An Australian hospital’s training program and referral pathway within a multi-disciplinary health–justice partnership addressing family violence

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Family violence is recognized globally as a major health concern: almost one-third of all women worldwide have experienced violence by an intimate partner.1 The health impacts of such violence cover physical and psychological trauma, including injuries, chronic pain, depression and anxiety.1,2 In Australia, an estimated 17% of women over the age of 18 years have experienced partner abuse after the age of 15.3 After family and friends, health professionals are the most common first-line response for women, accounting for approximately one-quarter of women seeking help in relation to the abuse, with a smaller percentage seeking help from other services such as a legal service.2 Research and guidelines have mainly focused on identifying and asking about family violence within healthcare settings, with the World Health Organization recommending health professionals be trained in identifying and appropriately responding.4,5 The World Health Organization also recommends that health professionals who identify family violence should provide immediate practical support assisting the woman to access information and connect to services and supports including legal services.1 In providing comprehensive care, medical–legal care should be provided either on-site or through non-government and community organisations that minimise the number of contacts women need to make.5

At the time of the evaluation, there was little available evidence on health–justice partnerships in Australia, although they are becoming more common.1 Hum and Faulkner (2009) provide a review of how health–justice partnerships, well-established in the United States (US), could be of benefit in Australia.7 In the US, these partnerships originated in child medical and legal issues. The partnerships sought to enable, in the one place, access for families to both medical care and assistance with broader issues.5 Health–justice partnerships provide the means to assist women experiencing family violence at the point of disclosure with immediate assistance offered concurrently by healthcare providers, family violence services and legal advisors. Legal issues for women experiencing family violence are often complex, requiring advice beyond an intervention order, and can include family law, child protection, immigration law, debt and bankruptcy, the criminal justice system and housing. Baker (2011) examines multidisciplinary practices

Abstract

Objective: An innovative health–justice partnership was established to deliver legal assistance to women experiencing family violence who attended an Australian hospital. This paper reports on a multifaceted response to build capacity and willingness of health professionals to identify signs of family violence and engage with referral pathways to on-site legal assistance.

Methods: A Realistic Evaluation analysed health professionals’ knowledge and attitudes towards identification, response and referral for family violence before and after training; and use of referral pathways.

Results: Of 123 health professionals participating in training, 67 completed baseline and follow-up surveys. Training improved health professionals’ self-reported knowledge of, and confidence in, responding to family violence and understanding of lawyers’ roles in hospitals. Belief that patients should be referred to on-site legal services increased. Training did not correspond to actual increased referrals to legal assistance.

Conclusion: The program built capacity and willingness of health professionals to identify signs of, and respond to, family violence. Increase in referral rates to legal assistance was not shown. Potential improvements include better data capture and greater availability of legal services.

Implications for public health: Strong hospital system supports and reliable recording of family violence referrals need to be in place before introducing such partnerships to other hospitals.

Key words: family violence, hospital, health–justice partnership

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Submitted: May 2017; Revision requested: July 2017; Accepted: September 2017

The authors have stated the following conflict of interest: Author Gyorki is employed by Inner Melbourne Community Legal. Authors Maher, Vye and Llewelyn are employees of the Royal Women's Hospital.

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that include medical and legal services in the US providing care to women experiencing domestic violence. Multidisciplinary practice enables a woman facing multiple challenges from domestic violence to obtain the range of professional supports required at the same time in the same location. Those providing such supports do so with an understanding and recognition of the need for collaboration with the other professional services. However, Baker also raises the issue of professional, cultural and practice differences and the challenges these differences give rise to, such as lawyer–client privilege and confidentiality.

An innovative health justice partnership program using a multi-disciplinary approach was established to deliver legal advice and consultation to women experiencing family violence who presented at The Royal Women’s Hospital (the hospital) in Melbourne, Australia (the Acting on the Warning Signs Program, hereafter, the program). The program aimed to complement family violence training for staff at the hospital and the on-site legal service that Inner Melbourne Community Legal (IMCL) had delivered at the hospital since 2009, co-located with the hospital’s Social Work department. IMCL provided one legal advisory session a week within the hospital, which increased following the evaluation. The health justice partnership between the on-site legal service and the hospital builds on a strong organisational foundation that the hospital has developed to address violence against women. The program involved; building the capacity and willingness of health professionals to identify signs of family violence; providing information on referral pathways, including to the on-site legal service; building on existing clinical practice guidelines; and concurrently providing patients with legal assistance alongside other services as part of a multifaceted response to family violence.

Best practice evidence informed the program’s training workshops and involved: consultation with domestic violence experts and a reference group; general and specific sessions for different professional groups within the hospital; multidisciplinary presenters; use of survivor voices; use of case studies; community resources and knowledge of the legal system; and promotion of those trained to become family violence champions. Three key conditions must be satisfied to lead to practice change within a hospital: hospital management must provide active support; adequate resources must be available, and tailored training must be provided to staff.

In this program, the hospital provided top-level support and encouragement for health professionals to participate in a training workshop covering a range of topics related to family violence, including training in the new referral pathway supported by the hospital and on-site legal service.

The aim of the training was to improve referral rates by hospital staff to the social work department and the new legal service. Training content included: understanding family violence; legal assistance; reporting requirements; working as part of a multidisciplinary team (including working with advocacy groups and linking to community resources); developing an awareness of own responses and behaviours and how these can affect clinical care; and understanding the cultural background, needs and preferences of patients.

Training also drew upon Warshaw et al’s suggested learning objectives and skill-based competencies, including: problem awareness; family violence 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; and provider issues, responses and concerns. Consistent with Feder et al’s (2011) advice on successful training programs, training was delivered by clinicians and experts in family violence who were based at the hospital. The workshop facilitators came from a variety of roles including legal, allied health, clinical education and operations managers. The program was implemented collaboratively by IMCL and the hospital’s social work department, senior management, human resources and clinical education team.

This paper reports on the following key questions:

- Did health professionals who attended the program’s workshops self-report increases in skills and confidence in identifying, responding and referring in relation to family violence and improvements in knowledge about the role of lawyers?
- Did training of health professionals increase referral rates to social work and subsequently to the on-site legal service?

Ethical clearance for the evaluation was provided by the hospital’s Human Research Ethics Committee.

Methods

We used Pawson and Tilley’s (1997) Realistic Evaluation model for the evaluation that took place from 2012 to 2014. 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). Our goal was to provide a more complete understanding of how the program works within the context of health and legal systems. The evaluation documented the processes that generated intended and unintended outcomes, and identified resources and other factors that acted as limiting or facilitating factors. This approach enables further refinement of the program model, and its adaptation or translation to other contexts. An overview of the program is shown in Figure 1.

Health professionals who had registered for one of the program’s workshops were invited via email sent from the hospital’s human resources department (HR) to complete a confidential survey prior to attending the workshop (baseline survey), and three months after attending the workshop (follow-up survey). They could complete the survey online or in paper-based format. The survey covered the health professionals’ attitudes towards, knowledge of, and confidence in identifying and responding to family violence. Results from the baseline and follow-up surveys completed online automatically downloaded to an excel spreadsheet to which paper-based surveys were manually added by a member of HR. Each participant was given a code by a member of HR before the de-identified data was provided for analysis using SPSS software. The five-point Likert scales in the survey were dichotomised so that ‘Agree/Strongly agree’, ‘Somewhat confident/Very confident’, and ‘ Likely/Very likely’ were coded as 1, and all other responses were coded as 0. Percentages were calculated for these dichotomised variables, and McNemar’s test was used to analyse pre/post differences.

We manually extracted referral data from the paper-based internal hospital referral sheets. IMCL manually extracted the on-site legal service referral data from referral sheets and appointment diaries as well as IMCL’s database.
Two snapshots of client data from IMCL’s CLSIS database, one year apart, were provided to the researchers. Client files for the time period were downloaded from the central CLSIS data system by IMCL and filtered to identify clients referred and seen at the IMCL outreach clinic at the hospital. The clients were then filtered by two factors: 1) those presenting for a family violence legal issue; and 2) those where family violence indicators were identified (regardless of the legal issue). Clients will overlap between the two categories.

The first data snapshot included all clients referred from the hospital into the on-site legal service between 1 June 2012 and 30 November 2012, the period leading into the program’s training roll-out; the second snapshot was taken 12 months later (1 June 2013 and 30 November 2013). In both snapshots, the number of clients was very small. After clients (n=9) who did not want their data used for research purposes were screened out, a total of 48 clients were reviewed (snapshot 1, n=26; snapshot 2, n=22) and only descriptive summary analysis can be provided. Of these 48 clients, 30 were categorised as family violence clients (12 in 2012 and 18 in 2013). Both sets of data were descriptively analysed using SPSS.

Results

Pre/post-training survey

A total of 123 health professionals participated in the program’s training workshops across nine months. Of these, 96 health professionals completed the baseline survey (96/123; 78%) and 67 completed both baseline and three-month follow-up surveys (67/123; 54%). The majority of participants were female (89%, n=58) and permanent staff at the hospital, and were split almost equally across full-time and part-time status. Two-thirds of the participants were midwives or nurses, with almost half of the participants coming from the maternity sector, reflecting the hospital’s proportion of nursing compared to other clinical staff.15

There was no difference in the characteristics of those who only participated at baseline and attended training and those who participated at both baseline and three-month follow-up (see Table 1).

Half of the participants had received prior training in family violence (48.5%, n=32), and this was mostly through a one-off workshop external to the hospital (28.8%, n=19), the others were self-taught (27.2%, n=18). From a list of common psychosocial issues, health professionals who had seen patients in the past three 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. One of the biggest impacts of the training workshop was the significant change in what health professionals saw as presenting symptoms that would prompt them to suspect family violence. By follow-up, all symptoms were significantly (p=≤0.002) more likely to be thought of as potential indicators of family violence. ‘Injuries’ was the only symptom that showed no significant change, but almost all health professionals (n=61, 93.8%) recognised this as an indicator at baseline, so the increase was only marginal.

These changes were mirrored in discussions with health professionals who had attended the training, illustrated by the quote below: 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’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? [Participant B]
In terms of feeling comfortable in asking about family violence, there was a significant improvement (p=0.007) after health professionals had attended the workshop. At baseline, more than two-thirds of health professionals (n=45, 69.2%) believed that all women should be screened for family violence and this figure significantly increased (p=0.003) at follow-up (n=57, 90.5%). There was also a significant increase (p=0.002) in the proportion of health professionals reporting that they asked all new patients about family violence, although the overall proportion was still quite low at post-training (from n=10 [15.4%] to n=23 [36.5%]). A small number of 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%). There was no significant change in the proportion of health professionals who believed this following the training.

None of the health professionals attending the workshops 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 decrease (from 29.2%, n=19 to 9.5%, n=6) in health professionals who reported that they did not have the skills to discuss family violence with women from a different cultural background. However, post-training, 19% (n=12) still felt overwhelmed when responding to such sensitive issues.

Overall, the participants had a good understanding of family violence; however, there were several aspects that continued to be misunderstood. Pre-training, fewer than half of participants (n=30, 45.5%) understood that women are at greater risk of injury when they leave a relationship, and this only increased marginally after 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), despite the training not advocating this view. One-quarter of participants believed men who abuse partners cannot control their anger (n=17, 25.8%), and there was no change in this belief following training (n=16, 25.4%). When considering how to respond to family violence, there was a significant increase in health professionals feeling somewhat or very confident that they had the skills and knowledge to carry out almost all the potential responses posed (see Table 2).

Understanding of the assistance a lawyer can provide women was already high among health professionals before they attended the training. Almost all participants understood that a lawyer can assist a woman to protect her rights regarding her children (93.9%) and 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=0.004) improved their understanding of intervention orders, particularly regarding how an intervention order can be tailored to the woman’s circumstances and needs (from n=32 [48.5%] to n=54 [85.7%]; p<0.001), see Table 3.

The workshops appeared to have been successful in changing the perceptions of health professionals’ views of potential health–justice partnerships, as there was a significant increase (from n=43 [66.2%] to n=57 [90.5%]; p<0.000) in the number of health professionals who believed it was a good idea to have a lawyer in a hospital. Health professionals’ confidence in having sufficient knowledge and skills to carry out referrals significantly improved (see Figure 3). Significant increases (n=4 [6.2%] to n=12 [18.5%]; p=0.002) were shown in the

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**Table 1: Training workshop participant demographics.**

<table>
<thead>
<tr>
<th>Clinical sector</th>
<th>All baseline respondents (N=96)</th>
<th>Baseline &amp; three-month follow-up respondents (N=67)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age (mean:SD)</strong></td>
<td><strong>mean</strong></td>
<td><strong>SD</strong></td>
</tr>
<tr>
<td>Female</td>
<td>83</td>
<td>91.2</td>
</tr>
<tr>
<td>English is first language</td>
<td>74</td>
<td>81.3</td>
</tr>
<tr>
<td>Employment status</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Casual/locum</td>
<td>5</td>
<td>5.6</td>
</tr>
<tr>
<td>Full-time</td>
<td>43</td>
<td>48.3</td>
</tr>
<tr>
<td>Part-time</td>
<td>41</td>
<td>46.1</td>
</tr>
<tr>
<td><strong>Clinical sector</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency Care</td>
<td>3</td>
<td>3.1</td>
</tr>
<tr>
<td>Gynaecology, Women’s Cancer &amp; Perioperative</td>
<td>11</td>
<td>11.5</td>
</tr>
<tr>
<td>Maternity</td>
<td>41</td>
<td>42.7</td>
</tr>
<tr>
<td>Mental Health</td>
<td>2</td>
<td>2.1</td>
</tr>
<tr>
<td>Neonatal Services</td>
<td>13</td>
<td>13.5</td>
</tr>
<tr>
<td>Non-clinical</td>
<td>5</td>
<td>5.2</td>
</tr>
<tr>
<td>Reproductive Services</td>
<td>2</td>
<td>2.1</td>
</tr>
<tr>
<td>Women’s Health</td>
<td>13</td>
<td>13.5</td>
</tr>
<tr>
<td>Other (please specify)</td>
<td>5</td>
<td>5.2</td>
</tr>
<tr>
<td>Profession</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Allied Health</td>
<td>5</td>
<td>5.2</td>
</tr>
<tr>
<td>Doctor (Consultant,HMO,Medical Officer,Unit Head; Resident)</td>
<td>16</td>
<td>16.6</td>
</tr>
<tr>
<td>Midwifery</td>
<td>30</td>
<td>31.3</td>
</tr>
<tr>
<td>Nursing</td>
<td>31</td>
<td>32.3</td>
</tr>
<tr>
<td>Social Work</td>
<td>8</td>
<td>8.3</td>
</tr>
<tr>
<td>Other</td>
<td>5</td>
<td>5.2</td>
</tr>
</tbody>
</table>

*Denominators may vary due to missing responses: all baseline respondents (n=96); baseline and follow-up respondents (n=64-66).

**Table 2: Percentage of participants who felt confident/somewhat confident in having sufficient knowledge and skills to carry out responses (n=61).**

<table>
<thead>
<tr>
<th>Health professional responses to a woman experiencing family violence</th>
<th>Pre-training</th>
<th>Post-training</th>
<th>P*</th>
</tr>
</thead>
<tbody>
<tr>
<td>I should encourage a woman to talk about things that might be on her mind</td>
<td>51 (78.5%)</td>
<td>58 (93.5%)</td>
<td>0.039</td>
</tr>
<tr>
<td>There are services that I can access for myself if I become distressed responding to a woman experiencing family violence</td>
<td>43 (66.2%)</td>
<td>59 (95.2%)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>I should identify women who may be experiencing family violence</td>
<td>34 (52.3%)</td>
<td>54 (87.1%)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>I should consider whether the children of a woman experiencing family violence are at risk of harm</td>
<td>32 (49.2%)</td>
<td>49 (79.0%)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>I should provide her with family violence patient education or resource materials</td>
<td>31 (47.7%)</td>
<td>51 (82.3%)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>I should explore the options open to her</td>
<td>26 (40.0%)</td>
<td>48 (77.4%)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>I should offer to contact the police</td>
<td>24 (36.9%)</td>
<td>35 (56.5%)</td>
<td>0.004</td>
</tr>
<tr>
<td>I should give advice on legal options including referrals</td>
<td>18 (27.7%)</td>
<td>41 (66.1%)</td>
<td>&lt;0.001</td>
</tr>
</tbody>
</table>

*a: McNemar’s Test
frequency of self-reported referrals being made to the on-site legal service (either through social work services 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 training already felt they should be making referrals to services such as the social work department, the Centre Against Sexual Assault, Badjurr-Bulok Wilam – for Aboriginal and Torres Strait Islander women – and the hospital’s Alcohol and Drug Service (WADS), and their reported confidence in referring women to each of these service points improved (see Figure 2).

However, the increase in health professionals’ confidence did not align with an increase in actual referrals to the on-site legal service. Unsurprisingly, as the concept and provision of an externally managed on-site legal service within a hospital was relatively new, referrals to the on-site legal service were among the lowest made to any service in the hospital. Social work was still the primary point to which professionals refer at the hospital.

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. [Participant E]

**Evaluation of the referral pathway**

A key question in the evaluation was whether staff training led to increased referrals. The hospital’s social work department received 2,842 referrals between October 2012 and October 2013. Of these, 271 (9.5%) were referred for issues that may have been violence-related (current violence, previous violence, history of child abuse or general relationship issues). 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. Although the number of referrals fluctuated each month, the rate trended positively (18.7) with a modest slope (0.31 referrals/month).

Unfortunately, information was not available on the referral sheets to identify whether the referring staff member had undertaken the program’s training. As a proxy, any potential changes in referral patterns following on from the training dates were explored. The information below (in Figure 3) presents an overlay of the training dates. 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.

Monthly referrals to the on-site legal service averaged 4.6 per month with a total of 56 for the 12-month period. Of these 56 women, 33 had family violence related issues that 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. It did not appear that there was any correlation between training dates and overall referrals to the on-site legal service. However, there did appear to be a proportional increase of the referrals identified with family violence issues between June–October 2013, from 9% to 13%.

Most referrals to the on-site legal service came from social workers (89%, n=50). It is unknown whether any of the referring social workers received the program’s training (6.1% of training participants were social workers). 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 on-site legal service, the program and access to training may layer together among social work staff and lead to a pooling of referrals in relation to this issue. Overall, there has been a notable increase in total referrals to the on-site legal service in 2013 compared with previous years, including both family violence and non-family violence related clients (see Figure 4).

Increased referrals to IMCL began to occur prior to the workforce family violence training. However, it is possible to speculate that the lift in numbers between 2012 and 2013 is associated with the training that began in November 2012 and the increased presence of the legal service at the hospital.

The range of issues presenting were examined to understand whether the legal needs of these clients changed over time. More than half of the clients in 2013 (n=33, 59%) were identified with family violence

### Table 3: Understanding of intervention orders (percentage of participants who responded ‘agree’ or ‘strongly agree’ to each statement about intervention orders)

<table>
<thead>
<tr>
<th>Statement</th>
<th>Pre-training</th>
<th>Post-training</th>
<th>P*</th>
</tr>
</thead>
<tbody>
<tr>
<td>A woman will not be forced to leave her home if she takes out an order</td>
<td>33</td>
<td>45</td>
<td>0.004</td>
</tr>
<tr>
<td>A lawyer can assist in applying to the court for an order where the woman can remain with her partner but where her partner is prohibited from certain conduct</td>
<td>32</td>
<td>54</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>An intervention order can be tailored to a woman’s particular circumstances</td>
<td>47</td>
<td>60</td>
<td>&lt;0.001</td>
</tr>
</tbody>
</table>

*McNemar’s Test*
issues and, for nearly all of these women (n=27), family violence was the legal issue for which they were referred. A range of 33 different legal problem types were spread across the snapshot samples. Clients with family violence issues recorded a more extensive range of problem types. In fact, the 30 family violence related on-site legal service clients had 134 problems recorded overall (Avg 4.4) that were identified across 29 different problem types, in comparison to 50 problems (Avg 2.7) across 18 problem types for non-family violence related clients. The problem types most often recorded for family violence clients were: intervention orders (n=20;15%); family violence (n=16;12%); child support (n=15;11%); and parenting (n=16;12%). This is consistent with research that shows those experiencing family violence often have a clustering of legal needs.16

Conclusions

The development of a health–justice partnership in the engagement and training of health professionals has built capacity, confidence and willingness of health professionals to identify signs of family violence. Health professionals increased their knowledge of legal options. Appropriate legal assistance from the on-site service has been provided alongside other services as part of a multifaceted response within the hospital. This was achieved with provision of external funding for only a limited time and with limited resources to pilot such a new approach.

Using the Realistic Evaluation Model, the context at the hospital of an existing Violence Against Women strategy, in which top-level support and champions played a part, was vital to the implementation of the health–justice partnership model. This supports existing literature that shows that champions of interventions within teams are recommended to help ensure changes in organisational culture.12,17 As described, this program formed a part of long-standing work by the hospital to address violence against women. As such, 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 was absent. Furthermore, even with strong hospital management support, this did not necessarily filter down to each level within each department of the hospital. Support from the institution is vital to develop and sustain change in health professionals’ responses to family violence.18

While over the five-year development of the on-site legal service at the hospital there was a steady increase in referrals reported by IMCL, no additional increase in referrals that could be attributed to the program could be ascertained. A greater number of referrals from health professionals might be visible with better data capture of referrals, and may also occur when the on-site legal service increases its hours of availability at the hospital, which subsequently happened at the conclusion of the evaluation. As Ramsay et al. found (2005), while referral rates may increase in the short term following training of health professionals, in order to sustain referral rates, reinforcement of training is required.19 The recommendations arising from the review suggested team training on partner violence in healthcare settings needs to be regularly implemented and any training should be conducted collaboratively with community-based advocacy services.

Although the training provided as part of the program appeared successful overall, there were still a number of key areas to be addressed. In particular, there was still scope to increase response parameters such as ‘belief’. This would ensure that safety is explored without fear of offending patients,4 while also ensuring health professionals understand the current guidelines around screening for family violence. The findings suggested training delivered by the program may have needed revision to change practice and improve referral rates.
The number of health professionals participating in training was relatively 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 has been largely descriptive rather than causal or relational. While some trends over time are apparent, small overall numbers may be influenced by particular changes in policy or priority in the health practitioner’s practice. Referrals fluctuated each month but show an increasing trend; however, a longer timeline analysis is required to determine whether this represents a significant and sustained increase. As with many hospital recording systems, challenges relating to data, including availability of sophisticated information technology data capture systems, were experienced. Barriers to good-quality data can affect the findings of such an evaluation and would need redress for future investigations of the program.

Implications

In the research literature, education models have been more effective at improving knowledge and confidence than at changing actual practice. Educational meetings alone are not likely to be effective for changing complex behaviours. Change in healthcare practice is challenging and requires complex, multi-modal educational strategies combining predisposing, enabling and reinforcing factors. Predisposing factors include disseminating information, communication and didactic teaching. Enabling factors facilitate the desired change in performance by using protocols, guidelines and providing resources. Reinforcing factors consolidate learning through reminders and feedback from peers and experts. A recent scoping review on knowledge translation in the context of domestic and sexual violence service provision also found various strategies are required to translate evidence into practice. A combination of strategies, at the individual and collective levels and through use of structural practices/procedures and staff training with ongoing support, would be the most effective option to successfully implement change.

Training content and institutional changes need to address obstacles that health professionals face in responding to family violence. In particular, health professionals may be faced with the frustrations of working within increasingly stringent time constraints, limited community resources and an unresponsive criminal justice system. Knowledge of the legal system, community resources, and strategies to protect women’s safety are essential components of a framework for teaching about family violence. Any education model must address the conditions that shape clinicians’ interactions with family violence victims as well as abusive patients, including the provision of support for staff who are victims of family violence themselves, and the model must acknowledge the need to transform conditions that limit health professionals’ abilities to respond. Lack of attention to provider issues and lack of institutional reinforcement can all have an impact on training effectiveness.

The program built capacity and willingness of health professionals to identify signs of family violence. Legal assistance was provided alongside other services as part of a multifaceted response. However, an increase in referral rates were not shown. This might be visible with better data capture of referrals and may occur with greater availability of the on-site legal service. The evaluation suggests that prior to developing further health–justice partnerships in hospitals, the model needs to be strengthened with greater hospital system support along with recommended data recording systems and processes. Since completion of the evaluation, the program has continued to be developed with changes made to training delivery, with an increase in the number of sessions at the on-site legal service and with an associated increase in referrals. The program’s training is now part of a broader hospital model called the Strengthening Hospital Response to Family Violence, funded by the Victorian Government in 2014.

References