultation and advice, liaison with police, governmental/non-governmental agencies, and protecting women and children, as well as assistance locating shelters.(60) An Indian study (61) identified that women were unlikely to access legal support unless they were recommended to do so by someone in an authoritarian role or someone they trusted as having knowledge about the appropriateness or benefit of legal support. This could successfully be done in a healthcare setting.

While intended benefits of the legal advocacy-health alliances vary, it is clear that a notable proportion of users are women and children experiencing violence.

Importance of health system addressing violence against women

As early as 1998 (revised 2002), the Australian Medical Association (AMA) released a position paper on domestic violence. Quoting seminal prevalence studies within Australian healthcare settings, the paper identified that health practitioners are likely to encounter partner violence at rates of: 1 in 7 people attending Accident and Emergency Departments (62) and 23% of women presenting to Accident and Emergency;(63) 22% of patients in relationships attending general practice;(64) and one third of women attending a public hospital ante-natal clinic.(65)

More recently, in a survey of women attending GP clinics who also reported fear of their partner, it was identified that 34% had five or more visits to their general practitioner within the past 12 months.(66) Combined with the frequency with which victims of violence seek health care services, the AMA (67) also recognised both the direct and indirect impacts of violence on the health of the patients and their children. Further research has identified violence against women as the leading cause of morbidity and mortality for women of child bearing age.(68)

The overall prevalence rate of violence against women from a known person (36% of women over the age of 15) (69) alongside increased awareness and public education on violence against women will make it more likely than ever that abuse will be identified and disclosed within a healthcare setting.

In addition, social and healthcare practitioners are most often the first place women are likely to demonstrate warning signs of violence and women expect these practitioners to be skilled in asking questions or offering the opportunity for women to disclose.(70-73) Subsequently, women also expect health care professionals to respond appropriately including: validation of their experience without blaming them; provision of practical advice; and offering specialist referral.(74-80)

There is ample evidence that many healthcare professionals do not adequately investigate the warning signs of violence.(70, 80-84) While some of reasons for ignoring the connection between abuse and medical conditions is related to the time pressures and lack of privacy in some areas of the hospital,(77, 80) it is also the case that health professionals are unsure how to respond or are unsure how to diagnose.(70, 85) They are also likely to see violence against women as a social issue and do not easily recognise the connection between violence and health.(86)

The negative impact of healthcare professionals not attending to interpersonal violence has been articulated as: missing the opportunity to address the underlying etiology or cause of the presenting medical condition; failing to engage in preventative measures; and failing to diagnose one of the most important risks to a woman's health and well-being.(29, 83, 84) Most importantly, the denial of the problem within the health system further serves to isolate and reinforce the futility women may expect in seeking support for the abuse.(36, 83, 84) That is, while the symptoms may be treated (e.g. anxiety, depression, headaches, pelvic pain), the underlying etiology is not being addressed.(66, 83, 84)

Violence against women impacts both the immediate and long-term health of women within the areas of female health specialisation for which The Women's is internationally known to excel. In particular, women experiencing violence are likely to present with physical symptoms of sexually transmitted diseases, vaginal and pelvic pain and disorders, urinary tract infections, appetite loss, abdominal pain and digestive problems, gynaecological problems, and central nervous system problems.(29, 87, 88) They are also more likely to engage in poor health practices and less likely to participate in chronic disease preventative health screening.(28, 89) In addition, they are at greater risk of experiencing severe psychological distress than non-abused women, including depression, post-traumatic stress disorder (PTSD), and substance abuse.(90-94)

The combination of the high prevalence of violence against women and its negative health impact suggests likely benefits of including health care within an integrated system of response to violence against women, and in particular from specialists in women's health. As an international leader in women's health, The Women's is a natural fit to pilot projects responding to violence against women, of which the AOWS project is one pathway of response.

It is likely that a large proportion of patients of The Women's, as well as the female workforce, have experienced violence. According to the Australian Bureau of Statistics *Personal Safety Survey* (95) more than one in every three Australian women (36%) experience physical or sexual violence from a known person in their teenage or adult years (i.e. since the age of 15). This prevalence is likely to extend to the population of women attending The Women's and many of these women may need support of some kind, including legal advice.

On an annual basis this hospital cares for more than 100,000 women and provides around 29,500 inpatient and 171,000 outpatient services. This is approximately 200,000 services to 100,000 women. For the purposes of this discussion, this averages out to two services per woman.

Extrapolating the rate of prevalence of violence against women, in their lifetime from a known person, to the population of women attending this hospital (assuming the majority of women attending the hospital are adults) it is likely that around one third (33,000) have been, or will be, a victim of violence from a known person. In their experience with this hospital, each woman will have an average of two service points where they could disclose information about their experience, or warning signs, of violence to a staff member. While acknowledging that not all women who experience violence will disclose, and of those who do disclose, a large proportion will not require a service or will not be ready for a service, it is likely that a substantial proportion of women with warning signs of violence are not identified and offered support.

Therefore, it is not simply a matter of evaluating whether legal services within the hospital improve health outcomes for patients, it is also important that employees of organisations similar to The

Women's (interfacing with a large portion of the adult female population) are skilled in identifying the warning signs of violence and offering appropriate response and referral pathways. This evaluation examines not only the impact of legal advice on health outcomes, but the overall intersection between violence against women, provision of legal support (often difficult to access by women in general and especially those experiencing violence) and opportunities to improve the overall circumstances of women in Victoria.

Health and legal models: System change

A number of responses to domestic violence in health settings have been explored. One approach raised consistently is to introduce systematic screening. However the benefits of screening are inconclusive. While systematic reviews of the literature identify that systematic screening of all patients within healthcare and community services may increase the likelihood that abused women are identified, it has not been established that screening leads to a better outcome. Unless screening is part of an overall pathway of response to violence it does not necessarily lead to any response or referral, nor does it necessarily increase long-term benefits.(96-99)

Findings from a Delphi expert consultation on treatment for victims of violence and abuse identified most importantly that there is no single 'preferred' model of response for victims.(100) That is, while systematic screening may identify victims of abuse, it is not appropriate to follow this with a 'one-size-fits-all' response. Instead, it is clear that there are some approaches more suitable for victims of different forms of abuse and at different stages of life. Responses need to be non-judgmental, flexible and centred on the individual's needs and readiness to disclose and deal with the issue.(100) These findings reinforced an earlier meta-analysis of research among victims of violence and abuse.(74) Therefore, a regime of screening is only helpful if it can be accompanied with appropriate training of staff supported by a range of appropriate specialist referral services.(74, 86, 100, 101)

In terms of professional training, Itzin and colleagues (100) identified three levels; the first, or primary, being the common core information and skills critical for all professionals including appropriate identification and response to signs of violence, key messages to impart, referral resources and assistance with referrals. The secondary and tertiary levels of training should provide more depth of knowledge and resources for working directly with the victims.(100:28) In addition, there was support for professional training to be embedded across all professions within a system, to be inclusive of refresher-training and reflective practice between colleagues, and to be assessed by competence rather than attendance.(100)

Coben's Delphi review of measurement of the *quality* of hospital based domestic violence programs (101) reinforced the importance of professional training in addition to systems and culture change. Coben's review identified higher quality in programs including 37 key performance measures in the nine domains of activity.

Some examples of hospital-based interventions include one US hospital embarking on a three year continuous improvement project to implement system change enabling better identification, documentation and response to domestic violence.(85) While not specifically following Coben's review, system change at this hospital involved most of the elements. In Finland, Husso and colleagues (86) examined specifically the understanding and frame of reference health practitioners have toward IPV. They found that by increasing all-around understanding of violence against women they could improve health responses across the system.

Evidence of the positive impact of short or long-term domestic violence intervention, and particularly hospital-based intervention, has been inconclusive due to both the lack of robust program evaluations and the variation of measures between those which do exist. While there is evidence that some forms of intervention lead to increased safety and reduced physical abuse, there is little evidence that intervention decreases depression or improves short or long-term psychological well-being and quality of life.(102) In addition, a recent historical review of primary IPV interventions identified the need specifically for further research into intervention policy and practice to inform future program directions in prevention, advocacy, intervention, and treatment.(103)

While there is no definitive guide to the degree and mix of intervention options which lead to improved short and long-term outcomes, qualitative research with victims clearly articulates the structure of advocacy, intervention and support women say they want. Most importantly they want access to a non-judgmental approach and a range of flexible options available at different times to allow tailoring to individual needs.(35, 55, 91, 104) To make the referral pathway most successful, a range of options combining medical, social and legal support is required, especially among marginalised groups of women.(34, 45, 55) Access to a range of options through a healthcare facility, where women attend for reasons other than violence, but may be related to violence, can offer a pathway to support which otherwise may not be sought.

Aim of Part 2

To evaluate the uptake of social support and legal advice services *after* health professionals have identified or suspect past or current experiences of violence, as well as the appropriateness and usefulness of this referral.

Research Questions

1. Was the client satisfied with access to Social Work and the IMCL outreach service, the assistance provided, and the outcome obtained as a result of the assistance provided?
2. How many women are accessing the IMCL outreach service and what is the demographic of those that do?
3. Has the referral pathway to the IMCL outreach service been developed, and, if so, is it being implemented by health professionals at The Women's?
4. What are women's perceptions of the impact of the health and legal information provided to them through access to Social Work and IMCL outreach service from which situation improvement can be guided?

Outcomes versus Process evaluation

As the questions above suggest, Part 2 of the Evaluation began as an outcome evaluation but as it progressed it became clear that systems were not in place to collect the data required for such an evaluation. In particular, the following gaps could not be overcome:

- it could not be determined whether staff referring had also participated in the AOWS training;
- information regarding 'reason for referral' into Social Work was recorded with ambiguity and subsequently, even after reading the de-identified file it was often difficult to ascertain whether 'relationship issues' masked family violence;
- some women who were invited into the evaluation did not choose to participate (possibly due to time commitments, crisis, language problems);
- recruitment of clients into the Evaluation was heavily screened by the workers which led to a slow recruitment rate and inability to achieve targets within the Evaluation period;
- data fields for recording information about the referring staff member (either to Social Work or IMCL outreach service) were often too general to gain a sense of common referral sources or possible links to AOWS training (for example often the referral information into social work was the ward rather than the position of the staff member; referrals into IMCL were listed as either social worker or 'other' and did not provide information on areas of the hospital from where she may have been originally referred); and
- the number of women who did not attend any appointments was not systematically recorded and therefore prevents calculation of translation of referral into service for both Social Work and IMCL outreach service.

Although the research questions were addressed, an outcome evaluation has not been possible. To gain value from the Project for all stakeholders, a process evaluation methodology was applied to the analysis. A process evaluation identifies different learnings than an outcome evaluation and in this project is more valuable to inform Stage 2 of the Project and future evaluations (see explanation box).

There were four research activities included in the initial project brief for Part 2 in order to measure the research questions as outlined above. Some changes to the project design subsequently impacted upon the items from the brief which were able to be included in the evaluation. For example, the original design included printed legal information 'fact sheets'. It was decided early in the project not to proceed with the fact sheets and therefore the impact of the fact sheets was removed from the evaluation criteria⁸. The elements listed below are those included in the final evaluation design.

Process itself as an outcome or alternative form of evaluation was identified in the mid 1980s.(1, 2) The term 'process use' was coined to refer to changes in program participant thinking and behaviour or change in organisational procedures and culture, due to the learning that occurs during the evaluation process.(3)(p. 90)

Methods

Questionnaires and interviews

During the Evaluation women who attended Social Work and/or the IMCL outreach service and for whom issues of violence were identified by health professionals, were invited to participate in the Evaluation. Because the Evaluation was focused on referral pathways into Social Work and the IMCL outreach service and not details of her case, women could be invited to participate regardless of whether they had named their experience as violence or not. This approach aligned with the training which was designed to assist health professionals to identify *Warning Signs* even when women themselves could not name their experience as family violence. The Evaluation questions were focused on referrals, staff communication and service provision, not case details.

Women were informed of and invited to the research by their worker, as a trusted professional. They were offered three options: to complete a questionnaire in a private room within Social Work; to take the questionnaire with them and return by post; or to leave their contact details and receive a questionnaire directly from the researcher at the University of Melbourne. At the end of the questionnaire women could volunteer to participate further in an optional interview. At the end of interviews, arrangements were made for a shopping voucher to be sent to women as reimbursement for their time.

Two questionnaires were designed; one for women attending Social Work; and one for women attending IMCL outreach service. If women used both services, they could be approached at both points. Some women who were referred to both services did complete both questionnaires and also volunteered to participate in an interview. In these circumstances they were only interviewed once with questions appropriate to both services being covered.

⁸ At the time of writing this report we were informed that the fact sheets will be introduced at the end of 2014.

Interviews took place at a time and location convenient to the woman and optionally could be completed over the telephone. Interviews took between twenty minutes to one hour depending on the amount of information women wished to discuss.

Referral data – Social Work

Referral data from Social Work was obtained from hard copy referral sheets and manually entered into an Excel spreadsheet. Information about whether a woman attended her appointment was not available and therefore referral rates cannot be calculated. The data fields extracted included information on:

1. who referred;
2. for what reason they were referred;
3. basic demographic details of age and indicators of culture and language diversity.

Referral data – IMCL outreach service

Referral data was extracted from the IMCL Community Legal Services Information System (CLSIS) database by IMCL and provided in de-identified form. De-identified Information from all clients referred to IMCL outreach service during the Evaluation period with family violence issues was included. Analysis was undertaken first to identify the proportion of clients referred to the IMCL outreach service from The Women's and their demographics. Similar to the Social Work data, the data fields extracted included:

1. whether family violence issues were flagged;
2. who referred;
3. for what reason they were referred;
4. basic demographic details of age, whether client was Aboriginal or Torres Strait Islander, indicators of culture or language diversity, disability issues, children present, region of Victoria;
5. type of legal issue supported.

Results

[Caution: Throughout this analysis most populations and samples are small. When working with small numbers a change in only one or two people can have a large impact on proportions and therefore the analysis is largely descriptive rather than causal or relational. While some trends over time are apparent, the small overall numbers could easily be influenced by changes in policy or priority.]

Evaluation of the referral pathway (Aug 31 2012-November 2013)

Between August 31st 2012 and November 2013, the IMCL outreach service aimed to provide 25 instances of legal advice to women; and open ten on-going casework files. Data was collected through IMCL's CLSIS database.

It was intended that this part of the Evaluation measure changes in use of the referral pathway following the implementation of the AOWS training. Issues included:

- increasing use of the referral pathway to the IMCL outreach service by a range of health professionals;
- increasing numbers of women accessing the IMCL outreach service;
- increasing numbers of women referred to the IMCL outreach service from culturally diverse backgrounds; and
- increasing numbers of women referred to the IMCL outreach service who spoke primarily a language other than English (in particular Arabic, Mandarin, Cantonese, Turkish or Vietnamese).

Social Work referral data was manually extracted from the internal hospital referral sheets based on data fields indicating a woman had either experienced physical or sexual violence, or there were relationship issues where the staff were concerned for her safety.

IMCL outreach service referral data was manually extracted by IMCL from referral sheets and appointment diaries as well as the CLSIS database. Clients were identified as being referred from either a social worker or other professional at The Women's and screened on data fields indicating she presented for either a family violence legal issue or another issue, and regardless of the legal issue, the lawyer identified whether there were family violence indicators (not necessarily the legal issue).

For this Project the referrals to Social Work included a wider range of violence issues than women counted among the IMCL outreach service.

Intake and referral rates

Data extracted from Social Work referral sheets and the IMCL CLSIS database provided the basis for examination of intake and referral rates during the period of AOWS training.

Information was extracted about clients referred for suspected violence related issues. In addition to counting the numbers of women identified and referred, we explored language and migration issues as well as a description of the issue / problem in order to better understand how clients and staff recorded their concerns. This will potentially assist in further training staff. Language and migration information is collected to ensure the service adequately meets the needs of all clients. All information was provided in a de-identified format and care has been taken to write the analysis to further ensure individual women cannot be identified.

Social Work: Referrals

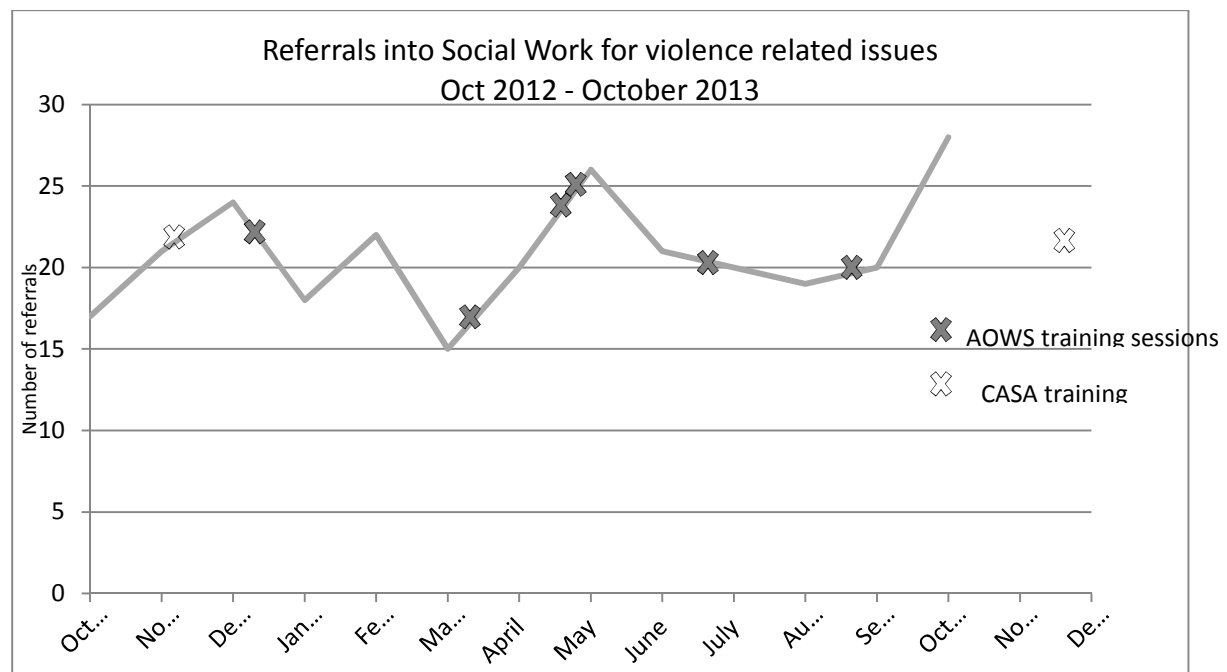
Social Work received 2,842 referrals between October 2012 and October 2013. Of these, 271 (9.5%) were referred for issues which may have been violence related (current violence, previous violence, history of child abuse or general relationship issues⁹). During the period of data collection, an average of 21 violence related referrals were made per month, ranging from 15 in March 2013 to 28 in October 2013. Referrals fluctuated each month and appear to be trending toward an increase over time, however a longer timeline analysis is required to determine whether there is a real increase.

A key question of the evaluation was whether staff training offered through the AOWS project led to increased referrals. Unfortunately information was not available on the referral sheets to identify whether the referring staff member had undertaken AOWS training. As a proxy we explored whether there were any changes in referral patterns following on from the AOWS training dates. The information below (in Figure 13) presents an overlay of the AOWS training dates and CASA (violence against women) training dates (which bookend the evaluation period¹⁰). The graph does not illustrate any clear relationship pattern between training and referral rates. While there are peaks and troughs to the referrals, the small numbers suggest they are natural variations based on the fluctuation of patients presenting to the hospital at any given time.

⁹ 'General relationship issues' is included upon the recommendation of the social workers identifying it a common catch-all phrase used by referring health professionals when they are uncertain whether violence is present.

¹⁰ The CASA training provided generic training on violence against women without the same AOWS concerted effort to engage and attract staff to the training. These dates provide a limited benchmark to compare whether the referral rates might be the same or different in relation to similar training without the engagement. CASA training is similar in that it provides guidance on warning signs of, and referrals pathways for clinical staff concerned about women who may be experiencing violence.

Figure 13: Social Work: Number of referrals for violence related issues and scheduled AOWS training by month (October 2012-October 2013)



Base = 271

A regular and sustained pattern of increased referrals into social work in relation to AOWS training could not be identified.

Women were referred into Social Work from all areas of the hospital from patient educators, accounts staff and external services through to specific wards and clinics. The largest referral pathways appeared to be through the Antenatal Clinic, outpatient clinic and young mother's clinic (Table 10). Most of the information on referral source was limited to hospital ward or department / area. Very little is known about the relationship between the referrer and the client, or the position of the health professional making the referral (eg doctor, nurse, administrative position).

Table 10: Social Work: From where did the referral originate (October 2012- October 2013)

Social Work: from where client was referred		
	n	%
ANC (Antenatal clinic)	80	30%
Outpatient clinic (OPC)	42	16%
Young Mother's Clinic (YMC)	26	10%
Women's Emergency Care (WEC, The Women's Emergency department)	22	8%
4 South & East	15	6%
Self-referral	13	5%
Misc single counts of each (accounts, DHS, Interpreter, consumer advocate + oncall SW+ PACU + Diabetes educator +DOMb + misc doctor + unknown)	13	5%
External hospital or service	11	4%
5 South & 5 North (inpatients)	10	4%
WADS + WHICH + WIN	8	3%
CWMH (Centre for Women's Mental Health)	7	3%
Midwife - Gynaecological clinic in Women's Health	6	2%
Physiotherapist at The Women's	5	2%
Dr - Gynaecological clinic in Women's Health	4	1%
Birth Centre (BC)	3	1%
Cosmos	3	1%
FMU + NICU	3	1%
Total	271	100%

Profile of clients referred to Social Work

Little background or demographic data about the women referred into Social Work for violence related issues was able to be provided to the evaluation team. One item which was recorded was the age of the client, illustrating that this group of women were mostly aged between 21 and 35 with the largest sub group between 26-30 years (Table 11). Data was not provided for the remainder of the patients referred into Social Work so it is unknown how the age of these women compares with women referred for other issues.

Table 11: Social Work: Age of clients

	Age of client	
	n	%
17 years and younger	7	3%
18-20 years	14	7%
21-25 years	40	19%
26-30 years	58	28%
31-35 years	45	22%
36-40 years	30	14%
41-45 years	8	4%
46 and older	6	3%
Total*	208	100%

Base = 271, no response from 63 clients

Language spoken and cultural diversity of the Social Work clients

According to The Women's Annual Report, in each year the hospital services women from 165 countries, speaking more than 60 different languages and following 42 separate religious faiths. Therefore it is important that Social Work is able to engage the same diverse range of women.

One of the intentions of AOWS was to increase the numbers of women from culturally diverse backgrounds accessing the program. Among the sample of 271 women referred into Social Work for violence related issues 33 women (12%) spoke 13 different languages between them. The most common languages were Arabic, Vietnamese, Dinka and Somali (Table 12). Twelve of the 13 women required interpreters when seeking support. From the data provided we were unable to ascertain any cultural information other than language spoken. Numbers recorded over the 12 months were too small to identify any significant change during the evaluation period.

Table 12: Social Work: Languages spoken other than English (October 2012- October 2013)

Arabic
Bengali
Dinka
Greek
Indonesian
Nepali
Persian (excluding Dari)
Somali
Swahili
Tigrinya
Turkish
Urdu
Vietnamese

While some descriptions can be provided of the clients referred into Social Work for violence related issues, the limitation of data fields on the referral sheets and the manual form of data extraction means that analysis is limited. We have been unable to measure whether the AOWS training impacted on referral rates or identification of violence issues. Similarly we are unable to present more than very general patterns of referral by hospital area or clinic. Finally, we have been unable adequately to describe the women referred to Social Work for violence related issues.

As evaluators and researchers, we would encourage The Women's to consider the detail captured in the data fields of the referral sheets and explore opportunities for more accurate and automated data collection into a computerised system.

IMCL: Referrals and appointment attendance

For this evaluation, we have attempted to report both the number of women referred to the IMCL outreach service as well as the number of appointments made and the proportion of clients who attended their appointments.

Monthly referrals into IMCL are small (Figure 14) with an average of 4.6 per month and a total of 56 for the twelve month period. Of these 56 women, 33 had family violence related issues which may or may not have been the legal issues for which they were referred. This equates to an average of 2.75 family violence related referrals per month (also in Figure 14). The largest numbers of family violence referrals were received in September and October (6 and 7 respectively).

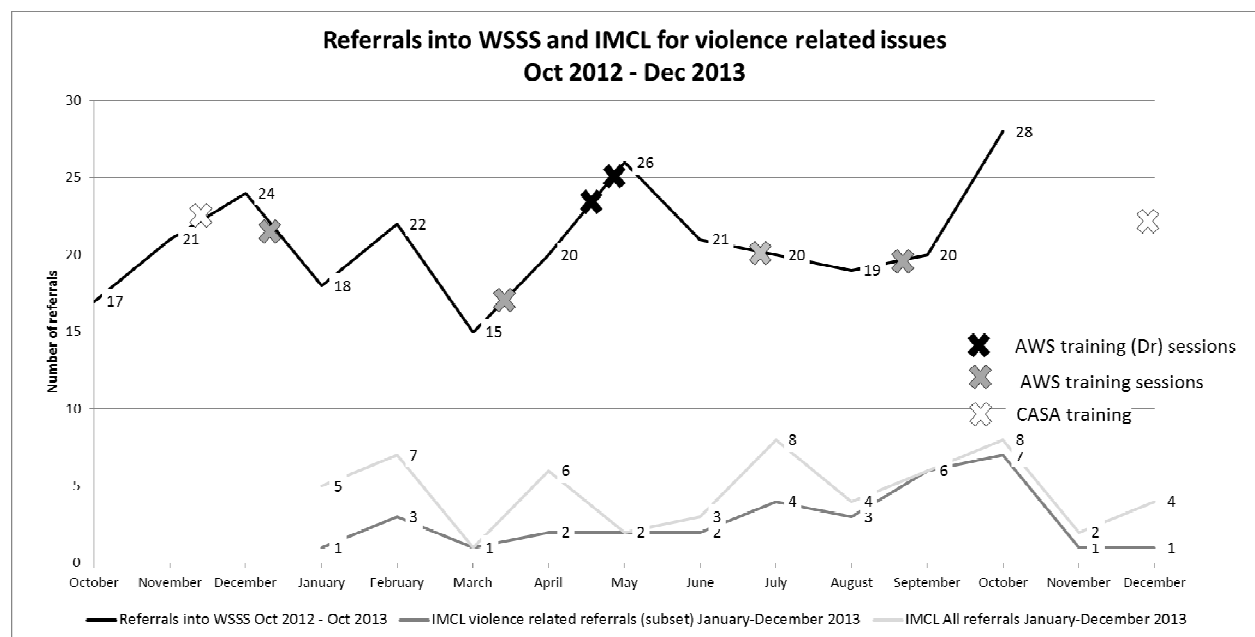
Alongside the IMCL referral data in Figure 14 are the same violence related referrals into WSSS as well as markers for AOWS clinical staff training sessions (replicated from Figure 13). It does not appear that there has been any correlation between training dates and overall referrals into IMCL.

However there does appear to be a *proportional* increase of the referrals identified with family violence issues between July-October 2013.

While specific information about individual referrers and access to AOWS training was not available in the data, it is known that most referrals came from social workers (50 of the 56 see Table 27 in Appendix 14). It is unknown whether any of the referring social workers received AOWS training. It is also unknown what proportion of the social workers were located in Social Work where the IMCL outreach service is co-located or in other areas of the hospital such as Pregnancy Advice and Support Service. It is also unknown from which area of the hospital the patient came from if the social worker is not the first service point. Due to the close working relationship between IMCL outreach service and Social Work it is likely that a majority of referrals originate in Social Work.

Although overall referral numbers did not increase, explanations for the proportional increase in clients with family violence related issues can be speculated. It is possible that increased awareness of the IMCL service, the AOWS program and access to training may layer together among social work staff and lead to a pooling of referrals in relation to this particular issue. This period of increase also coincides with the evaluation task of recruiting clients in the program to complete surveys and participate in interviews. Between early August and October 2013 the evaluation team attended four social work team meetings to brief workers on inviting appropriate clients to complete surveys.

Figure 14: Social Work and IMCL: Number of referrals for violence related issues and scheduled AOWS training by month (October 2012-December 2013)



Overall there has been a notable increase in total referrals to IMCL in 2013 compared with previous years, including both family violence and non-family violence related clients (see

Figure 16 and Table 25 in

Appendix 14). Increases have occurred prior to the AOWS clinical training and speculation could be made that referrals have been boosted with the consistent and regular legal presence leading up to the AOWS program.

More than half of the clients in 2013 (n=33, 59%) were identified with family violence issues and for nearly all of these women (n=27) family violence was the legal issue for which they were referred (see

Figure 16, Table 25 and Table 26).

IMCL outreach appointment attendance rates

Across the 56 referrals we have sought to explore the number of appointments made by reviewing the appointment booking sheets.

Accurate reporting systems were not in place during the evaluation, and therefore all figures are estimates. Impacting on the accuracy of reporting are the following:

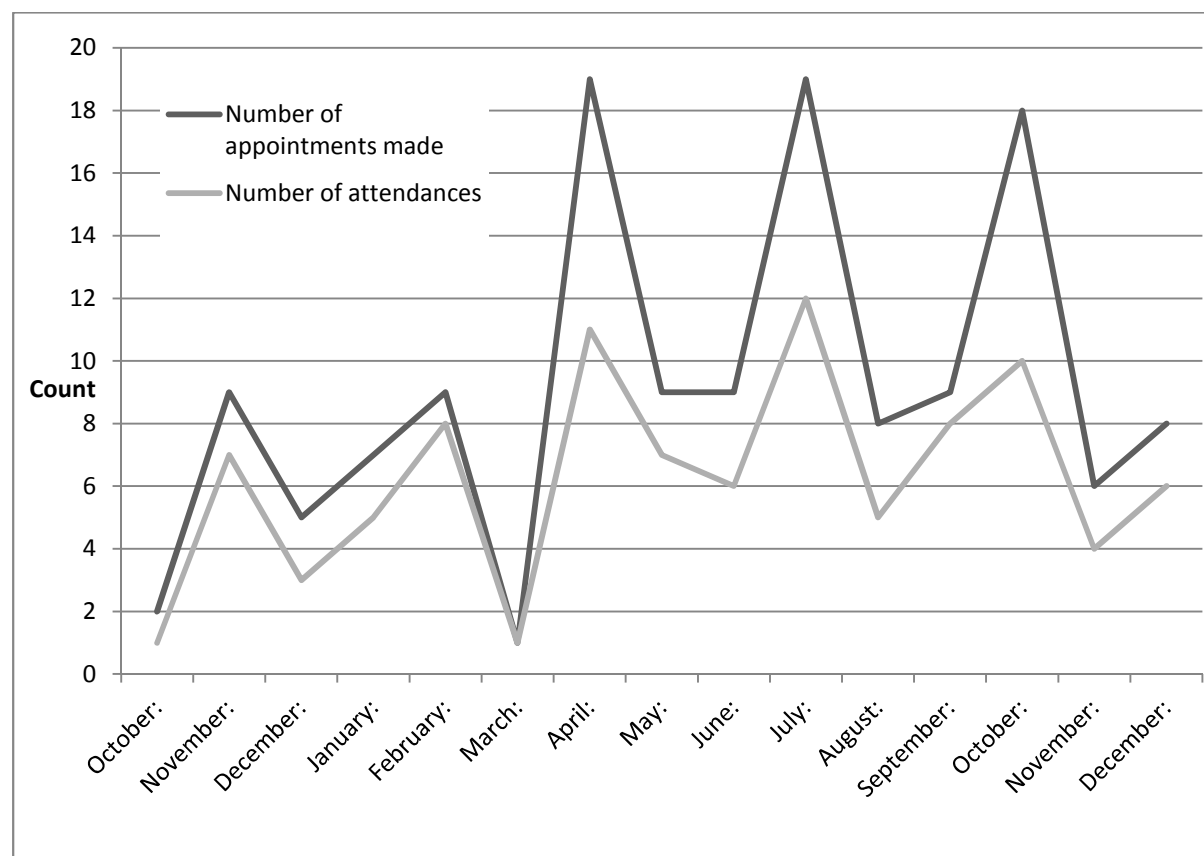
1. There were a small number of appointments made outside of standard outreach hours and these may not have been recorded in the appointment booking sheets but contained in individual lawyer diaries. These are included in the appointment analysis when they could be located.
2. Appointment booking sheets did not track whether women who did not attend their appointment subsequently re-scheduled their appointment.
3. The appointment booking sheets do not systematically record whether a client is attending for a new issue or on-going advice related to the same issue which means it difficult to separate clients from sessions of advice and clients may be counted multiple times.
4. Many CLSIS data fields are not mandatory and therefore referral information may not identify all clients referred from The Women's if she attended the IMCL office rather than the outreach at the hospital. In addition, if family violence is not the legal issue for which she was referred other indicators of family violence may not be recorded.
5. Only violence identified as 'family violence' is recorded. Other forms of violence against women will not be identified among the IMCL outreach service clients whereas Social Work record all forms of violence.

Data was collected over a 15 month period to examine the patterns of appointment and attendance rates prior to the evaluation period, and then as the training and evaluation rolled out. According to the referral booking sheets and appointment diary, between October 2012 and December 2013 138 appointments were made in the IMCL outreach clinic and 94 attendances were recorded¹¹. The overall estimated attendance rate was 68% (during the 12 month evaluation period there were 122 appointments and 83 attendances, also a 68% attendance rate). Starting with two appointments and one attendance in October 2012, over the 15 month period IMCL outreach service received an

¹¹ Data represents appointments and attendances for advice rather than individual clients. That is, women attending multiple sessions have been counted for each session of advice.

average of nine appointments and six attendances per month¹². Appointments peaked at 19 in April 2013 and attendances at 12 in July 2013 (see Table 23). Figure 15 below presents a relatively consistent pattern of the peaks and troughs of appointments and attendances during the evaluations period.

Figure 15: IMCL: Number of appointments and attendance by month (all referrals October 2012-December 2013)



Base = 138 appointments, 94 attendances

IMCL outreach conversion to on-going clients

During the evaluation period 56 women were seen by a lawyer at The Women's IMCL outreach service (Table 24).¹³ Thirty-eight clients, or 68%, were also provided with casework in addition to advice. The difference between advice and casework has been articulated by IMCL as:

Advice files: Provision of advice only to a client. The advice may be one consultation or several consultations, each recorded as an individual instance of advice.

¹² The median and mode for appointments were also 9. The median attendance was 6 with multiple modes of 1, 5, 6, 7 and 8.

¹³ The difference between the 56 clients recorded in the CLSIS database and the 83 attendances reported above can be attributed to the same client seeing the lawyer on multiple occasions.

Casework: Any assistance provided to a client which results from the provision of advice, including drafting letters, drafting court documents, representation at court, etc.

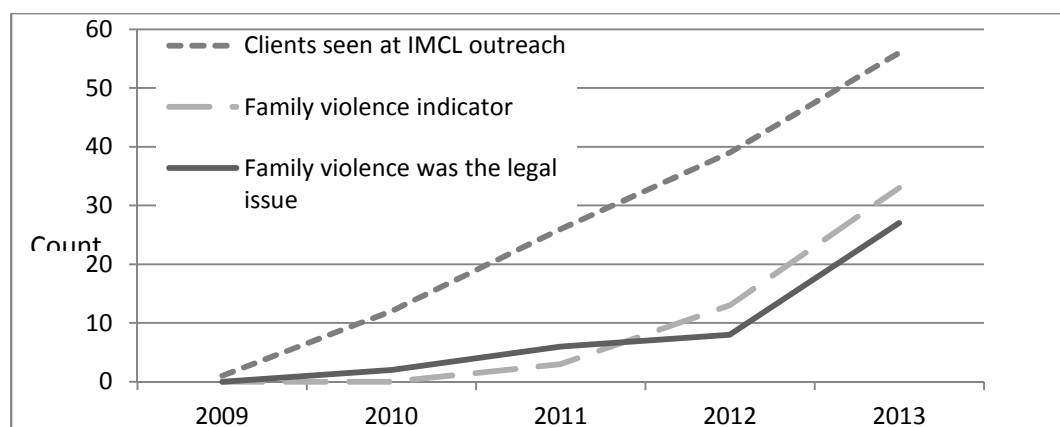
Casework clients would be considered *on-going* clients for the purposes of this evaluation. One of the aims of the project was to open 10 new on-going cases, which was achieved with the notably larger number of 38 on-going clients. A second objective was to provide 25 instances of advice however this information could not be extracted from data provided to evaluation team.

Table 13: IMCL: Summary of women seen in the IMCL outreach at The Women's over a 12 month period (Jan 2013-Dec 2013)

Client status	N	%	Explanatory notes
Appointment attendances	83	68%	Attendance rate based on appointments made.
Referrals to IMCL	56	67%	Conversion rate of IMCL CLSIS recorded clients referred from The Women's based on appointments attended.
Referrals to IMCL with family violence issues	33	59%	Proportion of IMCL CLSIS recorded clients referred from The Women's with Family Violence indicators
Appointments made	122	100%	

Note: Total => 100% due to overlapping classification of clients

Figure 16: IMCL: Number of clients seen at IMCL outreach service by year (CLSIS data extract January 2009- December 2013)



Base = 134 clients

Profile of clients referred from The Women's to IMCL outreach service

Part of the Evaluation was to identify the value of the IMCL outreach service at The Women's. Information about the types of clients using the service, the services provided and the range of issues presenting assists in understanding the needs and is useful for further training health professionals. In addition, clients presenting with issues of violence and those without will be compared in order to understand commonalities and differences.

Two snapshots of client data from the IMCL CLSIS database, 1 year apart, were extracted to compare any change between the two snapshot periods. The first data snapshot included all clients referred from The Women's into IMCL outreach service between 1 June 2012 and 30 November 2012, the time period leading into the AOWS training roll-out; the second snapshot was taken 12 months later, also of clients referred from The Women's, and during the same time period (1 June 2013 and 30 November 2013). The second snapshot was half-way through to the end of the evaluation period. All clients were female. In both snapshots the number of clients is very small and only descriptive summary analysis can be provided.

For each six month period similar numbers of clients in the database had been referred from The Women's hospital, 27 in 2012 and marginally more in 2013 (n=30). Unfortunately, some clients had to be removed from further analysis as they did not agree for their information to be used for research purposes. One client in 2012 and eight clients in 2013 were removed from the following analysis. While not including these clients from the already small population limits what we know about the referrals, their removal did not change the proportional distribution of family violence to non-family violence clients. The table below (Table 14) provides an overview of the clients.

Table 14: IMCL: Snapshot report of the number of women listed as clients of IMCL who were referred from The Women's (June-November)

Clients of IMCL between 1 June and 30 November who were referred from The Women's Hospital				
	Snapshot 1: June – December 2012		Snapshot 2: June – December 2013	
	All clients	Clients giving permission to be included in research	All clients	Clients giving permission to be included in research
Family	13 (48%)	12 (46%)	23 (77%)	18 (81%)

violence clients				
Non family violence clients	14 (52%)	14 (54%)	7 (23%)	4 (18%)
Total	27 (100%)	26 (100%)	30 (100%)	22 (100%)

The number of women referred from The Women's was marginally larger in the 2013 snapshot, and among them is a greater proportion of women with family violence issues in 2013 (80%) compared with less than 50% in 2012.

The remainder of analysis in this section is limited to the 26 women from snapshot 1 and 22 women in snapshot 2. Because the numbers of clients were small individual anonymity may be at risk when reporting unique demographic data items such as country of birth, legal issue or problem type. Therefore only aggregate data was provided to the research team without actual numbers, only counts in ranges of 5 clients (e.g. 1-5 or 6-10). Only limited descriptive analysis can be presented with any meaning.

Cultural diversity of the IMCL outreach service snapshot samples

One of the key aims of the project was to increase access to justice for women of diverse backgrounds, particularly those for whom English is not their first language. This question could not be answered because of the small number in the population and the format in which the data was provided to the Evaluation Team (Table 15 and Table 32). While the range of countries in which women were born was provided, numbers were only provided in broad aggregates and therefore the proportion of Australian born or overseas born could not be calculated. However, we do know that those born overseas migrated relatively recently, all of them since the year 2000.

Table 15: IMCL – Client country of birth (Clients of IMCL who had been referred by The Women's, Snapshot data extraction June – November)

Family violence related clients			
Country of birth	Snapshot 1: June – November 2012 (range)	Country of birth	Snapshot 2: June – November 2013 (range)
Australia	6 – 10	Australia	11 - 15
China	1 – 5	Chile	1 - 5
India	1 – 5	Colombia	1 - 5
Philippines	1 – 5	East Timor	1 - 5
Sudan	1 – 5	Italy	1 - 5
Thailand	1 – 5	Lebanon	1 - 5
Vietnam	1 – 5	Somalia	1 - 5
		South Pacific	1 - 5

Base unknown

Similar to information about country of birth, information on language spoken was only provided in aggregate categories within the sample. Subsequently we can provide a list of languages spoken but cannot examine whether there has been a proportional increase or decrease in women speaking a

language other than English (Table 32). What can be reported is the range of languages spoken varies in each of the sub-groups within each of the snapshots. It is apparent that accessibility to interpreters across a variety of languages is important.

The number of women requiring an interpreter is equally difficult to identify. Interpreter information was recorded in relation to whether the woman required an interpreter at the time of booking her appointment. In this circumstance, only 4 women within the two snapshot samples required an interpreter (

Table 33). It is possible that an interpreter was required for more complex conversations during legal consultations but not when making an appointment. While this information was not recorded, information was provided about the preferred or main language spoken.

Summary of demographics and legal issues of the snapshot samples

A descriptive analysis was undertaken to understand the women using the IMCL outreach service referral pathway through The Women's hospital (Table 16). The sample was very small, however it was thought important to provide data about the context of the IMCL clients e.g. whether clients had dependent children. There were no identifiable differences between the 2012 and 2013 snapshots.

Similarly, description of the legal issues and problem types among the two snapshot samples assists in understanding the context of the service provided. While there are a few notable differences between clients with family violence issues and those without, there is very little change between the two snapshot data periods. The summary in Table 17 provides a descriptive overview which could be more meaningful if compared in future years or with larger samples.

Table 16: IMCL – Demographic (Clients of IMCL who had been referred by The Women’s, Snapshot data extraction June – November)

Descriptive Demographics	Summary of results
Age of client	Most clients were aged between 20 to 40 years (Table 28) with the non-family violence clients seemingly slightly older with caution on interpretation due to small numbers. When the age of family violence clients are directly compared with the age of women referred into Social Work for violence related issues (Table 29) the distribution is similar with the largest proportion aged between 20-29 years.
Dependent children	Clients where family violence issues were not identified were slightly more likely to have dependent children as compared to those with family violence issues (Table 28).
Income	Approximately half of both client groups (family violence related and non-family violence) obtained their income through a pension or benefit and one third were in paid employment (Table 31).
Disability	In 2013 four women with family violence indicators were identified as having a disability and in 2012 there were 2, one with family violence issues and one without.

Table 17: IMCL – Service description or legal issue for which client is seeking advice (Clients of IMCL who had been referred by The Women’s, Snapshot data extraction June – November)

IMCL service description or legal issue	Summary of results
Activity type	Clients with family violence issues more often were provided with casework activities rather than simply advice in both the 2012 and 2013 data snapshots (Table 35). The proportion of casework activity did appear to increase in 2013.
Relationship between parties	Not surprisingly, clients with family violence issues presented with legal issues most often between current (58%) or previous partners (21%). Clients where family violence was not identified more often relayed legal issues in relation to a previous partner (38%), the father of a child or unborn child (19%) or government and non-government agencies (28%) (see Table 34).
Problem types	<p>A range of 33 different legal problem types were spread across the snapshot samples (Table 36). Within the two sample periods clients with family violence issues recorded a more extensive range of problem types. In fact, the 30 family violence related IMCL clients had 134 problems (Avg 4.4) identified across 29 different problem types and the 18 non-family violence clients recorded 50 problems (Avg 2.7) across 18 problem types.</p> <p>Family violence clients most often recorded problem types including: intervention orders (15%), family violence (12%), child support (13%) and parenting (12%). Clients without family violence issues frequently identified a similar range of problem types: child support (26%), Parenting (16%) and birth certificates (16%).</p>
Matter type	The majority of clients (75%) were provided with advice related to child support matters (Table 38). This was the case for both 2012 and 2013 snapshot samples and regardless of whether they were identified with family violence issues or not.
Referred out from IMCL to another service	IMCL lawyers often refer clients onto services including other legal centres, specialist legal advice and a range of other social services including housing support and child support. The most notable finding from the current data is that lawyers recognise the complex needs of clients with family violence issues and were more likely to refer them for further support or advice rather than not refer (Table 37). In particular for further legal advice or another Community Legal Centre.

Evaluate client satisfaction with Social Work and the IMCL Outreach Service

Clients of Social Work and IMCL outreach service referred for issues of violence were invited to provide feedback on the social work and legal services received at the hospital through voluntary participation in self-administered questionnaires and interviews. Clients were invited to participate through each service and therefore women accessing both services may have been invited by both their social worker and the lawyer. While we do not know the extent of overlap between the anonymous surveys returned, we do know that seven of the nine women interviewed did access both Social Work and IMCL outreach service.

Women were not asked about their experience of violence, only about the service received and their interaction with staff including:

- access to the clinic;
- the appropriateness, range and 'helpfulness' of assistance provided; and
- the value of the service and assistance provided.

The information below is taken from both the questionnaires and interviews. Due to delays in commencement and barriers to sample recruitment discussed earlier, only a small number of women participated in the research. Therefore, the findings discussed below are useful illustrations of the experiences of women throughout the evaluation period; however they cannot be generalised to the population. In particular, the responses are limited to those women whom staff of Social Work and IMCL felt comfortable inviting into the research. Women who may have been in crisis circumstances, or less satisfied with the service may not have been offered the opportunity to provide feedback.

Social Work satisfaction surveys

Fourteen women completed a questionnaire, which is six per cent (5%) of the 271 clients referred into Social Work who were in scope of this evaluation. Nine of the women also volunteered to be interviewed or 64% of the questionnaire respondents.

Sample description

Two of the women were living with their partner and the rest were either separated or reported being single. Half of the women (n=7) were born outside of Australia including Hong Kong, the United Kingdom, Lebanon, Somalia and Ethiopia with four women speaking a language other than English (Arabic, Amharic and Somali). Four women reported a disability most often related to a cognitive impairment.

Six women were employed either part-time or full-time and three were studying. Another six women were neither employed nor studying. Half of the women indicated they were either homeless¹⁴ or at risk of becoming homeless because of the uncertainty of their circumstances.

Access and referral to Social Work

Women self-reported most often that they were referred to Social Work by either a doctor or midwife (Table 18). Five women reported that they asked to be referred or were unsure whether they asked to be referred (Table 19). Three women said there were not given any assistance to

¹⁴ A broad definition of homeless has been used including women living with family and friends until they find permanent accommodation of their own.

access the service but only one of them thought she would have liked more assistance. Two of the women offered assistance would have like more assistance.

Table 18: Social Work – Who referred you to Social Work?

Who referred you to Social Work?		
	n	%
Social Worker from another area in the hospital	1	7
Self-referral	1	7
Doctor	5	36
Midwife	5	36
Other	2	14
Total	14	100.0

Table 19: Social Work – Did you ask to be referred?

Q2 Did you ask to be referred?		
	n	%
Yes	3	21
No	9	64
Not sure / Maybe	2	14
Total	14	100

Most women (n=10) were given assistance to access Social Work by the health worker or receptionist making an appointment for them. In addition, five women had their referral sent over to the service, two were given clear directions about how to get there and one woman was walked over to the service. It is unknown how many women were referred but did not make appointments or did not attend their appointments and therefore the effectiveness of the different forms of support is unable to be examined.

All but one of the fourteen women completing the survey believed that legal advice would or may be helpful (Table 20). Ten of the fourteen women were offered a referral to the IMCL outreach service and a further three women were uncertain whether they were offered a referral or not.

Table 20: Social Work – Do you think you need any legal support for the issues you’ve discussed with your worker at Social Work?

Q13 Do you think you need any legal support for the issues you’ve discussed with your worker at WSSS?		
	Count	%
Yes	8	57%
No	1	7%
Not sure / Maybe	5	36%
Total	14	100%

Satisfaction with referral services from the hospital and Social Work

All the women reported the information provided to them was very helpful, the staff throughout the hospital responded sensitively to their needs and any questions asked of them in relation to violence was done in a sensitive way. Twelve of the women reported that they now had more information about their situation than they had prior to their referral and all but one would recommend the social work service to others. Five women had suggestions to improve the service they received. None of the suggestions were to improve the service but related to either additional support or better access to the service. One woman reported she felt her confidentiality had been breached when information she shared with the social work staff had been passed on to her family by a staff member from another area of the hospital. The list of improvement suggestions includes:

- better computer access for staff;
- clearer signage to find legal clinic;
- someone from Centrelink to help with paperwork;
- main hospital receptionist could be more friendly (not referring to social work reception);
- increased confidentiality.

In terms of increased confidentiality there were two examples provided. The first involved a hospital staff member speaking to family about the information provided to the social worker. The second was an incident where the client negotiated concerns raised about the safety of her children with a worker but then found child protection had been contacted. The client believed that child protection would not have been contacted and felt this was a breach of trust. It was unclear whether the worker had called child protection or if someone else had.

IMCL Outreach Service Satisfaction surveys

Eight women completed an IMCL outreach service questionnaire, which is 24% of the known number of clients referred into IMCL outreach service who were in scope of this evaluation (N=33). Five of the women also volunteered to be interviewed or 63% of the questionnaire respondents and a similar proportion to the rate of interview volunteers from the Social Work questionnaires.

IMCL outreach service sample description

Five of the eight women were either divorced or single. One woman self-reported she had a disability. More than half were not born in Australia (n=6), nor was English their first language (n=5). The countries of origin included Ethiopia, Indonesia, Lebanon, Somalia and the United Kingdom. In

addition, more than half (n=5) were neither studying nor working; only two were employed. Three of the eight women thought they might be at risk of homelessness either now or in the near future.

Access and referral to IMCL outreach service

All eight women were referred into IMCL outreach service by a social worker but only two specifically asked for a referral. All but one woman were given assistance to access the legal service; eight had an appointment made for them by a staff member and two were given the phone number. Half of the women thought they were given adequate assistance accessing the legal service and four thought they would have liked more assistance. Two women made additional comments validating the importance of having an appointment made for them:

The receptionist made the appointment over the phone. It can be intimidating to get legal advice. [id 210]

Seven of the eight women reported it was more convenient to see a lawyer in the hospital as opposed to the office in North Melbourne and all seven reported the day of the clinic was convenient for them¹⁵. Women were positive about the convenience of the outreach clinic and assistance received to make an appointment.

Because I already had an appointment here [at The Women's] it was easy to see the lawyer. [id 208]

I am working so appointments are difficult, but the appointments were quick, convenient and easy. [id 212]

I called the legal service on Tuesday and had an appointment in the same week on Thursday. [id 211]

There were no barriers [to accessing the service], they phone and then you come in. It was amazing. [id 210]

Only two women thought they would not have seen a lawyer if they had not had the opportunity to see one in the hospital. All others recognised that they needed legal advice and this opportunity in the hospital meant they received advice more quickly than if they had sourced it themselves. One woman made an appointment at the IMCL North Melbourne office instead of the hospital as the scheduling options worked better for her that way, however she learned about the service through her worker at the hospital.

Satisfaction with referral services to IMCL outreach service

All eight women reported that staff throughout the hospital responded sensitively to their needs and questions asked in relation to violence and abuse were done in a sensitive way. All eight also thought it was a good idea to have a legal service at The Women's.

¹⁵ This finding should be interpreted with caution as we were only able to interview women who attended the outreach thereby already suggesting that this was a convenient service. Women who did not or could not attend were not able to be interviewed due to the adopted recruitment methodology.

All the women reported that the information provided to them by the lawyer was appropriate and addressed their situation; they also reported the outcome of legal assistance was helpful in some way.

A couple of suggestions for improvements for IMCL outreach service were made and included:

- access to private room for appointments¹⁶;
- more expert advice on legal aid;
- better signage and information to know the service exists.

Evaluate the impact of legal information on women's health, knowledge and behaviour

To ascertain the value of placement of a legal service within a healthcare context and in this instance specifically to support women experiencing violence within a major metropolitan public hospital, it was important to assess the impact of provision of legal information and the intersection between legal issues and health improvement.

An immediate question might appear to be whether obtaining legal advice had a positive impact upon a woman's health status. However it may be more likely that a woman seeking assistance for her experience of violence will face immediate and difficult circumstances when making decisions and implementing change to address the violence. It is therefore also quite likely she will experience a negative impact on her health through emotional and psychological stress as well as the potential of increased risk of physical violence. The positioning of an outreach legal service in a hospital context therefore may not have an immediate health benefit. However, the most frequent first point of contact for women seeking assistance is from a health care professional (other than police in a crisis situation) (36). It has also been found that healthcare professionals under-report the non-physical signs of violence and do not necessarily offer appropriate referral pathways (thus supporting the need for training). (For detailed discussion of these issues see the Literature Review for Part 2 above).

Nevertheless, women were asked about the impact of access to legal information upon their health as well as their knowledge and understanding of legal options

Five of the eight women thought they had more information about their legal circumstances and while three did not think they had *more* information (Table 21), all but one reported the actual information they received to be helpful. The one woman indicating the information was not helpful stated that it simply confirmed what she already knew but this was useful in itself.

¹⁶ Throughout the evaluation period IMCL outreach had access to private rooms for appointments, however at least one woman reported she was discussing her legal situation in a more public space.

Table 21: Knowledge of legal options

Q17 Do you have more knowledge and options about your situation than you had before you came to IMCL?		
	Count	%
Yes	4	50
No	3	38
Not sure / Maybe	1	13
Total	8	100

Seven of the eight women believed that receiving legal advice had a positive impact upon their psychological and emotional health immediately during or after the consultation.

Peace of mind and confirmed I am heading in the right direction. I am emotionally improved when I speak with the lawyer. [id 211]

Helped my mental health & clarified circumstances with my child [id 212]

I feel emotionally and mentally stronger. I have more confidence. [id 209]

Women articulated that while they did not believe the legal advice assisted their physical health, they did believe it was important for their mental and emotional health. Women connected the legal advice received to supporting their decision to change their circumstances and proceeding to act on those decisions. It was these changes they thought would improve their health (for themselves and their children) over the long-term.

The partnership between The Women's and IMCL goes one-step toward implementing system change to improve recognition of patients who have been or are victims of violence, as well as increasing response through referral options. The evaluation results show that while elements which are important to system change have been introduced (ie training of professional and allied health care staff as well as multiple referral pathways) there is further to go before system change will be embedded and result in increased referral rates.

To build on what has been provided with the AOWS project, The Women's would need to generate a greater awareness across all staffing areas to:

- further educate staff on the links between health and violence against women in order to generate greater interest among the staff to attend training, identify violence and refer appropriately; and
- extend and promote the referral pathways inclusive of social work services, IMCL as well as services external to the hospital.

Second Stakeholder Workshop

The 2nd Stakeholder Workshop involved a half day workshop with a range of stakeholders designed to:

- ❖ Present preliminary findings from the Evaluation
- ❖ Seek feedback from stakeholders on the findings and in particular:
 - explore the environmental factors that may have impacted on engagement by health professionals
 - hear stakeholders views of the context of the existing referral pathways at The Women's
 - discuss how the Project may be improved, supported and sustained over time
 - hear suggestions for how the final report by the Evaluation Team may be framed to assist the Project going forward

The workshop took place on 13th June 2014 The programme is attached at Appendix 13.

A range of staff from The Women's attended covering clinical staff, key administrative and education staff. Preliminary findings were provided by the Evaluation Team and discussed within the Workshop. Stakeholders were asked to comment on key issues within the Project through breakout sessions:

1. How aware are hospital staff / clinicians about in-house training around violence against women? How could awareness be improved?
2. How aware are hospital staff / clinicians about the support available for women / patients experiencing violence? How could awareness be improved?
3. How aware are hospital staff / clinicians about the referral pathway when violence is identified? (Pathway of support through Social work & IMCL outpost)? What would be some opportunities to improve the referral pathways or awareness of the pathways?
4. To what extent are there environmental or contextual factors impacting on engagement with the training & referral pathway?
5. How could the Acting on the Warning Signs program be improved, now and over time?

One of the key matters addressed was the acknowledgment that it is difficult to evaluate or review processes such as referral pathways without efficient and effective data recording facilities.

Feedback received from the Stakeholders is summarised in Table 1.

Table 22: Key feedback arising from the 2nd Stakeholder Workshop

Increase awareness of the Project	<ul style="list-style-type: none">▪ Promotion to come from the top, with unit leaders encouraging staff to attend▪ Training to be compulsory▪ Creative marketing and use of intranet▪ Make use of testimonials and highlight importance of training
Support for clients experiencing family violence	<ul style="list-style-type: none">▪ Some clinical groups are avoiding Social Work▪ Potential for re-branding of Social Work

Referral pathways	<ul style="list-style-type: none"> ▪ Direct pathway to IMCL is relatively new and requires further and ongoing promotion ▪ Warm referrals, supporting clients to attend services ▪ Greater awareness in multidisciplinary teams as information flow greater between staff
Environmental and contextual factors	<ul style="list-style-type: none"> ▪ Provision of varied training formats: full, half training days and in-service sessions with online learning tools, potential for modules ▪ Customise training to align with hospital working hours ▪ Time and workload limiting factors for attendance to training
Improving the Project	<ul style="list-style-type: none"> ▪ Customise training further for the setting and to different clinicians ▪ Training to include issues around cultural diversity ▪ Re-launch required to maintain impetus ▪ Making use of varied training modalities including audio-visual tools

Recommendations for future models

Training

- Given the prevalence of family violence and its impact on health, family violence training should be mandatory, recurrent and ongoing for all staff at The Women's and other similar hospitals.
- A funded clinical lead from the hospital, together with the legal project manager would further enhance the training and assist to sustain the relevance of the training.
- To maximise attendance, delivery of training needs to continue to be flexible and responsive, utilising a variety of formats such as workshop based, audio visual, online and delivered across several sessions or in-service.
- Any future training provided at The Women's could be enhanced by coordination with any other existing training programmes on violence against women e.g. sexual assault.

Early intervention requires greater system changes within the hospital

- Sustained system changes within a large hospital such as The Women's would require more staff to be trained and more than a part time designated manager. The current program trained almost 10% of clinical staff, however a larger critical mass of trained and sensitised staff are needed to sustain changes.
- For training to be even more effective in the future, it needs to be further embedded in the Women's strategic plan to systematically change the culture of the hospital in the area of family violence and violence against women. This could include ongoing organisational and management support, and recurrent communication of flexible training opportunities associated with violence against women in the hospital.
- For AOWS to make an ongoing greater impact on referrals;
 - health professionals need to perceive a greater need to ask about family violence through the support of a hospital wide campaign on family violence;
 - it needs to be associated with other system changes that assist women to access help e.g. posters, warm referrals (women supported and accompanied to the legal clinic);
 - Effective, good quality databases/recording systems are required to capture and track referrals within The Women's, including demographics and reasons for presentation.

Outreach legal service

The co-location of a regular and consistent legal practitioner within Social Work appears to be the mechanism that led to increased awareness and accessibility for social workers to refer women to this service. Analysis of referrals into the legal outreach pre-AOWS and during the evaluation period suggests that this co-location is the clearest explanation for increased referrals in the current model.

The main reasons for this include:

- ❖ maintaining regular and consistent hours of IMCL outreach ensured regular referrals;
- ❖ the consistent presence of a primary lawyer with a special interest built strong relationships with Social Work and enabled trust in stability of the program and advice being offered; and
- ❖ the co-location of IMCL outreach within Social Work enabled social workers to make appointments on behalf of their clients, even on the same day.

This part of the model could be strengthened by:

- better signage to the IMCL outreach service for clients and staff;

- freely available information sheets, especially outside of Social Work operating hours or to encourage women to self-refer without accessing Social Work (this has been enacted in 2014);
- increased availability of the IMCL outreach service (an extra half day began in January 2014, post-evaluation).

Conclusion

This innovative Legal Advocacy Health Alliance of engagement and training of over 100 health professionals has built capacity, confidence and willingness of health professionals to identify signs of family violence. Health professionals clearly increased their knowledge of legal options. Appropriate legal assistance from the outreach service has also been provided alongside other services as part of a multifaceted response within the hospital. Over the five year development of the legal clinic at The Women's there has been a steady increase in referrals reported by IMCL. Greater referrals from health professionals might be visible with better data capture of referrals and may occur with greater availability of the IMCL outreach service.

The legal partnership with The Women's builds on a strong organisational foundation to address violence against women. The Women's Clinical Practice Guideline, on-going staff training, and leadership within senior management at the hospital have been consistent for more than a decade. The AOWS project exemplifies the strengthening of this response. The implementation has involved not only the once a week legal clinic, but also staff training and extensive relationship building between IMCL and The Women's to strengthen the Legal Advocacy-Health Alliance. It is difficult to assess what the effect of implementation of the model in other health settings would be, particularly if strong organisational support for violence against women activities is absent.

The further development of the model in the next phase to increase the number of legal assistance sessions, on-going (and possibly mandatory) family violence training, stronger, practical support for women to access the legal clinic, and experimenting with whether legal support can be provided directly without the intermediary social work support service provide promising extensions for the future development of the legal service within the hospital.

Appendices

Appendix 1: Example AOWS Training Programme

Date: 13 March 2013

Time: 8:30-17:00 (registration from 8:15 onwards)

Venue: Conference Room A

TIME	SESSION	FACILITATOR
8:30 – 9:00	Addressing family violence through a multi-disciplinary approach	Linda Gyorki Project Manager & Solicitor North Melbourne Legal Service
9:00-9:30	What is family violence under the <i>Family Violence Protection Act</i>	Linda Gyorki
9:30 –10:30	Family violence across the lifespan	Dr Fleur Llewelyn Manager Clinical Education Team Royal Women's Hospital & Elvira Earthstar COSMOS one-to-one midwife Blue team Royal Women's Hospital
Morning Tea 10:30-10:45		
10:45 – 11:30	Talking about violence	Alia Dash Social Worker Women's Social Support Services Royal Women's Hospital
11:30 – 11:50	Clinical Practice Guidelines and appropriate referrals	Alia Dash
11:50 – 12:00	Legal assistance outreach service at the Women's	Linda Gyorki
12:00– 1:00	Applying sensitive practice	Alia Dash
Lunch 1:00 – 1:30 Women's Health Information Centre Stall In-Touch Multicultural Centre against Family Violence Stall Family Violence Advisor – City of Melbourne, Victoria Police		

1:30 -2:15	The role of the law in protecting and supporting women and the legal options available to women	Linda Gyorki
2:15 – 2:55	Mandatory Reporting under the Children, Youth and Families Act and appropriate note-taking	Karen Cusack Corporate Counsel Royal Women’s Hospital
Afternoon Tea: 2:55-3:10		
3:10 – 3:40	Cultural sensitivity towards Aboriginal and Torres Strait Islander people in family violence matters	Aunty Pam Pedersen Community engagement worker Aboriginal Family Violence Prevention Legal Service & Tania McKenna Manager Policy & Education Aboriginal Family Violence Prevention Legal Service
3:40 – 4:20	Case studies	Dr Fleur Llewelyn, Elvira Earthstar Alia Dash & Linda Gyorki
4:20-4:40	Support for staff and self-care	Janine Petersen Health, Safety & Wellbeing Manager, Royal Women’s Hospital
4:40 – 4:50	The role of clinical champions and evaluation	Linda Gyorki
4:50 – 5:00	Formal close of study day	Lisa Dunlop Executive Director Clinical Operations Royal Women’s Hospital

Appendix 2: Advertisement for AOWS Training for Doctors

The North Melbourne Legal Service in partnership with the Women's invites you to an information session for Doctors at the Women's about:

Acting on the Warning Signs: addressing family violence through a multi-disciplinary approach

Family violence has detrimental consequences for the health of Victorian women. A report by VicHealth has found that intimate partner violence is the leading preventable contributor to death, disability and illness in Victorian women aged 15-44.¹⁷ At this multi-disciplinary information session, you will have the opportunity to hear from medical staff, social workers and lawyers about the warning signs of family violence and appropriate referrals. The study session will be followed by a Question & Answer session with medical directors and the multi-disciplinary panel.

The panellists include:

- Associate Professor Leslie Reti, Clinical Director, Gynaecology, Cancer Services and Clinical Governance, The Women's
- Dr Christine Bessell, Executive Medical Advisor, The Women's
- Dr Susan Nicolson, General Practitioner in the Green Maternity Team and the Perinatal Mental Health Team, The Women's
- Karen Cusack, Corporate Counsel, The Women's
- Anne Dive, Social Worker, Women's Social Support Services, The Women's
- Linda Gyorki, Project Manager and Solicitor, North Melbourne Legal Service

The session will be held twice, as follows:

SESSION 1: Wednesday 17th April 2013, 4:30pm-6pm

Conference Room A, Ground Floor, The Women's

SESSION 2: Monday 22nd April 2013, 4:30pm-6pm

Conference Room B & C, Ground Floor, The Women's

RSVP: by Thursday 4th April 2013 to Linda Gyorki by sending an e-mail to Linda.Gyorki@thewomens.org.au or calling (03) 9328 1885 or (03) 8345 2916

CPD Points: This meeting has been approved as a RANZCOG Approved O&G Meeting. Eligible Fellows of RANZCOG will earn 2 CPD points for attendance. Fellows who choose to complete a clinical risk management activity reflection worksheet at the end of the session can claim 5 PR&CRM points for each completed worksheet. A certificate of attendance will be provided to all attendees.

Afternoon tea will be provided by North Melbourne Legal Service.

¹⁷ VicHealth, The health costs of violence: measuring the burden of disease caused by intimate partner violence: a summary of findings, DHS 2004 (reprinted 2010), p10.

Appendix 3: Stakeholder Workshop Programme

Acting on the Warning Signs

A health-legal partnership between North Melbourne Legal Service and the Royal Women's Hospital to address violence against women through a multi-disciplinary approach

First Stakeholder Workshop

Friday 28th September 2012, 9a.m.-12p.m.

Conference Room A, Ground Floor, Royal Women's Hospital

Time	Session	Presenter/Facilitator
9:00a.m.- 9:10a.m.	Welcome and outline of the goals of the workshop, introduce team members, program processes and action model.	Stuart Ross
9.10a.m.– 9.20a.m.	Outline of the Project, avenues for referrals and how people can find out more as the project is implemented.	Linda Gyorki
9:20a.m.- 9:30a.m.	How the project may bear on the work of stakeholders including what will be required of each agency and what benefits the program will generate.	Khoi Cao-Lam
9.30 am - 9.35 am	Related Project: The Womens Against Violence project by Elizabeth McLindon	Kelsey Hegarty
9:35a.m.– 9:55a.m.	Overview of the evaluation including evaluation goals, data collection processes and program logic model summary.	Stuart Ross
9:55a.m.–	Group discussion of key issues which include:	Evaluation Team

10:30a.m.	6. Is the Acting on the Warning signs program logic model likely to work? 7. How to engage health professionals in the training assessment? 8. How to engage clients in the satisfaction survey and personal interviews? 9. How will the Acting on the Warning Signs project maintain support over time?	
10:30a.m.– 10:45a.m.	Morning Tea	
10:45a.m.– 11:00a.m.	Continue to review key issues; participants to prepare a brief response back to the workshop	Evaluation Team
11:00a.m.– 11:45a.m.	Participants to report back and plenary discussion	Evaluation Team
11:45a.m.– 11:55a.m.	The future for the evaluation of the project	Dr Stuart Ross
11:55a.m.– 12p.m.	Thank you and formal close of workshop	Tanya Farrell & Stuart Ross

Appendix 4: Health Professional Baseline Survey

Welcome to the Acting on the Warning Signs Survey

How to complete the survey:

Please read the questions carefully and follow the instructions.

Your candid responses to this survey will greatly assist us in our attempt to evaluate the training being provided by the North Melbourne Legal Service and The Women's regarding a multi-disciplinary approach to family violence.

Some questions may seem similar to others. However, we ask that you answer all questions to help ensure the reliability of the evaluation.

Your answers will remain confidential.

If you wish to write further comments, please do so in the space provided at the end of the survey.

Some people may find some questions upsetting or distressing. Please contact one of the services listed at the end of the survey if this happens to you.

Thank you for taking the time to complete this survey.

Please write the date in the space below on which you are completing this survey:

DATE: _____

SECTION A: The Care you Provide

In this section we ask you about your experiences of caring for women at The Women's.

1. In which clinical sector of the Women's do you typically work? (*Please tick one box*)

- ☐ Gynaecology, Women's Cancer & Perioperative
- ☐ Maternity
- ☐ Neonatal Services
- ☐ Women's Health

2. Which of the following professions does your position best align with? (*please tick one box*)

- ☐ Social Work
 - ☐ Allied Health
 - ☐ Medical support service (imaging, pharmacy)
 - ☐ Medical Officer (Registrars, Consultants, HMOs)
 - ☐ Midwifery
 - ☐ Nursing
 - ☐ Other (*please specify*)
-

3. Have you seen patients in the last 3 months?

- ☐ Yes
- ☐ No

- *if you answered 'yes' to this question, please continue to the next question*
- *if you answered 'no' to this question, please skip to **question 6***

4. Thinking about the care you have provided in the last 3 months, how often did you encounter women experiencing any of the following?
(please tick one box on each line)

	Never	Rarely, 1-3 times	Occasionally, 1-3 times per month	Regularly, 1-3 times per week	Often, every day
General anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Relationship problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Past sexual abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Family violence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sexual problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drug and alcohol problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

5. Thinking about the care you provided in the last 3 months, how comfortable did you feel asking about any of the following? (please tick one box on each line)

	Never asked	Very comfortable	Comfortable	Uncomfortable
General anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Relationship problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Past sexual abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Family violence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sexual problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drug and alcohol problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

6. The next question is about your care of women who you suspect may be experiencing family violence.

How often do you use and/or refer to the following when you suspect a woman may be experiencing family violence? *(please tick one box on each line)*

	Never	Rarely, 1-3 times	Occasionally, 1-3 times per month	Regularly, 1-3 times per week	Often, every day
The Women's Clinical Practice Guideline "violence against women: management and referral options"	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Maternity team care meetings or case meetings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The Women's Social Support Service (WSSS)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Centre Against Sexual Assault (CASA)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The Women's on-call social worker (weekends)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Aboriginal Women's Health Business Unit (AWHBU)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The Women's Alcohol and Drug Service (WADS)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Centre for Women's Mental Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Police	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Domestic Violence Crisis Service of Victoria	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sexual Assault Crisis Line	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
North Melbourne Legal Service (either through WSSS or directly)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Another lawyer or legal service	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (please specify)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SECTION B: Your Knowledge of Family Violence

This section asks you about your knowledge and understanding of family violence.

7. Below is a list of actions against a woman that could be thought of as family violence. To what extent do you agree they should be called family violence? (please tick one box on each line)

	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
Hit or tried to hit her with something	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tried to make her think she was crazy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Forced her to have unwanted sex	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Threatened to hit her	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Told her that she was ugly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Yelled at her	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did not want her to go to self improvement activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tried to keep her from seeing or talking to her family or friends	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pushed, grabbed or shoved her	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Denied money or income to her	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Forced her to have an abortion or continue with a pregnancy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Punished or deprived the children when angry at her	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tortured or killed pets to hurt her	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Became upset if dinner/housework wasn't done when he thought it should be	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

8. In the Family Violence Protection Act 2008, to whom do you think ‘family violence’ refers? (please tick one box on each line)

	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
Spouse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Parent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Work colleague	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sibling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Niece/ Nephew	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neighbour	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Aunt/ Uncle	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cousin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Son/ Daughter	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Friend	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Grandparent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Carer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

9. Please read the following statements about family violence and indicate whether you agree or disagree with each statement (please tick one box on each line)

	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
Women could leave the relationship if they wanted to	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If a woman does not acknowledge the violence, there is very little that I can do to help	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
A lawyer can assist a woman to protect her rights regarding her children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If a woman wants to divorce her husband, she does not have to give family violence as the reason for divorce	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The majority of men who abuse their partners have a serious mental disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
A woman will not be forced to leave her home if she takes out an intervention order	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Women experiencing family violence can be assisted by the legal system	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol consumption is the greatest single predictor of the likelihood of family violence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Whatever is discussed between a woman and her lawyer is kept completely confidential	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Women are at greater risk of injury when they leave the relationship	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
A lawyer can assist in applying to the court for an intervention order where the woman can remain with her partner but where her partner is prohibited from certain conduct	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Men who abuse their partners cannot control their anger	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
An intervention order can be tailored to a woman's particular circumstances	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
A lawyer's role is to provide different legal options to a woman experiencing family violence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
A lawyer can assist a woman experiencing family violence to better understand her rights and entitlements	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

10. How likely would any of the following presenting symptoms prompt you to suspect family violence? (please tick one box on each line)

	Very unlikely	Unlikely	Not sure	Likely	Very likely
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic pelvic pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vaginal discharge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Irritable bowel syndrome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Premature labour	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Miscarriage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sexual problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhoea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety/depression symptoms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lethargy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Substance abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Injuries	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Homelessness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eating disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

11. Have you ever received ANY training about family violence (this includes partner violence and sexual assault)?

☐ Yes

☐ No

➤ if you answered '**yes**' to this question, please continue to the next question

➤ if you answered '**no**' to this question, please skip to **SECTION C**

12. How many hours of family violence training have you have received?

(please tick one box on each line)

	None	1-3 hours	4-6 hours	7-9 hours	10-15 hours	16+ hours
Self-taught	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In-service session/s at The Women's	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In-service session/s at another hospital	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
One-off workshop, external to hospital training	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
External short course	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Certificate/ Diploma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

We appreciate your time and effort!

Please continue to the next section.

SECTION C: Your Opinion of and Preparedness to Respond to Family Violence

This section asks your opinion about and preparedness to respond to someone who is experiencing family violence.

13. Below is a list of statements about how health professionals may respond to a woman experiencing family violence. Please read each statement and indicate your level of agreement by ticking one box on each line.

	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
The best advice to offer a woman in a family violence situation is to leave	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
It is not important to ask a woman about safety at the first visit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
A multidisciplinary approach is effective in responding to women experiencing family violence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Women are more likely to tell a female health professional about family violence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
It is a good idea to have a lawyer in a hospital	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If a patient refuses to discuss family violence, staff can only treat the patient's injuries	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asking about family violence is likely to offend those who are asked	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reasons for concern about family violence should not be included in a patient's chart if she does not disclose it	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Health care providers should work with lawyers in responding to family violence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Allowing partners or friends to be present during a patient's history and physical exam ensures safety for a woman experiencing family violence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
All women should be screened for family violence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

14. Below is a list of statements about how YOU may respond to a woman experiencing family violence. Please read each statement and indicate your level of agreement by ticking one box on each line.

	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
I find it difficult to respond to family violence because I am often seeing the partner as well	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Responding to sensitive issues such as family violence makes me feel overwhelmed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I do not have enough time to respond to family violence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
There is not much point identifying family violence because I am unable to help women with these issues	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I prefer to deal with clinical issues rather than social issues	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I find it difficult to support a woman who stays in a violent relationship	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If I find a patient who is experiencing family violence, I don't know what to do next	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I don't have the necessary skills to discuss family violence with a woman who is from a different cultural/ethnic background	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I ask all new patients about family violence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

15. Below is a list of interventions for female patients.

This two part question asks you about a) what you consider your role to be in responding to a woman who is experiencing family violence; and b) what you consider to be your level of preparedness.

For each activity you will be first asked in part a) to what extent you agree or disagree that the activity should be a part of your care of female patients who experience family violence and secondly in part b), how confident you feel to undertake that activity.

a) To what extent do you agree?

	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
I should encourage a woman to talk about things that might be on her mind	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I should identify women who may be experiencing family violence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I should explore the options open to her	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I should consider whether the children of a woman experiencing family violence are at risk of harm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I should provide her with family violence patient education or resource materials	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I should document injuries and treatment relating to injuries in the medical record	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I should give advice on legal options including referrals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I should offer to contact the police	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
There are services that I can access for myself if I become distressed responding to a woman experiencing family violence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

b) How confident do you feel in having sufficient knowledge and skills to carry this out?

	Not confident	Not very confident	Unsure	Somewhat confident	Very confident
I should encourage a woman to talk about things that might be on her mind	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I should identify women who may be experiencing family violence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I should explore the options open to her	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I should consider whether the children of a woman experiencing family violence are at risk of harm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I should provide her with family violence patient education or resource materials	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I should document injuries and treatment relating to injuries in the medical record	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I should give advice on legal options including referrals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I should offer to contact the police	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
There are services that I can access for myself if I become distressed responding to a woman experiencing family violence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

16. Below is a list of interventions relating to referrals for female patients.

This next two part question again asks you a) about what you consider your role to be in responding to a woman who is experiencing family violence; and b) what you consider to be your level of preparedness.

For each referral presented you will be first asked in part a) to what extent you agree or disagree that the referral should be a part of your care of female patients who experience family violence; and secondly in part b) how confident you feel to undertake that referral.

a) To what extent do you agree?

	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
I should provide my patient with a referral to The Women's Social Support Service (WSSS)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I should provide my patient with a referral to the Centre Against Sexual Assault (CASA)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I should provide my patient with a referral to the Domestic Violence Crisis Service of Victoria	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I should provide my patient with a referral to a family violence or women's telephone help line, such as the Sexual Assault Crisis Line (SACL)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Where appropriate, I should provide my patient with a referral to the Aboriginal Women's Health Business Unit (AWHBU)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Where appropriate, I should provide my patient with a referral to the Women's Alcohol and Drug Service (WADS)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I should provide my patient with a referral to the North Melbourne Legal Service	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

b) How confident do you feel in having sufficient knowledge and skills to carry this out?

	Not confident	Not very confident	Unsure	Somewhat confident	Very confident
I should provide my patient with a referral to The Women's Social Support Service (WSSS)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I should provide my patient with a referral to the Centre Against Sexual Assault (CASA)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I should provide my patient with a referral to the Domestic Violence Crisis Service of Victoria	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I should provide my patient with a referral to a family violence or women's telephone help line, such as the Sexual Assault Crisis Line (SACL)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Where appropriate, I should provide my patient with a referral to the Aboriginal Women's Health Business Unit (AWHBU)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Where appropriate, I should provide my patient with a referral to the Women's Alcohol and Drug Service (WADS)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I should provide my patient with a referral to the North Melbourne Legal Service	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SECTION D: About Yourself

This section asks you for some background details about yourself.

17. How old are you?

_____ years

18. Are you:

- ☐ Male
☐ Female

19. Is English your first language?

- ☐ Yes
☐ No

20. How many years have you worked at The Women's? *(please tick one box)*

<input type="checkbox"/>	<1 year
<input type="checkbox"/>	1-3 years
<input type="checkbox"/>	4-5 years
<input type="checkbox"/>	6-10 years
<input type="checkbox"/>	>10 years

21. What is your current employment status? *(Please tick one box)*

<input type="checkbox"/>	Full time - Permanent / ongoing
<input type="checkbox"/>	Full time - Fixed term
<input type="checkbox"/>	Part time - Permanent / ongoing
<input type="checkbox"/>	Part time - Fixed term
<input type="checkbox"/>	Casual / locum

22. How many hours per week do you typically work? (Please tick one box)

<input type="checkbox"/>	0 - 7.9 hours
<input type="checkbox"/>	8 - 17.9 hours
<input type="checkbox"/>	18 - 27.9 hours
<input type="checkbox"/>	28 - 37.9 hours
<input type="checkbox"/>	38+ hours

SECTION E: Comments

23. Please provide any additional comments below:

Many thanks for the time and effort you have given in completing this survey

Your answers will remain confidential.

If you became upset or distressed as a result of any questions in the survey, please contact The Women's Employee Assistance Program on 1300 360 364.

You can also talk to someone you trust at the Women's, such as:

- Your manager
- Human Resources on 8345 2080

You may wish to contact other services, such as:

- Your GP
- Women's Social Support Service: (03) 8345 3050
- Women's Domestic Violence Crisis Service of Victoria: (03) 9322 3555, toll free 1800 015 188
- Sexual Assault Crisis Line: 1800 806 292 (24hours)
- Centre Against Sexual Assault (CASA): (03) 9635 3610 (24hrs)
- in-Touch Multicultural Centre Against Family Violence: (03) 9413 6500

Appendix 5: Health Professional Follow-up Survey

Welcome to the Acting on the Warning Signs Survey

How to complete the survey:

Please read the questions carefully and follow the instructions.

Your candid responses to this survey will greatly assist us in our attempt to evaluate the training being provided by the North Melbourne Legal Service and The Women's regarding a multi-disciplinary approach to family violence.

Some questions may seem similar to others. However, we ask that you answer all questions to help ensure the reliability of the evaluation.

Your answers will remain confidential.

If you wish to write further comments, please do so in the space provided at the end of the survey.

Some people may find some questions upsetting or distressing. Please contact one of the services listed at the end of the survey if this happens to you.

Thank you for taking the time to complete this survey.

SECTION A: The Care you Provide

In this section we ask you about your experiences of caring for women at The Women's.

24. Have you seen patients in the last 3 months?

- ☐ Yes
☐ No

- if you answered '**yes**' to this question, please continue to the next question
- if you answered '**no**' to this question, please skip to **question 4**

25. Thinking about the care you have provided in the last 3 months, how often did you encounter women experiencing any of the following? (please tick one box on each line)

	Never	Rarely, 1-3 times	Occasionally, 1-3 times per month	Regularly, 1-3 times per week	Often, every day
General anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Relationship problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Past sexual abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Family violence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sexual problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drug and alcohol problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

26. Thinking about the care you provided in the last 3 months, how comfortable did you feel asking about any of the following? (please tick one box on each line)

	Never asked	Very comfortable	Comfortable	Uncomfortable
General anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Relationship problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Past sexual abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Family violence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sexual problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drug and alcohol problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

27. The next question is about your care of women who you suspect may be experiencing family violence.

How often do you use and/or refer to the following when you suspect a woman may be experiencing family violence? *(please tick one box on each line)*

	Never	Rarely, 1-3 times	Occasionally, 1-3 times per month	Regularly, 1-3 times per week	Often, every day
The Women's Clinical Practice Guideline "violence against women: management and referral options"	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Maternity team care meetings or case meetings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The Women's Social Support Service (WSSS)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Centre Against Sexual Assault (CASA)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The Women's on-call social worker (weekends)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Aboriginal Women's Health Business Unit (AWHBU)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The Women's Alcohol and Drug Service (WADS)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Centre for Women's Mental Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Police	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Domestic Violence Crisis Service of Victoria	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sexual Assault Crisis Line	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
North Melbourne Legal Service (either through WSSS or directly)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Another lawyer or legal service	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (please specify)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SECTION B: Your Knowledge of Family Violence

This section asks you about your knowledge and understanding of family violence.

28. How many hours of family violence training have you have received?

(please tick one box on each line)

	None	1-3 hours	4-6 hours	7-9 hours	10-15 hours	16+ hours
Self-taught	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In-service session/s at The Women's	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In-service session/s at another hospital	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
One-off workshop, external to hospital training	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
External short course	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Certificate/ Diploma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

29. Below is a list of actions against a woman that could be thought of as family violence. To what extent do you agree they should be called family violence? (please tick one box on each line)

	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
Hit or tried to hit her with something	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tried to make her think she was crazy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Forced her to have unwanted sex	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Threatened to hit her	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Told her that she was ugly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Yelled at her	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did not want her to go to self improvement activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tried to keep her from seeing or talking to her family or friends	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pushed, grabbed or shoved her	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Denied money or income to her	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Forced her to have an abortion or continue with a pregnancy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Punished or deprived the children when angry at her	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tortured or killed pets to hurt her	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Became upset if dinner/housework wasn't done when he thought it should be	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

30. In the Family Violence Protection Act 2008, to whom do you think ‘family violence’ refers? (please tick one box on each line)

	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
Spouse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Parent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Work colleague	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sibling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Niece/ Nephew	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neighbour	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Aunt/ Uncle	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cousin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Son/ Daughter	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Friend	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Grandparent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Carer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

31. Please read the following statements about family violence and indicate whether you agree or disagree with each statement (please tick one box on each line)

	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
Women could leave the relationship if they wanted to	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If a woman does not acknowledge the violence, there is very little that I can do to help	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
A lawyer can assist a woman to protect her rights regarding her children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If a woman wants to divorce her husband, she does not have to give family violence as the reason for divorce	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The majority of men who abuse their partners have a serious mental disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
A woman will not be forced to leave her home if she takes out an intervention order	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Women experiencing family violence can be assisted by the legal system	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol consumption is the greatest single predictor of the likelihood of family violence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Whatever is discussed between a woman and her lawyer is kept completely confidential	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Women are at greater risk of injury when they leave the relationship	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
A lawyer can assist in applying to the court for an intervention order where the woman can remain with her partner but where her partner is prohibited from certain conduct	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Men who abuse their partners cannot control their anger	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
An intervention order can be tailored to a woman's particular circumstances	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
A lawyer's role is to provide different legal options to a woman experiencing family violence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
A lawyer can assist a woman experiencing family violence to better understand her rights and entitlements	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

32. How likely would any of the following presenting symptoms prompt you to suspect family violence? (please tick one box on each line)

	Very unlikely	Unlikely	Not sure	Likely	Very likely
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic pelvic pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vaginal discharge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Irritable bowel syndrome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Premature labour	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Miscarriage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sexual problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhoea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety/depression symptoms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lethargy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Substance abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Injuries	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Homelessness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eating disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

We appreciate your time and effort!

Please continue to the next section.

SECTION C: Your Opinion of and Preparedness to Respond to Family Violence

This section asks your opinion about and preparedness to respond to someone who is experiencing family violence.

33. Below is a list of statements about how health professionals may respond to a woman experiencing family violence. Please read each statement and indicate your level of agreement by ticking one box on each line.

	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
The best advice to offer a woman in a family violence situation is to leave	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
It is not important to ask a woman about safety at the first visit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
A multidisciplinary approach is effective in responding to women experiencing family violence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Women are more likely to tell a female health professional about family violence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
It is a good idea to have a lawyer in a hospital	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If a patient refuses to discuss family violence, staff can only treat the patient's injuries	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asking about family violence is likely to offend those who are asked	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reasons for concern about family violence should not be included in a patient's chart if she does not disclose it	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Health care providers should work with lawyers in responding to family violence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Allowing partners or friends to be present during a patient's history and physical exam ensures safety for a woman experiencing family violence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
All women should be screened for family violence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

34. Below is a list of statements about how YOU may respond to a woman experiencing family violence. Please read each statement and indicate your level of agreement by ticking one box on each line.

	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
I find it difficult to respond to family violence because I am often seeing the partner as well	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Responding to sensitive issues such as family violence makes me feel overwhelmed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I do not have enough time to respond to family violence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
There is not much point identifying family violence because I am unable to help women with these issues	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I prefer to deal with clinical issues rather than social issues	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I find it difficult to support a woman who stays in a violent relationship	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If I find a patient who is experiencing family violence, I don't know what to do next	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I don't have the necessary skills to discuss family violence with a woman who is from a different cultural/ethnic background	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I ask all new patients about family violence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

35. Below is a list of interventions for female patients.

This two part question asks you about a) what you consider your role to be in responding to a woman who is experiencing family violence; and b) what you consider to be your level of preparedness.

For each activity you will be first asked in part a) to what extent you agree or disagree that the activity should be a part of your care of female patients who experience family violence and secondly in part b), how confident you feel to undertake that activity.

c) To what extent do you agree?

	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
I should encourage a woman to talk about things that might be on her mind	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I should identify women who may be experiencing family violence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I should explore the options open to her	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I should consider whether the children of a woman experiencing family violence are at risk of harm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I should provide her with family violence patient education or resource materials	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I should document injuries and treatment relating to injuries in the medical record	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I should give advice on legal options including referrals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I should offer to contact the police	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
There are services that I can access for myself if I become distressed responding to a woman experiencing family violence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

d) How confident do you feel in having sufficient knowledge and skills to carry this out?

	Not confident	Not very confident	Unsure	Somewhat confident	Very confident
I should encourage a woman to talk about things that might be on her mind	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I should identify women who may be experiencing family violence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I should explore the options open to her	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I should consider whether the children of a woman experiencing family violence are at risk of harm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I should provide her with family violence patient education or resource materials	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I should document injuries and treatment relating to injuries in the medical record	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I should give advice on legal options including referrals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I should offer to contact the police	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
There are services that I can access for myself if I become distressed responding to a woman experiencing family violence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

36. Below is a list of interventions relating to referrals for female patients.

This next two part question again asks you a) about what you consider your role to be in responding to a woman who is experiencing family violence; and b) what you consider to be your level of preparedness.

For each referral presented you will be first asked in part a) to what extent you agree or disagree that the referral should be a part of your care of female patients who experience family violence; and secondly in part b) how confident you feel to undertake that referral.

c) To what extent do you agree?

	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
I should provide my patient with a referral to The Women's Social Support Service (WSSS)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I should provide my patient with a referral to the Centre Against Sexual Assault (CASA)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I should provide my patient with a referral to the Domestic Violence Crisis Service of Victoria	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I should provide my patient with a referral to a family violence or women's telephone help line, such as the Sexual Assault Crisis Line (SACL)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Where appropriate, I should provide my patient with a referral to the Aboriginal Women's Health Business Unit (AWHBU)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Where appropriate, I should provide my patient with a referral to the Women's Alcohol and Drug Service (WADS)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I should provide my patient with a referral to the North Melbourne Legal Service	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

d) How confident do you feel in having sufficient knowledge and skills to carry this out?

	Not confident	Not very confident	Unsure	Somewhat confident	Very confident
I should provide my patient with a referral to The Women's Social Support Service (WSSS)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I should provide my patient with a referral to the Centre Against Sexual Assault (CASA)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I should provide my patient with a referral to the Domestic Violence Crisis Service of Victoria	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I should provide my patient with a referral to a family violence or women's telephone help line, such as the Sexual Assault Crisis Line (SACL)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Where appropriate, I should provide my patient with a referral to the Aboriginal Women's Health Business Unit (AWHBU)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Where appropriate, I should provide my patient with a referral to the Women's Alcohol and Drug Service (WADS)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I should provide my patient with a referral to the North Melbourne Legal Service	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SECTION D: About Your Employment

37. Has your job changed in the last 3 months? Please provide details.

SECTION E: Comments

38. Please provide any additional comments below:

Many thanks for the time and effort you have given in completing this survey

Your answers will remain confidential.

If you became upset or distressed as a result of any questions in the survey, please contact The Women's Employee Assistance Program on 1300 360 364.

You can also talk to someone you trust at the Women's, such as:

- Your manager
- Human Resources on 8345 2080

You may wish to contact other services, such as:

- Your GP
- Women's Social Support Service: (03) 8345 3050
- Women's Domestic Violence Crisis Service of Victoria: (03) 9322 3555, toll free 1800 015 188
- Sexual Assault Crisis Line: 1800 806 292 (24hours)
- Centre Against Sexual Assault (CASA): (03) 9635 3610 (24hrs)
- in-Touch Multicultural Centre Against Family Violence: (03) 9413 6500

Appendix 6: Health Professional Training Evaluation Survey

Workshop Evaluation

Please take a few minutes to complete this Workshop Evaluation. All responses are strictly confidential.

1. In which clinical sector of the Women's do you typically work? (please tick one box)

<input type="checkbox"/>	Gynaecology, Women's Cancer & Perioperative
<input type="checkbox"/>	Maternity
<input type="checkbox"/>	Neonatal Services
<input type="checkbox"/>	Women's Health
<input type="checkbox"/>	Other (please specify) _____

2. Which of the following professions does your position best align with? (please tick one box)

<input type="checkbox"/>	Social Work
<input type="checkbox"/>	Allied Health
<input type="checkbox"/>	Medical support service (imaging, pharmacy)
<input type="checkbox"/>	Medical Officer (Registrars, Consultants, HMOs)
<input type="checkbox"/>	Midwifery
<input type="checkbox"/>	Nursing
<input type="checkbox"/>	Other (please specify) _____

3. How strongly do you agree or disagree with the following statements about the Workshop?

	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
The workshop was well coordinated	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Communication about the workshop was clear, and timely	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The workshop fitted in well around my other responsibilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The way the workshop was delivered supported my learning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

The depth and breadth of the workshop content was right for me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Training resources and materials assisted my learning during the workshop	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Participation in the workshop was a worthwhile experience	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

4. How strongly do you agree or disagree with the following statements about the facilitators?

	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
They were well prepared for the workshop	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
They made connections between the learning materials and activities, and my workplace	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
They demonstrated a sound knowledge and understanding of the workshop content	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
They presented in a clear and stimulating manner	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

5. What were the most useful aspects of the Workshop?

**6. What was the least useful aspect of the Workshop? How could we improve the Workshop?
Can you make any specific suggestions?**

7. Please rate the training overall.

<input type="checkbox"/>	Excellent
<input type="checkbox"/>	Very Good
<input type="checkbox"/>	Good
<input type="checkbox"/>	Fair
<input type="checkbox"/>	Poor

8. Undertaking the Workshop was a positive learning experience.

<input type="checkbox"/>	Strongly Agree
<input type="checkbox"/>	Agree
<input type="checkbox"/>	Neither agree nor disagree
<input type="checkbox"/>	Disagree
<input type="checkbox"/>	Strongly disagree

9. I would recommend the Workshop to colleagues

<input type="checkbox"/>	Strongly Agree
<input type="checkbox"/>	Agree
<input type="checkbox"/>	Neither agree nor disagree
<input type="checkbox"/>	Disagree
<input type="checkbox"/>	Strongly disagree

10. Final Comments and Suggestions

Many thanks for the time and effort you have given in attending the workshop and completing this survey.

Appendix 7 Focus Group and Telephone Interview Guide

Focus Group Guide

INTRODUCTION

1. Explanation of evaluation of AOWS and aim of focus grp
2. Confidentiality
3. Consent to audio

BASIC INFORMATION

1. What is your role at The Women's?
2. How long have you worked there?
3. Have you heard of Acting on the Warning Signs?

THOUGHTS ON ACTING ON THE WARNING SIGNS

4. What are your thoughts on the training programme, Acting on the Warning Signs?
 - a. How were you informed about the training programme?
 - b. What prompted you to attend/not attend?

REFERRAL PATHWAYS

5. What do you consider to be the referral pathways at The Women's for a woman who discloses family violence?
 - a. How do you know about these pathways?
 - b. What do you think of them?
 - c. If you were presented with a case of family violence, how would you use referral pathways?
 - d. What would you do differently with a woman where you suspect family violence but the woman has not disclosed?

OUTCOMES

6. What do you believe the outcomes of the Acting on the Warning Signs training programme were?
 - a. How did it impact the way in which you managed your patients?
 - b. What impact did it have on your decision to refer and to whom?
 - c. What did you feel you learnt about family violence?

What did you feel you learnt about the role of the law and lawyers with regards to patients who disclosed family violence?

Telephone Interview Guide:

Context

1. Can you let me know what role you have at The Women's?

(part time, full time? Department?)

2. How long have you worked there for?

Identifying women experiencing family violence

3. Have you identified any women disclosing family violence, or where family violence is suspected, before or after attending the training?

4. How did you handle the case differently based on the training?

Thoughts on training programme, Acting on the Warning Signs

5. What are your thoughts on the training programme, Acting on the Warning Signs?

a. How were you informed about the training programme?

b. What prompted you to attend/not attend?

Referral pathways

6. What do you consider to be the referral pathways at The Women's for a woman who discloses family violence?

7. What about for women for whom you might suspect family violence?

a. How do you know about these pathways?

b. What do you think of them?

c. If you were presented with a case of family violence, how would you use referral pathways?

d. What would you do differently with a woman where you suspect family violence but the woman has not disclosed?

Outcomes from AOWS

8. What do you believe the outcomes of the Acting on the Warning Signs training programme were?

a. How has it / will it impact the way in which you manage your patients?

b. What impact did / will it have on your decision to refer and to whom?

- c. What did you feel you learnt about family violence?
- d. Did you learn anything about the role of the law and lawyers with regards to patients who disclosed family violence?
 - i. if yes - what was that?

Suggestions

9. Are there any suggestions you would make about content or delivery of the training?

Anything else you'd like to mention?

Appendix 8: Questionnaire for women attending Social Work

WOMEN'S CLIENT SURVEY (Women's Social Support Services)

This project is about improving services for women who attend The Women's Social Support Services. **Your views and experiences are important** and we would appreciate your feedback about your experience in accessing the right service for you.

We know that you are probably very busy, but we would really appreciate you taking 10 minutes to fill in this questionnaire. All the information you provide is **strictly confidential** and no information in the final report will identify any woman who takes part. Your involvement in the project is of course voluntary and you are free to withdraw at any time. If you choose not to participate, it will in no way affect your ability to access services or care.

The evaluation team comes from the University of Melbourne, Departments of Social Work, Arts and General Practice.

If you have any queries or concerns, please contact Cathy Humphreys (8344-9427) or Kristin Diemer (8384-9425)

How to complete this survey

Please read the questions carefully and follow the instructions. There are no right or wrong answers, just what you believe or have experienced.

Most of the questions can be answered by placing a tick in the box next to the answer that best applies to you. Please tick only one box per question.

If you wish to write further comments, please do so at the end of the survey.

Section A : Referral Pathway to Women's Social Support Services (WSSS)

Please tick the box which applies to you. We are trying to find out whether it was easy for you to gain a referral and an appointment with The Women's Social Support Service.

Q 1. Who referred you to Women's Social Support Services?

- ☐ Social Worker from Women's Social Support Services
- ☐ Social Worker from another area in the hospital
- ☐ Self
- ☐ Doctor
- ☐ Nurse
- ☐ Midwife

☐ Other (please specify) _____

Q 2. Did you ask to be referred?

☐ Yes

☐ No

☐ Not sure / Maybe _____

Q 3. Have you been referred more than once to Women's Social Support Services but initially chose not to go?

☐ Yes

☐ No

☐ Not sure / Maybe

Q 4. Were you provided with support to access Women's Social Support Service?

☐ Yes

☐ No

Q 5. If Yes, what support was provided?

Health worker or administrative staff made an appointment for me ☐Yes ☐No ☐Not sure

Health worker or administrative staff walked me to the Service ☐ Yes ☐No ☐Not sure

Health worker or administrative staff gave me clear directions ☐Yes ☐No ☐Not sure

A referral was faxed on my behalf ☐Yes ☐No ☐Not sure

Other (please specify) _____

Q 6. Would you have liked more help in being referred to Women's Social Support Service?

☐ Yes

☐ No

☐ Maybe

Q 7. Women's Social Support Services is also known as the Social Work Department. Did you know this?

☐ Yes

☐ No

Q 8. If Yes, did you have concerns about coming to Women's Social Support Services / the Social Work Department?

- ☐ Yes
- ☐ No
- ☐ Maybe

Q 9. If Yes, did these concerns initially prevent you from attending Women's Social Support Services?

- ☐ Yes
- ☐ No
- ☐ Maybe

Section B: Service received at Women's Social Support Services (WSSS)

Please answer the following questions about Women's Social Support Services (WSSS). There is a box for No or Yes, followed by another group of boxes in which you are also asked how helpful you found the service.

	No	Yes	If Yes, how helpful was this?				
			Very helpful	Fairly helpful	Some help	Very little help	No help at all
Q 10. Did WSSS staff provide you with helpful information about your situation?							
Q 11. Did WSSS staff respond sensitively to your situation?							
Q 12. Did WSSS staff ask questions about family violence and abuse in a sensitive manner?							

Q 13. Do you think you need any legal support for the issues you've discussed with your worker at WSSS?

- ☐ Yes
- ☐ No
- ☐ Maybe

Q 14. If yes, were you offered a referral to a legal service?

- ☐ Yes

- ☐ No
- ☐ Maybe

Q 15. Do you have more knowledge and options about your situation than you had before you came to the WSSS?

- ☐ Yes
- ☐ No
- ☐ Maybe

Q 16. Would you recommend the WSSS to other women?

- ☐ Yes
- ☐ No
- ☐ Maybe

Q 17. Are there any improvements that you would recommend to the service?

- ☐ Yes
- ☐ No
- ☐ Maybe

If yes, could you please outline what might be helpful?

.....

Thank you for taking the time to answer the questions so far. In order to better understand your experience it is important that we know a little about you. For example we may find that women have different experiences or needs depending on whether they are younger or older; live in Melbourne, or elsewhere in Victoria; were born in Australia or in another country, etc.

All the information you provide is confidential. There is no possibility of any individual information you provide being given to any other person or organisation.

ABOUT YOU

Q 18. What is your postcode?

Q 19. If you do not know the postcode, please write the name of your suburb _____

Q 20. Were you born in Australia? Yes ☐ No ☐

Q 21. If no, what is the name of the country where you were born?

Q 22. How many years have you lived in Australia (Number) _____

Q 23. Are you of Aboriginal or Torres Strait Islander origin?

☐ Yes, Aboriginal ☐ Yes, Torres Strait Islander

☐ Yes, both Aboriginal and Torres Strait Islander

☐ No

Q 24. Is English your first language?

☐ Yes ☐ No If no, what is your first language?

Q 25. Do you currently work in a paid job or are you studying? (you may choose more than one answer)

☐ Yes, I work in a paid job

☐ Yes, I am studying

☐ Yes, I am studying and working in a paid job

☐ No, I am not studying or working in a paid job

☐ I work in unpaid work, for example family business or home duties

Q 26. What is the main source of income for your household? (you may choose more than one answer)

☐ Wages or salary?

☐ Pension or benefit?

☐ Spouse's income?

☐ Other _____

Q 27. What was the total income (before tax) of your family in the last year?

\$20,000 or less ☐

\$20,001 - \$30,000 ☐

\$30,001 - \$40,000 ☐

\$40,001 - \$50,000 ☐

\$50,001 - \$60,000 ☐

\$60,001 - \$70,000 ☐

More than \$70,000 ☐

Q 28. Are you:

- ☐ Married
- ☐ Living with a partner, but not married
- ☐ Divorced or separated
- ☐ Widowed
- ☐ Single

Q 29. Are you homeless or at risk of becoming homeless?

- ☐ Yes ☐ No ☐ Maybe

Q 30. Do you have a disability?

- ☐ Yes ☐ No

Q 31. If yes, what is the nature of your disability? _____

Please add any other comments you would like to make.

We would very much like to INTERVIEW women about their experience of WSSS and particularly about service development at The Women's.

Would you be prepared to be interviewed by one of our researchers in an interview lasting about 30-60 minutes? If yes,

Please write your name, address and how we could safely contact you.

Name _____

Safe contact details _____

Thank you very much for the time and effort you have taken in completing this survey.

Please leave this questionnaire in the box provided (sealed in the envelope) or mail it to the researchers. If you have misplaced the envelope please mail the questionnaire to: Dr Kristin Diemer, Dept of Social Work, University of Melbourne, Parkville, Vic 3000

If you provide your contact details you may remove this page from the questionnaire and place it in the box separately, or you may leave it attached.

COPY OF FINAL SUMMARY REPORT

If you would like a copy of the summary report of this project please supply a safe way for us to get this to you: Postal Address or email address

CONTACT FOR THE RESEARCH PROJECT

Kristin Diemer, Research Fellow, The University of Melbourne on 03 8684-9425 or 0413 047 277 (texting is ok), or kdiemer@unimelb.edu.au

CONTACT FOR THE ROYAL WOMEN'S HOSPITAL

The Consumer Advocate at The Women's is available Monday to Friday from 9am to 5pm and can be contacted by phone on (03) 8345 2290 or by email at: consumer.advocate@thewomens.org.au

Appendix 9: Questionnaire for women attending IMCL Outreach Service

WOMEN'S CLIENT SURVEY (North Melbourne Legal Service Outreach)

This project is about improving services for women who attend The North Melbourne Legal Service Outreach. **Your views and experiences are important** and we would appreciate your feedback about your experience in accessing the right service for you.

We know that you are probably very busy, but we would really appreciate you taking 10 minutes to fill in this questionnaire. We realise you may have already filled in questionnaire for the Women's Social Support Service. We appreciate you taking the time to fill in this questionnaire as well. All the information you provide is **strictly confidential** and no information in the final report will identify any woman who takes part. Your involvement in the project is of course voluntary and you are free to withdraw at any time. If you choose not to participate, it will in no way affect your ability to access services or care.

The evaluation team comes from the University of Melbourne, Departments of Social Work, Arts and General Practice.

If you have any queries or concerns, please contact Cathy Humphreys (8344-9427) or Kristin Diemer (8384-9425)

How to complete this survey

Please read the questions carefully and follow the instructions. There are no right or wrong answers, just what you believe or have experienced.

Most of the questions can be answered by placing a tick in the box next to the answer that best applies to you. Please tick only one box per question.

If you wish to write further comments, please do so at the end of the survey.

Section A : Referral Pathway to North Melbourne Legal Service Outreach (NMLS)

Please tick the box which applies to you. We would like to understand how you came to know about The North Melbourne Legal Service Outreach.

Q 32.

How did you come to know about The North Melbourne Legal Service Outreach (NMLS)?

- ☐ Friend
- ☐ Health professional
- ☐ Social Worker
- ☐ Other (please specify) _____

Q 33. Did you ask to be referred for legal help?

- ☐ Yes
- ☐ No
- ☐ Not sure / Maybe _____

Q 34. Who referred you to The North Melbourne Legal Service Outreach?

- ☐ Social Worker from Women's Social Support Services
- ☐ Social Worker from another area in the hospital
- ☐ Self
- ☐ Doctor
- ☐ Nurse
- ☐ Midwife
- ☐ Other (please specify) _____

Q 35. Have you been referred more than once to NMLS but initially chose not to go?

- ☐ Yes
- ☐ No
- ☐ Not sure / Maybe

Q 36. Were you provided with support to access NMLS?

- ☐ Yes
- ☐ No

Q 37. If Yes, what support was provided?

Health worker, social worker or administrative staff made an appointment for me ☐Yes ☐No

Health worker, social worker or administrative staff walked me to the Outreach ☐Yes ☐No

Health worker, social worker or administrative staff gave me clear directions ☐Yes ☐No

Health worker, social worker or administrative staff gave me the phone number ☐Yes ☐No

Other (please specify) _____

Q 38. Would you have liked more help in being referred to NMLS?

- ☐ Yes

- ☐ No
- ☐ Maybe

Q 39. NMLS has an Outreach service at The Women's and an office in North Melbourne. Did it suit you to attend the Outreach at The Women's?

- ☐ Yes
- ☐ No
- ☐ Maybe

Q 40. If No, have you been able to access the service at North Melbourne?

- ☐ Yes
- ☐ No

Q 41. Do you think you would have gone to see a lawyer if the lawyer was not located in the hospital?

- ☐ Yes
- ☐ No
- ☐ Maybe
- ☐ I did not see a lawyer in the hospital, I attended the NMLS North Melbourne office

Q 42. Was the day that the Outreach is held convenient for you?

- ☐ Yes
- ☐ No

Q 43. Were there any barriers to you attending the NMLS at either North Melbourne or The Women's? Please explain.

Section B: Service received with the North Melbourne Legal Service Outreach (NMLS)

Please answer the following questions about the NMLS Outreach. There is a box for No or Yes, followed by another group of boxes in which you are also asked how helpful you found the service.

	No	Yes	If Yes, how helpful was this?
--	----	-----	-------------------------------

			Very helpful	Fairly helpful	Some help	Very little help	No help at all
Q 44. Did NMLS staff provide you with information that addressed your situation?							
Q 45. Did NMLS staff respond sensitively to your situation?							
Q 46. Did NMLS staff ask questions about family violence and abuse in a sensitive manner?							
Q 47. Do you think that a legal service at The Women's is a good idea?							

Q 48. Do you have more knowledge and options about your situation than before you came to the NMLS Outreach?

- ☐ Yes
- ☐ No
- ☐ Maybe

Q 49. Have you found the outcome of your legal assistance helpful?

- ☐ Yes
- ☐ No
- ☐ Maybe

Q 50. Do you think being able to speak with a lawyer has improved your health in any way?

- ☐ Yes
- ☐ No
- ☐ Maybe

If yes, how is that?

Q 51. Are there any improvements that you would recommend to NMLS?

- ☐ Yes

- ☐ No
- ☐ Maybe

Q 52. If yes, could you please outline what might be helpful?

Thank you for taking the time to answer the questions so far. In order to better understand your experience it is important that we know a little about you. For example we may find that women have different experiences or needs depending on whether they are younger or older; live in Melbourne, or elsewhere in Victoria; were born in Australia or in another country, etc.

All the information you provide is confidential. There is no possibility of any individual information you provide being given to any other person or organisation.

ABOUT YOU

Q 53. What is your postcode?

Q 54. If you do not know the postcode, please write the name of your suburb _____

Q 55. Were you born in Australia? Yes ☐ No ☐

Q 56. If no, what is the name of the country where you were born?

Q 57. How many years have you lived in Australia (Number) _____

Q 58. Are you of Aboriginal or Torres Strait Islander origin?

☐ Yes, Aboriginal ☐ Yes, Torres Strait Islander

☐ Yes, both Aboriginal and Torres Strait Islander

☐ No

Q 59. Is English your first language?

☐ Yes ☐ No If no, what is your first language? _____

Q 60. Do you currently work in a paid job or are you studying? (you may choose more than one answer)

☐ Yes, I work in a paid job

☐ Yes, I am studying

☐ Yes, I am studying and working in a paid job

☐ No, I am not studying or working in a paid job

☐ I work in unpaid work, for example family business or home duties

Q 61. What is the main source of income for your household? (you may choose more than one answer)

☐ Wages or salary?

☐ Pension or benefit?

☐ Spouse's income?

☐ Other _____

Q 62. What was the total income (before tax) of your family in the last year?

\$20,000 or less ☐

\$20,001 - \$30,000 ☐

\$30,001 - \$40,000 ☐

\$40,001 - \$50,000 ☐

\$50,001 - \$60,000 ☐

\$60,001 - \$70,000 ☐

More than \$70,000 ☐

Q 63. Are you:

☐ Married☐ Living with a partner, but not married

☐ Divorced or separated

☐ Widowed☐ Single

Q 64. Are you homeless or at risk of becoming homeless?

☐ Yes ☐ No ☐ Maybe

Q 65. Do you have a disability?

☐ Yes ☐ No

Q 66. If yes, what is the nature of your disability?

Please add any other comments you would like to make.

--

Thank you very much for the time and effort you have taken in completing this survey.

Please leave this questionnaire in the box provided (sealed in the envelope) or mail it to the researchers. If you have misplaced the envelope please mail the questionnaire to:

Dr Kristin Diemer, Dept of Social Work, University of Melbourne, Parkville, Vic 3000

We would very much like to INTERVIEW women about their experience of WSSS and particularly about the service development at The Women's.

Would you be prepared to be interviewed by one of our evaluators in an interview lasting about 30 minutes? If yes, Please put your name, address and how we could confidentially contact you.

Name _____

Safe contact details _____

Thank you very much for the time and effort you have taken in completing this survey.

Please leave this questionnaire in the box provided (sealed in the envelope) or mail it to the researchers. If you have misplaced the envelope please mail the questionnaire to: Dr Kristin Diemer, Dept of Social Work, University of Melbourne, Parkville, Vic 3000

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COPY OF FINAL SUMMARY REPORT

If you would like a copy of the summary report of this project please supply a safe way for us to get this to you: Postal Address or email address

CONTACT FOR THE RESEARCH PROJECT

Kristin Diemer, Research Fellow, The University of Melbourne on 03 8684-9425 or 0413 047 277 (texting is ok), or kdiemer@unimelb.edu.au

CONTACT FOR THE ROYAL WOMEN'S HOSPITAL

The Consumer Advocate at The Women's is available Monday to Friday from 9am to 5pm and can be contacted by phone on (03) 8345 2290 or by email at: consumer.advocate@thewomens.org.au

CONTACT FOR NORTH MELBOURNE LEGAL SERVICE

The Executive Officer of North Melbourne Legal Service can be contacted on (03) 9328 1885

Appendix 10: Women's client survey interview schedule

WOMEN'S CLIENT SURVEY: PATHWAY TO SUPPORT

We are trying to improve the services for women who attend The Women's Support Service. **Your views and experiences are important** and so we would appreciate your feedback about your experience of accessing the right service for you.

We thank you for volunteering to take part in this interview and know that you are probably very busy as we will keep it to the minimum amount of time which allows your experience to be discussed.

All the information you provide is **strictly confidential** and no information will identify you as having taken part. Most importantly, your participation will not impact any current service or future service you receive from either the Royal Women's Hospital or the North Melbourne Legal Service.

The evaluation team comes from the University of Melbourne, Departments of Social Work, Arts and GP Practice.

Your involvement in the project is of course voluntary and you are free to withdraw at any time.

If you have any queries or concerns, please contact Kristin Diemer (83849425) or Cathy Humphreys (83449427).

In order to fully concentrate on our discussion, I would like to record our interview rather than take detailed notes. Would that be OK with you? Obtain verbal consent on recorder. If no – then proceed with note-taking.

I'm going to start by asking you about your experience at the RWH and how you came to be referred to either The Women's Support Service (WSS) or the North Melbourne Legal Service (NMLS).

1) Can you tell me a little about that - your experience at the Royal Women's hospital and how you came to be referred to the WSS or NMLS?

Question Probes:

Who spoke with you? Who referred you? What sorts of questions did they ask? How comfortable were you in speaking about the violence you've experienced?

2) When the hospital staff spoke with you about your experiences of violence, or the risks you may be facing, How was that for you? Was it unexpected? Could they have done anything differently to make it easier?

Now some questions about your experience at either / both the WSS or NMLS.

3) Can you tell me a little about that – how was it for you to make an appointment or did someone else make it for you?

4) How was it for you to attend the service? Which services were you referred onto?

Question probes

Were they appropriate for you? Did you find out anything more than you knew before attending?

5) Were you referred for any legal advice (if not mentioned above)? If yes - Did you feel this was appropriate / if no – would you have like to have been referred for legal advice?

Question probes

Were you able to obtain legal advice? Was the advice relevant for you? Were you screened out from legal advice for any reason?

6) overall – do you think you have any more knowledge about the options available to you and how to keep yourself (and children safe)? Tell me about that and what knowledge you’ve gained from the support through referral at The Women’s . *In particular – probe about knowledge about the law and their options in relation to family violence arising from information provided by Health Professionals.*

Those are all the questions I have for you.

Thank you for taking the time to speak with me.

Just to re-assure you again, all the information you provide is confidential. There is no possibility of any individual information you provide being given to any other person or organisation.

COPY OF FINAL REPORT

Please let us know if you would like a copy of the report of this project.

Safe way to supply the report: Postal Address or email address

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CONTACT FOR THE AWS PROJECT

Kristin Diemer, Research Fellow, The University of Melbourne on 03 8684-9425 or 0413 047 277 (texting is ok), or kdiemer@unimelb.edu.au

Appendix 11 Specifications for Client / Patient referral data (IMCL and Social Work)

The purpose of collecting this information is to evaluate the translation of staff training into service referral. The Women's clinical staff members are being invited to participate in training on the recognition of the warning signs of domestic and family violence.

The purpose of this evaluation is to identify if the training translates through to increased referrals and from where they are being referred *prior* to a woman obtaining a service. **Please note:** this is *not* the questionnaire with women who experience violence, this is general referral information to be recorded by the administration staff when making an appointment.

We understand that the issue of family violence may not be known at the time a woman makes an appointment, please record the information as far as possible where it is known that this is the reason for referral.

IMCL –information to record when women are referred to IMCL for family violence related issues

Number of women referred to IMCL for family violence related issues (before accessing an appointment)

- Who referred her – how did she know to come here? (please be as specific as possible eg social worker, gynecologist, speech pathologist etc.)
- Reason for referral (eg safety and protection, children's issues, family law issues etc. please be as specific as possible)
- Has she also attended other services through Social Work for this current issue?
- Has she attended IMCL previously?
- Did you provide her with any information sheets / brochures etc (please specify)
- Number of women screened-out / out of scope clients and reason why (e.g. conflict or issue not able to be addressed etc please be as specific as possible)
- Number of women for which an appointment is made and how many result in an actual appointment
- For all the women who made and attended appointments – the CLSIS data to be extracted (this will be requested at a later date)

Social Work –information to record when women are referred to Social Work for family violence related issues

Number of women referred to Social Work for family violence related issues (before accessing an appointment)

- Who referred her – how did she know to come here? (please be as specific as possible eg gynecologist, speech pathologist etc.)
- Reason for referral (eg safety and protection, children's issues, family law issues etc. please be as specific as possible)
- Has she attended Social Work previously?
- Did you provide her with any information sheets / brochures etc (please specify)
- Number of women screened-out or unable to have an appointment made and reason why (eg issue not able to be addressed, professional unavailable when client wanted to attend etc please be as specific as possible)
- Number of women for which an appointment is made and how many result in an actual appointment

- Number of women referred on to IMCL for service

Appendix 12: Specifications for IMCL Snapshot data extract from CLSIS

Acting on the Warning Signs (AOWS):

North Melbourne Legal Service CLSIS data extraction request (REVISED based on legal advice offered to IMCL that privacy protocols would prevent the delivery of data in the preferred format) De-identified, raw data in one of the following formats SPSS, or Excel, or ASCII

Revised, alternative format of data delivery: IMCL to provide data tables (frequency counts only) of the following data items for the clients with family violence problem types, seen within a 6 month period, extracted at three points in time to enable top-level comparative analysis prior to and during the period in which health professions have been trained to better screen for and refer patients with family violence related issues for legal advice.

The two points in time include:

November 30 2012 - data from IMCL clients with family violence related issues over the previous 6 months (June 2012-November 2012 - prior to the AWOS training program within The Women's)

November 30 2013 - data from IMCL clients with family violence related issues over the previous 6 months (June 2013 – November 2013) after training program completed and awareness has hopefully increased and become embedded or transferred across staff and continuing to filter through The Women's referral pathway.

Purpose of request for the Project:

The data items specified below are requested with the expectation that they will provide information suitable for exploring the diversity of, and range of needs among clients accessing IMCL for family violence related issues, or in association with family violence. Understanding the diversity of clients and their needs will provide information to assist IMCL to better prepare to meet their needs and potentially to explore unknown avenues for referring clients into IMCL.

Name/description of the Agency & database	Describe the information that will be collected. List of all data items	Preferred format of data requested	Reasons for request
North Melbourne Legal Service: Community Legal Services Information System (CLSIS)	Region of Victoria (eg inner Melbourne)	Frequency counts	To map the geographic region from which clients are drawn to IMCL
	Age of client (in 10 year age groupings)	Frequency counts	To examine the diversity & needs of the clients seen by IMCL
	Whether client has dependent children living with her (Yes / No)	Frequency counts	To examine the diversity & needs of the clients seen by IMCL
	Disability indicator (Yes / No)	Frequency counts	To examine the diversity of the clients seen by IMCL
	Gender of client	Frequency counts	Nature of the research is to focus on female clients, this is requested to ensure that males are excluded
	Other party type* (relationship between the parties in relationship categories)	Frequency counts	To examine the diversity of the clients seen by IMCL

	Family type	Frequency counts	To examine the diversity of the clients seen by IMCL
	Indigenous status	Frequency counts	To examine the diversity of the clients seen by IMCL
	CALD status Detailed CALD status, not by broad region	Frequency counts	To examine the diversity of the clients seen by IMCL
	Main language Language spoken / preferred language (not by region, actual language)	Frequency counts	To examine the diversity of the clients seen by IMCL – especially the need for interpreters – One of the objectives in the original project brief was for IMCL and The Women’s to increase access among women speaking the following languages (Arabic, Mandarin, Cantonese, Turkish or Vietnamese)
	Country of birth	Frequency counts	To examine the diversity of the clients seen by IMCL
	Year of arrival in Australia (Can be provided in a range of years of arrival in Australia, eg five year groupings)	Frequency counts	To examine the diversity of the clients seen by IMCL – especially the identification of special needs of new arrivals
	Nature of the activity provided by the service	Frequency counts	To examine the nature of service delivered in association with or in response to family violence

	Legal Aid provision	Frequency counts	To examine the number of clients exposed to family violence eligible for legal aid
	Problem type Note: need to be able to identify/ confirm family violence problems – could be done through selection criteria	Frequency counts	Descriptive analysis of the problem type for which service was delivered
	Referral from Note: need to be able to identify/ confirm referrals from The Women's	Frequency counts	Explore the awareness of IMCL service provision across the service sector by examining the diversity of services referring women into IMCL (especially in relation to The Women's)
	Referral to	Frequency counts	Explore the diversity and range of services for which IMCL clients are referred for additional support
	Service type	Frequency counts	To examine the nature of service delivered in association with or in response to family violence
	Child support matter	Frequency counts	To examine the nature of service delivered in association with or in response to family violence

	Welfare support matter	Frequency counts	To examine the nature of service delivered in association with or in response to family violence
	Tenancy matter	Frequency counts	To examine the nature of service delivered in association with or in response to family violence
	Employment	Frequency counts	To examine the economic security issues among clients seen by IMCL in association with or in response to family violence
	Income source	Frequency counts	To examine the economic security issues among clients seen by IMCL in association with or in response to family violence
	<u>Language spoken</u> according to from <u>Where a woman is referred from</u> (to meet specific request in the Brief from The Women's)	Cross tabulation of numbers	To identify the numbers and languages among women being referred from The Women's to IMCL

Appendix 13: 2nd Stakeholder Workshop Programme

Second Stakeholder Workshop Programme

Acting on the Warning Signs

A health-legal partnership between North Melbourne Legal Service and the Royal Women's Hospital to address violence against women through a multi-disciplinary approach

Second Stakeholder Workshop

Friday 13th June 2014, 9a.m.-12p.m.

Conference Room A, Ground Floor, Royal Women's Hospital

Time	Session	Presenter/Facilitator
9:00a.m.- 9:10a.m.	Welcome Outline of the goals of the workshop Introduction of team members Review evaluation aims & design.	Lisa Dunlop Executive Director Clinical Operations, The Women's Hospital Stuart Ross – Chief Investigator Evaluation Team
9:10a.m.- 9:30a.m.	Overview of evaluation findings – Part A Health professional surveys & focus groups	Kelsey Hegarty – Chief Investigator Evaluation Team Kirsty Forsdike - Senior Researcher Evaluation Team
9.30 am - 9.50 am	Overview of evaluation findings – Part b Intake and referral rates Client case studies	Cathy Humphreys – Chief Investigator Evaluation Team Kristin Diemer – Senior Research Fellow Evaluation Team

Time	Session	Presenter/Facilitator
9:55a.m.– 10:30a.m.	<p>Group discussion of key issues which include:</p> <ol style="list-style-type: none"> 1. How aware are hospital staff / clinicians about <u>in-house training</u> around violence against women? How could awareness be improved? 2. How aware are hospital staff / clinicians about the <u>support available for women</u> / patients experiencing violence? How could awareness be improved? 3. How aware are hospital staff / clinicians about the referral pathway when violence is identified? (Pathway of support through Social work & IMCL outpost)? What would be some opportunities to <u>improve the referral pathways</u> or <u>awareness</u> of the pathways? 4. To what extent are there environmental or contextual factors impacting on engagement with the training & referral pathway? 5. How could the Acting on the Warning Signs program be improved, now and over time? 	Evaluation Team
10:30a.m.– 10:45a.m.	Morning Tea	
10:45a.m.– 11:00a.m.	Continue to review key issues; participants to prepare a brief response back to the workshop	Evaluation Team
11:00a.m.– 11:45a.m.	Participants to report back and plenary discussion	Evaluation Team
11:45a.m.– 11:55a.m.	<p>AOWS Where to next?</p> <p>Key related points from study tour</p>	Linda Gyorki – AOWS Project Manager & Lawyer IMCL
11:55a.m.– 12p.m.	Thank you and formal close of workshop	Stuart Ross

Appendix 14: Part 2 Evaluation Analysis Data Tables

Table 23: Estimate number of clients making appointments at the IMCL outreach at The Women's and appointment attendances over a 15 month period by month (Oct 2012 – Dec 2013)*

	2012			2013												15 month total
	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
Number of appointments made	2	9	5	7	9	1	19	9	9	19	8	9	18	6	8	138
Number of clients attending	1	7	3	5	8	1	11	7	6	12	5	8	10	4	6	94
Number of clients not attending (row A-B)	1	2	2	2	1	0	8	2	3	7	3	1	8	2	2	44
Rate of attendance appointments	50%	78%	60%	71%	89%	100%	58%	78%	67%	63%	63%	89%	56%	67%	75%	68%

* This data has been compiled from appointment booking sheets for the clinic and the primary lawyer diary for appointments outside of outreach standard hours. The count will be an estimate as it does not include re-scheduled appointments. This table also excludes appointments at the IMCL office instead of the hospital. Countering this underrepresentation is the likelihood that on-going clients may be counted more than once.

Table 24: Clients seen at the IMCL outreach all legal issues (not limited to family violence) by year and month (January 2009 – Dec 2013)

	Total monthly count of clients seen at The Women's outreach from 1 Jan 2009 – 3 Dec 2013												
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
2009	0	0	1	0	0	0	0	0	0	0	0	0	1
2010	0	0	0	0	0	2	2	2	3	0	2	1	12
2011	0	0	0	3	4	5	2	0	3	2	4	3	26
2012	1	3	2	1	4	5	3	3	6	4	5	2	39
2013	5	7	1	6	2	3	8	4	6	8	2	4	56
Total	134												

Table 25: Clients seen at the IMCL outreach where family violence was identified, but not necessarily the legal issue by year and month (January 2009 – Dec 2013)

	Monthly count of number of clients seen by IMCL at The Women's where family violence indicator was ticked from 1 Jan 2009 to 30 December 2013												
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
2009	0	0	0	0	0	0	0	0	0	0	0	0	
2010	0	0	0	0	0	0	0	0	0	0	0	0	
2011	0	0	0	0	3	0	0	0	0	0	0	0	
2012	0	0	0	0	1	2	0	2	2	2	4	0	
2013	1	3	1	2	2	2	4	3	6	7	1	1	
Total													

Table 26: Clients seen at the IMCL outreach where family violence was the legal issue by year and month (January 2009 – Dec 2013)

	Monthly count of number of clients seen by IMCL at The Women's where family violence was the legal issue from 1 Jan 2009 to 30 December 2013												
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
2009	0	0	0	0	0	0	0	0	0	0	0	0	
2010	0	0	0	0	0	0	0	0	0	0	2	0	
2011	0	0	0	1	2	0	0	0	1	1	1	0	
2012	0	0	0	0	0	0	0	1	2	2	3	0	
2013	0	1	1	1	2	2	4	3	6	5	1	1	
Total													

Table 27: Clients referred to the IMCL outreach by a social worker at The Women's over a 12 month period by month (January 2013 – Dec 2013)*

	Monthly count of referrals from a social worker at The Women's to IMCL Outreach at The Women's from 1 January 2013 – 31 December 2013												
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
Family violence as the legal issue	0	1	1	0	2	2	3	3	6	5	1	1	
Family violence indicator ticked	0	3	1	1	2	2	3	3	6	7	1	1	
Non-family violence related referrals	1	4	0	5	1	1	4	0	0	1	1	2	
Total all referrals	1	7	1	6	3	3	7	3	6	8	2	3	

* This data has been extracted from CLSIS and figures represent clients not instances of advice. For example, if a client has attended IMCL outreach more than one time only the first attendance has been counted.

Table 28: IMCL - Age of client (Clients of IMCL who had been referred by The Women's, Snapshot data extraction June – November)

Age of client						
	IMCL family violence related clients snapshot 1 & 2 combined		IMCL non-family violence related clients snapshot 1 & 2 combined		Total	
	n	%	n	%	N	%
Between 10 to 19	1	3%	2	11%	3	6%
Between 20 to 29	14	48%	5	28%	19	40%
Between 30 to 39	12	41%	8	44%	20	43%
Between 40 to 49	2	7%	3	17%	5	11%
Total	29	100%	18	100%	47	100%

Table 29: Social Work - Age of client (Clients of Social Work referred for violence related issues categorised in age groups comparative with IMCL data)

Age of client		
	Social Work clients referred for violence related issues (IMCL age groups)	
	n	%
Between 10 to 19	16	7.7
Between 20 to 29	92	44.2
Between 30 to 39	83	39.9
Between 40 to 49	14	6.7
50 and older	3	1.4
Total	208	100

Table 30: IMCL - Presence of dependent children (Clients of IMCL who had been referred by The Women's, Snapshot data extraction June – November)

Whether client has dependent children living with her						
	Family violence related clients snapshot 1 & 2		non-family violence related clients snapshot 1 & 2		Total	
	n	%	n	%	N	%
Yes	12	41%	11	61%	23	49%
No	16	55%	7	39%	23	49%
Unknown	1	3%	0	0%	1	2%
Total	29	100%	18	100%	47	100%

Table 31: IMCL - Source of income (Clients of IMCL who had been referred by The Women's, Snapshot data extraction June – November)

Source of Income						
	Family violence related clients snapshot 1 & 2		non-family violence related clients snapshot 1 & 2		Total	
	n	%	n	%	N	%
Pension/Benefit	16	52%	9	45%	25	49%
Earned	11	35%	6	30%	17	33%
None	2	6%	3	15%	5	10%
Parents	1	3%	0	0%	1	2%
Intimate partner	1	3%	0	0%	1	2%
Unknown	0	0%	2	10%	2	4%
Total	31	100%	20	100%	51	100%

Table 32: IMCL - Preferred main language spoken (Clients of IMCL who had been referred by The Women's, Snapshot data extraction June – November)

Family violence related clients referred from The Women's to IMCL			
Main language spoken	Snapshot 1: 2012 (range)	Main language spoken	Snapshot 2: 2013 (range)
English	6 - 10	English	11 - 15
Thai	1 - 5	Somali	1 - 5
Austronesian language	1 - 5	Spanish	1 - 5
Dinka	1 - 5	Arabic	1 - 5
Vietnamese	1 - 5	Major Chinese language	1 - 5
Mandarin	1 - 5		
Non-family violence related clients referred from The Women's to IMCL			
Main language spoken	Snapshot 1: 2012 (range)	Main language spoken	Snapshot 2: 2013 (range)
English	6 - 10	English	1 - 5
Arabic	1 - 5	Spanish	1 - 5
Mandarin	1 - 5	Amharic	1 - 5
Somali	1 - 5		

Base = unknown

Table 33: IMCL- Whether an interpreter was required (Clients of IMCL who had been referred by The Women's, Snapshot data extraction June – November)

Whether an interpreter was required at booking (both family violence and non-family violence clients)		
	Snapshot 1: June – December 2012 n	Snapshot 2: June – December 2013 n
Yes	4	0
No	22	21
Unknown		1
Total	26	22

Table 34: IMCL - Relationship between parties (Clients of IMCL who had been referred by The Women's, Snapshot data extraction June – November)

	Family violence related clients snapshot 1 & 2 combined		Non family violence clients snapshot 1 & 2 combined	
	N	%	N	%
Govt agency/enforcement agency	3	9%	3	14%
Ex-partner (husband/fiance/boyfriend)	19	58%	8	38%
Current partner (husband/fiance/boyfriend)	7	21%	2	10%
Father of child/father of unborn child	3	9%	4	19%
Non-govt agency	1	3%	3	14%
Professional person / organisation	0	0%	1	5%
Total	33	100%	21	100%

Table 35: IMCL - Nature of the activity provided by IMCL (Clients of IMCL who had been referred by The Women's, Snapshot data extraction June – November)

Family violence related clients: nature of the activity provided by the service						
	Snapshot 1: June – December 2012		Snapshot 2: June – December 2013		Total	
	n	%	n	%	N	%
Casework	4	33%	9	50%	13	43%
Advice	8	67%	9	50%	17	57%
Total	12	100%	18	100%	30	100%
Non-family violence related clients: nature of the activity provided by the service						
	Snapshot 1: June – December 2012		Snapshot 3: June – December 2013		Total	
	n	%	n	%	N	%
Casework	3	21%	0	0%	3	17%
Advice	11	79%	4	100%	15	83%
Total	14	100%	4	100%	18	100%

Table 36: IMCL - Problem type (Clients of IMCL who had been referred by The Women's, Snapshot data extraction June – November)

	Family violence related clients snapshot 1 & 2 combined		Non family violence clients snapshot 1 & 2 combined	
	n	%	n	%
Guardianship order	0	0%	1	2%
Infringements	1	1%	2	4%
Parenting	16	12%	8	16%
Child support	18	13%	13	26%
Divorce	3	2%	1	2%
Tenancy	2	1%	1	2%
Birth certificates	15	11%	8	16%
Property	6	4%	1	2%
Childbirth expenses	1	1%	3	6%
Intervention orders	20	15%	0	0%
Family violence	16	12%	0	0%
Debts	1	1%	1	2%
Complaint	1	1%	2	4%
Passports	3	2%	2	4%
Social security	2	1%	2	4%
Removal of child	1	1%	0	0%
Paternity	2	1%	1	2%
Migration	1	1%	1	2%
Name change	1	1%	0	0%
Crime	2	1%	0	0%
Vocat	6	4%	0	0%
Personal injury	2	1%	0	0%
Motor vehicle	1	1%	0	0%
Child protection	5	4%	0	0%
Relocation	1	1%	0	0%
Housing	2	1%	0	0%
Traffic	1	1%	0	0%
Administration orders	1	1%	0	0%
Airport watch list	2	1%	1	2%
Citizenship	1	1%	0	0%
Adoption	0	0%	1	2%
Neighbour dispute	0	0%	1	2%
Total	134	100%	50	100%

Table 37: IMCL – Referred onto other services (Clients of IMCL who had been referred by The Women’s, Snapshot data extraction June – November)

Referred onto other services						
	Family violence related clients snapshot 1 & 2 combined		Non family violence clients snapshot 1 & 2 combined		Total	
	n	%	n	%	N	%
No referrals	10	27%	13	62%	23	40%
Support agency	4	11%	0	0%	4	7%
Child support agency	2	5%	2	10%	4	7%
Tenants union	1	3%	0	0%	1	2%
Local/specialist CLC	10	27%	1	5%	11	19%
Law Institute of Victoria	0	0%	1	5%	1	2%
VLA funded family lawyer	2	5%	1	5%	3	5%
Other lawyer with specialist expertise (eg migration)	5	14%	2	10%	7	12%
Family relationship centre	0	0%	1	5%	1	2%
Family dispute resolution service	1	3%	0	0%	1	2%
Children's contact service	1	3%	0	0%	1	2%
Housing service	1	3%	0	0%	1	2%
Total	37	100%	21	100%	58	100%

Table 38: IMCL – Matter type (Clients of IMCL who had been referred by The Women’s, Snapshot data extraction June – November)

Matter type						
	Family violence related clients snapshot 1 & 2		non-family violence related clients snapshot 1 & 2		Total	
	n	%	n	%	N	%
child support matter	17	77%	12	75%	29	76%
social security rights matter	3	14%	2	13%	5	13%
tenancy matter	2	9%	2	13%	4	11%
employment	0	0%	0	0%	0	0%
Total	22	100%	16	100%	38	100%

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