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Facilitating best clinical practice in domestic violence work with hospital social workers

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ABSTRACT

Background: Domestic and family violence (DFV) is a major public health issue mainly affecting women and children. Health services are an important site in the identification and initial response to DFV. Social Workers often lead the psychosocial response to DFV. This study aimed to explore the experiences of internal referrers to a hospital-based social work led DFV Service.

Methods: Qualitative study design. Participants were purposively sampled from health professionals referring to the DFV service at a single, tertiary metropolitan hospital in Sydney, Australia and invited to participate in an online focus group. The focus groups explored participants' experiences of referring to a specialist DFV service and any practice change that occurred from working with the service. Focus group transcripts were analyzed using reflexive thematic analysis.

Results: A total of 10 internal referrers participated across two focus groups; all were social workers. Four key themes were identified; i) integration of the DFVS with existing services; ii) consultation and complexity, iii) professional development and iv) the importance of social work values. Integration of the DFV service into the Social Work Department enhanced professional relationships and avenues for collaboration. Responsive consultation helped to build social workers' skills and confidence and to manage their anxiety when dealing with safety concerns and addressing complex needs, such as the needs of people with mental health conditions or violence experienced by multiple perpetrators. Education from the DFV service further assisted referrers with developing their knowledge and skills in identifying various forms of violence, assessing risk and providing intervention. Alignment of social work values enabled a shared practice lens especially in trauma informed care.

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Discussion: A social work-led hospital-based DFV Service has benefits for the practice of hospital and health social workers who identify and provide the initial response to DFV. Implementation of such models in practice provides opportunities for increased awareness, assessment and responsiveness to the complex needs of people experiencing DFV.

Introduction

The World Health Organization (WHO) defines domestic and family violence (DFV) as "any act of gender-based violence that results in, or is likely to result in physical, sexual or mental health harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life" (World Health Organisation, 2024). One in three women worldwide experience either physical and/or sexual intimate partner violence or no partner sexual violence in their lifetime (World Health Organisation, 2024).

Domestic and sexual violence is a major health and welfare issue, and is common in Australia, across all socioeconomic and demographic groups, but predominantly affecting women and children (Australian Institute of Health and Welfare, 2018). According to the recent Australian Bureau of Statistics (ABS) Personal Safety Survey, one in four women and one in eight men have experienced physical or sexual violence from an intimate partner since the age of 15 (Australian Bureau of Statistics, 2022).

The health effects of DFV are serious and profound, and globally there is an increasing awareness of the need for proactive measures to address DFV. In four in ten hospitalizations for female assault victims, a spouse or domestic partner was the perpetrator (Australian Institute of Health and Welfare, 2018). The health effects are not only injury related, but can affect multiple domains of physical and mental health, and continue beyond the relationship in which the violence occurred (Australian Institute of Health and Welfare, 2018; NSW Health, 2021). Women experiencing DFV use health services at a higher rate than the general population and the public health system is often the first point of contact (Cowan et al., 2020).

Awareness of DFV presentations and routine screening within emergency department presentations for intimate partner violence has improved in the USA over the past decade (Bennett et al., 2024), however recent studies of domestic violence screening practices in Australian emergency departments have found routine screening remains uncommon (Spangaro et al., 2020; Sweeny et al., 2023), with only 2% of health professionals reporting screening all adults or all women, and nearly half (45%) reporting not knowing how to screen for DFV (Sweeny et al., 2023). Similarly low rates of family violence

screening have been found in other hospital settings, such as inpatient wards and subacute care (Fisher et al., 2020).

Social workers bring a holistic approach to DFV work and access to 24/7 social work services has been identified as an enabler of domestic violence screening practices (Sweeny et al., 2023). Social workers are often the first point of contact for responding to domestic and family violence, particularly in hospital settings (Mandara et al., 2023); with other health professions commonly referring to social work for assistance with DFV presentations (Cleak et al., 2021). The professional values of social work focus on a commitment to social justice and human rights in the context of the individual. Thus, the profession is well placed to provide a significant contribution to the prevention and intervention of violence against women (Australian Association of Social Workers, 2020). An Australian-based survey of qualified social workers found that whilst participants could recognize DFV and offer victims support, undertaking a risk assessment was less commonly reported (11%) and most would refer on to specialist DFV services for further intervention (Mandara et al., 2023).

One of the major barriers to identifying and responding to domestic and family violence in the first instance is a lack of knowledge and training (Cleak et al., 2021; Cowan et al., 2020). Many health care professionals feel unprepared for DFV work and so are not systematically screening for DFV nor accessing people who need their support (Cowan et al., 2020). Health professionals report they do not have sufficient understanding of DFV (Cleak et al., 2021; Cowan et al., 2020), with one Australian study of health professionals finding that almost half of respondents (46%) who had worked in the health service for ten or more years never having received training in the assessment and management of DFV (Cleak et al., 2021). Provision of training in responding to intimate partner violence has been shown to improve health professionals' attitudes and beliefs toward intimate partner violence, however limited studies have explored the impact on the social work workforce (Kalra et al., 2021). Hospital social workers have expressed that they believe they should be educating the multidisciplinary team about DFV and the social work role, but do not always feel confident to provide this education (Cowan et al., 2020). Peer support, consultation with experienced senior staff and clinical supervision have been identified as important supports in assisting respondents to feel confident in their DFV work (Cowan et al., 2020).

Another potential strategy to address current gaps in the screening, identification and management of cases of domestic and family violence within hospitals is to adapt models of care to enhance access to staff with specialist skills in DFV. Within the United Kingdom, co-locating Independent Domestic Violence Advisors (IDVAs) in the hospital setting as an alternative service model has been explored (Dheensa et al., 2020). Co-location led to improvements in service visibility and working

relationships with frontline hospital staff. Hospital staff also reported that following the introduction of the co-located service they felt more aware of domestic violence and abuse, clearer on what to do in suspected cases and more comfortable with enquiring (Dheensa et al., 2020). Healthcare professionals valued the ongoing training the IVDAs offered (Dheensa et al., 2020). Of note, the IVDAs were consider external to the National Health Service (NHS) and needed to apply to access patient identifiable data. This lack of access could represent a challenge to assessing cumulative risk in patients (Dheensa et al., 2020). Within the USA, the introduction of alternative service models have also improved DFV screening, intervention (Clery et al., 2023) and health professional behaviours (Short et al., 2002). The implementation of an integrated, not-for-profit healthcare program (WomanKind) for victims of domestic and intimate partner violence at three hospitals in the USA resulted in improvements in health professional knowledge, attitudes, beliefs and behaviors in relation to DFV (Short et al., 2002). Higher screening and referral to support services and documentation of DFV in medical records were also observed at hospitals with the integrated model, than at comparison hospitals (Short et al., 2002). These models demonstrate that integration of specialist DFV services into hospital services may improve health professional awareness, screening and management of DFV.

A Domestic and Family Violence Service (DFVS) has been operating at St Vincent's Health Network Sydney (SVHNS) for over 20 years. The DFVS operated under a community care focused model until July 2019, when there was a shift in clinical service management and governance, with the DFVS becoming part of the Hospital Social Work Department. With this shift in governance, there was also a shift in service delivery, away from a community health-based model and toward in-reach to acute services. A key goal of this change was to improve health professional skills in identifying and responding to DFV across all hospital services. This in-reach support takes the form of ongoing education for staff, readily accessible consultation on risk assessment and care planning for patients who present with DFV concerns (including after hours and on weekends), and a streamlined referral pathway into the DFVS for further assessment, trauma counseling, short-term case management and referrals. In addition to receiving internal referrals, the DFVS also receives external referrals from the community, either directly from potential clients themselves or from community DFV services, police or child protection services.

To the best of our knowledge, this model of social work-led service delivery combining both in-reach to acute care and community facing service provision is the only one of its kind operating in a public hospital setting in Australia.

We undertook an evaluation of this new service model to explore whether the service was meeting local needs, if there were gaps in service delivery and how the service addresses the complex and diverse needs of mostly marginalized inner-city populations. The aim of this study was to explore the experiences of hospital social workers referring to the Domestic and Family Violence Service revised model of care.

Method

Research design

A service evaluation of the social work-led DFVS was undertaken, consisting of two parts. Part A consisted of a retrospective file audit of 200 clients of the service, describing client demographics, referral sources, levels of risk and degree of service engagement. Part B consisted of a qualitative exploration of the experiences of internal and external referrers to the DFVS. The service evaluation report, outlining evaluation procedures and outcomes, is available from the corresponding author. The present study focuses in depth on the experiences of the internal referrers. In describing their perspectives on working with the model, they illuminate exciting new ways of working between first responders to DFV and specialist DFV services.

A qualitative descriptive research design employing focus groups was used to explore the insights and experiences of internal referrers to the Domestic and Family Violence Service. This design is commonly used within implementation research to elicit the perspectives of key stakeholders involved in and/or affected by implementation; in this case, internal referrers to the social work led domestic and family violence service (National Cancer Institute, 2018). Given the revised model of care within the service, these perspectives are essential to ensuring the model of care is addressing patient needs and acceptable to clinicians within practice.

The focus groups took place in December 2021. Due to COVID public health restrictions, planned in-person focus groups took place virtually using Microsoft Teams. The local Human Research Ethics Committee provided ethical approval for the study (2021/ETH10904).

Sample and procedure

A list of 15 SVHNS social workers who had referred recently to the DFVS was compiled. This purposive sample of potential participants received an e-mail with a Patient Information and Consent Form inviting them to participate in the study. Participants could choose to attend one of two focus groups.

An interview schedule containing six questions guided the focus group discussions (see supplementary material 1). The guide explored participants

experiences of referring to, and working with a specialist DFVS integrated into the Hospital Social Work Department, and the changes to practice the participants experienced from working with this specialist service. Offering two smaller focus groups, rather than one large one, acknowledges the relationship between the number of participants and the volume and depth of insights gained within a session, to provide opportunities for deeper follow-up of participants' experiences (Santhosh et al., 2021). Each focus group was between 60 and 90 minutes in duration.

An experienced qualitative researcher (PA) facilitated the focus groups online. PA is a social worker with 36 years of professional experience. The groups began with introductions, the establishment of ground rules (such as confidentiality, turn taking) and a discussion of the purpose of the study. PA invited participants to respond to each question and to offer agreement or different perspectives on each other's responses. Prompts were provided to encourage a range of perspectives from participants working within different clinical settings, and to encourage input from all participants for each question, for example *"We've heard a couple of examples from the ED, would someone from mental health like to offer their perspective?"*.

Clarifying and follow-up questions invited participants to expand on their responses. The Microsoft Teams recording function produced a transcript of the focus groups. PA edited the transcript for accuracy and checked against the recording where meanings were unclear to produce a document ready for data analysis.

Data analysis

Analysis of the focus group transcripts was undertaken by PA, guided by reflexive thematic analysis (Braun & Clarke, 2022). The researcher's multiple roles as a clinician, researcher, colleague to the participants and investigators and occasional internal referrer to the DFVS meant reflexivity was a vital consideration. Reflexive practices included scrupulous attention to the participants' own voices in explicating themes during the analysis and the reporting of their diverse perspectives. Areas of discomfort or disagreement participants experienced in their dealings with the DFV are included in the results.

Data familiarization and prolonged engagement involved reading and re-reading the transcripts and highlighting words and phrases that related to the objectives of the evaluation. Transcripts were then inductively coded line by line to develop an initial coding framework. Codes were then categorized and collapsed into topic summaries and initial themes (Braun & Clarke, 2022).

To enhance study rigor participants received copies of the transcript and a preliminary summary of the data analysis for member checking (Johnson et al., 2020) and did not respond with any corrections or concerns. A reflective journal recorded creative, emotional and intellectual responses to the data

Table 1. Participant demographics.

Name	Discipline	Work Area
SW1	Social Worker	Emergency
SW2	Social Worker	Emergency
SW3	Social Worker	Emergency
SW4	Social Worker	Community Mental Health
SW5	Social Worker	Inpatient Mental Health
SW6	Social Worker	Community Mental Health
SW7	Social Worker	Hospital (Acute)
SW8	Social Worker	Hospital (Sub-Acute)
SW9	Social Worker	Emergency
SW10	Social Worker	Inpatient Alcohol and Other Drugs Service

analysis. Peer debriefing with the broader research team and social work management via discussion of preliminary themes was completed throughout the analysis process at group meetings with ASM, BC, LJC and MB. Researcher LJC, whilst employed within the health network where the study was undertaken, is external to the social work department (an occupational therapist). LJC is an experienced qualitative and health services researcher with eight years' experience in conducting implementation research embedded in public health settings.

Results

Twelve staff members initially agreed to participate. Two people did not attend the focus group on the date they had chosen and declined any alternative option to participate, with a final sample of ten social workers participating. Each focus group had five participants. Table 1 shows the participants' profession and clinical area. Data on participant gender and years of experience is omitted to protect the anonymity of the participants.

The analysis identified four key themes. These themes are the effects of integration of the DFVS with existing health and hospital services, the value of consultation for complex DFV cases, professional and skills development in DFV work and the importance of shared social work values in DFV work. Edited quotes from the participants' responses illustrate these themes.

Integration of the DFVS with existing services

Integration of the DFVS into the hospital social work department, and the deliberate focus on in-reach into acute services, means the internal referrers now interacted with the DFVS in multiple ways. All participants learned about the DFVS and the social work role in responding to DFV as part of orientation at the health service. Their knowledge built from this introduction with regular in-services from the DFVS to the social work department and from

their on-call training. They spoke about what has become routine engagement with the DFVS. SW7 said:

> Five years ago, when I first started, it used to be when there's a fairly hectic or significant case, you might make an approach [to the DFVS], but now it's much more routine. It is just part of our practice, and so I think it means that much more engagement . . . there is much more [of a] relationship. They will actually come and see [patients] within Emergency which is something that didn't really exist before.

Several of the other Emergency social workers agreed the DFVS workers' willingness to engage in "warm referrals" improved access to the service for patients.

Speaking from the perspective of a mental clinician working in a homelessness service, SW4 said:

> [DFV] is such a huge issue for Community Mental Health. We go to the women's shelters and we find DFV is such a primary driver of homelessness and mental health issues. So it's been really important to have the DFVS there. The other side of it is that the majority of people that we're working with have quite chaotic situations, and sometimes it can be hard for them to follow through [with engagement with the DFVS].

Participants felt that given the value the DFV service provides, further staffing was needed to address the significant demand for DFV counselling within the local community. The service is currently staffed by only two clinicians and some participants raised concerns about the number of referrals they made and whether this may impact on the timeliness with which clients could be followed up.

Consultation and complexity

The participants gave many examples where consultation with the DFVS assisted them to work through the complexity of the DFV cases they manage. For example, speaking from their perspective as a social worker in an inpatient mental health unit SW5 said:

> In in-patient Mental Health we have crises where we identified people at serious threat in that moment, so getting guidance to flag that in Safety Action Meetings, trying to establish the right supports and safety, particularly because they're in that inpatient setting already . . . [to incorporate into] discharge planning.

In this situation, the urgency with which SW5 and their team works is palpable. They have a small window of opportunity, while the patient is in hospital, to treat the mental health issue and plan supports and safety, before she returns to the relatively uncontrolled environment she came from.

In their work in ICU, SW3 encounters situations where the mechanism of injury or circumstances surrounding an accident are unclear or contested.

> We had a woman who fell down the stairs and cut her throat on glass . . . but we did not know the real story. From what the surgeons were saying . . . it didn't seem like quite a natural way of falling and there was just a few other complexities to it . . . even though we couldn't get a sense from the patient what had actually happened because she [was intubated].

With increasing suspicion that this may be a case of DFV, SW3 and the team made early referrals to the DFVS and engaged in care planning incorporating risk and safety for the patient.

Complex DFV presentations could take many forms. For example, some participants encountered patients who would not accept a referral to the DFVS for further follow-up. SW2 said, *"A lot of the patients don't want support, no case management, no therapeutic interventions or counselling. It does almost feel a bit funny sometimes that we have to put the referral through anyway."* Other participants also reported this reluctance, or at least ambivalence on the part of some patients to accept a referral to the DFVS. SW2 and the others attributed this to the *"chaotic situations"* (SW4) many of the patients lived in, and the effects of the traumas they had experienced.

In Emergency, SW9 said the DFVS helps them and their team to identify and work with unclear dynamics of family violence including:

> . . . a big cohort of Aboriginal people who experienced family violence. There were really complex cases coming that weren't necessarily intimate partner violence now [starting] to be picked up and responded to and . . . not even just about Aboriginal patients but also elder abuse.

Continuing the theme of complex family violence, SW6 said the DFVS assists with complexity:

> . . . where it is not clear who the perpetrator is, whether it's the intimate partner or other family members. Because there is sometimes multiple allegations being thrown around . . . and then the layer of working with people who may have a cognitive impairment, so it's difficult to understand the level of accuracy, from the information from the actual patient. So the family violence focus is important, particularly in mental health settings where sometimes mental health could be more of the focus.

This point captures the importance of understanding how mental health presentations and symptoms could be a result of, or exacerbated by DFV.

SW4 has another variation on how the DFVS assists with complexity. They worked with a young woman with a developmental disability experiencing DFV and:

> . . . getting [her] accommodation was a nightmare, linking her with other services was a nightmare, but at least just doing the DFVS referral and going through the Domestic Violence Safety Assessment Tool (DVSAT) and putting it through to [DFVS workers] . . . that was the easiest part and they were responsive the very next day. They were all over it and had put it through to the Safety Action Meeting (SAM) . . . So I think it's really helpful to have the contrast of just a really simple process and people that have expertise

> and can hold on, and also can hold you, and the situation for a moment. And make a really clear good plan.

SW4's graphic description of a complex situation reveals much about workers' emotional challenges in these moments of hectic frontline DFV practice. That they experience the feeling "held" by the DFVS as part of the consultation is an important finding.

Whilst the support of the DFV service in managing complex presentations was valued, one of the challenges raised by some participants was the requirement of mandatory referral of all DFV presentations to the DFV service, even in circumstances where the patient did not wish to engage with the service. Some participants felt that mandatory referral in circumstances where the patient had expressed that they did not wish to engage with the service, could undermine the patient's agency and interfere with their own ongoing therapeutic relationship with the patient.

Professional development

The participants spoke frequently about the role of the DFVS in building their knowledge and skills in their DFV work. For example, SW7 said:

> [Input from the DFVS taught me] not only physical violence constitutes DFV. I had a woman who had left her partner in the context of an extreme amount of coercive control in that relationship, and now I keep this on my radar when assessing people, acknowledging just how impactful some of those non-physical violence matters could be.

The participants welcomed the learning opportunities the DFVS provide. SW5 said:

> They educate us … make sure we are actually on board with the requirements for reporting as well. Also leaning on them a lot for guidance and reassurance that we are doing the right thing [with our DFV patients] and [building] great [safety] plans.

SW1 draws attention to a more advanced level of professional development, namely collaborating to develop clinical reasoning: "*I have found conversations [with the DFVS] open and reasonable and the experience I've had of them is very much that focus on clinicians should be able to trust their clinical judgment, and they support people to do that*." SW8 takes this point further:

> … even if you're an experienced social worker, to talk through a domestic violence case so you can feel okay in your clinical decisions, especially around safety of women, and ensure you haven't missed something or to ensure your safety points are covered. Yeah, so many of the reasons I refer to the DFVS go to providing the best practice, and to ensure what the next steps are in my intervention.

The importance of social work values

An incidental follow-up question "*What difference does it make for you as social workers to be referring to a social work lead service?*" produced rich reflections from the participants. SW8 said:

> I think it does make a big difference, because we talk a lot to [DFVS worker] and we know that she holds men, sorry, generally holds the perpetrator very accountable for the DFV and she's got a trauma lens and she doesn't like mental health labels. Or, you know, she likes to talk about symptoms of abuse, so I think it's not a pathologising approach to DFV, which is really important.

SW7 agreed with these comments:

> It's good knowing that you're handing over to somebody that shares an understanding [of] where you're coming from as a social worker, taking into account that holistic perspective of an individual's life and you're handing over to somebody that will be able to follow on appropriately. [For example] if I put through a referral for a male DFV victim I know they will follow up with it. But yeah, I think it's a pretty confident process to refer on to another social worker.

SW6 said:

> I feel like how the hospital has a DFVS shows to me that they recognize that [DFV] is a huge health issue . . . and responding to DFV is mainly with the social work response. [However] across [St Vincent's Health Network Sydney] different social workers would have a different level of skill around DFV and being able to respond. Some may only ever get occasional cases because of their clinical area, so they might not have strong expertise. So then having people to go to for that strong advice and consultation and then even a referral for ongoing work I think is really good.

Discussion

This study explored the perspectives of the social work internal referrers to an integrated, social work led DFVS located in a hospital social work department. Referrers felt they have ready and responsive access to the DFVS. They also feel resourced to take on the leadership role social workers play in the psychosocial response to DFV in health settings. Accessibility of the service also allows for the development of positive professional relationships between the DFVS and the internal referrers to grow over time. This finding about the importance of relationship echoes the research of Dheensa et al. (2020). In both of these contexts, proximity and access seem to be crucial elements to building trust and encouraging collaboration between front-line staff and specialist DFV workers, including in complex clinical areas, such as mental health and in working with First Nations people. In contrast to our findings, other studies exploring the experiences of mental health practitioners in Australia have described clinicians reporting a lack of knowledge and training in domestic violence and a lack of awareness of support mechanisms available

for victims when violence is disclosed (Gillespie et al., 2023). These factors then pose a significant challenge for clinicians who are frequently working to address DFV concerns whilst also supporting the patient during a mental health crisis (Gillespie et al., 2023). Our current study highlights the value of integrating a DFV service within a hospital setting that is both inward and outward facing. This approach allows referrals to be received from all clinical areas across the hospital and continuity of care, providing clinicians from all areas the opportunity to upskill in DFV screening, assessment and intervention and to link patients with support services prior to transferring back into the community. Additionally, consist with the findings of Owen et al. (2024), despite differences in Australian geographical location (metropolitan versus regional health service), the complexity of DFV hospital presentations was highlighted, including people experiencing homelessness, drug and alcohol misuse, as well as First Nations people within the local community experiencing DFV (Owen et al., 2024). These findings further support the need for DFV services to be integrated within the hospital and trauma informed, providing linkage with other specialist health services as well as the need for culturally safe care for First Nations people that includes First Nations healthcare professionals.

A recent Cochrane systematic review found that whilst training in intimate partner violence may improve health professional knowledge, attitudes and self-reported readiness to respond to survivors, it is likely to be insufficient on its own to address DFV and will need to be supported by wider organizational strategies to support health professionals to address DFV (Kalra et al., 2021). Within our current study, participants felt they could approach complex DFV situations in their work with confidence due to the consultation and collaboration the DFVS provides. They are constantly aware of the profound health impacts of DFV (especially repeat presentations) to their services. Ongoing formal and informal education received from the DFVS significantly increased social workers' knowledge and clinical skills in the area of DFV, while also being supportive of them as they experience the intense emotional aspects of the work. Reflecting on the work of Cowan et al. (2020), where participants said they felt unprepared for DFV in the hospital setting, in contrast no such hesitation comes through from participants in this study. This suggests that the use of an integrated DFV model, that encompasses not only specialist expertise but opportunities for education and capacity building of non-specialist, referring staff may have greater success at addressing some of the current challenges in DFV screening and intervention.

The discussion of social work values further upholds the acceptability of this model of DFVS to these internal referrers. The significance of the model goes deeper than changes to governance and administrative processes. Indeed, the DFVS model of care is based on a trauma and violence informed, person centered clinical practice framework,

informed by feminist methodology. There is a crucial alignment of this clinical framework with that of social work professional theories, ethics and values (Laing & Humphreys, 2013). Further, this professional alignment is vital in the understanding and acknowledgment that, the perpetration of violence and abuse are social justice, human rights, health and gendered societal issues that have an unequal impact on women and children (Commonwealth of Australia Department of Social Services, 2022). This study clearly showed that participants connect with the DFVS through shared social work values and utilization of non-pathologising, trauma informed therapeutic frameworks.

There are several limitations to this study. First, we conducted the study as a local project, at a single site, which may limit the generalizability of the findings to other services. Three of the four investigators are part of the St Vincent's Health Network Sydney Social Work Department and only a single investigator conducted the focus group interviews and data analysis. The reflexive strategies employed in the analysis will have helped to reduce but not eliminate bias. Investigators external to the health service may have provided different perspectives and may have reached different conclusions in the analysis of the data. There is also a risk of selection bias with the participants recruited, as those with neutral or negative views of the services may not have agreed to participate in the focus groups.

Additionally, due to COVID-19 restrictions, the focus groups were conducted online, rather than in person, which may have impacted on the level of participant interaction and the level of depth of the data (Jones et al., 2022). There were also numerous pre-existing relationships within the focus groups, for example, the presence of both junior and senior social workers from the same clinical area, which may have resulted in some participants feeling constrained to speak critically. To address these challenges, proactive steps were taken by the facilitator to encourage responses from all participants and critical comments and points of difference were expressed during the process.

Despite these limitations, the results reveal strongly positive perspectives of the DFVS from the participants. It is clear they feel lucky they have the DFVS as an expert resource available and accessible to consult at all hours of the day and night. This gives them the strength and courage to take ownership of their DFV work. Many of the responses of the participants in this project reveal the skill, passion and pride they have for this part of their social work practice. In conclusion, despite the Australian context, we believe this service model provides clear benefits to health social workers who are at the front line of public health responses to DFV and, as such, may be of interest to other health services considering redesign of their DFV services.

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Ethics approval

The St Vincent's Hospital Sydney Human Research Ethics Committee approved this study. All participants gave written informed consent before data collection began.

References

Australian Association of Social Workers. (2020). *Scope of social work practice family violence*.

Australian Bureau of Statistics. (2022). *Personal safety Australia*. https://www.abs.gov.au/statistics/people/crime-and-justice/personal-safety-australia/latest-release

Australian Institute of Health and Welfare. (2018). *Family, domestic and sexual violence in Australia*. https://www.aihw.gov.au/reports/domestic-violence/family-domestic-sexual-violence-in-australia-2018/summary

Bennett, C. L., Kit Delgado, M., Pasao, M., Espinola, J. A., Boggs, K. M., & Camargo, C. A., Jr. (2024). Preventive health services offered in a sampling of US emergency departments, 2022-2023. *The Western Journal of Emergency Medicine*, *25*(5), 823–827. https://doi.org/10.5811/westjem.18488

Braun, V., & Clarke, V. (2022). *Thematic analysis: A practical guide*. Sage Publications.

Cleak, H., Hunt, G., Hardy, F., Davies, B., & Bell, J. (2021). Health staff responses to domestic and family violence: The case for training to build confidence and skills. *Australian Social Work*, *74*(1), 42–54. https://doi.org/10.1080/0312407X.2020.1808029

Clery, M. J., Olsen, E., Marcovitch, H., Goodall, H., Gentry, J., Wheatley, M. A., Jackson, N., & Evans, D. P. (2023). Safe discharge needs following emergency care for intimate partner violence, sexual assault, and sex trafficking. *The Western Journal of Emergency Medicine*, *24*(3), 615–621. https://doi.org/10.5811/westjem.59072

Commonwealth of Australia (Department of Social Services). (2022). *National plan to end violence against women and children 2022-2023*. Department of Social Services.

Cowan, C., El-Hage, N., Green, J., Rice, L., Young, L., & Whiteside, M. (2020). Investigating the readiness of hospital social workers to respond to domestic and family violence. *Australian Social Work*, *73*(3), 357–367. https://doi.org/10.1080/0312407X.2019.1675735

Dheensa, S., Halliwell, G., Daw, J., Jones, S. K., & Feder, G. (2020). "From taboo to routine": A qualitative evaluation of a hospital-based advocacy intervention for domestic violence and abuse. *BMC Health Services Research*, *20*(1), 129. https://doi.org/10.1186/s12913-020-4924-1

Fisher, C. A., Galbraith, G., Hocking, A., May, A., O'Brien, E., & Willis, K. (2020). Family violence screening and disclosure in a large metropolitan hospital: A health service users' survey. *Women's Health*, *16*, 1745506520952285. https://doi.org/10.1177/1745506520952285

Gillespie, K., Branjerdporn, G., Tighe, K., Carrasco, A., & Baird, K. (2023). Domestic violence screening in a public mental health service: A qualitative examination of mental health clinician responses to DFV. *Journal of Psychiatric & Mental Health Nursing*, *30*(3), 472–480. https://doi.org/10.1111/jpm.12875

Johnson, J. L., Adkins, D., & Chauvin, S. (2020). A review of the quality indicators of rigor in qualitative research. *American Journal of Pharmaceutical Education*, *84*(1), 7120. https://doi.org/10.5688/ajpe7120

Jones, J. E., Jones, L. L., Calvert, M. J., Damery, S. L., & Mathers, J. M. (2022). A literature review of studies that have compared the use of face-to-face and online focus groups. *International Journal of Qualitative Methods*, *21*. https://doi.org/10.1177/16094069221142406

Kalra, N., Hooker, L., Reisenhofer, S., DiTanna, G. L., & García-Moreno, C. (2021). Training healthcare providers to respond to intimate partner violence against women. *Cochrane Database of Systematic Reviews*, *2021*(5), Art. No.: CD012423. 5 December 2024. https://doi.org/10.1002/14651858.CD012423.pub2

Laing, L., & Humphreys, C. (2013). *Social work and domestic violence*. SAGE Publications.

Mandara, M., Wendt, S., McLaren, H., Jones, M., Dunk-West, P., & Seymour, K. (2023). First contact social work: Responding to domestic and family violence. *Australian Social Work*, *76*(4), 589–602. https://doi.org/10.1080/0312407X.2021.1977969

National Cancer Institute. (2018). *Qualitative methods in implementation science*. National Institutes of Health. https://cancercontrol.cancer.gov/sites/default/files/2020-09/nci-dccps-implementationscience-whitepaper.pdf.

NSW Health. (2021). *Strategy for preventing and responding to domestic and family violence 2021-2026*. NSW Ministry of Health. https://www.health.nsw.gov.au/parvan/domestic-violence/Publications/strategy.PDF

Owen, L., Hare Breidahl, S., Mussared, M., Brownlea, S., & Kault, D. (2024). A descriptive study of domestic and family violence presentations to an emergency department in the northern territory. *Emergency Medicine Australasia*, *36*(5), 703–709. https://doi.org/10.1111/1742-6723.14418

Santhosh, L., Rojas, J. C., & Lyons, P. G. (2021). Zooming into focus groups: Strategies for qualitative research in the Era of social distancing. *ATS Scholar*, *2*(2), 176–184. https://doi.org/10.34197/ats-scholar.2020-0127PS

Short, L. M., Hadley, S. M., & Bates, B. (2002). Assessing the success of the WomanKind program: An integrated model of 24-hour health care response to domestic violence. *Women & Health*, *35*(2–3), 101–119. https://doi.org/10.1300/J013v35n02_07

Spangaro, J., Vajda, J., Klineberg, E., Lin, S., Griffiths, C., Saberi, E., Field, E., Miller, A., & McNamara, L. (2020). Intimate partner violence screening and response in New South Wales emergency departments: A multi-site feasibility study. *Emergency Medicine Australasia*, *32*(4), 548–555. https://doi.org/10.1111/1742-6723.13452

Sweeny, A. L., Bourke, C., Torpie, T. M., Sargeant, S., Hughes, J., Watson, J., Conroy, S., Carrasco, A., Tighe, K., Thornton, N. S., Cumner, A. S., & Baird, K. (2023). Improving domestic violence screening practices in the emergency department: An Australian perspective. *Emergency Medicine Journal*, *40*(2), 114–119. https://doi.org/10.1136/emermed-2021-211167

World Health Organisation. (2024). *Violence against women factsheet*. Accessed via: https://www.who.int/news-room/fact-sheets/detail/violence-against-women on 18/04/2024.