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Domestic Violence Identification and Response for Refugee Women in Settlement Services (The SAHAR Study)

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Abstract

Around one third of refugee women in Australia are estimated to have experienced domestic violence (DV) and many face multiple post-migration challenges. Universal screening for domestic violence, and response, is recommended for women in priority populations and has been implemented in health services across diverse jurisdictions. Universal screening for domestic violence involves asking all women a small number of standardised and validated questions about experiences of violence at home. Asking women directly about experiences of abuse increases disclosure and creates opportunity for supportive intervention. However, this is untested with refugee women accessing settlement services.

The Safety and Health after Arrival (SAHAR) study, funded by the Australian Research Council and SSI, introduced and evaluated a culturally tailored DV identification and response strategy with women accessing five refugee settlement services in NSW, Australia, four in the greater Sydney area and one regional NSW site.

In Australia, government funded settlement support programs include the Humanitarian Settlement Program (HSP) which provides case-management support for refugees during the first 18 months in Australia; and the Settlement Engagement and Transition Support Program (SETS) which offers individual and group support from 18 months to five years after arrival. The SAHAR study was initially undertaken with four SETS sites. Just prior to the intervention being commenced, these providers received funding to employ DV specialist workers. Subsequently, a pilot study was conducted at one HSP service site.

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Domestic violence screening and response for refugee women in settlement services

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Research Partners, Chief Investigators and Research Team

The research was led by the University of Wollongong with industry partner SSI. Other research partners who provided advice throughout the project include the Settlement Council of Australia, Australian Institute of Health and Welfare, Australian Institute of Family Studies, Domestic Violence NSW, NSW Education Centre Against Violence, and the NSW Refugee Health Service.

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Research team: Dr Nigel Spence, Study Manager, University of Wollongong, Dr Chye Toole-Anstey, University of Wollongong; Dr Jeannette Walsh, University of Wollongong.

Terminology

ACTS	The four item validated DV screening tool used in the study that asks women how often in the last 12 months a partner or former partner has made them 'Afraid', 'Controlled', 'Threatened' or 'Slapped/ physically hurt' them.
Domestic violence (DV)	Defined in line with the WHO as 'a pattern of behaviour by a current or former partner causing physical, sexual or psychological harm, such as physical aggression, sexual coercion, psychological abuse and/or controlling behaviours' [12].
Domestic violence identification	Approaches and strategies that facilitate recognition of any experience of intimate partner violence. Domestic violence screening is one part of domestic violence identification.
Domestic violence screening	Routine application of standardised and validated tools to elicit responses that allow identification of likely experience of violence in intimate partner relationships [13]. It involves asking all women attending a service a small number of questions about experiences of violence at home, to raise awareness and offer support.
Domestic violence specialist	In this study, refers to dedicated DV positions in the SETS and Tier 3 workers in the HSP providing more specialised responses to DV disclosures following screening.
Humanitarian Support Program (HSP)	Australian government funded settlement support program delivered by non-government organisations that provides individual case-management support for refugees on arrival and for the first 18 months.
Refugee	People forced to leave their home countries for many reasons including conflict and violence, and have arrived in Australia within the past five years as humanitarian entrants, usually holding a Refugee visa (subclass 200, 201, 203 and 204) or a Global Special Humanitarian visa (subclass 202).
Settlement Engagement and Transition Support Program (SETS)	Australian government funded settlement support program available to refugees from 18months to five years after arrival, delivered by non-government organisations.
SSI	Previously Settlement Services International, SSI, is a large, Australian not-for-profit organisation providing dedicated human and social services, including extensive support services for newly arrived refugees
Tier 3 workers	Provide intensive support within the Humanitarian Support Program for those with complex needs such as disability, intensive medical needs, mental health issues, and domestic violence.

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SAHAR Key findings

The Safety and Health after Arrival (SAHAR) study, funded by the Australian Research Council and SSI, introduced and evaluated a culturally tailored domestic violence (DV) screening and response strategy with women attending five Australian refugee settlement services. Screening was undertaken with 354 women accessing the five sites. Women identified as experiencing DV were offered a followed up response. A survey was undertaken with 321 women who had attended the sites during the study period, seven of whom also participated in individual interviews. Caseworker focus groups and site manager interviews were held with a total of 29 participants.

DV is commonly experienced by refugee women, as with women in the community

Routine DV screening in settlement services is feasible

Being asked about DV is acceptable to women accessing settlement services

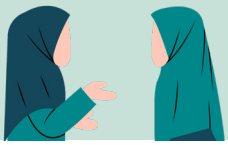
For most women, the study intervention was their first experience of being asked about DV

Women thought asking about DV created opportunities to get help & protection

Refugee women face multiple barriers to disclosure and help-seeking

Settlement staff said asking women about DV provided opportunities to disclose and get help

Talking about DV is enabled by worker care, language match, safe spaces, female workers



Implementation was aided by clear and simple tools, training, and support

Policy and programs should consider building DV identification and response into settlement services

Executive Summary

Around one third of refugee women in Australia are estimated to have experienced domestic violence (DV) [1] and many face multiple post-migration challenges [2-4]. Universal screening for domestic violence, and response, is recommended for women in priority populations [5] and has been implemented in health services across diverse jurisdictions. Universal screening for domestic violence involves asking all women a small number of standardised and validated questions about experiences of violence at home. Asking women directly about experiences of abuse increases disclosure and creates opportunity for supportive intervention [6-8] However, this is untested with refugee women accessing settlement services.

The Safety and Health after Arrival (SAHAR) study, funded by the Australian Research Council and SSI, introduced and evaluated a culturally tailored DV identification and response strategy with women accessing five refugee settlement services in NSW, Australia, four in the greater Sydney area and one regional NSW site.

In Australia, government funded settlement support programs include the Humanitarian Settlement Program (HSP) which provides case-management support for refugees during the first 18 months in Australia; and the Settlement Engagement and Transition Support Program (SETS) which offers individual and group support from 18 months to five years after arrival. The SAHAR study was initially undertaken with four SETS sites. Just prior to the intervention being commenced, these providers received funding to employ DV specialist workers. Subsequently, a pilot study was conducted at one HSP service site.

Intervention

Caseworkers and DV specialist workers at the participating settlement services' sites received two days of training with an additional half day provided for the DV workers at each site. The intervention, delivered for a four month period, comprised:

- Universal DV screening with all women visiting the service using the four item validated ACTS tool [9] which asks women how often in the last 12 months a partner or former partner has made them 'Afraid', 'Controlled', 'Threatened' or 'Slapped/ physically hurt' them. Screening was conducted in community languages using translated tools.

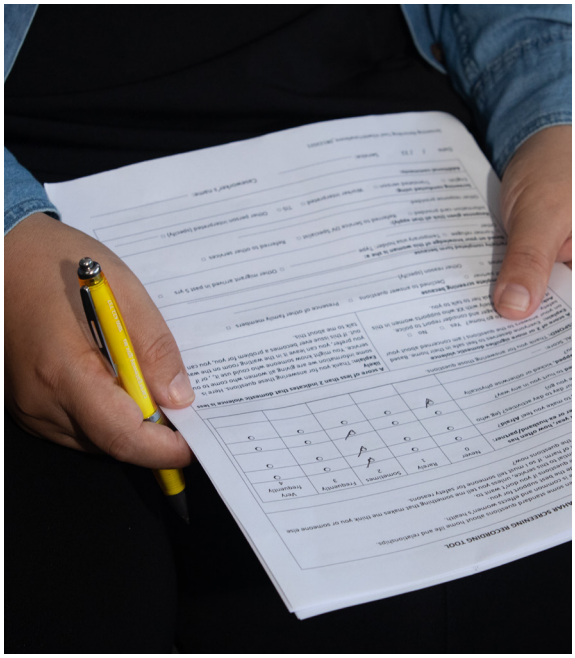
- Provision of a discreet wallet sized DV information card, in a range of community languages, offered to all women regardless of response.

- Where DV was identified, women were offered a referral to an onsite DV worker to provide risk assessment using the Danger Assessment for Immigrant Women [10], safety planning using a purpose designed booklet adapted from the US DOVE intervention [11], and external referral as appropriate.

Evaluation Methods

The mixed-method evaluation included:

- Anonymised screening data collected at study sites during the intervention.
- A three month follow up survey with women who visited the SETS sites during the four-month study period.
- In-depth interviews with a subgroup of survey participants who indicated they disclosed DV when visiting the service. Seven women completed interviews, conducted in their language by Research Assistants under the supervision of the research team.
- Focus group discussions at each site including a total of 24 caseworkers and four DV specialist workers, as well as interviews conducted with each of the five site managers.



Results

Around one third of refugee women in Australia are estimated to experience DV.

Over 90% of survey participants were very comfortable or reasonably comfortable being asked about DV.

Only 14% reported being asked questions about DV at other services.

Screening data

At the four SETS sites DV screening was completed with 309 (87%) of 354 women visiting the services.

Of this group 90 women (29%) were identified as experiencing DV. In the HSP service, 45 DV screenings were undertaken, and 4 women (9%) were identified as experiencing DV.

Survey participants

429 women visiting the SETS sites were invited to be contacted for the survey of whom 375 (87%) gave consent.

Of the 375 women who consented, 321 were reached by the Research Assistants and agreed to be surveyed, a response rate of 86%. Women surveyed:

- ranged in age from 18 to 80 years – mean 44.3 years;
- were living with their husband/partner (71%) with most of this group also living with their children;
- originated from 24 countries with the largest group born in Iraq (47%), followed by (in order) Syria, China, Afghanistan and Iran;
- spoke a total of 25 languages at home, most commonly Arabic, followed by Chaldean, Assyrian, Dari and Mandarin;
- 67% were 'refugees and humanitarian entrants', 12% were unsure of their visa type.

Key Findings for Women

DV is commonly experienced by refugee women, as with women in the broader community

- DV was identified with 29% (90/309) of women screened while accessing SETS.
- Of the 90 women who screened positive, 38% indicated all 4 abuse types on the ACTS tool.

Routine DV screening in settlement services is feasible – with appropriate planning, resources and support

- Across four SETS sites a screening rate of 87% was achieved (309 of 354 screening attempts).
- 5% of women declined to answer the screening questions.

Asking women about DV is acceptable to women accessing settlement services

- 93% of survey participants were very or reasonably comfortable with being asked about DV.
- 84% agreed that it was appropriate for settlement services to ask about DV.

For most women, the study intervention was their first experience of being asked about DV

- Only 14% (41/289) of women reported being asked questions about DV at other services.

Women thought asking about DV created opportunities to get help and protection

- Women agreed with asking about DV 'so women can get help/be kept safe' (51%; 159/314). Other reasons were empowerment, enabling women to talk about DV, increasing awareness of DV.

Talking about DV is enabled by worker care, language match, safe spaces, female workers

- Women ranked 'care shown by the worker', 'talking to someone in my own language', 'trust in the confidentiality of the service' and 'talking to a female worker' as the most important factors enabling discussion of DV.

Refugee women face multiple barriers to disclosure and help-seeking

- Women and settlement staff reported many barriers to DV disclosure and help-seeking, similar to locally born women, such as fear of retribution, concerns about the consequences of disclosure, not wanting to break up the family and economic insecurity.
- Refugee women face additional challenges – language barriers, lack of knowledge about Australian laws and services, visa insecurity and complex relationships with communities.
- Of those who screened positive 31% took up the offer of referral to the DV specialist.

Key Findings for Settlement Services

Settlement staff said that asking women about DV gave women opportunities to disclose and get help

- Caseworkers said the DV questions helped facilitate disclosure and increased awareness about DV.
- Most participating staff were in favour of continuing DV screening and response in their services.
- Screening was successfully incorporated into organisational procedures during the study period.

For settlement staff, implementation was aided by clear and simple tools, training, and support

- Implementation was supported by pre-intervention training, regular check in meetings, clear and simple tools translated into community languages, referral options for women who disclose, private places to talk, enough time, and a relational connection to clients.
- Caseworkers found that DV screening became easier with practice. Confidence to talk about DV increased.
- Challenges included sensitivity of the issue for staff and clients that made it uncomfortable to discuss, some women's reluctance to disclose, perceived normalisation of some forms of control, and organisational factors that limited the opportunity for screening including restrictions on office-based face-to-face work post-COVID, staff turnover, and the DV response being a new area of practice.
- Policy and programs should consider building DV identification and response into settlement service provision.
- Settlement services demonstrated capacity to offer inclusive, community-based settings, language matching and cultural safety that create a conducive context for discussion of DV.

Conclusion

The SAHAR intervention was effectively implemented by the settlement service providers. The relatively high disclosure rate, and high levels of acceptance of the intervention with both refugee women and settlement staff, demonstrate the feasibility of culturally tailored, universal DV screening and response in settlement services. Successful implementation of DV screening and response requires: planning and preparation, organisational commitment, training, translated tools and resources, staff support during implementation, guidelines and referral protocols.

1. BACKGROUND

Domestic violence (DV) is a leading contributor to ill health and premature death among women in Australia [14]. In this study we use the World Health Organization definition for DV as 'a pattern of behaviour by a current or former partner causing physical, sexual or psychological harm, such as physical aggression, sexual coercion, psychological abuse and/or controlling behaviours.' [12] (p. vii). Around one third of refugee and migrant women in Australia are estimated to experience domestic and family violence [1] however, refugee women are less likely to report to police or use formal services, and are more likely to remain in abusive relationships than locally-born women [15-18].

Vulnerability for refugee women during settlement is exacerbated by separation from family, exposure to pre-arrival trauma, limited social support networks [3, 19] and lower utilisation of mainstream health services [3, 4, 20]. Language, lack of knowledge about services and institutions, procedural hurdles, and visa status create additional barriers to help-seeking [21, 22]. At the same time, refugee and migrant women act with resourcefulness and agency during settlement [23], with many who are experiencing DV exercising choice and agency, drawing on individual, family and community strengths to promote change [24].

The Australian Government funds settlement services, that operate alongside mainstream services, to assist migrants and refugees in their settlement journey [25, 26]. These services are primary sites for the identification, response and referral of women experiencing DV, as refugee women access them frequently. Indeed, these services already identify and respond to women experiencing DV. However, there is little research into evidence-based, culturally tailored interventions that identify and respond to the impacts of DV experienced by refugee women in these settlement services as they start a new chapter of their lives in Australia. The National Settlement Services Outcome Standards and the joint Commonwealth and State Governments' National Plan to End Violence Against Women and Their Children 2022-2032 prioritise the wellbeing, social and health outcomes of refugee women and their children [27, 28].

Global evidence supports DV screening with women of reproductive age, and provision of ongoing support [12, 29]. WHO guidelines emphasise the importance of routinely screening women in high risk groups [29]. DV screening involves asking all women a small number of standardised and validated questions about experiences of violence at home. Asking women directly about experience of violence increases disclosure and creates opportunity for supportive intervention [7, 8]. DV screening using validated tools has been implemented in diverse health settings including ante-natal clinics, primary health care, emergency departments, baby health clinics, substance treatment programs and mental health services [30, 31]. While significant evidence indicates that most women experiencing abuse are strongly in favour of DV screening [32] there is a need to assess this with refugee and newly-arrived migrant women in the Australian context and to tailor responses to their needs [17].

SAHAR is the first Australian study to test universal DV screening and response in settlement services.

2. AIM

The SAHAR study's overarching aim is to improve the identification of, and response to, domestic violence experienced by refugee women in Australia, with the specific objectives to:

1. Introduce and evaluate a culturally sensitive DV screening and response strategy within refugee settlement programs;
2. Establish the acceptability of screening and response for DV among refugee women;
3. Describe the disclosure rate of DV in a refugee population and associations with social and health issues;
4. Explore and incorporate practice learnings from settlement service workers in relation to DV screening and response;
5. Understand the mechanisms and contextual factors contributing to i) the introduction of screening and response, and ii) positive outcomes for women;
6. Promote comprehensive knowledge translation through development and dissemination of practice tools for scale up across settlement services for refugee and migrant women.

The study specifically focuses on violence within intimate partner relationships, using the World Health Organization definition cited above.

3. SITES

The study was conducted in two government funded settlement support programs, the Humanitarian Settlement Program (HSP) and the Settlement Engagement and Transition Support Program (SETS). The HSP provides individual case-management support for refugees on arrival and for the first 18 months in Australia with a focus on integration, accommodation, employment, access to education and training, and learning English [33]. SETS is available to refugees from 18months to five years after arrival and offers a range of individual and group supports including assistance with English language skills, gaining access to mainstream services, healthcare, employment, housing, family issues, transport, civic participation, citizenship, legal and administrative systems [34]. HSP and SETS are delivered by non-government organisations, located in the community, and staffed by bicultural workers.

The study was initially planned to be undertaken in four HSP sites, however border closures during the pandemic resulted in a change of strategy and shift to the SETS sites which were not impacted by the loss of migrant intake. Initially, four SETS services were selected as study sites, three in metropolitan Sydney and one in a major NSW regional centre. Sites were chosen on the basis that they had large and diverse client populations, were ready and willing to participate in the research, and were accessible to the research team.

The intervention was implemented by staff at the SETS sites March – July 2022. Subsequent to this phase and after the Australian refugee intake re-commenced, an HSP service was selected to explore the intervention with refugee women in their first phase of settlement. An SSI HSP team in Western Sydney was selected and the intervention was piloted at the six month review visit with women accessing that service in March – June 2023. All SETS sites had at least one specialist DV worker within the team for DV referral and capacity-building[1], while in the HSP service Tier 3 workers were trained to accept referrals following DV identification through screening.

[1] Prior to implementation, SETS services received additional funding for full or part-time specialist positions to focus on responding to DV.

4. INTERVENTION

Caseworkers, SETS DV specialist workers and HSP Tier 3 workers at the study sites received two days of face-to-face training from the research team on the nature and impacts of DV, barriers to disclosure, context for refugee women, the screening tool, responding to disclosure and study processes. Multiple opportunities to practice using the tools were included. An additional half day of training on response tools was provided to DV specialists and Tier 3 workers. During the study period, members of the research team visited the services approximately every three weeks , to provide support and debriefing, enable staff to raise questions about the intervention, build capacity and help ensure fidelity of the research. The extent of this training and provision of support were based on international findings pointing to this as best practice to sustain screening interventions [35-37].

Figure A: ACTS Screening Tool

EXPLAIN:

In this service we now ask all women some standard question about home life and relationships. That's because abuse in the home is common and effects women's health.

- Your answers will help us provide the best support for you.
- You do not have to answer the questions if you don't want to.
- Your answers will be confidential to this service, unless you tell me something that makes me think you or someone else is at immediate serious risk of harm. If so I must tell someone for safety reasons.
- Is it OK for me to ask you the questions nows?

ASK: Thinking about the last year, how often has your husband/partner or ex-husband/partner: (score from 0-4)	Never 0	Rarely 1	Sometimes 2	Frequently 3	Very Frequently 4
1. Done something to make you feel **Afraid**?	❍	❍	❍	❍	❍
2. **Controlled** your day to day activities? (eg who you see/where you go)	❍	❍	❍	❍	❍
3. **Threatened** to hurt you in any way?	❍	❍	❍	❍	❍
4. Hit, **Slapped**, kicked or otherwise physically hurt you?	❍	❍	❍	❍	❍
TOTAL Score:					

The caseworkers implemented a DV intervention that comprised:

- ▷ DV screening using the ACTS [9] screening tool with all women visiting the service. ACTS is a recently validated four-item DV screening tool that includes a preamble explaining that the service asks all women about safety and relationships, and requests agreement to proceed before asking how often in the last 12 months a partner or former partner has made them 'Afraid', 'Controlled', 'Threatened' or 'Slapped/ physically hurt' them. (Figure A). The tool was translated into the most spoken languages at the sites: Arabic, Farsi, Urdu, Chinese and Vietnamese.
- ▷ Provision of a discreet wallet-sized DV information card produced by the NSW Education Centre Against Violence in a range of community languages including the languages most spoken by women visiting the sites.
- ▷ For women who screened positive, offer of referral to the SETS DV specialist or HSP Tier 3 worker.
- ▷ Immediate contact to emergency services if indicated.

DV specialists and Tier 3 workers provided a follow-up response comprising:

- ▷ Risk assessment using the Danger-Assessment for Immigrant women [10].
- ▷ Guided discussion and safety planning using the eight-page SAHAR booklet translated into the five most commonly spoken community languages at the sites (Arabic, Farsi, Urdu, Chinese and Vietnamese). This was adapted from DOVE a brief evidence-based psycho-educational intervention from the USA [11].
- ▷ Referral to police, child protection or other external specialist services as needed.

In most instances caseworkers were fluent in the language spoken by the women and delivered the intervention in the relevant community language using the translated SAHAR tools. Interpreters were rarely required. In the HSP pilot, where a wider range of languages were spoken by women, language support (translation) by SSI Multicultural Support Officers was used on several occasions.

The ACTS tool was validated by its developers against the Composite Abuse Scale a comprehensive, multidimensional measure of DV covering 30 different forms of physical, sexual, and psychological abuse [8]. Validation of screening tools allows experience of violence to be identified with the smallest number of questions possible. According to the statistical analysis, DV is indicated by a score of 1 or more on the ACTS tool.

5. EVALUATION METHODS

An interrupted time series was initially planned for this study, designed to compare identification of DV at the same sites before and after introduction of screening. However the closure of Australian borders over an extended period, due to the COVID-19 pandemic, resulted in a disrupted environment for comparison and a change to the study design.

The mixed-method evaluation included:

a) Screening and disclosure data collected at sites during the intervention.
b) A three month follow up survey with 321 women who visited SETS sites during the four-month study period and conducted using a survey translated into four languages (Arabic, Farsi, Chinese and Vietnamese), by a team of multi-lingual Research Assistants covering the languages of Arabic, Assyrian, Chaldean, Dari, Farsi, Mandarin, Turkish and Vietnamese.
c) In-depth interviews with a subgroup of survey participants who indicated that they disclosed DV at the service. Seven women completed interviews conducted in their language by Research Assistants under the supervision of the research team.
d) Five focus group discussions, one per site, involving twenty four caseworkers as well as a focus group for four DV specialist workers, and interviews conducted with each of the five site managers.

6. FINDINGS

6.1 Participants

Of the 429 women visiting the four SETS study sites, 375 (87%) gave consent to be contacted for the follow up survey. Of the 375 women, 321[2] were reached by the Research Assistants and agreed to be surveyed, a response rate of 86%.

Women surveyed:

- ranged in age from 18 to 80 years, with the mean age being 44.3 years (Figure A);
- most were living with their husband/partner (71%) with most of this group also living with their children (Figure B);
- originated from 24 countries with the largest group born in Iraq (47%), followed by Syria, China, Afghanistan and Iran (Figure D); (NB, the countries of origin in the sample reflect the populations in the locations of the study sites, and are not reflective of Australia's total humanitarian intake);
- spoke a total of 25 languages at home with the most common spoken languages being Arabic, followed by Chaldean, Assyrian, Dari and Mandarin;
- 86% had been in Australia less than 5 years;
- most had permanent visas designating them as 'refugees and humanitarian entrants' (67%), while 12% were unsure of their visa type;
- visits to the SETS service ranged from once only (37%) to more than 10 visits (20%);
- the assistance most frequently sought from the SETS services was: information, advice or referral; group activities or events; education/training/employment; financial advice/income support/money matters.
- said what they most liked about SETS services were: the care and helpfulness of staff; talking to someone in my own language; and the quality of the information the service provides.

[2] The screening group and survey participant groups do not exactly align. Some women were recruited for the study on the day they attended the site and did not see a caseworker so were not asked the screening questions. Conversely a small number of women were asked the screening questions on days or at outreach locations where the recruitment team were not present, and as a result, were not included in the survey cohort.

Figure A: Age of participants (mean=44.3 years)

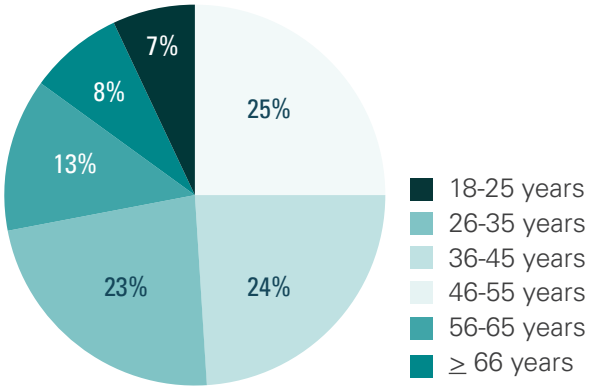


Figure B: Household composition

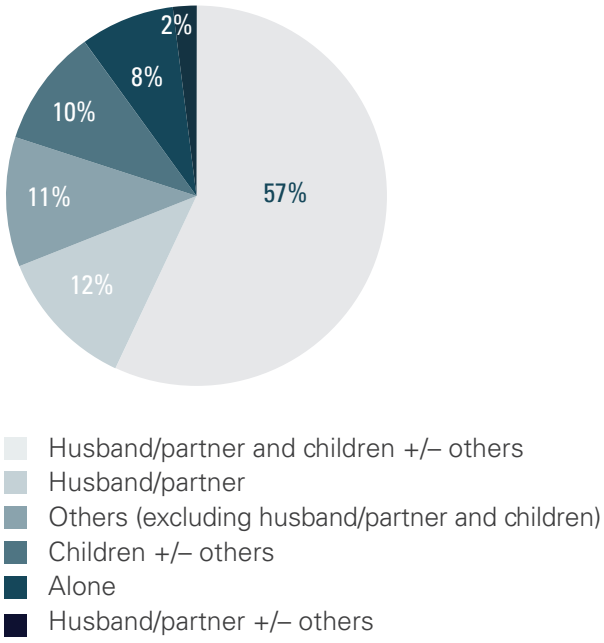


Figure C: Time since arrival in Australia

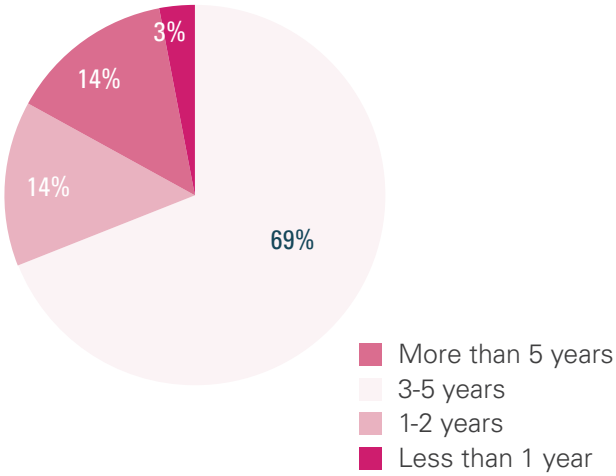
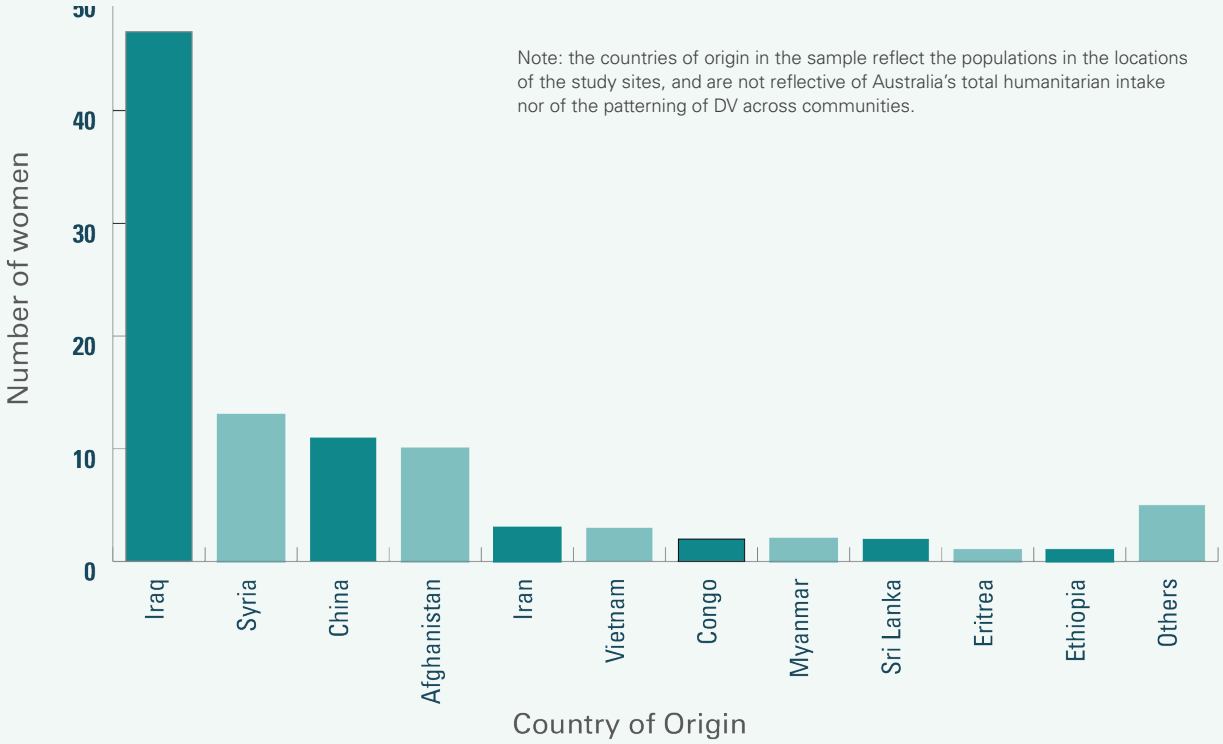


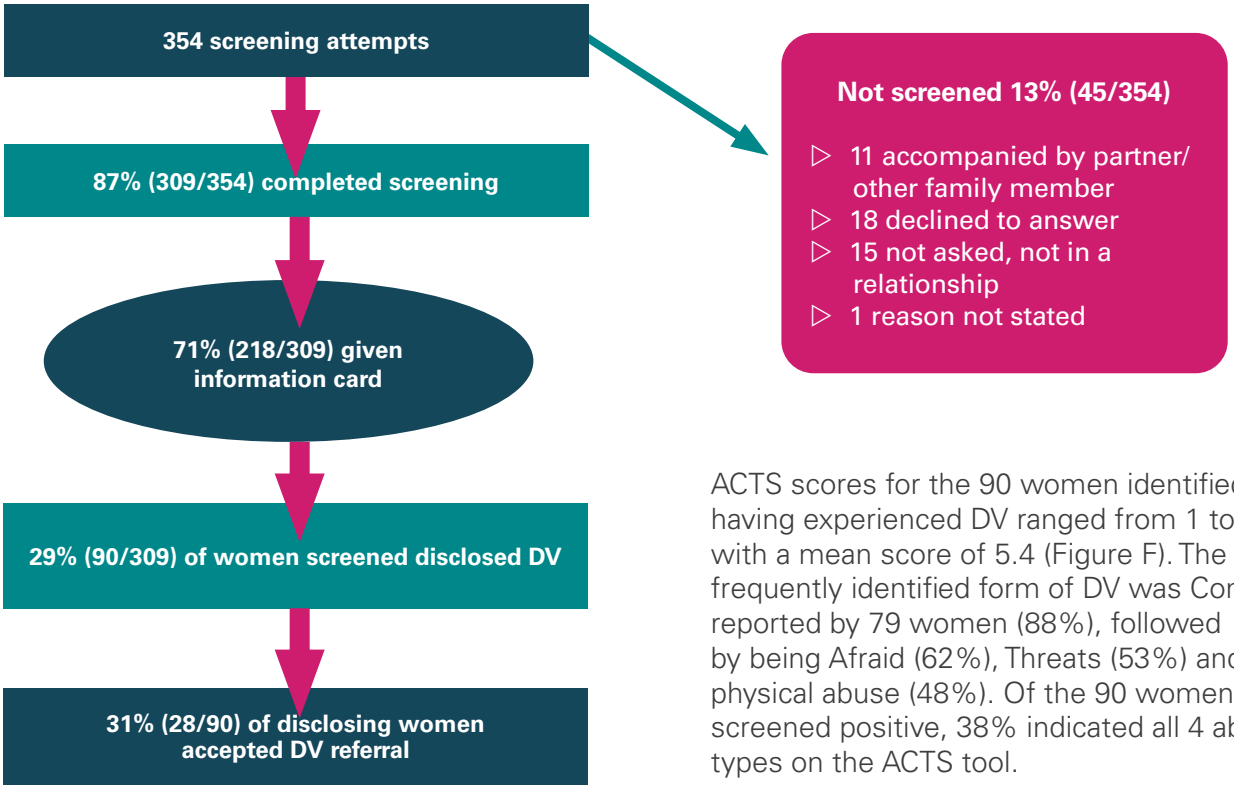
Figure D: Country of origin



6.2 DV is commonly experienced by refugee women, as with women in the broader community

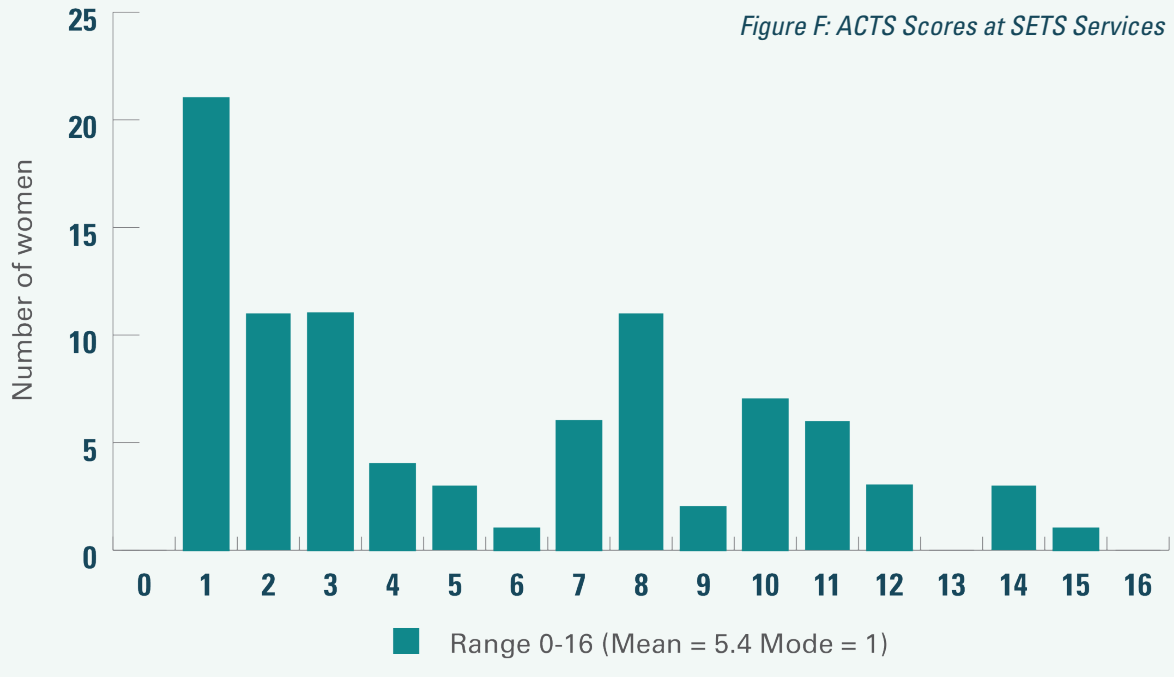
DV screening identified many women with experience of fear, threats, control, physical and/or sexual violence. Of the 309 women screened at SETS sites, 90 scored 1 or higher on the ACTS screening tool which has a cut-off point of 1, giving a disclosure rate of 29% (Figure E). Across these four sites the disclosure rates ranged from 19% to 39%.

Figure E: Screening and disclosure rates



ACTS scores for the 90 women identified as having experienced DV ranged from 1 to 15, with a mean score of 5.4 (Figure F). The most frequently identified form of DV was Control, reported by 79 women (88%), followed by being Afraid (62%), Threats (53%) and physical abuse (48%). Of the 90 women who screened positive, 38% indicated all 4 abuse types on the ACTS tool.

Figure F: ACTS Scores at SETS Services



In the HSP pilot 45 women were screened with 4 women recording 1 or higher on the ACTS screening tool. This gave a disclosure rate of 9%. ACTS scores for the four women who screened positive ranged from 1 to 3. All had a score for 'Controlled', one also had a score for 'Afraid'.

Discussion with implementing staff suggested that the lower disclosure rate in the HSP service compared to the SETS services could be due to women in the HSP having less awareness of Australia's laws, norms and services due to the relative recency of their arrival; screening in the HSP being undertaken outside of the service's office (eg, in a local library or community centre); the presence of language support staff for several screenings; and the more formal client-service relationship in HSP where women are required by the Department of Home Affairs to attend interviews and, consequently, some women being reluctant to have their experience documented. It is also the case that the HSP sample is much smaller than the sample of women visiting SETS services. Further testing of the intervention is warranted with women who are in their first two years after arrival.

6.3 Routine DV screening in settlement services is feasible – with training, appropriate tools and support

Despite the study occurring at a challenging time, with SETS services returning to face-to-face service provision after COVID restrictions, there was robust implementation of the screening procedure with a screening rate of 87%, that is 309 women were asked the questions out of 354 who were eligible. Only 5% of women declined to answer the questions. Similarly, implementation was successful in the HSP service, despite high workloads and the challenges within an outreach model of service of finding safe spaces in which to conduct screening. In the HSP, where screening was undertaken at the six month review, 45 were completed.

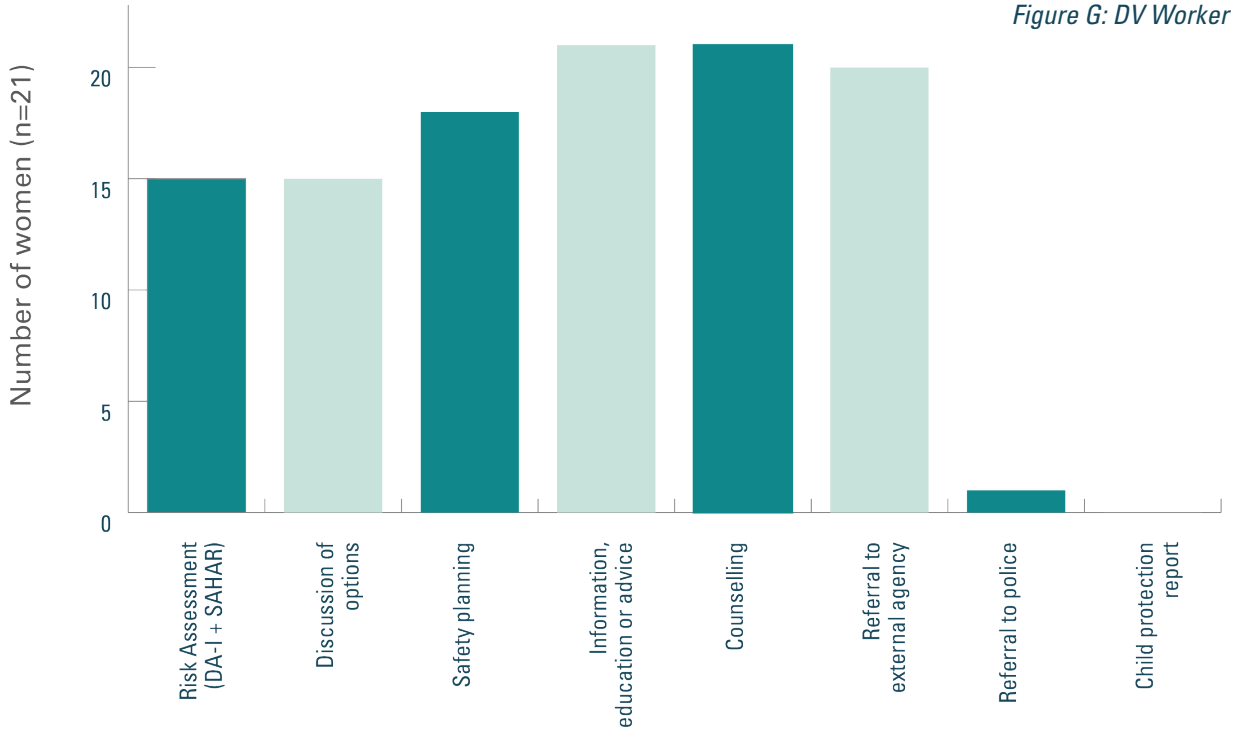
Site managers and caseworkers reported that the success of the SAHAR implementation was due to many factors including the pre-intervention training, regular check in meetings with the research team, clear and simple tools translated into community languages, safe places to screen, having sufficient time, and having referral options for women who disclosed.

6.4 Women choose different response options – most women elected not to accept further support

Only 28 of the 90 women who screened positive at the SETS sites (31%) took up the referral to the service's specialist DV worker with four of these women also referred to other services. This is a lower referral rate than expected by the research team but similar to the median referral rate of 32% found in the Miller et al. (2021) systematic review [38]. Discussions with settlement service caseworkers suggest that the reasons for not taking up the offer of referral included women choosing not to take action at that time, reluctance to talk to another worker, and internal referral protocols not being well established due to the recency of establishment of the dedicated DV support.

SETS DV specialist workers reported on follow up activity with 21 women referred following screening. DV workers saw women for an average of 5.5 sessions (range 2-10). For most women, the DV worker response included risk assessment, discussion of options, safety planning, provision of information, counselling and referral (Figure G).

Figure G: DV Worker Activity



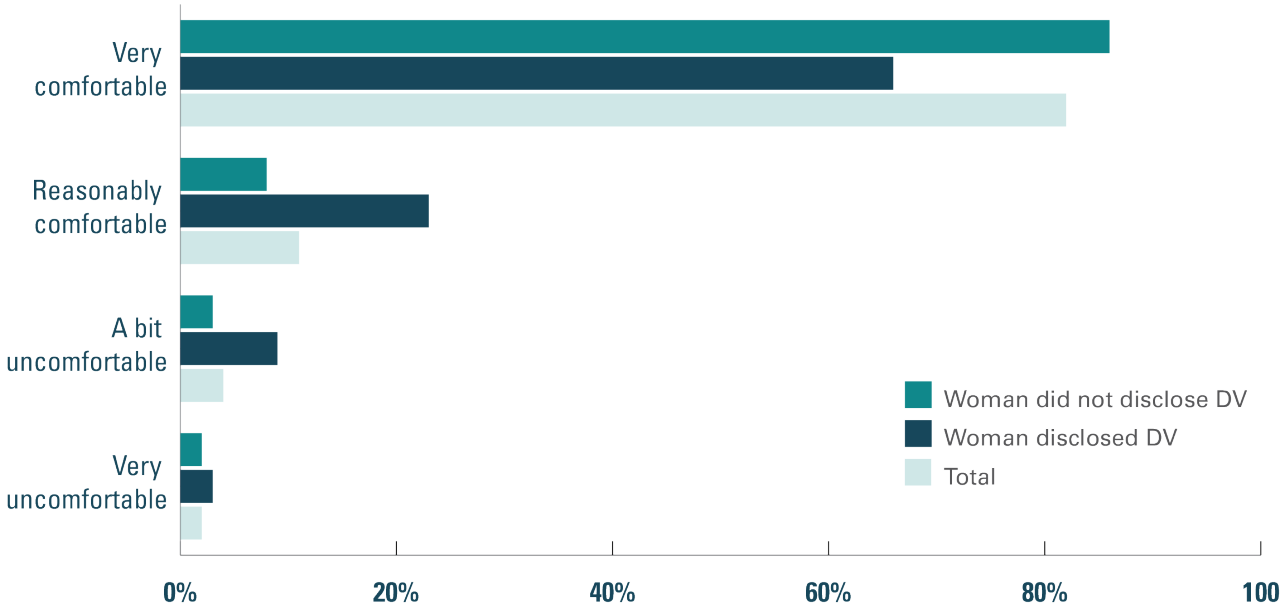
6.5 Asking about DV is acceptable to women accessing settlement services

Acceptability of screening was gauged through two survey questions, one about agreement with settlement services asking the questions, and the second relating to women's comfort with being asked the questions.

The 180/321 survey participants who recalled being asked the DV questions when visiting the SETS service were asked survey questions about how comfortable they were being asked about being frightened, controlled or hurt by their partner. As shown in Figure H, 82% (148/180) reported being 'very comfortable' and 11% (20/180) 'reasonably comfortable' with the ACTS screening questions.

A significant difference in the degree of comfort was found between women who disclosed DV and those who didn't, with 86% (125/145) of women who did not disclose DV reporting

Figure H: Comfort with screening questions (n = 180)
How comfortable/uncomfortable were you in being asked these questions?

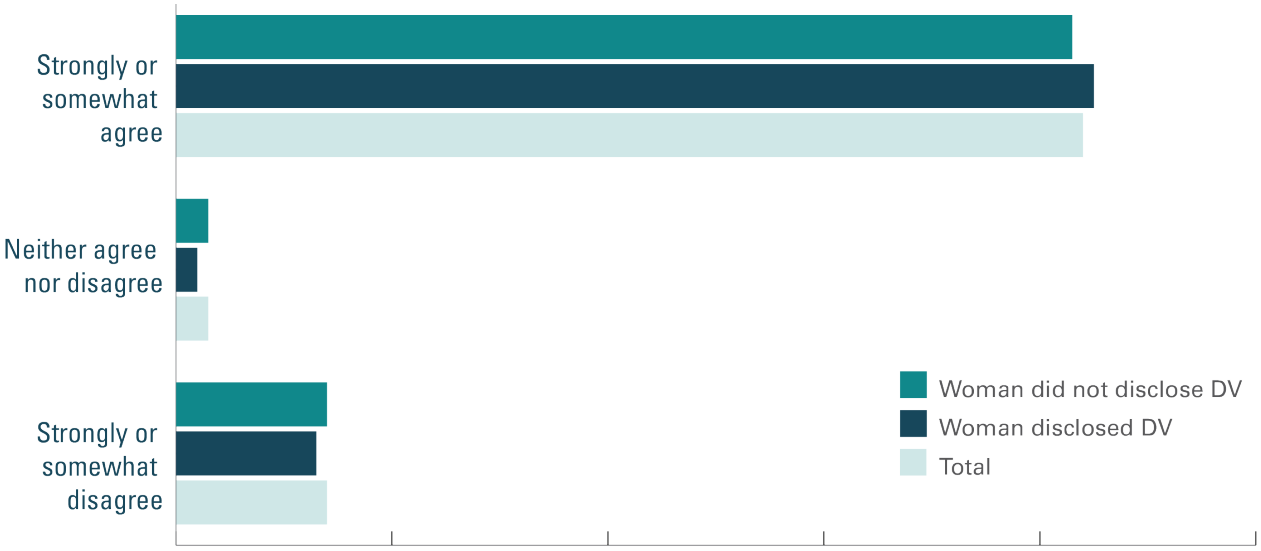


being 'very comfortable' compared to 66% (23/35) of women with direct experience of DV (Fisher's exact p=0.02).

All survey participants were asked if they agreed with settlement services asking women about being frightened, controlled or hurt. High levels of agreement were found with more than 84% of the total sample (264/316) 'strongly' or 'somewhat' in agreement, while 14% (44/316) were strongly or somewhat in disagreement. There was no significant difference in agreement levels between women who did (87%, 41/48) and did not (86%, 223/268) screen positive for DV (Fisher's exact p=0.99) (Figure I)[3].

Differences were found in the level of agreement between those who weren't asked or didn't remember being asked the DV identification questions, and those who remembered being asked the questions. Those with no recall of the questions had lower levels of overall agreement (77%, 107/139) and higher levels of disagreement (19%, 26/139) compared to those who recalled being asked the screening questions (88%, 159/180; and 10%, 18/180; respectively). This suggests that women who have been asked the questions are more in favour of being asked than those who have not been asked.

Figure I: Agreement with settlement services asking about DV (n = 319)
Do you agree that services like [SITE] should ask women about being frightened, controlled or hurt?



[3] During the survey, 27 participants said they recalled the screening questions and had disclosed. Survey participants who did not recall the screening questions and participants who indicated they had not disclosed when visiting the service, were asked the ACTS questions again under survey conditions of anonymity. Eight women who said they had not disclosed at the service and another 13 women who had said they weren't asked or didn't recall being asked, screened positive for DV during the survey. This gave a total of 48 women who identified DV. Five participants in the group who said they weren't asked or didn't recall being asked at the service and did not answer the screening questions during the survey, were excluded from the analyses.

6.6 SAHAR was most women's first experience of being directly asked about DV

Fourteen percent of respondents (41/298) reported that they had been asked questions about DV at other services. This question was only asked of women who did not recall screening and women who screened negative at the service visit. For most women the study intervention appears to be their first experience of being asked directly about DV.

Forty-eight percent of the survey participants who indicated they had disclosed DV at the SETS service in response to screening said that was the first time they had told anyone about the DV (13/27).

6.7 Women thought asking about DV created opportunities to get help

All survey participants were asked to provide an explanatory comment about why they agreed or disagreed with settlement services asking women about being frightened, controlled or hurt. Of the 321 survey participants, 314 (98%) provided a comment. The research team coded comments to one of a list of reasons formulated by the research team, as reported in Table 1.

Table 1: Reasons for agreement/disagreement with settlement services asking women about being frightened, controlled or hurt (n = 314)

	DV status		
	DV +ve	DV -ve	Total
Reasons for agreement			
1. So women can get help/be kept safe	20	139	159
2. To enable women to talk about DV	7	38	45
3. To increase awareness/education about DV	3	8	11
4. To empower women; unburden women; realise women's rights	13	38	51
5. Other	1	18	19
Reasons for disagreement			
6. Discomfort	0	4	4
7. Opposed	0	3	3
8. Privacy/confidentiality concerns	1	2	3
9. Questions unnecessary	0	2	2
10. Other	0	0	0
Reasons unclear (could be agree or disagree)			
11. Reason not clear	3	14	17
TOTAL	**48**	**266**	**314**

The most common (156/ 314) reasons for women's agreement with DV enquiry related to it being a means for women getting help or being kept safe or protected. Women who had disclosed DV commented, for example, that they agreed with being asked about DV, *To get help like I did*, and *Because many new arrival women may be subject to DV verbal abuse, physical abuse, etc and they need support to navigate and seek help*. Other comments (51/314) related to women's empowerment and/or feeling unburdened by speaking about DV, such as these quotes from women who disclosed DV:

"When you get to talk to the right person, speak out about what happened, I feel lightened and find out solutions to my problems."

"I know my rights."

"There is someone who hears me without judging me and this helps to release the internal pressure."

Women also commented that asking the questions could help to overcome barriers to talk about DV, such as, *Many women [are] afraid, hesitate to talk about DV, but when having a chance to talk about it is a good thing*, and, *Because many people experiencing DV do not have enough courage to talk about it unless someone asks about it.* A woman who did not report DV agreed with the questions being asked, *Because some women are subjected to violence and are unable to disclose and speak, but these questions help women to say their feeling.* The value of DV enquiry for raising awareness was also noted, *I think we can speak out, sharing the experiences we have been through, other people can understand more about DV and from different perspective.*

Twelve participant comments expressed opposition to the questions being asked, or queried their necessity. As one woman who had experienced DV noted, *The worker has to be 100% make sure all these things are confidential because of our cultural connection.* Other comments from women who had not disclosed abuse included:

> **"Women shouldn't tell others family problems because they might advise her to divorce."**

> **"I have no issues with my husband or my kids and I do not like those kinds of questions."**

> **"Family secret must keep secret and should not tell others about it."**

6.8 Talking about DV is encouraged by worker care, language match between women and staff, private spaces, female workers

The factors ranked by survey participants as most important for enabling women to talk about DV were 'care shown by the worker', 'talking to someone in my own language', 'trust in the confidentiality/privacy of the service' and 'talking to a female worker' (Table 2). These four factors were ranked highly by all survey participants, including women who disclosed DV who also identified as important: 'knowing and trusting the worker', and 'feeling confident the worker will know what to do' (Table 2).

Table 2: Factors that would make a difference for women talking about DV (n=316)

Factor that would make a difference	FREQUENCY (%)		
	DV screening status		Total
	Positive	*Negative*	
Care shown by worker	36 (75)	192 (72)	228 (72)
Talking to someone in my own language	35 (73)	197 (74)	232 (73)
Trust in the confidentiality/privacy of the service	33 (69)	156 (58)	189 (60)
Talking to a female worker	25 (52)	163 (61)	188 (59)
Knowing and trusting the worker	24 (50)	123 (46)	147 (47)
Feeling confident the worker will know what to do	26 (54)	87 (32)	113 (36)
Talking to a worker who has a similar background to me	16 (33)	75 (28)	91 (29)
Talking to a worker who has a different background to me	1 (2)	9 (3)	10 (3)
Other*	0 (0)	8 (3)	8 (3)
TOTAL	48 (100)	268 (100)	316 (100)

** Other included: Making the woman feel safe (3) and the caseworker not being biased towards women (1). Multiple responses were allowed so column totals are>100%*

6.9 Refugee women face multiple barriers to disclosure and help-seeking

In-depth interviews were conducted with seven women who indicated during the survey that they had disclosed DV when visiting the SETS service. The interviews were conducted in the women's languages by bilingual Research Assistants under the supervision of the research team. The following themes were identified:

- The nature of the abuse and the steps taken by women varied widely. The decision to disclose (instance and reasons) was usually not a clear single event.
- Language matching with settlement workers was valued.
- Some women had established strong trusting relationships with DV specialists. These relationships were highly valued.
- Barriers to disclosure and help-seeking included: fear of retribution; fear of losing the children and/or breaking up the marital relationship; visa insecurity; normalisation of some forms of abuse; concern about private information becoming known to the community, lack of knowledge about Australian laws and services.
- Women who disclosed DV accessed a range of services and supports including financial help, housing, police, legal, vocational training and personal support groups.
- Knowledge of Australian law and support from other women were described as important enablers for help-seeking.

"I feel very comfortable talking to [DV specialist]. She's the one that comforts me. And I psychologically feel better when I talk to her. She helped me with many, many things. I feel very good. Very relaxed when I talk to her."

"You feel comfortable when someone speaks your language and also the background ... You feel like she understands you better."

Refugee women accessing settlement services and who experience DV face many of the same barriers to disclosure and help-seeking as experienced by locally born women such as fears about the safety of themselves and their children, concern about the consequences of disclosure, lack of material resources, and limited service options [7, 17]. The study finds that refugee women experience many additional challenges including language barriers, lack of knowledge about Australian laws and services, visa insecurity, complex relationships with their community, and migration vulnerability.

6.10 Settlement staff said asking women about DV increased awareness and gave opportunities to disclose and get help

Caseworkers said the DV questions helped facilitate disclosure and some women never previously had been given a direct opportunity to speak about their experience.

'there are some women they have never talked about it because they are not brave enough to talk about it. And not only that, there's no one asked them. They have been waiting for someone just to ask them'

The DV screening preamble and questions were also reported by participating staff to have benefits in increasing awareness about DV among refugee women.

'some clients who did not really have an idea about what DV is, so it actually also helped to give the awareness'

Caseworkers and DV specialists said that women may take some time before deciding to disclose and seek help. The DV screening could serve as a step in women's processes of decision-making toward disclosure.

Screening was successfully incorporated into organisational procedures during the study period. The five sites had different levels of capacity but all Managers indicated that incorporating the screening procedure was not difficult while also acknowledging the value of the training, tools and support from the research team.

Most participating staff were in favour of continuing DV screening and response within their services.

6.11 For settlement service staff, clear, simple tools, training and support mattered

The SAHAR intervention was implemented with a high degree of fidelity by study sites. Workers and managers found the tools relatively straightforward to implement and said they became easier over time as they gained experience in implementing the tools. Caseworkers reported increased confidence to talk about DV as a result of the pilot.

Enablers for the intervention were: the clarity and simplicity of the screening tool; translations of the tools and information cards; pre-intervention training; regular support from the research team. Caseworkers and DV specialist workers valued the two days of training from the research team received prior to implementing the SAHAR intervention.

"When I did the first screening, I was, to be honest, very scared because I wasn't exposed to that stuff...but doing it and then I'd just go to the questions again and again so that I feel more confident of asking."

"for me, it was quite easy because the wording was simple, easy to understand"

Challenges with the intervention included: women being reluctant to disclose; the sensitivity of the topic for staff that made it uncomfortable to raise with clients; different understandings of 'control' and the perceived normalisation of some forms of control. Also, organisational factors including restrictions on office-based face-to-face work post-COVID that limited the opportunity for DV enquiry; staff turnover; and DV response being a new area of practice for the services.

Workers and managers described many barriers to disclosure and help-seeking for women

including: fear of physical harm or other retribution by the partner; fear of losing their children; reluctance to break up the family; the risk of shame and exposure within their community; lack of knowledge of Australian norms, laws and services; migration vulnerability; visa insecurity including fear of being sent back to their country of origin.

'Usually, they've been threatened by husband that they will return them to their country, so they prefer to keep silent.'

'They don't want people from their community to know that they have the problem in the relationship.'

"The reason I think the client came to us, because they didn't have anywhere else to go ... So they come and say, 'This is actually happening. My husband ...'."

"If we are to dive deep into the domestic and family violence space, we've got to embed this particular screening tool."

Workers and managers said enablers for women to disclose and seek help included: greater awareness of legal protection (law and services); having support within their community; education; awareness about DV and the help available. Workers agreed that asking women directly provided an opportunity for women to speak about experience of violence.

A high level of acceptability of screening was reported by workers and managers. Nearly all were in favour of continuing DV identification and response within their services. At the conclusion of the intervention, managers at two of the sites said they would continue the screening in their organisations beyond the study period, with some adaptations. However, significant staff turnover has occurred at some of the sites since that time.

7. LIMITATIONS

1. The study design did not include a comparison group for testing the effectiveness of the DV screening and response. This reflected a change in methodology required due to COVID-19 border closures which halted refugee arrivals in Australia. 2. As a "pilot" study, participating services were motivated to improve their services by incorporating a response to support those impacted by DV. Other services may be less 'ready' to respond and their capacity for training and language matching may vary. 3. The survey sample did not completely align with the cohort of women screened. Some women were recruited for the survey who had not seen a caseworker on the day they attended the site and so were not asked the screening questions. It is also the case that a small number of women were asked the screening questions at times when the research assistants supporting the study were not present at the site and as a result were not included in the survey cohort.

8. IMPLICATIONS

This study demonstrates that routine DV enquiry for intimate partner violence is acceptable to recently arrived refugee women in the context of settlement services. This is an important finding for this population which is often hard to reach and, at the same time shows elevated levels of injury and death from DV. Policy and programming should give further consideration to building DV identification and response as one of the deliverables in refugee settlement service provision.

The study was undertaken successfully in both the SETS stream which responds to women 18 months to five years post-arrival, and with a smaller sample of women in the HSP which supports women within the first 18 months after arrival. A lower disclosure rate ensued for women in the HSP than for those accessing SETS. Discussion with implementing staff suggests that the lower disclosure rate may be due to women in the HSP having less awareness of Australia's laws, norms and services due to the relative recency of their arrival; screening in the HSP being undertaken outside of the service's office (eg, in a local library or community centre); the presence of language support staff for several screenings in HSP; and the more formal client-service relationship in HSP where women are required by the Department of Home Affairs to attend interviews. It was also the case that the HSP sample was much smaller than the sample of women visiting SETS services. Further testing of the intervention is warranted with women who are in their first two years after arrival, and with women in the immediate on-arrival service stream, given the different stressors women face in the earlier arrival periods.

Testing with a wider range of services and incorporating a control group would allow stronger comparison. Finally, most women in the survey had been in Australia from three to five years. More investigation of the intervention with refugee women at an earlier point in their settlement experience is warranted.

9. CONCLUSION

The SAHAR intervention was effectively implemented by SETS services, and subsequently in a small HSP pilot. The relatively high disclosure rate, and high levels of acceptance of the intervention found with refugee women and settlement staff, demonstrate the feasibility of culturally tailored, universal DV identification and response in settlement services.

Key factors associated with successful implementation include the culturally welcoming environment provided by settlement services, language matching, clear and simple tools translated into community languages, care shown by the worker, opportunity to develop trusting supportive relationships, privacy, having good referral options for women who screen positive, pre-intervention training for implementing staff, and continuing support for staff.

The SAHAR study finds that refugee women place a particularly high value on being able to talk with someone who speaks the same language. Language matching and culturally safe service environments are found to be important enablers for refugee women to decide whether to disclose and seek help. In this regard, the service setting offered by settlement organisations emerges as a key finding in the study. Refugee women value the proximity, accessibility, care shown by staff, cultural safety and ease of being able to communicate in their language. The inclusive, community-based setting serves to promote well-being [39] and is a conducive environment for conversations about a range of complex issues such as responding to DV.

Knowing and trusting the worker is identified as important which suggests that building rapport is an important condition for refugee women. It is also the case that many women in our study were visiting the settlement service for the first time and no association was found between the number of visits to the settlement service and disclosure, which suggests that rapport can be quickly established by skilled, caring workers.

This study demonstrates the feasibility of implementing universal DV enquiry and response in the settlement sector as a way to interrupt DV within these populations in Australia.

The study demonstrates the clinical utility of the ACTS screening tool which, unlike other screening tools, includes questions about coercive control. At the same time, there is a need to further investigate the diverse understandings and impacts of controlling behaviour with refugee women.

Following the identification of DV, most women chose not to take up a referral to the DV worker. Women who did see a site DV worker received support including risk assessment, discussion of options, safety planning, provision of information, counselling and external referral. SAHAR response tools were used and these were valued by the DV specialist staff. Nevertheless, the referral rate was lower than expected and women's stories point to the lack of culturally appropriate referral options and services.

This study demonstrates the feasibility of implementing universal DV enquiry and response in the settlement sector as a way to interrupt DV within these populations in Australia, and to enhance settlement services' capacity to provide a safe place for women to seek support for DV. Successful implementation of DV screening and response requires that the framework of resources and support provided in the SAHAR study be in place to maximise fidelity to the processes and procedures that contributed to the outcomes observed in the study, including: planning and preparation, organisational commitment, training, translated tools and resources, staff support during implementation, guidelines and referral protocols.

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SAFETY & HEALTH AFTER ARRIVAL

An toàn và Sức khỏe Khi đến

抵澳后人身安全和健康状况

السلامة والصحة بعد الوصول

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