Understanding encounters with Intimate Partner Violence (IPV) among Australian veterans and families

A preliminary study of service providers in a veteran-specific mental health support service

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Contents

Executive Summary

Background

Intimate partner violence (IPV) is a concern among current and ex-serving military personnel, and the purpose of this project was to address questions regarding recognition, current practices, and readiness to address IPV among providers of veteran-specific mental health and family support services in Australia. Specific objectives were to:

1. Demonstrate awareness, recognition, and frequency of encounters with service users who disclose IPV use and exposure, as reported by service providers;
2. Evaluate areas of perceived self-efficacy for addressing IPV;
3. Describe current practices of providers in relation to identification and responses to IPV disclosures;
4. Provide accounts of how service providers view and address IPV among current and ex-service personnel, and family members.

Approach

The project comprised a mixed-methods study involving an online survey of *n* = 214 service providers with Open Arms – Veterans & Families Counselling (Open Arms), and follow-up qualitative interviews with *n* = 16 service providers. Participants mostly identified as psychologists or social workers, and were typically engaged by Open Arms as Outreach Program Counsellors (OPCs) or employees.

Findings

Key findings from the online survey were as follows:

- Almost all service providers (> 90%) reported awareness that IPV exposure and use were both significant issues among Open Arms clients.
- Most service providers reported feeling confident about identifying and responding to clients who disclosed IPV exposure. However, there were significant minorities (> 20%) who were less confident in relation to risk assessment and safety planning.
- Service providers also reported less confidence about addressing IPV use among clients, relative to IPV exposure, and these differences were particularly large in relation to responses to IPV use.
- Although most respondents reported asking clients about IPV, there was significant variability in approaches (for example, less than half reported always asking new female clients about IPV).
- Majorities of service providers reported having recently (in the last 6 months) encountered clients who disclosed IPV exposure (82.6%) and IPV use (63.4%), respectively.
- Almost all providers reported conducting risk assessments or developing safety plans, despite previous indications of lower confidence in these domains.
- Just under half of respondents who had recently identified clients exposed to IPV reported engaging in care coordination.
- Almost all providers reported providing treatment to address the psychological impacts of IPV.
- Couples therapy was a common referral target for clients who were exposed to IPV and those who used violence in their relationships.

Additional findings from the qualitative interviews were organised in relation to three themes:

1. Divergent perspectives on IPV: Service providers reported different understandings of IPV, and tended to adopt perspectives that prioritised either (i) mental health difficulties and trauma histories, or (ii) gendered factors and power imbalances that align with a feminist perspective. These lenses had implications for difficulties identifying coercive control and typical responses to IPV.

2. Challenges attributed to the military context: Service providers described factors that were related to the military context and could uniquely influence IPV use and risk. These included training in the controlled use of force, as well as deployments and associated levels of family disconnection, which were described as contributing factors to IPV use. Participants emphasised unique dimensions of risk for partners of current personnel, including challenges in reporting and supporting disclosures of IPV exposure.

3. Inconsistent knowledge of risk and safety: Service providers also described variable approaches to IPV risk assessment, safety planning, and couples counselling. Approaches were seemingly informed by their individualised understandings of IPV.

Implications for Policy and Practice

Most service providers reported recent encounters with clients who disclosed IPV, and this signals a need for initiatives to support providers in addressing disclosures. Almost all respondents also reported awareness that clients may have experienced or used violence, and these findings suggest high receptivity to initiatives that endeavour to enhance responses to IPV among veterans and family members.

The findings indicated that service providers held variable understandings of IPV, and suggested inconsistent approaches to risk assessment and safety planning. This highlights the need for a unifying policy framework for Open Arms services, that is tailored to address features of the military context and veteran-specific service system. The framework should be supplemented by resources that include practice guidelines, training programs, and clinical tools that can help guide decision-making and standardise IPV identification, risk assessment, and safety planning.

On the basis of current findings, the resources should address at least three main areas of capability, including:

1. Identification and responses to clients who report IPV <u>exposure</u>, via resources which can provide greater understanding and identification of coercive control, improved consistency in risk management, guidance for mental health treatment following IPV, and support for care-coordination.
2. Identification and responses to clients that <u>use</u> IPV, via resources which provide enhanced knowledge of risk indicators, as well as guidance on responses including secondary consultation, proactive information sharing, and referral pathways for specialist services.
3. IPV risk management in the context of couples counselling, via tools to support assessments of IPV risk and underlying dynamics, and accordingly the appropriateness of couple-based interventions with safety planning.

Implications for Research

The aforementioned recommendations should be considered along with research providing up-to-date evidence to ensure that initiatives are feasible, maximise benefits for service users, and monitor any unintended consequences. In this context, there would seem to be at least four main areas of need for evidence and future research, including:

1. Examinations of the suitability and benefits of initiatives for improving identification and responses to IPV exposure (e.g., via trials of interventions to promote IPV identification, such as screening protocols).
2. Foundational research on novel initiatives to improve identification and responses to IPV use by current and ex-serving personnel.
3. Studies of the risks, contraindications, and potential uses of couples counselling in the context of IPV and Open Arms services;
4. Broader research outside of Open Arms services that can enhance understanding of the context, drivers, and appropriate targets for IPV interventions among current and ex-service personnel, and family members.

Background

Intimate partner violence (IPV) is a major public health issue and human rights violation (World Health Organisation, 2010), and comprises the single largest cause of disease burden for women aged 25 – 44 years in Australia (Ayre, On, Webster, Gourley, & Moon, 2016). IPV includes any behaviour in a current or former relationship that causes physical, psychological, or sexual harm (World Health Organization, 2012), and this subsumes physical aggression, sexual coercion, and psychological abuse. The latter also encompasses non-physical behaviours (e.g., insulting and humiliating a partner), including coercive and controlling tactics that aim to dominate the victim and restrict their autonomy. These may involve isolating a person from family and friends, monitoring movements, and restricting access to employment and financial resources (Stark & Hester, 2019). Exposure to IPV is a major cause of injuries and ill health, and also contributes to mental health problems including depression, anxiety, and posttraumatic stress disorder (PTSD) (Campbell, 2002; Spencer et al., 2019). Although research has traditionally emphasised the consequences of physical violence for victims, there is growing evidence that psychological abuse (including coercive and controlling behaviours) can have additional impacts on mental health (Mechanic, Weaver, & Resick, 2008; Potter, Morris, Hegarty, García-Moreno, & Feder, 2021). These all contribute towards significant economic costs of IPV, which are partly attributed to burdens on health care and mental health services (Peterson et al., 2018).

International research indicates that IPV is a significant concern among current and ex-serving military personnel, with available studies indicating high rates of both exposure to IPV (i.e., victimisation) (Sparrow et al., 2020) and use of violence (i.e., IPV perpetration) (Kwan et al., 2020). By way of illustration, a recent review of all available population surveys and population screening studies has indicated around one in five (21.0%) of all current personnel and veterans report recent exposures to IPV, with analogous figures of around one in eight (13.0%) for IPV use (Cowlishaw et al., 2021a). This review also examined variability in figures across studies, and indicated that IPV use and exposure were significant issues among men and women (which may be attributed in part to use of measures that do not clearly address coercive and controlling behaviours), while elevated rates of IPV use were commonly observed in studies of ex-service personnel, relative to current members. Finally, the review indicated that higher rates of IPV use were typically identified in military or veteran-specific health services, when compared to general population samples of current or ex-serving personnel, while there was a contrasting trend towards lower rates of IPV exposure identified in such services. This may be attributed to factors including obstacles to IPV disclosure that have been documented in preliminary studies of veteran-specific health services in the U.S. (Dichter et al., 2020; Dichter, Wagner, Goldberg, & Iverson, 2015).

Health services generally have a prominent role in multisector societal responses to IPV, as well as violence against women more generally (García-Moreno et al., 2015; World Health Organization, 2018), and it seems likely that this assertion extends to military and veteran-specific health services. There is nascent literature that has considered some components of IPV interventions in veteran-specific services (for an overview, see Cowlishaw 2021b). These include training programs for service providers (Chaffin & Richter, 2002), protocols and tools for improving case identification (Dichter, Haywood, Butler, Bellamy, & Iverson, 2017; Iverson et al., 2013) and risk assessment (Iverson et al., 2018), along with support programs for service users (particularly women) who disclose IPV exposure

(Danitz et al., 2019), and treatment programs for service users (particularly men) who use IPV (Taft, Macdonald, Creech, Monson, & Murphy, 2016). These have been shaped by studies of feasibility and acceptability of interventions in veteran-specific health services (Dichter et al., 2015; Iverson et al., 2019), which align with comparable literature in non-military settings. The latter includes quantitative and qualitative studies of service providers in primary care (Ramsay et al., 2012; Yeung, Chowdhury, Malpass, & Feder, 2012) and general mental health settings (Nyame, Howard, Feder, & Trevillion, 2013; Trevillion et al., 2014). Notwithstanding this, the comparable evidence underlying IPV interventions in military and veteran-specific services remains modest, while there are few examples of best quality trials that demonstrate benefits of these practices for service users. Critically, the aforementioned review also indicates that the entirety of relevant evidence for IPV interventions has been situated in Veteran's Health Administration (VHA) services in the U.S. (Cowlishaw et al., 2021b), which has limited generalisability to other jurisdictions that have different cultures and systems for providing care to current or ex-service personnel, and family members.

There is a need for research to inform the development of IPV interventions in military and veteran-specific health services, and the current project reflects an endeavour to address this in an Australian context. As far as we know, there have been no studies that have directly addressed IPV among Australian current or ex-service personnel and families, and this includes studies of specific mental health and family support services. The current project focusses on describing areas of self-efficacy and current practices of service providers in veteran-specific mental health and family support services in Australia. This focus on aligns with initial studies of responses to IPV in other contexts, including primary care (Ramsay et al., 2012) and general mental health services (Nyame et al., 2013; Trevillion et al., 2012). These have similarly addressed foundational questions regarding recognition, current practices, and readiness to address IPV among service providers in such settings (Hegarty et al., 2020; Tarzia et al., 2021).

Specific aims of the current study were to:

1. Demonstrate levels of awareness, recognition, and frequency of encounters with service users who disclose IPV use and exposure, respectively, as reported by service providers in mental health and family support services for current and ex-service personnel in Australia;

2. Evaluate areas of perceived self-efficacy for addressing IPV, as reported by service providers;

3. Describe current clinical practices of providers in relation to identification and responses to IPV disclosures by service users;

4. Provide in-depth accounts of how service providers view and address IPV use and exposure among current and ex-service personnel, and family members.

Method

Participants and Procedure

Invitations to participate in an online survey were distributed to all mental health professionals that provide services on behalf of *Open Arms – Veterans & Families Counselling (Open Arms)*, via a centralised email list maintained by the Open Arms National Office. Email invitations included links to the survey that was open for four weeks between February and March 2020. Participation was voluntary, and the survey was anonymous for participants, unless they chose to provide contact details in order to take part in interviews (see below).

Open Arms is Australia's leading provider of accredited mental health care for veterans and family members, and is a key service delivery arm of the Department of Veterans' Affairs (DVA). Open Arms provides 24-hour counselling and support which is free for any current or former Australian Defence Force (ADF) member with one day continuous full-time service, along with their partners and children. Reservists with hazardous service are also eligible, while parents and siblings can access support where there has been a death of a service person. Support is provided on the basis of clinical need, and there is no upper limit on the number of counselling sessions for eligible personnel or family members.

Open Arms services include: counselling for individuals, couples and families; care coordination for clients with complex needs; group programs to develop skills and enhance support; lived experience mental health Peer support; after-hours telephone counselling; mental health literacy and suicide awareness training; information, education and self-help resources; and referrals to other services or specialist treatment programs, as needed.

In 2020-21, Open Arms provided support to 38,073 unique clients through a total of 287,543 services delivered. This occurred across 35 Open Arms locations and through a network of 1,095 Outreach Program Counsellors (OPCs). In the same period, there were 107,730 calls received by Open Arms 1800 phone line, and 332,525 visits to the Open Arms website.

Table 1 summarises the background characteristics of survey respondents. As shown, usable surveys were returned by n = 214 mental health practitioners who provided services on behalf of Open Arms, and these were mostly female, aged over 44 years, and typically located in capital cities or regional centres. Service providers were trained mainly as psychologists or social workers, and were typically engaged by Open Arms as OPCs (i.e., an approved provider registered with Open Arms), or employees. The majority of service providers reported typically seeing current or ex-serving ADF members, as well as family members, daily or on most days, while 58.4% also reported seeing Open Arms clients who were couples. There were 56.5% of service providers that reported having previously received IPV training, although typically not in the last 12 months.

The final page of the online survey included an invitation to take part in follow-up qualitative interviews, and requested an email address if participants consented to contact. The provision of contact details was voluntary and an interview time was arranged with service providers who expressed interest. There were 16 semi-structured interviews conducted individually by telephone between April and May 2020. Interviews ranged from 21 to 66 minutes (mean: 49 minutes), and all were audio-recorded and transcribed verbatim.

The *n* = 16 service providers that participated in interviews included 13 OPCs, two middle management staff members, and one Peer worker. Nine participants identified as women and seven as men. Participants had varying levels of time working as providers for Open Arms, ranging from six months to 19 years.

Table 1. Background characteristics of survey respondents (n = 214).

		n	%
Gender			
	Female	159	74.3
	Male	46	21.5
	Other	2	0.9
Age			
	18-34	23	10.7
	35-44	44	20.6
	45-54	55	25.7
	55+	68	31.8
Location			
	Capital city	91	42.5
	Regional centre	93	43.5
	Rural / remote area	20	9.3
Professional background			
	Psychologist	115	53.7
	Social worker	66	30.8
	Other[a]	8	3.7
Role with Open Arms			
	Outreach Program Counsellor	130	60.7
	Employee	59	27.6
	Other[a]	20	9.3
In the past 6-months, how often have you typically seen clients who are…			
Current or ex-serving ADF members			
	Daily or most days	123	57.5
	Around weekly	41	19.2
	Less than weekly	41	19.2
Family members of current or ex-serving personnel			
	Daily or most days	115	53.7
	Around weekly	46	21.5
	Less than weekly	41	19.2
Does your work for Open Arms include seeing couples?			
	No	83	38.8
	Yes	125	58.4
Have you previously received IPV training?			
	No	88	41.1
	Yes, but not in the last 12 months	106	49.5
	Yes, in the last 12 months	15	7.0

[a] For example, includes Occupational Therapists, Mental Health Peer Workers.

Survey Design and Analyses

The survey comprised items based on self-report scales that have been developed for use in other health care settings. They measure dimensions of perceived 'readiness' to identify and respond to IPV (including self-efficacy) (Leung, Bryant, Phillips, & Hegarty, 2017), as well as clinical practices and workplace encounters with clients who disclose IPV (Short, Alpert, Harris, & Surprenant, 2006). The scales have been used mainly in primary care settings, and were adapted for the current context.

Adapted GP readiness to identify and respond to Intimate Partner Abuse Scale (GRIPS)

Perceived confidence in the ability to perform tasks that relate to IPV, including identification and responses to disclosures, was measured using items from the self-efficacy subscale of GRIPS (Leung et al., 2017). This consists of 13-items which reference the ability to identify and respond to IPV exposures, with modifications made for use with mental health providers (e.g., the term 'patients' was replaced with 'clients'). A second version of the scale was adapted to assess confidence identifying and responding to clients who used IPV. These adaptations involved changing words to address violence use (e.g., the term 'experiencing' was replaced with 'use'), while there were two items in the original scale (e.g., referencing concerns about child safety) that did not contribute meaningfully in reference to IPV use, when they were previously administered with reference to exposure. Thus, there were 13-items measuring confidence in the ability to identify and respond to IPV exposures (see Table 2), while 11-items measured confidence in the ability to identify and respond to IPV use (see Table 3). Finally, an additional item was developed to measure confidence identifying IPV in couples counselling. All items were scored using a Likert-type response format anchored from 1 'strongly disagree' to 4 'strongly agree'.

Adapted Physician Readiness to Manage Intimate Partner Violence Survey (PREMIS)

Survey items regarding clinical practices and encounters with clients who disclosed IPV were based on the PREMIS (Short et al., 2006). These included 13-items (see Table 4) which addressed IPV identification strategies, and comprised core items from the 'Practice Issues' section of the PREMIS (e.g., "I ask all new female patients about IPV"). New items were developed to address approaches to identification among male clients (e.g., "I ask all new male patients about IPV"), and to distinguish between identification strategies used for IPV exposure (e.g., "I ask female clients about their partner's use of violence in relationships") and use (e.g., "I ask female clients about their own use of violence in relationships"). A final item was developed which addressed approaches to identification of IPV in couples counselling. Responses were scored on a 3-point scale ('Never / almost never', 'Sometimes', 'Always').

There were two items which asked about the frequency of encounters with clients who disclosed IPV exposure and use, respectively, in the past 6-months (see Table 5). These were also adapted from the PREMIS, and were scored on a 5-point scale which ranged from 'None' to '21 or more'.

Typical responses to clients who disclosed IPV exposure were measured using 9-items which were based initially on the PREMIS, but included new items developed for this survey (see Table 6). An additional 8-items were also developed to address how service providers typically respond to clients who use IPV (see Table 7). Finally, participants who indicated providing or facilitating referrals were also asked about referral targets. These comprised 9 referral options for IPV exposure and 7 referral options for IPV use. Responses for all these items were scored on a 3-point scale *('Never / almost never', 'Sometimes', 'Always')*.

Data analyses initially involved preparation and cleaning of the data-file in SPSS version 27, while substantive analyses were conducted in Program R (4.1.0). These analyses were mainly descriptive and involved production of frequency statistics for items that referenced self-efficacy, clinical practices, and encounters with clients who disclosed IPV.

Interview Guide and Analyses

A semi-structured interview guide was developed that addressed the perceived role of service providers in responding to IPV exposure and use among current and ex-service personnel, and family members. Prompts were situated in the context of questions about examples of recent encounters with IPV among these client groups. They also explored understandings of possible underlying causes and contributing factors to IPV use, in addition to differences with non-veteran populations. Finally, the interviews explored services and service gaps for current and ex-serving ADF members and supports for service providers to improve their understanding and responses to IPV.

The qualitative analyses adopted a thematic analysis approach (Braun & Clarke, 2013) which focused on accounting for service provider perceptions of, and responses to, clients who had experienced or used violence in their relationship. An inductive method was utilised to code the data by the lead qualitative researcher, and was co-coded by co-authors, moving from descriptive codes to interpretative codes, and finally overarching themes. Relevant statements were coded with ample context to avoid data fragmentation and de-contextualisation. A final coding framework was agreed upon collaboratively with co-researchers and applied to the entire dataset. A selection of transcripts and quotes were reviewed collectively by all co-authors under each theme to ensure consensus (Braun & Clarke, 2012). The software program NVivo 11 was used to manage the data and support analyses.

Results

Survey Findings

Descriptive statistics for self-efficacy measures are presented initially, and are displayed in Table 2 and Table 3. These comprise item-level frequencies that relate to service provider encounters with IPV exposure and use, respectively. For the purpose of these analyses, the Likert scale response options were collapsed and frequencies indicate the proportion of service providers that endorsed '*Agree / Strongly Agree'* for each item.

Table 2 shows around 95.0% of service providers described being alert to the possibility that clients may be victims of IPV, while other items indicated high confidence identifying and addressing IPV exposure. For example, there were around 85.0% of respondents that reported knowing questions to ask when suspecting clients were victims of IPV, while 96.1% were comfortable asking clients they had known for some time about IPV. Conversely, only 15.2% reported hesitancy asking clients about IPV exposure in the first session. There were 87.0% of respondents that reported feeling confident identifying client needs when they were exposed to IPV, while around 84.0% reported adequate counselling skills to support these clients.

There were sizable minorities (> 20.0%) of service providers that reported low confidence in specific areas, and these related mainly to domains of risk assessment. By way of illustration, there were 27.0% of service providers reporting that they were not confident assessing whether clients were safe to go home in abusive situations, while around 22.0% indicated that they were not confident addressing client concerns about child safety. In contrast, the subsample of participants that reported seeing couples were asked an additional item which indicated 86.2% (n = 106) of these service providers were confident identifying abusive relationship dynamics during couples counselling.

Table 3 shows corresponding frequencies from items regarding clients who used IPV. These also indicated widespread awareness of the likelihood of IPV use among clients (94.7% of service providers described being alert to the possibility that clients were IPV perpetrators), and while the majority of participants evidenced efficacy for addressing IPV use, these levels were consistently lower when compared to IPV exposure. Such differences were relatively modest for items that addressed identification of IPV use, with 70.9% of providers reporting that they knew appropriate questions to ask (relative to 85.5% for IPV exposure), and 87.9% indicated being comfortable asking clients they had known for some time about using IPV (relative to 96.1% for IPV exposure). However, larger differences were observed in relation to responding to IPV use, with 60.8% of providers reported confidence identifying client needs when they used IPV (the corresponding figure was 87.0% for IPV exposure), while 52.9% reported adequate counselling skills to support these clients (the corresponding figure for IPV exposure was 83.7%).

Table 2. Frequency analyses for survey items adapted from the GRIPS self-efficacy scale, which referenced clients who were exposed to IPV.

		Total n	Agree / Strongly Agree *n*	*%*
1	I feel confident identifying client's needs when they are victims of IPV.	207	180	87.0
2	When I suspect that my clients are victims of IPV, I know what appropriate questions to ask.	207	177	85.5
3	I am able to recognize different kinds of clinical presentations of IPV in victims.	207	171	82.6
4	I feel confident addressing IPV victims concerns about their children's safety.	207	162	78.3
5	During appointments, I am able to pick up on cues given by clients who have been abused by their partners.	206	180	87.4
6	I have adequate counselling skills to support IPV victims.	203	170	83.7
7	I feel confident assessing whether my clients are safe to go home in an abusive situation.	204	149	73.0
8	I feel confident dealing with the uncertainty of the client's situation when supporting those experiencing IPV victimization.	200	150	75.0
9	I do not* have adequate knowledge of IPV issues to help clients being abused.	204	43	21.1
10	I am confident that I can locate resources (such as community agencies, referral services) for clients who are victims of IPV.	203	171	84.2
11	I feel comfortable asking clients who I have known for some time about their experience of IPV victimization.	205	197	96.1
12	I am alert to the possibility that my clients may be victims of IPV.	204	195	95.6
13	I am hesitant* to ask clients about IPV victimization at their first session	204	31	15.2

Notes: * Indicates survey items which are negatively framed.

Table 3. Frequency analyses for survey items adapted from the GRIPS self-efficacy scale, which referenced clients who <u>used</u> IPV.

		Total n	Agree / Strongly Agree	
			n	*%*
1	I feel confident identifying clients' needs when they are perpetrators of IPV.	189	115	60.8
2	When I suspect that my clients are using violence in their relationships, I know appropriate questions to ask.	189	134	70.9
3	I am able to recognize different kinds of clinical presentations of clients who use violence in their relationships.	190	133	70.0
4	During consultations, I am able to pick up on cues given by clients who may be using violence in their relationships.	190	150	78.9
5	I have adequate counselling skills to support IPV perpetrators.	189	100	52.9
6	I feel confident assessing whether my client who uses violence in their relationships poses a risk to others.	189	126	66.7
7	I do not* have adequate knowledge of IPV issues to help clients who use violence in their relationships.	189	58	30.7
8	I am confident that I can locate resources (such as community agencies, referral services) for clients who use violence in their relationships.	190	135	71.1
9	I feel comfortable asking clients who I have known for some time about their use of violence in their relationships.	190	167	87.9
10	I am alert to the possibility that my clients may be perpetrators of IPV.	190	180	94.7
11	I am hesitant* to ask clients about their use of violence in their relationships at their first visit.	191	49	25.7

Notes: * Indicates survey items which are negatively framed.

Table 4 displays frequencies for survey questions about IPV identification strategies, and comprised items that referenced approaches to identification among female clients (item 1-6), male clients (item 7-12), and in couples counselling (item 13).

As shown, there was a small number of service providers (< 10%) that reported never asking female clients about IPV, with more than a third indicating always asking new female clients, and also asking about IPV periodically during treatment. Most service providers reported always asking female clients about IPV when there were visible signs of abuse (95.2%), or risk factors for abuse (73.3%). It was common to ask about the partner's use of violence, as well as the client's own use of violence (although service providers were more likely to report this sometimes, rather than always).

It was common to ask male clients about IPV, although service providers were more likely to report doing so sometimes, rather than always. Most service providers also reported always asking male clients about IPV when there were visible signs of abuse (83.4%) or risk factors for abuse (59.1%). Male clients were commonly asked about their own use of violence, as well as about their partners' use of violence. Among respondents that that provided services to couples, there were 70.0% that reported always asking about IPV.

Subsequent items asked about the number of clients in the last 6 months that had disclosed IPV, and Table 5 displays frequencies for items that referenced IPV exposure and use, respectively. As can be seen, the large majority of service providers (82.6%) reported having recently encountered clients that disclosed being exposed to IPV (modal response: 1-5 clients). Although service providers were relatively less likely to report client disclosures of IPV use, there was still a majority (63.4%) that had encountered at least one client who reported using IPV in the previous 6 months (modal response: 1-5 clients).

Table 4. Frequency analyses for survey items regarding IPV identification strategies.

		Total n	Never / almost never		Sometimes		Always	
			n	*%*	*n*	*%*	*n*	*%*
1	I ask all new female clients about IPV.	173	15	8.7%	92	53.2%	66	38.2%
2	I ask female clients about IPV periodically during treatment.	170	11	6.5%	100	58.8%	59	34.7%
3	I ask female clients about IPV when there are risk factors for abuse.	172	7	4.1%	39	22.7%	126	73.3%
4	I ask female clients about IPV when there are visible signs of abuse.	166	1	0.6%	7	4.2%	158	95.2%
5	I ask female clients about their own use of violence in relationships.	173	15	8.7%	108	62.4%	50	28.9%
6	I ask female clients about their partner's use of violence.	171	3	1.8%	86	50.3%	82	48.0%
7	I ask all new male clients about IPV.	174	29	16.7%	101	58.0%	44	25.3%
8	I ask male clients about IPV periodically during treatment.	172	16	9.3%	110	64.0%	46	26.7%
9	I ask male clients about IPV when there are risk factors for abuse.	171	9	5.3%	61	35.7%	101	59.1%
10	I ask male clients about IPV when there are visible signs of abuse.	169	3	1.8%	25	14.8%	141	83.4%
11	I ask male clients about their own use of violence in relationships.	174	8	4.6%	94	54.0%	72	41.4%
12	I ask male clients about their partner's use of violence.	173	15	8.7%	103	59.5%	55	31.8%
13	I ask about IPV in the context of couples counselling.	100	3	3.0%	27	27.0%	70	70.0%

Table 5. Frequencies for estimates of the number of clients who had disclosed IPV in the last 6 months.

		n	*%*
In the last 6 months, while providing services on behalf of Open Arms, can you estimate:			
How many clients have disclosed (spontaneously or after questioning) being victims of IPV?			
	None	31	17.4%
	1-5	118	66.3%
	6-10	22	12.4%
	11-20	5	2.8%
	21+	2	1.1%
	Total n	178	
How many clients have disclosed (spontaneously or after questioning) using violence in their intimate relationships?			
	None	64	36.6%
	1-5	102	58.3%
	6-10	6	3.4%
	11-20	3	1.7%
	21+	0	0.0%
	Total n	175	

The next series of survey items addressed responses to IPV exposure (Table 6) and use (Table 7), and corresponding frequencies are provided for respondents that had indicated having recently identified IPV. Table 6 shows that the vast majority (> 90.0%) of service providers who had recently identified clients exposed to IPV also indicated always providing support and validation, counselling about options, and supporting decision making and service access. Almost all these respondents reported sometimes or always helping to develop a safety plan or conduct risk assessments. Notably, almost all service providers also reported providing treatment to address the psychological impact of IPV, while there were just over half of service providers that reported overseeing care coordination across services.

Comparable figures from Table 7 show that almost all service providers who had identified clients who used IPV reported always reinforcing that violence is unacceptable, while around 80.0% reported always counselling the client to take responsibility and change their behaviour. There were 63.0% that reported always conducting risk assessments for family members, while there was variability in reports of contacting family members (around half of providers did so sometimes or always). There was similar variability in reports of reporting potential harm to others, while around three quarters reported delivery of or referral for anger management. Almost all service providers reported providing referral information to clients who used IPV, while 80.0% reported sometimes or always helping the client to contact and engage with specialist services.

Table 6. Frequency analyses for survey items indicating typical responses to clients who are exposed to IPV.

		Total n	Never / almost never		Sometimes		Always	
			n	*%*	*n*	*%*	*n*	*%*
In the past 6 months, I took the following actions when having identified a victim of IPV:								
1	Provided preliminary emotional support and validation.	132	2	1.5	5	3.8	125	94.7
2	Counselled the client about their options.	131	1	0.8	12	9.2	118	90.1
3	Supported the client in making decisions and accessing services to promote safety and stability.	131	1	0.8	12	9.2	118	90.1
4	Helped the client to develop a personal safety plan.	131	2	1.5	20	15.3	109	83.2
5	Conducted a safety assessment for the victim and/or their children.	130	9	6.9	18	13.8	103	79.2
6	Oversaw care coordination across services (e.g., specialist family violence support) to ensure client safety and stability.	128	55	43.0	47	36.7	26	20.3
7	Provide treatment addressing the psychological impact of IPV, such as depression and post-traumatic stress.	130	8	6.2	30	23.1	92	70.8
8	Provided referral information (e.g., phone numbers, pamphlets).	132	6	4.5	31	23.5	95	72.0
9	Helped the client to contact and engage with specialist support services.	131	15	11.5	58	44.3	58	44.3

Table 7. Frequency analyses for survey items indicating typical responses to clients who use IPV in their relationships.

		Total n	Never / almost never		Sometimes		Always	
			n	*%*	*n*	*%*	*n*	*%*
In the past 6 months, I took the following actions when having identified a perpetrator of IPV:								
1	Reinforce to the client that violence is never acceptable.	95	2	2.1	3	3.2	90	94.7
2	Counselled the client to take responsibility and change their behaviour.	91	2	2.2	16	17.6	73	80.2
3	Conducted a risk assessment for family members of the client.	92	5	5.4	29	31.5	58	63.0
4	Contacted or attempted to contact family members of the client.	81	39	48.1	31	38.3	11	13.6
5	Reported potential harm to others from the perpetrator's use of violence.	87	32	36.8	32	36.8	23	26.4
6	Delivered or referred the client to an anger management intervention.	91	22	24.2	48	52.7	21	23.1
7	Provided referral information (e.g., phone numbers, pamphlets) to the client.	95	10	10.5	38	40.0	47	49.5
8	Helped client to contact and engage with specialist support services, such as a men's behaviour change program.	90	18	20.0	44	48.9	28	31.1

In the context of reports of referrals for IPV exposure and use, a final series of survey items addressed targets for onwards referral, and frequencies are displayed in Table 8. As shown, the most common referral targets for clients who were exposed to IPV were specialist women's services, child protection services, and police. Although housing, education, job, or financial assistance, as well as couples therapy, were the least common referral targets for IPV exposure, there were still substantial numbers of service providers that reported referring to such services sometimes or always (e.g., almost 40.0% of service providers reported sometimes referring clients to couples therapy). In contrast, the most common referral targets for clients who used violence were substance use counselling and men's behaviour change programs. Police and couples therapy were identified least frequently, although there were also non-trivial numbers of service providers that reported referring to these services at least sometimes.

Table 8. Frequency analyses for survey items addressing referral targets for both IPV exposure and use.

	Total n	Never / almost never		Sometimes		Always	
		n	*%*	*n*	*%*	*n*	*%*
IPV exposure							
Specialist women's service	127	8	6.3	63	49.6	56	44.1
Child protection services	122	22	18.0	79	64.8	21	17.2
Police	124	23	18.5	70	56.5	31	25.0
IPV hotline (e.g., 1800RESPECT)	123	25	20.3	41	33.3	57	46.3
Shelter for women and children	120	27	22.5	64	53.3	29	24.2
Specialist legal service	124	29	23.4	69	55.6	26	21.0
Substance abuse counselling	115	28	24.3	71	61.7	16	13.9
Housing, education, job or financial assistance	118	30	25.4	73	61.9	15	12.7
Couples therapy	115	60	52.2	44	38.3	11	9.6
IPV use							
Substance abuse counselling	92	15	16.3	67	72.8	10	10.9
Men's behaviour change program	87	21	24.1	49	56.3	17	19.5
Support group	87	21	24.1	54	62.1	12	13.8
IPV hotline (e.g., NTV Men's Referral Service)	91	28	30.8	45	49.5	18	19.8
Housing, education, job or financial assistance	87	38	43.7	46	52.9	3	3.4
Police	84	42	50.0	35	41.7	7	8.3
Couples therapy	86	47	54.7	32	37.2	7	8.1

Interview Findings

Findings from the qualitative analyses were organised in relation to three high-order themes that were developed on the basis of common narratives across interviews. These themes were characterised as follows:

1. *Divergent perspectives on IPV:* Service providers reported understandings of IPV that reflected two divergent perspectives, with some tending to focus on (i) mental health frameworks and understandings of IPV, while others described adopting (ii) gendered approaches that acknowledged structural factors and causes of violence.
2. *Challenges attributed to the military context:* Service providers described features of the military occupational context that uniquely influenced risk, IPV disclosures, and the way clients approached help-seeking.
3. *Inconsistent knowledge of risk and safety:* Service providers described variable approaches to risk assessment, safety planning, and couples counselling, which were seemingly informed by individualised understandings of IPV, rather than consistent approaches to risk and safety in the context of IPV.

Each of these themes is described below with illustrative quotes.

1. Divergent perspectives on IPV

Different service providers described two main and potentially divergent understandings or 'lenses' on IPV that were seemingly grounded in their individual professional backgrounds, training histories, and personal experiences. These have been labelled: (i) the mental health lens, and (ii) the gendered/feminist lens.

(i) Mental health lens

Some service providers tended to describe IPV in terms of mainly individual psychological and emotional factors or vulnerabilities, and in relation to a broad biopsychosocial framework.

These service providers tended to conceptualise the use or experience of IPV through a mental health lens and mainly focussed on individual psychological and emotional responses. They prioritised the trauma histories of those who experienced IPV and used violence in their case conceptualisations. Such histories encompassed childhood neglect and abuse, including sexual abuse or exposure to domestic and family violence, as well as historical experiences of IPV as an adult, and more recent (or ongoing) IPV exposures. For example, one participant described the impact of early experiences and attachment difficulties on current presenting problems, including controlling behaviours directed towards their partner:

> *"...the poor attachment is quite prominent. The jealousy issues, the fear of abandonment, the having to control the person. I think a person having poor self-esteem is a big issue in this as well…. This again is going back to your childhood"* (P4).

These providers commonly referenced co-occurring psychological problems, such as PTSD, mood disorders, substance use and gambling problems among clients who used IPV. They also described how trauma exposures and co-morbidities further complicated the experiences of clients who were exposed to IPV. This included a sense of responsibility and guilt:

> *"How bad would I look if I'd left him with PTSD? He's served our country, he has PTSD, I can't leave because he has PTSD.'* (P10).

Service providers who conceptualised violence through a mental health lens often reported difficulty identifying and responding to IPV. This included difficulty identifying coercive control and other forms of IPV when it was not disclosed spontaneously. They also described difficulties differentiating between relationship conflicts and IPV, and reported struggling to assist clients who used violence to understand and disclose IPV so that they could seek help.

Providers who described a mental health lens on IPV also tended to adopt a biopsychosocial approach to responses, which was characterised by the provision of psycho-education, CBT, schema therapy, attachment therapy, and emotion-focused therapy.

(ii) Gendered/feminist lens

There were other service providers who described viewing IPV through an alternative lens that reflected a gendered or feminist orientation. These providers often reported personal experiences of family or domestic violence, or had experience working in the family violence sector:

> *"I have a very strong feminist background, and involvement with women, and women's services, and I would see that as purely the power differential between men and women and the lower position of women in our society." (*P3).

These providers tended to frame IPV in terms of misogynistic and patriarchal attitudes, as well as power imbalances. These were viewed as influencing client behaviours, but also reflected broader societal issues that partly determined the experiences and risk profiles of clients. For these providers, mental health issues exacerbated IPV but did not cause violence:

> *"Intimate partner violence is not caused by mental health issues, not caused by PTSD, not caused by gambling, it's not caused by alcoholism. All of those can exacerbate…can create more impulsivity in the perpetrator, or the person using violence, but they don't cause it. What causes intimate partner violence is a belief that you have more rights than the other partner, and so it is gender-based, and it is based in the lack of equality in community, and beliefs around gender and entitlement."* (P2)

For many of these providers, the gendered perspective co-occurred with an expressed preference for working with female clients, while it also influenced typical responses to IPV. For example, these providers were more likely to describe inquiring about client experiences of IPV, validating disclosures and providing emotional support, and facilitating linkages with external services:

> *"…identifying that this actually does constitute a form of DV, as well as discussing how to move forward with this, the education to the client around the cycle of power and control, the cycle of violence, and discussing and identifying those current patterns, and how to help the client. Is there an opportunity for her to explore…does she need alternate support or an alternate plan to*

> *keep herself safe, is there a chance for it to escalate, and trying to investigate all of those, as well as the potential for other services, if necessary, that could get involved*". (P6)

These providers often describe a need for IPV informed professional development and policy and practice that was aware of IPV.

2. Challenges attributed to the military context

Service providers were asked about factors that could impact client experiences of IPV, and several emphasised how characteristics of military service could influence the use of violence, while others described how the military context could increase risk for clients who were exposed to violence and create barriers to help-seeking.

There were individual factors related to military service that were believed to contribute to IPV use. At this individual client level, service providers identified conditioning of emotional, cognitive and behavioural responses such as 'black and white thinking', anger, and controlled aggression, which were understood to be potentially adaptive responses when enacted in the context of training environments and during operational deployment, but were problematic in other contexts:

> *"For some of our clients, anger has been modelled and supported and trained as an adaptive response that they never deconditioned and it's the only thing that feels safe at those points" (P12).*

Some providers suggested that deployments and frequent relocations could contribute to feelings of disconnection from family, and this could trigger attachment-related schemas that exacerbated IPV use.

There were a few service providers that described structural factors that contributed to power imbalances and were potentially magnified in military contexts. These providers talked about the impact of attitudes and practices that perpetuate misogyny and use of violence:

> *"…perception of women…it's not helped by things like the Jedi Council [which refers to a group of ADF personnel who were investigated over distributing derogatory and sexually explicit emails using defence computer systems], or the prevalence of porn in male-dominant corps. There are multiple factors contributing towards the power imbalance"* (P16).

However, it was notable that these structural factors (either when discussed generally within the context of Australian society, or more specifically within the military) were not referenced by most participants, who were instead more likely to describe individual factors.

Several service providers described concerns about the unique risks associated with experiencing or reporting IPV for current or ex-service personnel, or family members of personnel. These included elevated risks for partners of current serving members, due to isolation because of frequent family relocations, difficulties maintaining gainful employment, lack of financial independence, and reliance on military housing. These also described risk to the service member's career if IPV was disclosed, which was viewed as a significant barrier to reporting.

Finally, there were some providers that expressed concern that if IPV use by a current military member was reported to authorities, then this may trigger a 'notice to show cause' which could escalate risk for the family member:

> *"…the notion of applying for an AVO [Apprehended Violence Order], and then knowing that the member will get a notice to show cause if that AVO is awarded. I know that that is enough to make women not want to proceed with an AVO. But it's also...if the woman is serving it wouldn't be surprising for that superior to say something along the lines of, "Well, how would that impact his career? You have to think about his career in this." (P16).*

As a result of perceived risk for the person who has experienced violence, some service providers indicated reluctance to ask about and report IPV.

3. Inconsistent approaches to managing risk and safety

Most providers described conducting risk assessments and involvement with some form of safety planning for clients who were exposed to IPV. However, this was not based on a consistent approach to risk management and safety planning in the context of IPV. Most providers used ad hoc strategies which were grounded in their previous experiences, or resources obtained from local services or State-based risk assessment frameworks.

The following quotes illustrate some variable approaches to risk assessment that were described by service providers:

> *"I have a background of working in a specialist DV service. I'm always actually listening for any indicators that clients might be at risk of violence from their current partners, ex-partners, or family members. So, assessing for risk of harm from others is central to my work, and I am always listening for it." (P6).*

> "*The [State] government put together some really good information if you wanted to look it up, the Responding To Violence Guide for service providers and service providers…and I think that's the one that has – that's where I got a set of safety questions, and I utilised those same set of questions in all my intakes."* (P7).

Some service providers described relying almost wholly on referral to specialist family violence support services as their strategy for safety planning:

> *"My first port of call is the 1800 811 811 number for the victim. I say, "Please call them, and they will give you some good strategies around putting a little suitcase apart with all the essential things you would need to have, putting some money away in a separate bank account somewhere, all those things that if things do get really tough, that you have an escape route. And, if necessary, they will find you somewhere to move you to, to be safe."* (P1).

Inconsistency with regards to the management of risk and safety was also apparent for participants who provided couples therapy. By way of example, one participant reflected on learnings from past experiences to inform identification strategies when working with couples:

“I actually changed the way that I did couple work after discovering, over a number of sessions, that there was DV. I went back to splitting both the couples on the very first session, but then after a private conversation with both of them, what I’m gauging, what could they want out of counselling, until I’m also asking straight out those safety issues, where if you have the other partner in the room, they probably aren’t going to be able to be truthful.” (P4).

Other service providers highlighted assessing risk over time with couples, but it was unclear how assessments were conducted and to what degree an understanding of coercive violence informed the structure and content of assessments:

“This particular couple is a chronic service consumer. They’ve certainly been in relationship counselling for pretty much their whole relationship. At that stage, it was about six years and with the same pattern of behaviour or constant pattern of the same behaviour and it was through Open Arms and we were able to do risk assessments and things like that over time. I was able to make that assessment through past behaviours, through the current situation and through talking to them both together and separate. In their initial session, the husband’s responses when the situation escalated past a point that I was comfortable within the session, so I was able to say stop, you need to leave the room and he stopped and looked at me and left the room. So, he was responsive and it never got to that point of violence. I was able to make that assessment and be confident that that was not a risk.” (P10).

A small number of service providers reported considering couples counselling when there were signs of current IPV, and also indicated variable approaches to assessing risk and safety. For example, one provider described an instance where couples counselling was considered while there was an intervention order (IVO) in place, and this prompted a discussion with senior clinicians:

“…there was an IVO. Reading the intake of this person’s wife, she seemed reluctant to have couple counselling due to the violence that had occurred. He was aggressive in trying to get counselling….and he was trying to control her behaviour… she said, “Yeah. I will have counselling, I suppose.” [The decision to proceed with couples counselling] was a discussion with our family therapists, and that was when we decided, ‘Let’s have a review and a good examination before we do it’.’” (P11).

This provider also described other instances when they had declined to provide couples counselling following consideration of the couple’s circumstances:

“…there have certainly been a couple of times when I’ve had to say to mainly men who have perpetrated and wanted to have couple counselling, that, “No. It’s not appropriate. You’re not going to get it. This is what you told me. This is what your wife has told me. Therefore, you need individual counselling before you go near couple counselling. And, if this behaviour is repeated, I have suggested to your wife or partner that they get an intervention order.” (P11).

In contrast, another provider described processes of scheduling individual sessions with both partners to assess IPV prior to engaging in couples counselling:

“I’m not saying that I will bring the couple together immediately. I need to do an assessment of the perpetrator. I had a couple a while ago, and I saw the man first, listened to what he had to

> *say, and said, "I'd like to hear what your wife has to say, as well. I'll see you again, if you would like to bring your wife in."* (P5)

Overall, these service providers typically indicated risk awareness and some form of risk assessment, but also described variable approaches to couples counselling in the context of IPV. Notwithstanding such variability, service providers described consistently seeking both internal (from Open Arms) and external supports to address concerns and refer clients:

> *"What are the risks? How current is their risk? What's the safety need around this? Is the violence coming from another current-serving member where we have different reporting requirements around that? And, if it's something we are finding difficulty in resolving we can certainly escalate it to the (Open Arms) assistant director level." (P6).*

> *"If I have immediate safety concerns, I would be consulting with police or services like that. If I have concerns about the agency of the person in terms of being in an abusive relationship, but they may not be in immediate danger, I would feel that I could liaise with relevant services like the women's refuge." (P14).*

Finally, many providers outlined the importance of feeling supported by Open Arms and being able to access clinical supervision and professional development to inform their knowledge and practices for assessing risk and safety issues in the context of IPV.

Limitations

The aforementioned findings from the current project should be viewed in light of key methodological limitations. Most notably:

- Participation was voluntary, and the survey response rate was around 18.0% (assuming an eligible population of around 1,200 service providers nationally). Accordingly, it is plausible that service providers who more frequently encountered clients who disclosed IPV (or who were more confident in addressing violence) were more likely to choose to participate. This may have inflated some figures, such as the estimated frequency of encounters with clients who disclosed IPV.
- Conversely, all findings from the current project were based on the perspective of service providers, and these are likely to provide underestimates of the true rates of some issues, such as the estimated frequency of encounters with clients who were exposed to IPV (for example, assuming the most instances of IPV are not disclosed by clients in mental health services).
- Survey measures were based on standardised scales that have been used in generalist health service contexts (e.g., primary care), but were modified for the current context and have not been subject to psychometric testing.
- Survey measures that referenced confidence addressing IPV use were also adapted from standardised scales addressing confidence addressing IPV exposure, and the former have not been used previously and have unknown properties.
- Follow-up interviews were conducted with a sub-sample of service providers who consented to be contacted after the survey, and there were insufficient numbers of participants to represent some sub-groups of service providers including peer support workers (who were also under-represented in the surveys).

Summary of Findings

Box 1 and Box 2 summarise the key findings from the survey and interview stages of the project, respectively.

Box 1

Key findings from the **survey** component of the project were as follows:

- There was widespread recognition and awareness that IPV exposure and use were both significant issues among Open Arms clients, including current and ex-service personnel, and family members.
- Most service providers reported feeling confident about identification and responses to clients who disclosed IPV exposure. However, there were significant minorities who were less confident in relation to risk assessment and safety planning.
- Service providers also reported less confidence about addressing IPV use among clients, relative to exposure, and these differences were particularly large in relation to responses to IPV use.
- Most respondents reported asking clients about IPV. However, there was variability in approaches; for example, less than half reported always asking new female clients about IPV (i.e., ‘universal screening’), while larger numbers reported asking given risk factors or signs of abuse (consistent with principles of ‘case-finding’).
- Encounters with clients who disclosed IPV exposure and use were reported commonly and by the majority of service providers.
- Almost all service providers reported conducting risk assessments or developing safety plans, despite previous indications of lower confidence in these domains.
- Just under half of respondents who had recently identified clients exposed to IPV reported engaging in care coordination.
- Almost all providers reported providing treatment to address the psychological impacts of IPV.
- Couples therapy was a common referral target for clients who were exposed to IPV and those who used violence in their relationships.
- Anger management was also a common referral target for clients who used IPV.

<u>Box 2</u>

Key findings from the **<u>interview</u>** component of the project were as follows:

- Service providers reported different understandings of IPV, and tended to adopt perspectives that prioritised either (i) mental health difficulties and trauma histories, or (ii) gendered factors and power imbalances that align with a feminist perspective.
- Service providers who viewed IPV through a mental health lens tended to report difficulties identifying coercive control, and distinguishing IPV from relationship conflict and violence not associated with coercive tactics.
- Providers suggested a range of individual and structural factors related to military service that could contribute to IPV use, such as training in the controlled use of force, as well as deployments and associated levels of family disconnection.
- Interviewees described unique risks for partners of current military personnel, which highlighted increased vulnerabilities (e.g., due to isolation attributed to frequent relocations, and reliance on military housing) and unique risks from reporting (e.g., which may trigger a ‘notice to show cause’ that goes to military personnel).
- Service providers described individualised and variable approaches to risk assessment and safety planning.
- Variable approaches to risk assessment and referral practices were also described in the context of couples therapy, with little evidence of a shared understanding of what criteria should be considered for engaging in couple counselling given IPV risk.
- Participants described regularly seeking both internal and external supports while managing clients who disclosed IPV, and identified Open Arms as an important source of support and guidance.

Implications for Policy and Practice

The study suggested that majorities of Open Arms service providers had recently encountered clients who disclosed IPV (both exposure and use), and this signals the need for initiatives to support providers in addressing IPV among veterans and family members. Almost all respondents reported further awareness that clients may have experienced IPV, or used violence in their relationships, while majorities reported confidence identifying and responding to clients who were exposed to IPV, and used IPV (although to a lesser extent). At the broadest level, these findings suggest high levels of receptivity to initiatives that endeavour to enhance responses to IPV among veterans and family members. These may exceed levels that have been observed in other mental health settings, including public health mental health services, which have typically identified at least some providers who express hesitance and limited recognition that addressing IPV is a legitimate part of their professional responsibilities (Trevillion et al., 2012).

The findings also indicated that Open Arms service providers held variable understandings of the nature and drivers of IPV, while both surveys and interviews suggested inconsistent approaches to some practices including risk assessment and safety planning. This variability highlights the importance of developing a unifying policy framework for Open Arms services, which provides foundational knowledge and information to support shared understandings of IPV, defines elements of essential professional practices, and also specifies the responsibilities of service providers in relation to IPV. This could be based on frameworks for non-veteran services that have been developed in some Australian jurisdictions, such as the Multi-Agency Risk Assessment and Management (MARAM) framework that is being implemented in Victoria[1]. However, the qualitative findings emphasised important military-specific factors which can influence the occurrence, disclosure, and reporting of IPV, and thus they signal the need for tailored approaches that address features of the military occupational context and veteran-specific service system. Such findings align with principles of military occupational health models, which also highlight unique features of this employment context (e.g., military cultural values, separate health service systems), and emphasise that civilian modes of intervention may require adaptation to suit such veteran-specific environments (Adler & Castro, 2013).

The aforementioned policy framework may provide directives for a range of supporting resources that can also be developed to enhance the consistency and quality of professional practices relating to IPV. Resources may include practice guidelines, training programs, and clinical tools that can help standardise the process of identification, risk assessment, and safety planning, which on the basis of current findings should address at least three main areas of capability and practice.

First, the findings highlight the need for resources that can support **improved identification and responses to clients who have experienced IPV**. These should aim to promote consistent practices and enhanced capabilities across areas including IPV identification, safe engagement and first-line responses to clients who disclose exposure, as well as the provision of effective risk assessment and safety planning, and ongoing support. However, the current findings suggest several specific areas that should be prioritised:

- *Improved understanding and identification of coercive control:* While surveys indicated that most providers felt confident identifying IPV exposure, the interviews identified some providers (particularly those who viewed IPV with a mental health lens) that reported difficulties identifying coercive and controlling behaviours, and differentiating IPV from non-abusive forms of relationship conflict. This suggests the need for improved understanding of the signs and drivers of non-physical forms of IPV, which should be a core focus of policy directives and supporting resources. Although it seems premature to recommend universal IPV screening to increase identification, given that benefits in this setting have not been examined (O'Doherty et al., 2014), there is likely value in the development of recommended screening tools that can be used by service providers. These should include items which expressly target coercive and controlling behaviours, or the impacts of such behaviours (e.g., pervasive fear, concerns about safety), and should be grounded in practice guidance that indicates how to respond appropriately to disclosures.
- *Improved consistency in risk management approaches*: The surveys provided evidence of some providers that reported lower confidence with regards to addressing risk and safety concerns, while interviews suggested inconsistent approaches to risk management including risk

[1] https://www.vic.gov.au/family-violence-multi-agency-risk-assessment-and-management

assessment and safety planning. Accordingly, the results suggest another area of need for resources to support risk management. These may involve tools based on standardised risk assessment instruments that have an existing evidence base (Messing & Thaller, 2015), while resources that are relevant to the Australian context have also been developed[2]. These include intermediate risk assessment tools and practice guidance for adult clients, brief versions that may be appropriate in time-limited contexts, and additional tools for use with children and young people. They also include safety planning guides and templates for recording information and referrals. Such resources should be adapted to suit the veteran-specific context, which may involve consideration of military-specific risk factors for IPV.

- *Improved guidance for planning of mental health treatment:* The findings highlighted other common practices that may suggest unique roles that Open Arms service providers can play in supporting the mental health of clients exposed to IPV. For example, the majority of survey respondents reported providing treatment for the psychological impacts of IPV, while interviews documented inconsistent approaches to case conceptualisation which suggests a need for guidance regarding the nature and timing of appropriate interventions. The latter may include therapies that can help promote recovery from long-term mental health impacts of IPV exposure (Cowlishaw et al., 2020), and can provide a basis for tools and guidelines to inform case formulation and treatment planning in order to fully address the mental health and safety needs of clients exposed to IPV.

- *Support for active engagement in care-coordination*: Close to half of survey respondents reported not having undertaken care coordination roles recently to ensure safety and stability, or meet the recovery needs of clients exposed to IPV. This finding is unsurprising given that training and structures for clinicians in Australia tend to support referral rather than active care-coordination models. However, this critical role could be strengthened in Open Arms services by providing tailored training and guidance on how to engage and plan care with other service providers, or by supporting increased engagement with specialised complex case coordinators at Open Arms. Support from these coordinators may be particularly important for OPCs who operate within a private practice model that typically does not afford the time or flexibility required to engage in care-coordination directly.

The survey results also indicated that respondents reported lower confidence in addressing IPV use, when compared to exposure, and these differences were most pronounced in relation to responding to clients that used IPV. Given that the majority of service providers still reported recent encounters with clients that disclosed IPV use, the findings thus highlight a second major area of need for polices and resources that can support **improved identification and responses to clients that <u>use IPV</u>**. A range of 'perpetrator-focussed' resources have been launched as part of the MARAM initiative[3], and could inform the development of suitable resources for Open Arms. Among other things, they include an identification tool that can help structure observations of risk indicators, and guidance on response options which may include secondary consultation, proactive information sharing with other agencies (in jurisdictions where this is legislated), and potentially the provision of referral information for specialist services and support options.

[2] https://www.vic.gov.au/maram-practice-guides-and-resources
[3] https://www.vic.gov.au/maram-practice-guides-professionals-working-adults-using-family-violence

It is important to acknowledge that there is less guidance generally for service providers regarding how best to address IPV use, while the evidence-base is underdeveloped when compared to literature on health service responses to IPV exposure. For example, there is limited evidence currently regarding properties of screening tools for IPV use (Davis & Padilla-Medina, 2021). Studies of interventions for individuals (mainly men) that use IPV also remain equivocal about the benefits in terms of reductions in violent behaviours (Tarzia, Forsdike, Feder, & Hegarty, 2020), while recent literature highlights the importance of tailoring approaches to address potentially heterogeneous client needs and forms of violence (Butters et al., 2021; Travers, McDonagh, Cunningham, Armour, & Hansen, 2021). Accordingly, it remains unclear whether existing intervention approaches will be suitable for all forms of violence encountered among veterans and family members. The suitability of these interventions should be viewed in relation to (a) the distinctive profiles and potentially unique characteristics of Open Arms clients, and (b) additional resources that are also available in this service-use environment (e.g., trauma-focussed therapies for co-occurring PTSD and anger dysregulation, which could be integrated with adjunctive IPV interventions). There is a particularly important role for ongoing research which can include pilot studies of novel tailored interventions and ongoing evaluations of both costs and benefits of these approaches (see below).

Finally, the survey results indicated that couples therapy was a common referral option for clients who disclosed IPV, while interviews provided evidence of inconsistent practices with regards to assessing violence risk and determining the suitability of couples therapy in the context of IPV. These findings are important to view in relation to debate surrounding the suitability of 'conjoint therapies' for IPV, and general acknowledgement that these interventions are unsafe in many circumstances and are contraindicated when coercive and controlling behaviours are present (Hurless & Cottone, 2018). However, there is a defensible position that violent couples which do not display coercive and controlling behaviours can benefit from conjoint therapies (Stith & McCollum, 2011), which may be appropriate when informed by ongoing risk management (Hurless & Cottone, 2018). As such, the current findings highlight the strong need for targeted resources that address principles of IPV **risk management in the context of couples counselling**, including tools to support assessments of IPV risk and underlying dynamics, and accordingly the appropriateness of couple-based interventions with safety planning. Although there are no templates for relevant resources that are widely implemented in Australia, there have been novel frameworks and protocols proposed recently to guide decision-making and practice in other jurisdictions (Todahl, Nekkanti, & Schnabler, 2020), and these may provide bases for new approaches that are tailored to the unique requirements of Open Arms services.

Implications for Research

The aforementioned implications for policy and practice signal priority areas for innovation that seem proportionate to the level of need for enhanced responses to IPV in Open Arms services. However, these responses should be considered in conjunction with a coordinated program of research which can provide up-to-date evidence that ensures initiatives are feasible and acceptable, maximise benefits for service users, relative to costs, and also identify any unintended consequences.

A critical platform for this research should be enhanced data collection standards and infrastructure in Open Arms' services, that can maximise the consistency and quality of information recorded routinely by service providers about clients and their experiences of IPV. Among other things, such standards may include standard data items and response categories, which enhance consistency of recording of the type of violence and relationships between parties, and provide administrative data that can comprise a resource for ongoing research and evaluation. By way of illustration, this data can be analysed in order to improve understanding of the number and profile of service users that disclose IPV in Open Arms services, and also quantify potential impacts of broader policy initiatives proposed above; for example, by providing a baseline metric for levels of IPV disclosure that can be used for purposes of comparison over time.

In the context of a coordinated program of research on IPV in Open Arms services, there would seem to be at least four main areas of need for evidence that should be used to organise and prioritise future research activities.

First, there is a pressing need for research that can inform evaluations of the suitability and benefits of initiatives that aim to improve identification and responses to **IPV exposure**. This may include:

- Comprehensive reviews of broader literature on the nature and benefits of responses to IPV in non-military health services, which can identify the most appropriate approaches to achieve objectives that include increasing identification of IPV exposure (e.g., via screening versus so called 'case-finding' strategies) (see (O'Doherty et al., 2014), and embedding specialist expertise and referral pathways in non-specialist services (e.g., via co-locating specialist 'advocate educator' roles in other service settings; Feder et al., 2011).
- Direct studies of service users (e.g., veterans and family members) which can provide data regarding the true extent, distribution, and implications of IPV exposure among Open Arms clients (including those that have not been identified by service providers), as well as qualitative data regarding barriers to engagement and acceptability of new initiatives that address IPV.
- Systematic evaluations of the benefits of initiatives (e.g., identification protocols involving electronic systems for prompting inquiries and recording IPV disclosures and referrals), which in some instances may involve variations of randomised controlled designs that can quantify effects in terms of increased rates of identification and referral, and improvements in client safety and wellbeing.

Second, there is an equivalent need for research that can inform the development of initiatives that aim to improve identification and responses to **IPV use** by current and ex-serving personnel, and family members. There is less evidence and fewer examples of clearly beneficial interventions for improving identification and responses to IPV use (relative to exposure), and thus there is likely to be a need for foundational research that can inform the design and evaluation of novel intervention approaches. This may include:

- Qualitative and quantitative studies of the nature and frequency of violent behaviours among Open Arms clients, which can distinguish coercive and controlling behaviours from other forms of violence that do not reflect control tactics, and can also illustrate the profiles (including readiness to change) and treatment needs of violent men and women encountered in veteran-specific contexts.
- Preliminary studies of the acceptability and properties of screening tools and protocols for IPV use in Open Arms services;

- Intervention development and pilot studies that involve integrating interventions for IPV use into broader services that already addresses co-occurring mental health issues including PTSD, depression, and anger. These may be based on programs for military personnel who use IPV that have demonstrated beneficial effects in U.S. studies, such as the Strength at Home Men's program (Taft, Macdonald, Creech, Monson, & Murphy, 2016), but are adapted to suit the Australian context and also address issues of power and control.

Third, there is also a clear need for studies that can shape understanding of the appropriate uses of **couples therapy** in the context of IPV and in Open Arms services. These may include syntheses of frameworks and protocols that are proposed to guide decision-making and practice with regards to usage of couples therapy in the context of IPV risk (Todahl et al., 2020). They may also include examinations of the suitability of such frameworks for use in the context of Open Arms services, Australian legislative environments, and in relation to expressed preferences of service users and providers.

Finally, there is also a broader and substantial need for research that may be situated **outside of Open Arms services**, but can enhance understanding of the context, drivers, and appropriate targets for IPV interventions among current and ex-service personnel, and family members. This may include:

- Direct studies of the frequency and distribution of IPV, and points of contact with the service system for all current and ex-service personnel, as well as their family members, who report IPV exposure and use;
- Focussed qualitative studies of the military cultural context and implications for IPV use, exposure, and help-seeking;
- Studies of identification and responses to IPV in other service use environments, including specific health services for current military personnel and family members (e.g., Garrison Health Services in Australia); and
- Studies of prevention programs that may help to reduce the incidence and impacts of IPV for personnel and families that are not currently connected with such services.

Given the breadth of evidence that is required to inform multiple areas of response to IPV among current and ex-service personnel, and family members, there would seem to be value in the development of an organising framework and comprehensive plan for future research. This plan should articulate near-term priorities for evidence that is urgently required to inform immediate policy directions. Furthermore, it should also have a longer view towards shaping integrative strategies for reducing the incidence and impacts of IPV, and may incorporate elements of prevention, responses to ongoing violence, and further initiatives to support recovery (Cowlishaw et al., 2021b). These priorities should be organised initially around the views and perspectives of veterans or family members with lived experience of IPV, as well as needs of military and veteran-specific support services. Furthermore, the development of an organising framework should be used to promote cross-sector engagement and partnerships with other agencies that are likely to have important roles in addressing this major public health issue in military and veteran-specific contexts. These include agencies and departments that have contact and responsibility for all current personnel or veterans (not just those accessing services), as well as non-military services that are involved in violence prevention and responses more broadly.

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