

A Primary Care Response to Children and Mothers Experiencing Domestic Violence

NCHDV March 2015

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Children Experiencing Domestic Violence

1 in 4 Australian children (Indermaur, 2001)



Use of health care services, even when the violence occurred before their birth

(Rivara et. al., 2007)



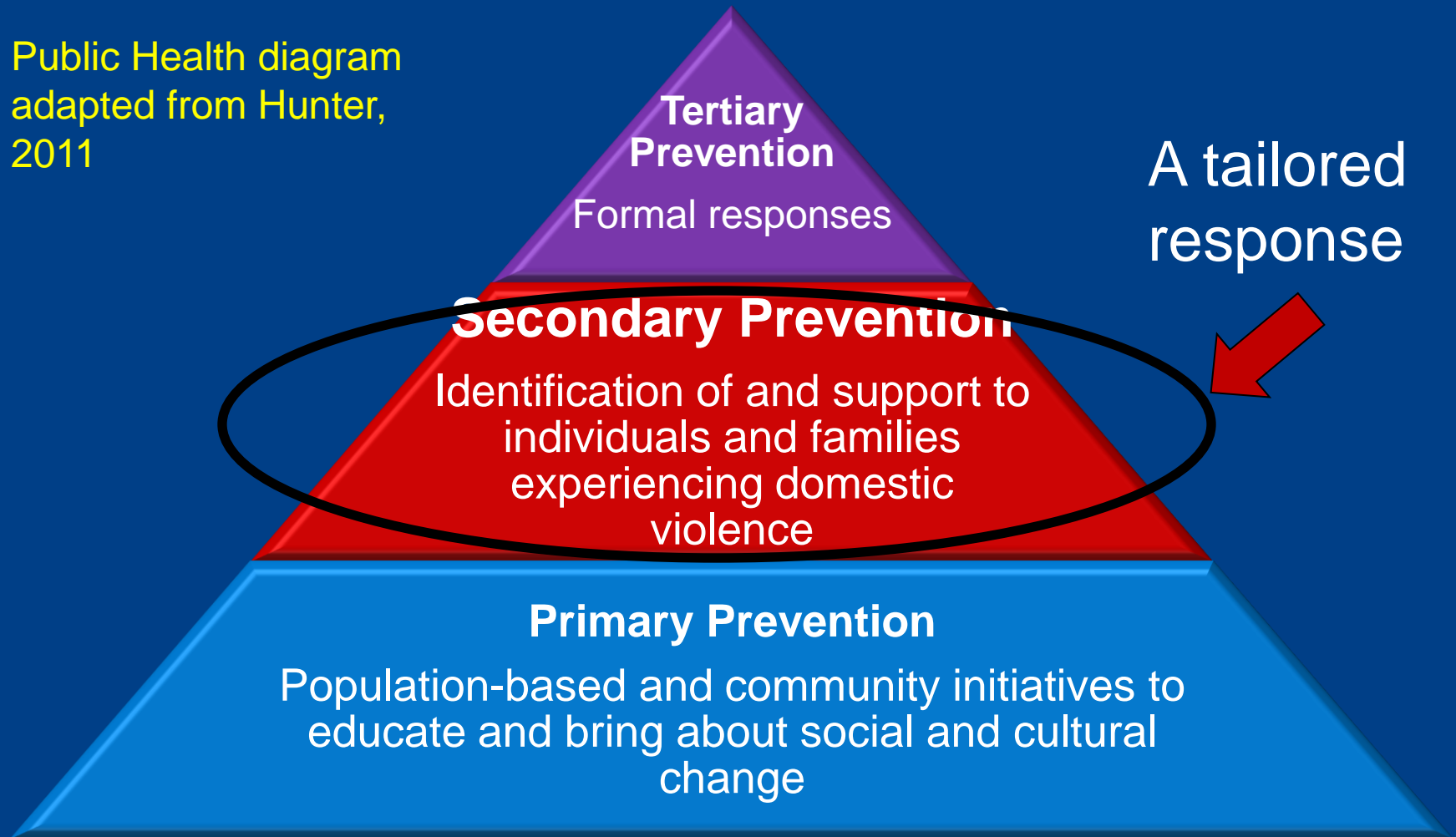
Social, emotional and psychological problems

(Holt et. al., 2008)

37% found to be resilient (Kitzmann, 2003)

Intervention Scope

Public Health diagram
adapted from Hunter,
2011



Current practice

Case finding for domestic violence (Taft, 2013)



Woman centred care: WHO Guidelines (2013)

GUIDELINES FOR HEALTH SECTOR RESPONSE →

WHO's new clinical and policy guidelines on the health sector response to partner and sexual violence against women emphasize the urgent need to integrate these issues into clinical training for health care providers. WHO has identified the key elements of a health sector response to violence against women which have informed the following recommendations:



Women-centred care:

Health-care providers should, at a minimum, offer first-line support when women disclose violence (empathetic listening, non-judgmental attitude, privacy, confidentiality, link to other services).



Training of health-care providers on intimate partner violence and sexual violence:

Training at pre-qualification level in first-line support for women who have experienced intimate partner violence and sexual assault should be given to healthcare providers.



Identification and care for survivors of intimate partner violence:

Health-care providers should ask about exposure to intimate partner violence when assessing conditions that may be caused or complicated by intimate partner violence, in order to improve diagnosis/identification and subsequent care.



Health-care policy and provision:

Care for women experiencing intimate partner violence and sexual assault should, as much as possible, be integrated into existing health services rather than as a stand-alone service.



Clinical care for survivors of sexual violence:

Offer comprehensive care including first-line support, emergency contraception, STI and HIV prophylaxis by any perpetrator and take a complete history, recording events to determine what interventions are appropriate.



Mandatory reporting of intimate partner violence:

Mandatory reporting to the police by the health-care provider is not recommended. Health-care providers should offer to report the incident if the woman chooses.

Rationale for Child Focused Intervention

Children know about the violence and want to talk about it with trusted adults (McGee, 2000)

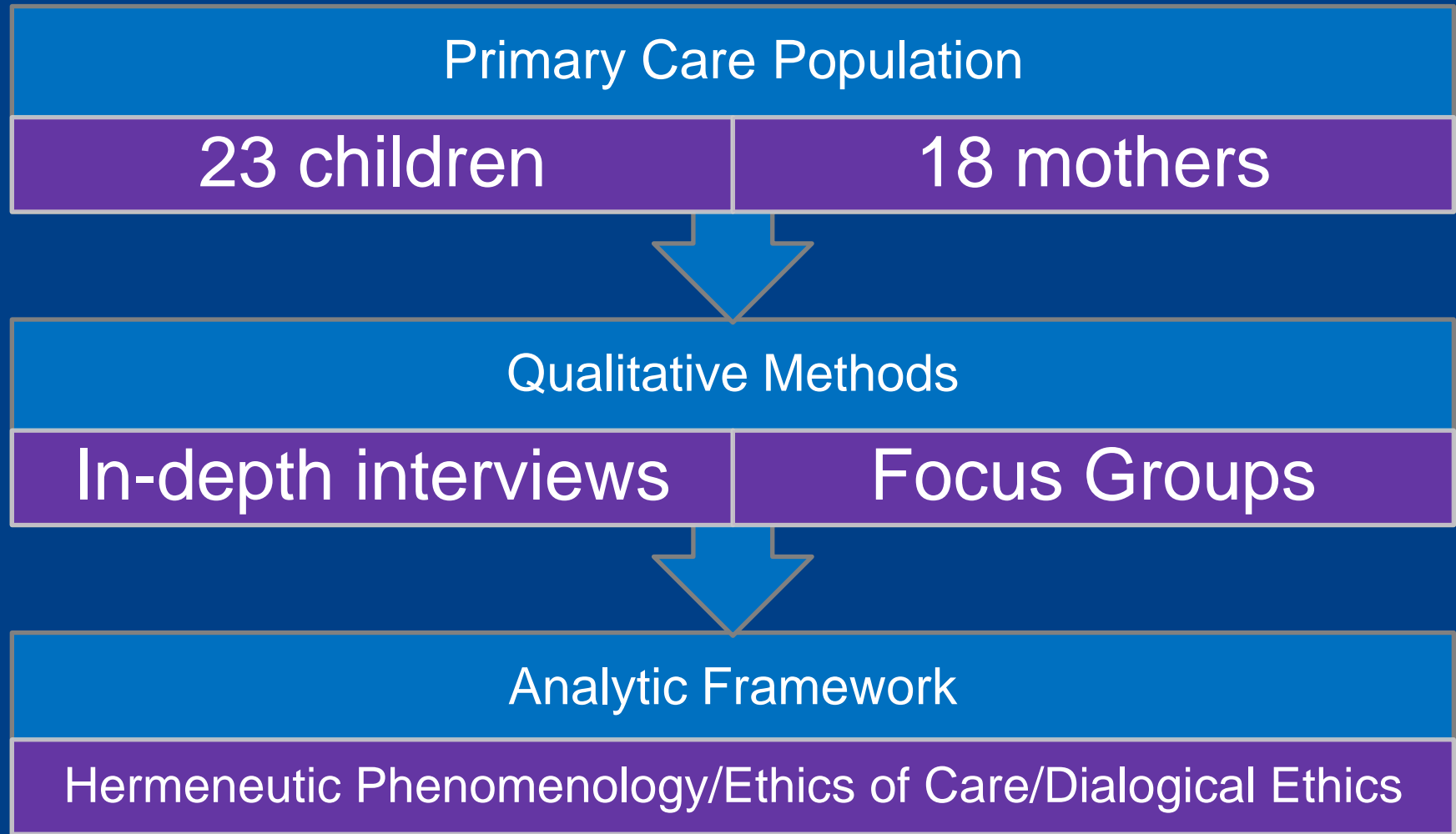
Children lack opportunities to have their voices heard (Tates, 2002;Humphreys, 2008, Feder, 2009)

Domestic violence research and responses focus on women and tailored interventions for children are lacking, particularly mother-child interventions (Feder, 2009; Hegarty, 2008)

Addressing the Research Gap: SARA Project



SARAH Project: Children's Safety & Resilience



Key Findings

Children require agency to negotiate their safety, including in the post-separation context



Primary care does have a role to respond to children experiencing domestic violence

Children's Agency

'Their capacity to act, interact and influence the shape of their childhood'

(Neale & Flowerdew, 2007, p. 28)

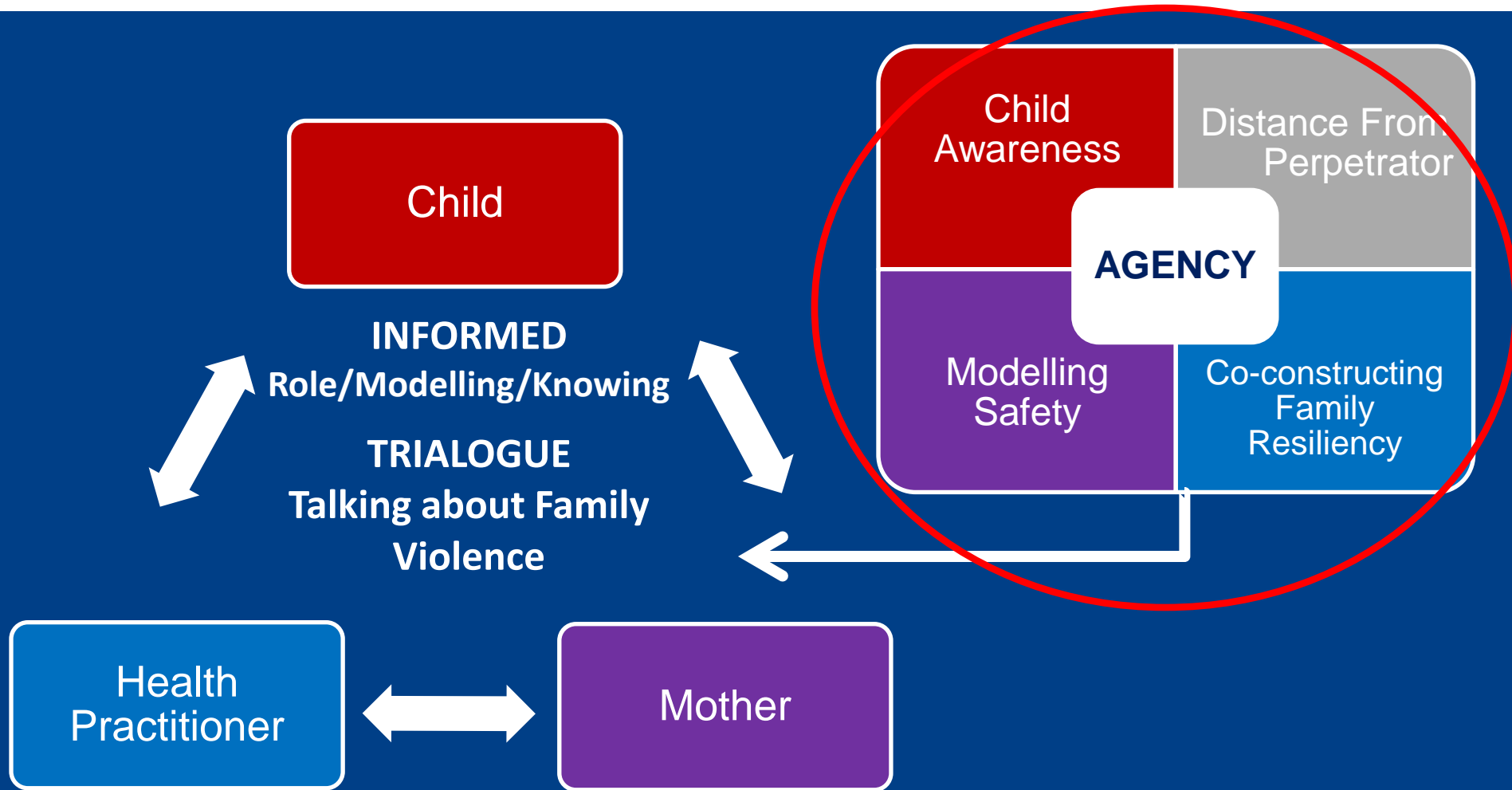
Agency is mediated by the child's familial and social context

(Lieten, 2008)

The child's voice, an expression of their agency...
'intentions, hopes, grievances and expectations'

(Pufull & Unsworth, 2004, p. 8)

Informed Trialogue & Model of Children's Agency



Model of Children's Agency

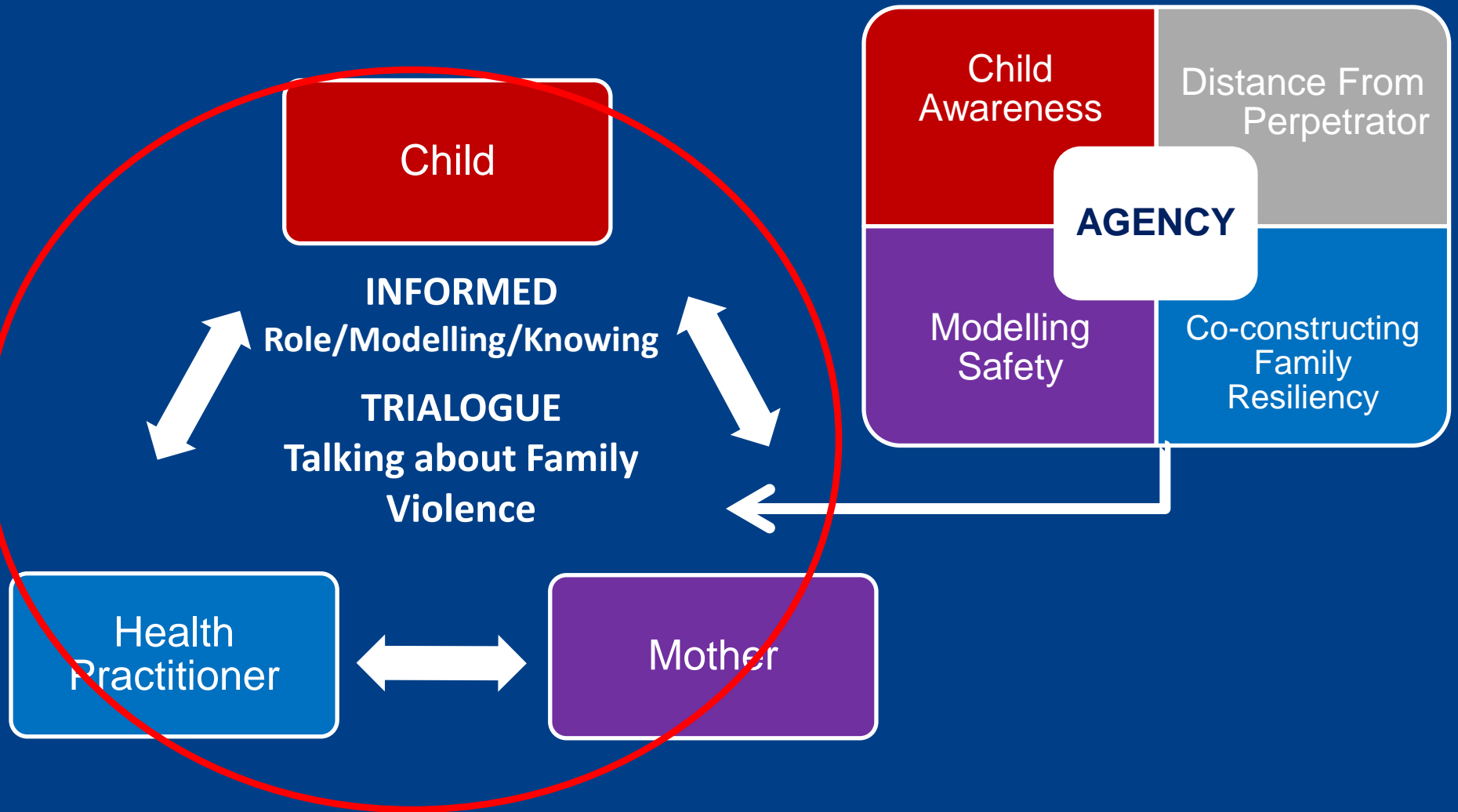
Awareness of disruption or danger in the parental relationship

Physical and emotional **distance** from the perpetrator

Modelling safety in relationships by trusted adults and older siblings

Co-constructing family resiliency: informal supports, reciprocal caring, rituals, playing together

Child-focused Intervention: SARAH Project



Child Focused Intervention: Informed Trialogue

Health practitioner **explains role and initiates questions*** about domestic violence.

Child wants to **know and be known** by the health practitioner

Mother **models her trust** in the health practitioner

Opportunity for mother and child to **talk about domestic violence**: Model of Children's Agency

*Consider HEEADSSS ax tool (**Golenring & Rosen, 2004**)

Are you safe at home and at school and that...and at Dad's (Fred, 9)

I brought up the fact that I wasn't sleeping like normal people and that it was affecting my school work. So he asked me a few questions to find out what else is affecting me...(Amelia, 15)

Child Focused Intervention

Ideal Routine care:

- Posters and information
- Non-judgemental health professional
- Assessment of risk
- Evidence of child abuse
- Safety planning
- Link to supports



Informed
Triologue
&
Model of
Children's
Agency

Children's need for agency to negotiate their safety

A child cannot **'leave'** a violent relationship.

Therefore, health practitioners can play a significant role in understanding and promoting a child's agency to negotiate safety in their relationships.

Publications

Hegarty, K., Morris, A. *Children outcomes and intimate partner violence research – Authors' reply*. The Lancet 2013 **382**(9901): p. 1326.

Morris, A., Hegarty, K., Humphreys, C. *Ethical and safe: Research with children about family violence*. Research Ethics 2012 **8**(2): p. 125-139.

Morris, A., Toone, E., Utter, M., Christovitchin, F., *Extending the reach: A timely and tailored response to children who experience family violence*. Parity Journal September 2011

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Thank You

Questions?

