Domestic violence
Domestic violence refers to a broad range of abuse and violence between intimate heterosexual and homosexual couples, who are either currently in a relationship or estranged. It includes any behaviour by a person adopted to control their victim, which results in physical, sexual, and/or psychological damage, forced social isolation, economic deprivation, and/or behaviour which leaves victims living in fear. Children who live with, or have regular contact with those involved in domestic violence situations are affected by the violence through either being victims or witnesses. (Based on the 1994 Tasmanian Government definition, and the ‘Responding to victims of domestic violence protocol training’ p11, Department of Community and Health Services, 1997).

The full extent of domestic violence is unclear as the majority of figures are provided by police, hospitals, government funded shelters and counselling services, and general practice. The unreported incidences or those where women do not seek support are not documented. The May 2000 report from UNICEF, ‘Domestic Violence Against Women and Girls’, estimates the worldwide incidence at somewhere between 20-50%. (Innocenti Research Centre, May 2000). Hegarty et al in the Medical Journal of Australia (MJA) provided a range of figures on prevalence, which include:

- a figure from clinical studies from antenatal clinics and emergency departments of 19.3% - 25% of women over their lifetime experiencing domestic violence;
- surveys from general practice in Australia showing partner abuse of between 8% and 28% in a period of 12 months; and
- figures from the Australian Bureau of Statistics 1996 population based study ‘Women’s Safety Australia’, which surveyed physical and sexual violence, and identified that of women who currently had partners 2.6% of women had experienced violence in the previous 12 months, and 8% had experienced violence at some stage in their relationship. (Hegarty et al, October 2000)

Pregnancy and domestic violence
Pregnancy is a time of increased risk for domestic violence and it may occur for the first time during pregnancy, the abdomen is more often targeted at this time. Astbury et al (page 428), notes the increased risk factors for women and their children, including infections, preterm labour and low birthweight infants (Astbury et al, 16 October 2000). During pregnancy and in early parenting women often access doctors and other health professionals more frequently than at other times. This places these service providers in a crucial role in the early identification and intervention of domestic violence. Some antenatal clinics in Australia are now routinely screening for abuse as part of their health assessment.
Support for victims of domestic violence
A general practice based prevalence study, by Mazza, found that doctors have been estimated to diagnose only one in twenty-five victims of domestic violence. The study found that the main reason women did not discuss issues of abuse in their relationship was because they were not asked. Community and personal beliefs about privacy and sanctity of relationships, shame or fear compound the difficulty in victims seeking assistance. However the impact on victims’ physical and mental health, and that of children living with them is considerable.

If women do discuss domestic violence an understanding and supportive response is important in assisting them in continuing to access support.

Victims of domestic violence who live in rural and remote areas often have more barriers than their urban counterparts when trying to deal with their situation. Even though specific domestic violence services are often some distance from rural communities, access to locally based rural health professionals, including general practitioners, is often possible. Many rural health professionals, however, do not have the knowledge and skills to provide appropriate support to those in domestic violence situations.

PROJECT OVERVIEW

Background
The Partnerships Against Domestic Violence: Training Delivery Model for Rural Health Professionals project is funded through the Department of Health and Human Services (DHHS), by the Commonwealth Department of Family and Community Services’ Partnerships Against Domestic Violence program. The University Department of Rural Health, Tasmania (UDRH) is managing the project in line with an agreement with Child Youth and Family Support, DHHS.

The submission, written two years ago, initially focused on providing an information resource to general practitioners (GPs). The idea was then expanded to include information and education to rural health professionals across the state. With its focus on rural health professional workforce and training issues the UDRH provides a valuable resource for the project. Schedule 2 of the project’s service agreement outlines the goals of the project.

Schedule 2 – services to be provided

2.1 Goals of the Project
2.1.1 Objectives and outcomes of service

The overall objective of the project is the development of a nationally applicable best practice model that encompasses a range of resources and approaches for providing support, conducting training and continuing education and education dissemination to rural health professionals on domestic violence. It is anticipated that this will combine electronic information and learning, hard copy resources and face-to-face contact.

The anticipated outcomes of the project would be:
• the provision of targeted support, information and education to rural health professionals with minimal disruption to service delivery;
• a greater awareness of domestic violence amongst health service providers within rural communities, with potentially increased detection and more appropriate responses to victims as a result;
• a model for information exchange and training delivery which may be applicable to other health related issues within rural communities; and
• a model for domestic violence information exchange and training delivery that may be applicable to health professionals in urban areas.

The 18-month project started at the end of April 2000, with the employment of a Project Officer. The Project Officer, based in Hobart, utilises the expertise of domestic violence and women's health services, independent consultants and the UDRH (Launceston) as necessary.

The project’s support structure
The project is supported by a Management Group and an Advisory Group. The Management Group consists of the: Project Officer, Director of the University Department of Rural Health, State Manager of Women’s Health (DHHS), Project Officer responsible for administering the project’s Service Agreement in Child Youth and Family Support (DHHS), and Women Tasmania. The broad role of this group is to discuss and guide direction and progress of the project, provide links between UDRH, DHHS and Women Tasmania, and provide support to the Project Officer.

The Advisory Group consists of representatives from: the Royal Australian College of General Practitioners, Tasmanian Division of General Practice, School of Nursing (University of Tasmania), Domestic Violence Crisis Service (representing the three regionally based services), DHHS (a rural Director of Nursing based at Smithton in the north west of the State, and the Manager of the Rural Health Unit based in Launceston), Tasmania Ambulance Service, Tasmania Police, Huon Domestic Violence Service (a rural service), Survivors (a post crisis support service based in Launceston), Health Professional Council, School of Social Work (UTAS), and the Management Group. This group’s broad role is to advise the Project Officer regarding the progress and direction of the project, providing expertise from the member’s organizations.

Introduction
The first 11 months of this project focused on consulting with key stakeholders, researching literature, beginning to form the framework and body of the model, in consultation with stakeholders, and developing information and education materials to be trialled.

Consultations and research
A range of key stakeholders were consulted, as listed below:
• Partnerships Against Domestic Violence (PADV) office Canberra.
• Women Tasmania.
• Australian Domestic and Family Violence Clearinghouse.
• (DHHS) – Child Youth and Family Support, Women’s Health Access Program (North, South and North West), Domestic Violence Crisis Service (South, North
and North West), Nursing Advisor, a number of rural community nurses and social workers, Aged Rural and Community Health, Family and Child Health Nursing.

- Huon Domestic Violence Service.
- Community Pharmacist, Dover.
- Tasmanian Division of General Practice.
- Divisions of General Practice (North, South and North West).
- Royal Australian College of General Practice (Hobart and Sydney – regarding national DV training).
- University – School of Nursing, Department of Psychology, School of Medicine via Manager of the Department of Rural Health, School of Sociology and Social Work, Department of Rural Health.
- Hobart Women’s Health Centre.
- PADV funded projects within Tasmania and interstate.
- Independent Women’s Organisations of Tasmania (IWOT) – representing a range of women’s services including shelters, support and information services.
- Women’s Emergency Service Providers (WESP) – representing a range of women’s services including shelters, support and information services.
- Survivors.
- Jireh House.
- Family Support Service.
- King Island service providers.

**The Consultation Process**

During the initial consultations, organisations/individuals were provided with a brief outline of the goals of the project. This included outlining the points raised in the project’s submission in relation to the importance of general practitioners (GPs) and other health professionals in providing a vital link for victims in domestic violence situations, and the infrequency of victims disclosing their situation to service providers. This information provision was enhanced with the development of a leaflet produced during June/July 2000.

In face-to-face meetings and over the phone, those consulted were informally asked a number of questions. These questions included:

1. What, if any, are the issues for your service/organisation members in relation to their clients and domestic violence?
2. Do you have any comments or information you think would be useful to the project?
3. Can you suggest other individuals/organisations who may be useful contacts for the project or who may be interested in being involved?
4. Would it be of benefit for your service/organisation to become involved with the project either in receiving further information and/or education, or in providing links or information when the project’s strategies are defined.
5. Which rural communities might be approached to work with the project?

**Summary of findings**

A number of issues were raised during the consultations including the following:

- A variety of information and training materials already exist (those identified during the project’s research will be listed in the project’s final report).
• Internet and other computer/information technology based education and information is of limited use to the majority of rural service providers, as many do not have access to these technologies and/or are not confident in utilising them.

• To be registered vocationally GPs have to participate in Continuing Medical Education (CME). A range of training modules is offered, each with a particular allocation of points. A certain number of points have to be accumulated before the GP can be vocationally registered and so claim higher Medicare reimbursements. In talking with the Tasmanian Division of General Practice and the regionally based divisions the view was that it would be highly unlikely that the majority of GPs would attend a CME session on domestic violence.

• GP Divisions also stressed the busy workload of GPs and the plethora of information they receive.

• It is important in rural communities for service providers to build and maintain strong networks to enhance their capacity to support clients, support each other, and to share resources and information in relation to DV.

• Service providers may fear for their safety and for their ongoing acceptance in small communities if they openly provide support to victims of domestic violence.

• Rural service providers may be reluctant to refer to urban-based providers if they are unsure as to the quality, underlying philosophy, safety and appropriateness of services.

• Various health professionals perceived barriers to cross referral between different health professions.

• Some GPs raised concerns about lack of feedback in relation to those of their clients who are referred on to their services.

• Very few rural areas have service providers skilled and confident in providing support to people in situations of domestic violence, with even fewer areas providing specific services to support victims of domestic violence.

• Most services providing support to victims of domestic violence are based in urban centres, and usually do not have adequate levels of resources to enable them to provide services in rural areas. All of these services considered it necessary for there to be support in rural and remote areas, and relayed their knowledge of the high need and unique difficulties in these areas.

• Many service providers commented on the fact that service quality and appropriateness is intrinsically linked to the values, attitudes, and knowledge of service providers. This was particularly seen to be the case in relation to police response, but also for GPs, and Ministers of religion.
• Apart from free call crisis support there are very few other services readily available to people in rural communities.

• GPs do not necessarily see the support of victims of domestic violence as being their role. Domestic violence may be seen as a social issue, not a medical issue.

• GPs are often in the situation of providing services to whole families/both members of an intimate relationship. This can make it difficult to provide support, particularly where a victim is requesting assistance with leaving a relationship.

• Those consulted said that trying to survey groups of health professionals, particularly GPs, or whole communities was a waste of time as people had been ‘surveyed out’.

**Literature review**
A range of hard copy and internet-based literature, including training and information resources, was reviewed. A full list of these references will be included in the final report, along with a summary of relevant points. The review of literature confirmed the need for a raised awareness of domestic violence by service providers and noted, that in comparison to urban areas, the reported incidence of domestic violence is higher in rural and remote areas.

**An evolving model**
From the consultations and literature review a model has been developed with two main groups of strategies.

**Education for Health Professionals**
One group of strategies aims to help meet the need of informing health professionals about domestic violence and enabling them to respond appropriately in providing support to those in situations of domestic violence. This group of strategies includes developing education materials and information resources for undergraduate and post-graduate students of nursing, psychology and medicine. These materials will also be able to be adapted to provide training and information to other service providers in a variety of settings, including workplaces.

The project has developed materials for the School of Nursing for undergraduate and post-graduate students. The undergraduate unit is run over four hours, and will be trialled in first semester 2001. A post-graduate continuing education unit for Family and Child Health Nurses, will be trialled in second semester. Materials are being developed for a one and a half day workshop for postgraduate students of the Department of Psychology. The workshop will be run at the beginning of May, 2001.

The project is about to begin the development of a hardcopy desktop resource for rural GPs and other health professionals. Initial consultation and development will focus on GPs with the aim that community nurses, social workers and psychologists (including those based in health centres and schools) will also be consulted and resources developed if time allows. This initial emphasis on GPs is in response to the project’s service agreement, and the present lack of priority placed on domestic violence education by the School of Medicine.
Working with communities – information, education and support

Another group of strategies is being developed and trialled within a community development framework. The project is approaching individual communities, providing them with a summary of the project, and inviting their involvement in the project. In meeting with individual service providers and groups of providers, several questions are asked:

• Is domestic violence an issue in your community?
• If it is, what are the particular issues, needs and difficulties for your community?
• What information, education and support needs could the project assist with? (keeping in mind that the project is time limited and cannot resource services that will require ongoing funding, such as counseling services).
• Within the framework of the project, what are your ideas for strategies that could assist your community?

Strategies raised by people in other communities were suggested as options to consider along with those raised by the service providers. These strategies have included:

• Use of media – e.g. using local personalities to make statements in advertisements in local papers about the unacceptability of domestic violence, followed by advertisements of services available.
• Producing posters, beer coasters, messages on milk cartons, bread, stickers, or fridge magnets with the unacceptability of domestic violence and a contact number of crisis services.
• Developing resource kits and information leaflets with basic information on the definition of DV, how to respond, and availability of services to support victims/survivors.

These strategies will increase in number and diversity as the project works with additional rural communities.

King Island

King Island is the first community to be approached, and the Project Officer is working with a group of service providers to develop training and information resources. Service providers in this community have requested assistance with a range of strategies, listed below.

• To be provided with short education sessions with sections tailored to particular health professionals. That these be provided by service providers with expertise in domestic violence face to face, via video-conferencing where necessary, and with accompanying hard copy and computer based resources including a website for information, references and links.
• To produce hard copy resources in the form of leaflets that can be given to clients and kits for service providers defining DV, giving information on appropriate responses and available services.
• To receive education to enable a few King Island service providers to run information sessions with local groups such as Rotary, CWA, and parent groups.

The project aims to run some education sessions in April 2001. These sessions will hopefully coincide with community awareness raising activities run by King Island’s Health Promotion Officer and visiting Anglicare Social Workers.
Sustainability
An important element of this project has been the attempt to ensure sustainability wherever possible. The intention of the project is that if the University units/workshops are successfully trialled that they will become a permanent component of the various curriculums.

In relation to community-based strategies, the project and service providers are considering how to build sustainability into the each strategy as it is developed. For example, in the case of King Island, copies of training materials developed for service providers, will be held by the Health Promotion Officer on the island, and service providers on the island will be trained to be able to run information sessions on the island, as noted above.

Opportunities and challenges
• The project has developed a domestic violence education template, and submitted it to the Women’s Health National Collaborative Core Curriculum Project, which is a collaborative venture involving eleven universities across the country. The project, working predominantly with departments of obstetrics and gynaecology, is in the process of developing a core syllabus in women’s health. The Core Curriculum Project represents a pioneering effort both nationally and internationally as few reports detailing the successful creation of women’s health core curricula have been published. The project will explore the inclusion of information on domestic violence with its national committee.

• The project is also exploring investing in a range of resources, including information booklets and leaflets, a website, videos and training manuals, to distribute to rural service providers including GPs.

• In collaboration with TasCOSS and a number of domestic violence victim support services, the project is about to develop a domestic violence information web page linked to the TasCOSS website.

• Domestic violence does not seem to be a priority with GPs and the School of Medicine, at present. This has made the task of involving GPs and the School of Medicine more difficult. Involving GPs and the School of Medicine may be easier as the other strategies of the project are trialled and hopefully shown to be successful.

• It has been vital that other PADV funded projects, with aims that overlap with this project, be identified to ensure there is no overlap and that resources are utilised as efficiently as possible across the State. This has particularly been the case with those projects aimed at rural areas, and the project based in Anglicare in the north and north west of the State.

• The amount of time the project allocates to individual communities will depend on each community’s needs. It is anticipated that there will be some variation in both time allocated and strategies utilised.
Evaluation
In discussions with DHHS, and the project’s Management Group the evaluation plan includes the use of questionnaires before and after project interventions, to assess people’s knowledge of domestic violence, and the application of that knowledge to client support. These questionnaires have been developed by the Project Officer in consultation with others experienced in survey design. As the project’s strategies will not begin to be trialled until April 2001, assessing the longer-term benefits of the strategies may be difficult prior to the end of the project.

Next Steps
The project is currently involved in a range of activities, which will continue through the next few months. The following points list the major activities.

• Trialling of the four hour under-graduate nursing unit. The trial will begin in first semester 2001. The training package for this unit has been developed by the project.
• Trialling of the four-six day Family and Child Health, continuing education unit in second semester 2001. The training package for this unit has also been developed by the project.
• Developing and trialling a post-graduate unit for the Department of Psychology.
• Possible further involvement with the Women’s Health Core Curriculum project.
• Working with a second rural community.
• Further collection of materials, and identification of an appropriate storage location, to provide resources for rural communities and those learning about domestic violence.
• Working with domestic violence services to develop an information web page.

Having completed its consultation, research, and the development of three education packages, the project is now ideally placed to complete the activities listed below.

1. To provide an opportunity to work with additional rural communities.
2. To provide additional time to inform and involve general practice.
3. To enable the planning and running of some rurally based detailing sessions with small numbers of GPs, and other service providers in combination with other projects and other issues. For example: providing sessions that combine basic information about domestic violence and how service providers can respond appropriately, information on female genital mutilation, midlife health, domestic violence and mental health, etc.
4. To enable the exploration of providing resources and education to school psychologists and social workers in rural areas.
5. To provide the time to conduct a follow through evaluation of people involved in both university and community based education/information sessions. To check how it has impacted on service providers’ work practices and ongoing knowledge of, and attitudes to domestic violence.
6. To further develop web sites that can be accessed by rural, urban, general and domestic violence specific service providers, students and general public. This
development includes the possibility of forming links between TasCOSS and UDRH web sites, providing the benefits of linking non-government organisations, the community, the university, Women Tasmania, and DHHS – Women’s Health Service networks.

7. To evaluate the long-term success of the yet to be developed hardcopy resource, and enable its modification, after twelve months of trialling and consultation.

8. To enable the exploration of opportunities for ongoing responsibility for delivery of education packages and appropriate repositories for information for rural communities.

9. To enable the pursuit of permanent inclusion of modules on domestic violence in nursing, psychology and medicine curriculum.

Conclusion
With the process of involving GPs being slower than expected, and in anticipation of the surplus funding, there seems to be an ideal opportunity to pursue the tasks above over a longer period of time. The UDRH is seeking an extension of twelve months for the project.

References
• Mazza 1996, MJA, Vol 164.

Contact details
Jane O’Day
Senior Project Officer
Department of Rural Health
University of Tasmania
PO Box 252-103, Hobart 7001
Phone: 03) 62264743, Email: Jane.ODay@utas.edu.au

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