"THE AVERAGE COUNSELLOR WOULDN'T KNOW": EXPLORING HOW GENERAL HEALTH PRACTITIONERS UNDERSTAND AND RESPOND TO DOMESTIC VIOLENCE

by

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Abstract

Individuals experiencing and perpetrating domestic violence are frequently in contact with general health and mental health services, which must be prepared to respond. Through interviews with general service providers (n=17), including psychologists and nurses, the present study uncovered ways in which domestic violence-related risks are, and are not, recognized and responded to within general health and mental health practice. Qualitative analysis revealed that service providers possess basic knowledge of risk factors but frequently lack the organizational direction required for effective follow-up. Implications for future research and practice include further examination of system-level practices and ensuring the fundamental organizational conditions to allow providers to address domestic violence confidently and effectively.

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1. Introduction

Domestic violence (DV) is endemic in Canada. In 2019, DV-related incidences accounted for one-quarter of all violent crime reported to the police. Women were the vast majority of those who experienced this violence, representing 67% of survivors in these cases (Statistics Canada, 2021). Given that rates of family violence are underreported to police, these statistics are likely a gross underestimation of the actual population experiencing DV (Canadian Centre for Justice and Community Safety Statistics, 2020). Indeed, as many as half of all women in Canada report experiencing some form of physical or emotional abuse over their lifespan (Canadian Women's Foundation, 2016). Relative to men, they are four times more likely to be victims of DV and are also at heightened risk of injury and death in intimate contexts (Statistics Canada, 2018; 2021). At its extreme, DV can culminate in domestic homicide, the murder of intimate partners or family members, with women representing 4 out of 5 domestic homicide victims between 2010 and 2015 (Dawson et al., 2018; Scott et al., 2020).

The sequelae of DV are well-documented. Victimization has invariably been associated with physical and mental health issues ranging from traumatic brain injury and musculoskeletal injuries to depression, anxiety, suicidality, and traumatic stress (Stewart et al., 2013; Symes et al., 2014; Wathen, 2012). These consequences do not necessarily stop when the violence ends, but may persist for years (Bonomi et al., 2006; Delara, 2016). Due to the impact of DV on health, women who have experienced violence are frequent users of health care services and are regularly in contact with primary care physicians, public health nurses, social workers, and mental health counsellors, among other service providers (Campbell, 2002; Feder et al., 2006; Garcia-Moreno et al., 2015). Perpetrators of DV have likewise been shown to interact with general mental health providers in the months leading up to major violent events, such as domestic homicides (Arias & Corso, 2005; Scott et al., 2020). Given that general service providers are the likely first professional contacts of many victims and perpetrators, they provide a crucial opportunity to identify and intervene in instances of DV (Stewart et al., 2020).

There have been widespread calls over the past decade for broader general knowledge about DV in health and social services. The World Health Organization (WHO, 2013) emphasized the need to make general service providers more aware of violence against women and encouraged an evidence-based service response to DV. The call to action for health service providers to improve their knowledge of and response to DV has likewise been echoed through

recommendations set forth by Domestic Violence Death Review Committees (DVDRC) across Canada (Ontario DVDRC, 2019; Scott et al., 2020). These multidisciplinary committees–tasked with identifying systemic shortcomings in the leadup to domestic homicides and making recommendations for effective intervention and prevention strategies–have noted the critical importance of increased training for healthcare professionals so that they are able to identify warning signs of DV. Moreover, general practitioners working in medicine, nursing, social work, psychology, psychiatry, and addictions have been recognized as key providers who should also be skilled in safety planning with potential victims and risk management with potential perpetrators (Ontario DVDRC, 2019).

As general recognition grows and a body of standards and best practices informing general health service responses to DV continues to evolve, it is essential to examine and understand current service provider practices. Prior research across the United States and Canada suggests that general service responses to DV vary dramatically (Ahmad et al., 2017; Alshammari et al., 2018; Macy et al., 2009). Interviews with therapists, social workers, nurses, and service users have identified a number of barriers to effective intervention, including a lack of comfort and expertise in the area, insufficient training, a paucity of time and resources, feelings of powerlessness in making a difference or offering a solution, and institutional constraints (Burns et al., 2020; Guillery et al., 2012; Rose et al., 2011; Tower, 2006). Furthermore, individuals seeking general health services for DV-related concerns often present with unique individual- and community-level risks that increase their vulnerability to DV and, correspondingly, the complexity of responding to these issues. In particular, structural violence– such as race-based policies that keep certain groups living under conditions of material deprivation, colonial policies relating to the large-scale removal of children from their families and into state care, policy-enforced poverty, confinement to reserves, cultural erasure, and disproportionate imprisonment–has shaped the health and risk of distinct populations in Canada, including Indigenous and newcomer communities (Marchand et al., 2015; Nelson & Wilson, 2018; Varcoe et al., 2014). One consequence of such inequities is an increased vulnerability for DV victimization and perpetration (Brownridge et al., 2017; Okeke-Ihejirika et al., 2018). Thus, responding to DV requires an intersectional framework so that one may appropriately address the needs of clients who have multilayered identities that intersect with political and socioeconomic realities–realities that often precipitate marginalization, oppression, and discrimination (Lockhart & Mitchell, 2010). General service providers in Canada, interfacing with increasingly diverse

populations, must understand such complexities in order to assess the impact of these identities on an individual's risk and access to opportunities and to implement effective risk assessment, management, and safety planning strategies (Symington, 2004).

The present qualitative study aims to provide descriptive information about the current assessment and intervention practices of general health and mental health service providers when working with men, women, and children in the context of DV. Such information is critical to identifying gaps in response and ensuring earlier and effective intervention for individuals experiencing and perpetrating DV. Furthermore, research examining how practitioners attitudinally approach and understand risk and safety will lend support in initiating change in the training and education of general practitioners. Finally, considering the diverse populace of Canada and the unique needs and risks faced by the distinct communities within its borders, exploring these topics within the Canadian context is key for an improved response when working with vulnerable populations.

2. Methods

The purpose of the current study was to examine general health and mental health practitioners' service responses to DV–to explore how these professionals understand, talk about, and address risk and safety, and shed light on the knowledge, training, and processes guiding their responses.

This study was conducted as part of the Canadian Domestic Homicide Prevention Initiative for Vulnerable Populations (CDHPIVP). The purpose of this initiative is to enhance collaboration through cross-sectional research to understand barriers to effective risk assessment, risk management, and safety planning. The CDHPIVP has a particular focus on identifying unique needs and risk factors that can heighten risk of violence for four vulnerable populations: immigrants and refugees; Indigenous communities; rural, remote, and Northern populations; and children exposed to DV. As part of this initiative, interviews were held with 372 key informants who interface with victims and/or perpetrators of DV through their work. Participants were from across Canada and identified as working within one of five different sectors: police; child protection; violence against women; partner assault response programs/corrections; and mental health, healthcare, and/or addictions programs. Of this total sample, 25 interviews were with informants working in the mental health, healthcare, and/or addictions sector and were screened for further inclusion in the present study. 8 interviews were excluded due to informants

endorsing a specialized DV role within their organization. For example, several nurses identified specifically as "sexual assault and domestic violence nurse examiners," a mental health professional noted that a significant portion of their role involved consulting on cases related to DV, and one counsellor endorsed working solely in a spousal violence program. The remaining 17 informants identified as generalist frontline professionals and were thus included in the present study. These individuals differed in their level of experience, in their roles within their respective agencies, in the degree they worked directly with clients, and with regard to the populations they self-identified as serving.

Prior to data collection, approval was obtained from the research ethics review boards at Western University and the University of Guelph–the lead universities for the CDHPIVP. Consenting informants were interviewed between 2017 and 2018 by graduate students with research or clinical backgrounds related to DV.

Interviews

A semi-structured question format was used to ensure a structured inquiry that still allowed participants to add to the depth of information that was collected (Fontana & Frey, 2003). Approximately 30 interview questions queried across two general areas: experiences with risk assessment, risk management, and safety planning practices; and challenges, unique risks, and promising practices associated with working with vulnerable populations (refer to Appendix A for the interview guide). Probes were used to elicit further elaboration regarding informants' responses. Interviews were completed over telephone and took approximately one hour to complete. They were audio recorded with informants' permission. They were subsequently transcribed by research assistants using NVivo software and double checked for accuracy by the original interviewer. Interviews did not include any identifiable information. Transcripts and recordings were stored on encrypted computers in a locked room.

Data Analysis

This study analyzed dominant themes through a qualitative analysis of the content of the interviews in order to gain a better understanding of practices currently used by frontline mental health and health care practitioners. Since the overarching goal was to build knowledge on the current state of practice as experienced by these professionals, a grounded qualitative approach was chosen because of the value that this approach places on subjective experience and participant expertise and beliefs (Charmaz, 2006). Thematic analysis emerged through a multi-

step process beginning with an initial familiarization of the interviews. This included a thorough reading and rereading of all the transcripts by the first author. The next step in the qualitative analysis involved the creation of codes which were used to identify the characteristics of the interviews including the topics, themes, and overall content that they contained. NVivo qualitative coding software (v12.6.0) was used to facilitate the qualitative analysis. A sample of the transcripts (n = 5) were provisionally coded by the present author and then collaboratively reviewed with their supervisor to determine the suitability of the codes and ensure consistency. Parent codes were included for each of three major areas discussed in the interviews: risk assessment, risk management, and safety planning practices; work with children; and work with vulnerable populations. These parent codes were then broken down into smaller subcodes to encapsulate the in-depth information provided in the interviews. This provisional codebook was applied to the remainder of the interviews in a reiterating process of comparing existing codes and deliberating the suitability of codes and additional emerging themes. Saturation of codes was reached by the completion of all 17 transcripts, suggesting that no new themes were emerging from the addition of more interviews. Consultations with other qualitative researchers continued throughout this process to ensure that procedures and interpretations were appropriate. Furthermore, codes were presented to and reviewed by other researchers and scientist-practitioners immersed in work related to DV and revised based on their feedback along the way. This process provided for the opportunity to analytically explore the relevance and specificity of the evolving themes (Saldana, 2011). The final list of codes is available for reference in Appendix B.

In conducting a qualitative analysis, it is critical to recognize that the position, experience, and world view of the researcher exerts a substantial influence on the manner in which research questions are raised and framed, methods selected, data collected and analyzed, and results reported (Austin & Sutton, 2014; Flick, 2009). The present first author identifies as a white, female graduate student studying in the field of school and clinical child psychology. In addition to completing clinical practica in various general mental health settings (including a public school board and university psychology clinic), this author is afforded knowledge of DV through involvement in a research lab investigating and aiming to reduce the impact of violence in family relationships.

Sample Characteristics

In total, 17 interviews with service providers were used for the current study (see Table 1). Of the service providers included in this study, a majority (82%) self-identified as working in community mental health and addictions centres or hospitals and the remainder provided mental health and health services within private practice, pregnancy care centres, or child, youth, and advocacy centres. Interviewees reported their specific roles within their organization as follows: social worker (n = 5); clinical supervisor *(*n = 3); addictions and mental health counsellor (n = 2); psychotherapist (n = 2); nurse practitioner (n = 1); natural health practitioner (n = 1); child and family therapist (n = 1); detox attendant (n = 1); and CEO (n = 1). A majority worked in Ontario (n = 11), with the remainder located in Alberta (n = 3), Saskatchewan (n = 2), and Manitoba (n = 1).

Table 1

Demographic characteristics of sample

Variable	$n = 17$
	n (%)
Location of agency (province)	
Ontario	11 (64.7)
Alberta	3 (17.6)
Saskatchewan	2 (11.8)
Manitoba	1 (5.9)
Role	
Social worker	5 (29.3)
Clinical supervisor	3 (17.6)
Addictions and mental health counsellor	2 (11.8)
Psychotherapist	2 (11.8)
Nurse practitioner	1 (5.9)
Natural health practitioner	1 (5.9)
Child and family therapist	1 (5.9)
Detox attendant	1 (5.9)
CEO	1 (5.9)

3. Results

Visual representations have long been used in qualitative research with the purpose of "illuminating rather than obscuring" the meaning of emerging themes from data (Eisner, 1997, p.8; Strauss). Metaphorical visual displays are used to convey complex insights using simple and common templates, often using multiple layers of representation (Verdinelli & Scagnoli, 2013). On one level, information is presented graphically in a structured and organized way. However, key features of the metaphor are also used to convey a second level of representation, which provides insight or implicit knowledge about the represented information (Lengler and Eppler, 2007). The present section uses such visual display–a "domestic violence supply room"–to depict the current state of practice of responding DV, based on the present interviews (see Figure 1). Several areas of service are represented as boxes on shelves to conceptualize the level of access and degree of competency described by generalist practitioners with regard to each respective matter. Commonly cited barriers to responding to DV are visualized as barricades on the door, while a step ladder represents aspects of practitioner training, experience, and knowledge that promote a more comprehensive and inclusive response–allowing practitioners to "reach" a higher shelf. A phone likewise represents the described propensity of general health and mental health service providers to "call out" in the form of mandatory reporting and external referrals. Each area is discussed in turn below. The reader is also referred to Appendix C for narrative summaries of the original codes, as described without reference to the present diagram.

Bottom Shelf: Accessible to General Service Providers

Items depicted on the bottom shelf of the DV supply room represent the themes that were consistently endorsed in the descriptions of all informants when describing their responses to DV. That is, bottom-shelf items are those things that are in the repertoires of general health and mental health practitioners–easily accessible to all. In particular, informants described knowing and listening for risk factors that are associated with a higher likelihood of DV perpetration and victimization. Many provided examples of factors that they consider in determining the presence of specific risks, as indicated by one informant:

> Is there alcohol involved with her partner? Is she herself judging herself at risk? Where is it that she is living? […] Are there extra vulnerabilities that she has? Does she have alcohol involved, drugs involved…this sort of thing. Have there been repeated occurrences of this violence? Has there been repeated separation of the couple? Is he a

> hunter? […] Where is the guy now; is he awaiting bail? Those are the things I look at.
> (Inf. 7)

Informants similarly described exploring risks related to a woman's relationship with the perpetrator of violence, including whether they were in continued contact, whether any legal conditions had been breached, and whether there were any concerns around the offender's mental health. Community- and systemic-level risks were also frequently considered by informants including factors such as poverty, lack of safe housing, and increased isolation from others. Importantly, this knowledge of risk factors was not limited to topics that informants queried for verbally, but also referred to the importance of remaining alert for subtle and nonverbal signs that a woman might be a victim of violence. For example:

> […] usually, physical abuse is all under your clothes, but there are all sorts of things: if a woman lowers her center of gravity to below her knees […] that is a sign that she is either torn or very hurt. If a victim of abuse continually apologizes […] somebody who apologizes for a very small thing […] that is an indicator that they are abused. (Inf. 15)

Lastly, informants demonstrated that their knowledge of risk factors extended beyond those general risks applicable to most women. Informants additionally possessed knowledge of risks specific to vulnerable populations in Canada including immigrants, refugees, and newcomers, Indigenous persons, and individuals living in rural, remote, or Northern communities. Unique risks for newcomer populations included language and cultural barriers impacting the ease of accessing services, unfamiliarity and distrust towards new systems and laws, increased isolation and lack of social support, financial barriers, prior trauma, and potential considerations around reputation within their cultural communities, such as shame and embarrassment. Risk factors specific to Indigeneity that were most discussed by informants included concurring addiction and mental health concerns, the impact of intergenerational trauma, and the lack of culturally-appropriate and Indigenous-led resources. Many risk factors specific to Indigenous communities also overlapped with those of rural, remote, and Northern populations including increased rates of poverty, lack of anonymity, increased isolation and distance from services, and greater access to weapons. Overall, all informants demonstrated their consistent reliance on the knowledge of those factors that elevate the risk of harm and violent victimization when assessing and responding to DV.

Figure 1: The Domestic Violence Supply Room
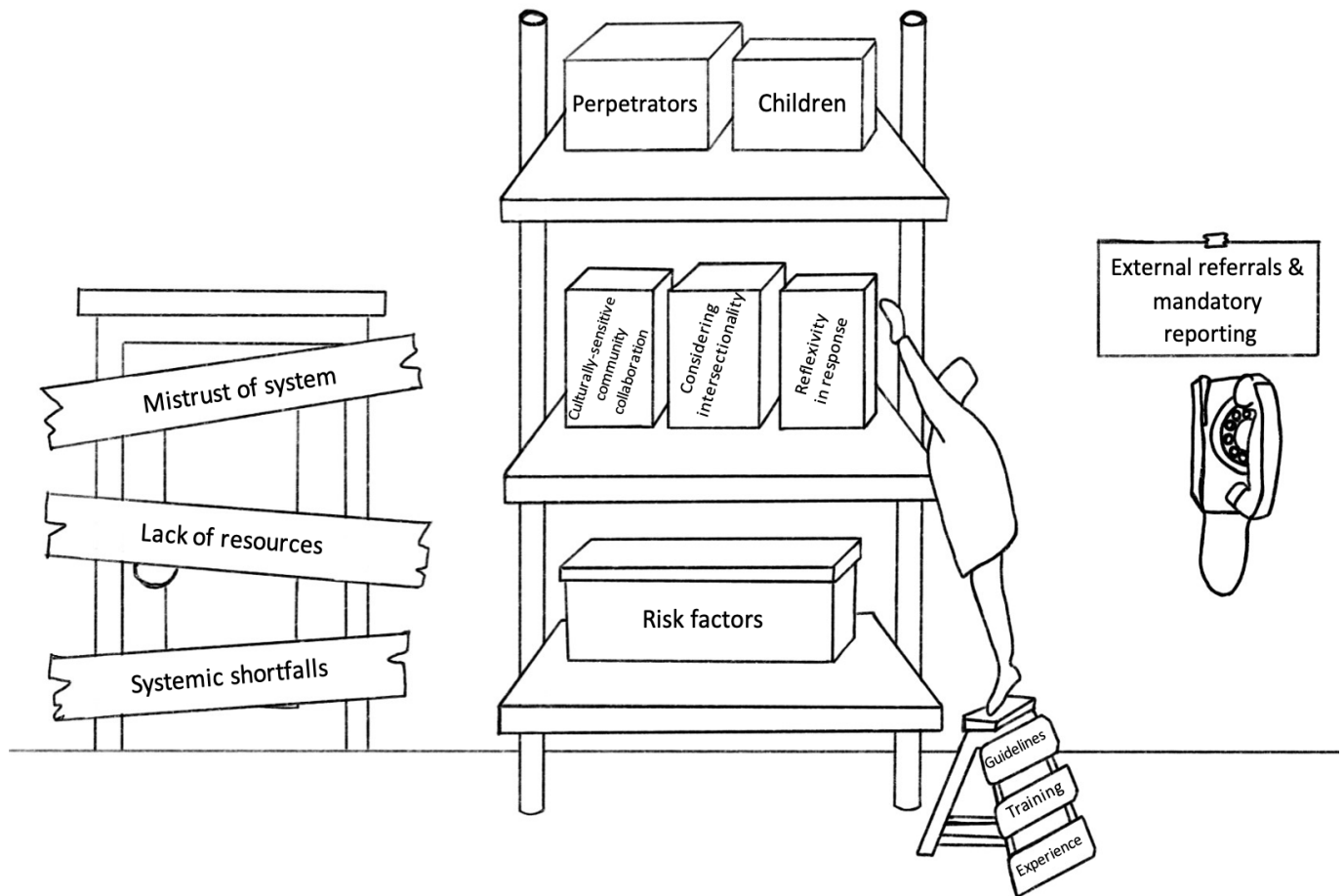
Top Shelf: Out of Reach for Generalist Service Providers

        Contrary to bottom-shelf items, those on the top shelf represent areas of practice that, based on information collected from informants, are currently out of the purview–completely out of reach–of the general practitioner's scope of competency when responding to DV. Most notably at this level of (in)access are matters related to working with children exposed to violence and perpetrators of violence.

        Most informants described children as being rarely–if ever–considered in their work with women presenting with concerns of DV. Children are described as being absent from their considerations of risk and planning around safety: "People forget about the children […] say a woman goes to the hospital because the man beats the hell out of her and nobody in adult mental

health or the hospital is asking, 'Where are the children?'" (Inf. 11). Other informants described children as being forgotten in the process, since general practitioners are "not trained to consider them" and "don't have that knowledge" (Inf. 6 and 16). And whereas a few informants maintained that the impact of DV is profound on children and that youth are often the most vulnerable party in situations of DV, others clarified the target of their service: "I don't worry about anything other than the patient in my bed" (Inf. 17). Overall, the prevailing perspective described by informants is one that implies that they are not responsible for the safety of children, and furthermore suggests some misunderstanding of the impact of exposure to violence early in youth:

> What I hear in my work is that they didn't get hurt […] so what is the big deal? They were sleeping, they were in the other room…that minimization about the impact that domestic violence can have on children and on their emotional development, on their physical development. (Inf. 17)

The burden of safety, instead, was frequently described as being placed on the mother, with informants "hoping that the mother would be keeping [the children] safe" (Inf. 3). Children, thus, are placed on the highest shelf in the DV supply room, effectively ignored in general service provision targeting DV.

Likewise, when informants were asked about their work with men and perpetrators of violence, there was an overwhelming consensus that the majority are "not really dealing with the perpetrator" (Inf. 3). Even when men are explicitly identified (or heavily suspected) to be perpetrators of violence, generalist providers noted that they neglect to address these concerns. For example:

> I know I have a perpetrator on my caseload. I will often ask questions on what's happening at home, but that is not within my scope of practice. I don't do counselling, and I'm not monitoring or supervising the perpetrator. (Inf. 10)

Instead, the focus of work with men is centred around the specific concerns that brought them to seek general services, such as their healthcare needs. Addressing concerns around the safety of his partner and managing his risk to reoffend is otherwise disregarded, even when informants are aware of the importance of involving these men in services:

> We know the current research is saying we need to make sure that we are thinking about [perpetrators] as well […] I don't have much information about [what to do with] men. (Inf. 11)

Overall, work with perpetrators to address concerns of violence is by-and-large omitted from general healthcare provision based on informant reports. Informants note a lack of clinical skills, information, and knowledge when addressing these issues, and agree that there is demand for more programs and organizations to specifically to address the needs of perpetrators. Work with men who harm is thus situated on the top shelf, out of reach for general practitioners.

Middle Shelf: Potentially Within Reach

The middle shelf of the DV supply room contains those pieces of knowledge, attitudes, and skills that informants depicted as being "within reach" for some general service providers but not all. Notably, this level of shelf becomes more accessible with a foundation of particular supports and experiences (described in the subsequent section). Nevertheless, given the idiosyncrasy that exists across organizational processes and individual practitioners' experiences and training, middle shelf items–that is, one's ability to consider intersectionality and lived experiences when responding to DV, to initiate culturally-sensitive community collaboration, to be reflexive, and to feel confident in one's capacity to respond–are only reflected in a minority of informant responses.

Only a few informants were able to describe working with clients presenting with concerns of DV through an intersectional lens that valued the individual's unique identity, experiences, and perspective. These informants described the importance of respecting the distinctive histories of individuals and emphasized the need to work with clients "on their terms," learning from these individuals and tailoring their services according to their unique needs. Similarly, these informants noted their consideration of "woman as expert" in her own life, and explained the value of believing the woman when it came to her perceptions of her situation, her safety, and her risk. A small minority of informants noted additional key items that made a different in connecting and fostering trust with women from vulnerable populations, such as providing services and resources in different languages, hiring clinicians who hail from similar backgrounds as their clients, and forging relationships with community cultural centres. Finally, the need to be reflexive in one's work–to question one's attitudes, values, habitual actions, and prejudices as it relates to working with vulnerable populations in particular–was explained as an important piece of competently responding to DV:

> You've got to process your assumptions and stick them in a jar somewhere and close that jar and work where the patient is and believe that patient. Regardless if they have been here 14 times intoxicated and today they are coming and telling you they were abused,

we are believing them and going with what they're telling us. And I see that as a move

forward with staff is that we are a place where [clients] are believed more so than not.

(Inf. 3)

In this way, some informants reflect some degree of access to the items depicted on the middle shelf.

However, the prevailing perspective of the majority of informants demonstrated the lack– and occasionally even the opposite–of these same considerations across their work with clients. For example, several informants expressed doubt regarding their ability to understand and consider the multiple and intersecting identities of their clients. They expressed discomfort in understanding "the complexity of the nuances of different circumstances and people's lives and the layers of identities that can contribute to privilege or oppression or marginalization" (Inf. 5). Others noted that their own background–different from that of their clients–made it difficult to understand these intersections. Still others noted some concern in believing a woman's own knowledge of her situation, suggesting instead that women over- or underestimate the risks they are experiencing, thereby making their reports unreliable. Many informant descriptions suggested an unawareness of existing cultural centres within their communities, and several informants expressed their continued disconnectedness from those centres that they were aware of: "Again, that's just that all of us in various agencies need to be aware of what one another does. I don't think we're very good at that either; I think we're pretty siloed, all of us" (Inf. 11). Finally, interviews with a majority of informants included, to some degree, their recognition of racism, bias, and stigma towards vulnerable populations within their respective organizations and, at times, even revealed informants' own biases. For example, one informant described their initial reaction to newcomer clients: "Whenever I hear 'immigrant' or 'refugee,' […] as soon as I hear that population, I think 'oh my gosh, they are coming to a hospital and they can't afford the bill' regardless of what the issue that they're coming for" (Inf. 8). Other informants stereotypically characterized vulnerable populations through their descriptions, illustrating some vulnerable populations as "always being drunk," or "relying on honour killings as the right thing to do," as two examples (Inf. 10). These statements reflect the persistence of biased perspectives among generalist care, leaving some informants "worrying that [these biased reasons] are what people blame [domestic violence] on, as opposed to actually responding to the violence" (Inf. 3). Thus, although some informants are seemingly able to access those items on the middle shelf, they remain out of reach for a majority of providers.

Step Ladder: A Way to Higher Shelves

Those items depicted on the step ladder serve as supports that allow some generalist service providers to reach the above-described middle shelf, hereby leading to an overall improved–but often still insufficient, in that the top shelf remains out of reach–response to DV. These "step ladder items" include increased experience in the field (and thus more opportunities to learn from prior encounters with DV), participation in DV-focused trainings, and the presence of an organizational process to guide the DV response.

Informants described the value of learning from their prior experiences of dealing with DV in improving their subsequent responses. Prior experience is described as helping informants to hone their professional judgment and "spidey senses" so that they are able to assess and respond to DV more accurately. Informants similarly described "learning as they go" and "picking up skills over the years." Whereby such prior exposure to cases of DV is suggested as one way to gain confidence and have an increased awareness of relevant cultural community supports, it also reminiscent of an overall reliance in general healthcare on more experienced members of staff. This is furthermore consistent with the fact that many informants described their agencies as relying on a few specific individuals to guide the DV response.

In addition to simply accumulating experience, participating in training activities is a manner by which informants described becoming more competent and confident in their response to DV. Whereas a few informants noted having received formal courses and refreshers over the years, most learning and training is reported to be completed informally (i.e., supervisory discussions, lunch-and-learns, etc.) and largely by choice (e.g., self-education, self-selection into relevant university courses, specialized practica, etc.). As an example, one informant noted that they have "done a fair bit of reading of the literature and [are] trying to incorporate that into [their] practice," which includes, "staying on top of any changes in legislation, policies, and programs in the city" (Inf. 1).

Finally, existing DV processes and procedures are idiosyncratic and generalist providers vary with regard to the degree of guidance that they receive from their agencies or organizations. Of the 17 informants in the present sample, only three were able to convey the reality of a clear, well-defined process that is routinely used to guide staff at their respective agencies in responding to DV. Another six informants vaguely alluded to the existence of procedures and screening tools at their organization, but were unfamiliar with specifics, unable to provide details about these guidelines, or explicitly noted that they did not refer to those procedures themselves.

The remaining eight informants reflected that the extent of any guidelines at their agencies were, at most, one-page pamphlets containing phone numbers for external specialist agencies. The absence of clear and consistent processes to guide the generalist response to DV is evident and many informants described their desire for additional guidance in this regard: "We've got to get more structured on this" (Inf. 7).

Those few informants who did report having a top-down, systemic approach to responding to DV at their organization, and who were able to explicitly describe the tools or processes they used, generally also endorsed feeling more knowledgeable and confident in their ability to address DV. Likewise, the existence of guidelines and procedures co-occurred with reports of increased availability of training opportunities. For example, one informant explained the attitude toward DV education and training at their workplace:

> [We have a] Violence Against Women Awareness Committee, which is pretty unique to this hospital. It's a committee that was created out of a case where a patient was killed by her husband many years ago. The focus is to continue education for staff in the hospital around violence against women and constantly raising awareness of the issues and constantly training staff to know what to do. You know, with disclosures and suspicions of abuse; just to keep it present as it's an important health care issue. (Inf. 3)

Overall, these items on the step ladder are described as supports and experiences that promote a more comprehensive response to DV. Yet, like higher levels of the shelves, even these step ladder items are not ubiquitous across all generalists' experiences: formal trainings are scarce, with the burden of learning falling on the individual; experience is only accrued with time; and processes are inconsistently available and often nonexistent. Given informant descriptions, it may even be apt to imagine the step ladder in the DV supply room as being frequently misplaced or missing altogether.

Ring, Ring: Relying on External Referrals and Mandatory Reporting

When it comes to taking concrete, actionable steps to help men, women, and children in the context of DV, informants depend on "reaching for the phone"; they described relying on their ability to get in touch with other organizations, either to refer clients externally or to follow through with their duty to report. For example, when working with women, all informants endorsed that they attempt to connect women presenting with concerns of violence to external services or professionals who may be able to provide them with more specialized support. The degree of involvement when doing so ranged from simply providing women with pamphlets for

community organizations to reaching out themselves–with the woman's permission–to ensure that the client was quickly connected to additional supports. The agencies that informants described frequently referring to include women's shelters, advocacy and sexual assault centres, and victim, police, violence against women, and specialized mental health services. Often, informants were able to name the specific organizations within their communities to which they might refer women experiencing violence.

When informants described potential steps to respond, address, and work with perpetrators around concerns of DV, the vast majority similarly indicated that they would refer these men to other services. Yet contrary to external referrals for women, they were unlikely to provide the names of specific agencies or organizations. Instead, informants spoke more generally about "encouraging patients to seek treatment," "directing people towards things and resources," and "involving other agencies" (Informants 2, 7, and 14). Many informants agreed that they "need more education and more programs for perpetrators" (Inf. 16).

When discussing their work with women who had children, every single informant mentioned, to some degree, their duty to report these cases to the Children's Aid Society (CAS). Some informants described their duty to report as their default plan of action, negating the need to collect additional information or clarify the situation at hand: "We don't necessarily have to assess the risk in those situations…we just need to have a reasonable suspicion and then we can make the referrals" (Inf. 11). In some cases, the decision to report was described as being based on the mother's ability to protect her children, disregarding the fact that she herself was a victim: "If I felt that the mother wasn't appropriately or unable to–for whatever reason–help protect the kids, then definitely Children's Aid" (Inf. 3). Other informants explained that their duty to report, in the context of DV, is often a "grey zone," and that they attempt to balance out the risk of reporting to the individual presenting for services, as well as to that individual's family members, especially their children (Inf. 2). Nevertheless, reporting to CAS is described as a staple action item for general providers. As one informant put it, "the challenge when you involve CAS is often you've alienated the mother, so it becomes this really dicey situation. But, keeping in line, our obligation is to keep the children safe, right?" (Inf. 1).

Blocking the Door: Barriers to an Effective Domestic Violence Response

Informants described several factors that impede their ability to address concerns of DV and prevent them from even entering the DV supply room in the first place. Barriers mentioned

by informants included a lack of trust (in services, in systems, in helping professionals) by clients and providers alike, a lack of resources, and several systemic shortfalls.

Numerous informants reported that they frequently experience a lack of trust between clients and clinicians which impedes the process of both clients disclosing, and practitioners addressing, abuse. One informant noted that, even when they suspect DV, they are often powerless in their response if a woman chooses not to report any concerns: "If the person feels that they are safe, I can't do anything…assuming that they're competent" (Inf. 1). Additionally, in the context of the initial, isolated, and short visits that typically characterize general care practice, it is difficult to communicate outcomes and build care and trust between service providers and clients:

> One of the issues we had was with asking these questions in an initial interview, because families don't trust and have not developed a relationship with you. Families don't want to say these things because it is reportable. (Inf. 9)

Over and above mistrust on the part of the clients, informants reported their own lack of trust in the existing systems. The worry is that current systems are neither coordinated nor organized, and therefore inadequate, to help women even if they, as clinicians, attempt to get them help. The difficulty, unease, and lack of clarity in navigating the greater system–not only for women, but for service providers and practitioners–leads to overall cynicism: "I wish they'd make it easier. I need to walk [women] through it [to access services] and have to get higher authorities involved before they can access. It's a brick wall and red tape […] the system is overloaded" (Inf. 12). One informant described a situation in which they were unable to help a woman qualify for needed services due to bureaucratic reasons: "The woman herself had charges–she was considered a perpetrator–and was not eligible for service with [community organizations…] she got swapped up in charges that really belong to her husband […] She still remains at risk from him" (Inf. 7). On top of mistrust, informants described that their organizations are generally lacking the resources to ensure necessary training and supports: "[We] neither have the expertise, the staff, nor the money" (Inf. 4). Even those institutions that "believe in training staff around violence" are described as having difficulty "doing it in the new budgetary way," resulting in it being more and more "impossible" to continue training doctors, nurses, and other generalists in responding to DV.

Finally, informants reported several systemic shortfalls related to the context of their work in a general care setting that get in the way of an effective response to DV. One informant,

speaking from their role in an emergency setting that necessitates quick and efficient treatment, explained that "it's not that I don't want to…it's just time" (Inf. 17). Others noted that the process of querying and responding to violence would add an extra layer of paperwork that "would be far too much" (Inf. 15). Additional systemic barriers centred around the structure of service provision. For example, one informant touched upon the nuances of client care in a hospital setting, noting, "It's tricky–they have to be a patient of the hospital. We've had cases where it's been disclosed that the partner is abusing and they're there, but we can't do anything unless they're a patient" (Inf. 3). Overall, general mental health and healthcare was described by informants as a system that often neglects to assess the whole person within the context of their relationships and environment, resulting in mis-appropriated services and an inability to appropriately respond to DV.

4. Discussion

This research study sought to examine current practices, attitudes, and perspectives of general health and mental health service providers across Canada as they relate to assessing and responding to DV. An analysis of interviews with 17 informants revealed consistencies–both encouraging trends and glaring absences–in the manner that these professionals understand, talk about, and address risk and safety.

Promising Practices

The present study reflected some promising practices in generalists' understanding of DV. Informants demonstrated a sufficient knowledge of potential behavioural indicators of abuse, such as increased use of health services, implausibly explained physical injuries, and deference to a partner, as well as specific evidence-based risk factors, such as recent separation, excessive alcohol and/or drug use, financial strain, and prior history of violence. In light of widespread calls over the past decade for broader knowledge about DV in health and social services, these are encouraging findings. Also consistent with guidelines for generalist service providers (VEGA Project, 2019), many informants described their capacity to refer community and specialist services for women presenting with concerns of DV, though referral sources were often only vaguely described.

Gaps in Service

The results also revealed gaps in general service providers' knowledge of DV. Lacking was a comprehensive understanding of the needs of children and perpetrators as well as a

consistent application of the nuances of working with diverse populations. While informants frequently referenced mandatory reporting regulations in the context of working with women who had children, there was no mention of child-specific risk assessment and management practices and limited focus on effectively addressing children's needs. This is consistent with prior findings in both generalist and specialist services (Reif, 2020). Informants similarly reported that the perpetration of DV by clients is largely unaddressed in their work, despite the growing literature suggesting high co-occurring rates of mental health problems, violence perpetration, and service use (Scott et al., 2020; Shorey et al., 2012). Furthermore, only a handful of informants endorsed those aspects of response that appreciate intersectionality, involve reflexivity, and allow for a more tailored approach that considers cultural and lived experiences. The present data, along with recent work examining the unmet health needs of distinct populations in Canada, demonstrates the implicit and explicit bias and racism that prevails in general care (Kitching et al., 2020; Marchand et al., 2015; Nelson & Wilson, 2018). Informants, through anecdotal examples, described the stigma and discrimination experienced by clients who were disadvantaged primarily because of differences in social positioning related to factors of class, gender, and ethnicity which, in turn, influenced the quality of care that generalists provided after disclosures or suspicions of DV. The impact of these prejudices has the potential to be all the more damaging in the context of DV given the already heightened risk of Indigenous and newcomer populations in the victimization and perpetration of violence–vulnerabilities that largely exist in the first place because of discrimination, colonialism, and racism (Garcia-Moreno et al., 2015).

Thus far, this discussion has considered individual-level factors relating to the knowledge, attitudes, and skills of independent general service providers. Yet, perhaps the most relevant and concerning implications of the present study are those related to the systems and structures–those items on the step ladder–that are (or are not) in place to support DV responses in general care settings. Of greatest significance, the present results suggest that a *consistent* and *empirically supported* approach to DV assessment and response is rare to find across generalist service provision. Most informants were unable to provide any description of well-defined institutional or organizational guidelines governing their response to DV. This is critical as general service providers, including nurses and mental health clinicians, have elsewhere recognized formal training and standardized procedures as key facilitators to improved DV practices (Beynon et al., 2012; Burns et al., 2021; Leppakoski et al., 2014; Olive, 2007). Yet,

these supports were reported as inconsistent or even absent in the present sample. In lieu of relying on protocols and training, interviews revealed an overreliance on experience in the field; informants endorsed acquiring DV knowledge primarily by learning on the job and described being dependent on experienced clinicians to direct DV follow-up. Prior work has similarly demonstrated that more experienced (and often older) clinicians are more likely to inquire about DV and report greater comfort when working with women experiencing violence (Beynon et al., 2012). In reality, both formal organizational supports and individual experience are associated with practitioners' increased feelings of preparedness, self-confidence, and control, as well as decreased feelings of anxiety when responding to DV (Gutmanis et al., 2007). However, whereas experience is indispensable to improving one's ability to respond, this accumulation of knowledge in generalist provision often relies on a *few* individuals who possess a combination of many years in practice, prior specialization in DV-related roles, and personal life experience–all easily undermined by changes in personnel. Training and guidelines, on the other hand, have the potential to be implemented at an organizational level to improve the responses of *many* providers. These, however, are often contingent on institutional and systemic priorities that may not yet exist (Garcia-Moreno & Watts, 2011; Rutherford et al., 2007).

Implications

Efforts to improve the DV response in general care have largely focused on individual-level change, using educational campaigns that target service providers' knowledge and attitudes (Turner et al., 2017; VEGA Project, 2019). The present study likewise highlights a continued need for increased individual knowledge specifically related to working with children and perpetrators. Yet, even more strikingly, these results suggest that further improvement in generalists' responses to DV necessitates top-down change at a *system*-level. Individual practitioners in the present study, for the most part, possess the basic knowledge to identify DV and ascertain when a more extensive course of action is needed. What is required to guide practice beyond this point is a closer examination of existing organizational practices, as well as the reinforcement of inter-organizational collaboration between generalist and specialist services. In lieu of focusing solely on increasing individual knowledge, organizations–as well as the greater system–must bear the responsibility of ensuring the fundamental conditions that allow providers to confidently respond to DV. This should include, as several examples, transparent referral networks, clear guidelines and protocols, regular training with feedback mechanisms and established trainers, boundary individuals to bridge connections between services, strong

leadership, and the overall prioritization of DV as a key healthcare issue (Basu & Ratcliffe, 2014; Dowrick et al., 2019; Garcia Moreno, Zimmerman, et al., 2015; Leppakoski et al., 2014). Relatedly, the present study revealed barriers to health equity that were reinforced at the level of both individuals, through racism, and systems, in the form of structural violence. Indeed, shortfalls in institutional policies and priorities are often linked to gaps in individual practice. Addressing such concerns, for example, might involve training that introduces practitioners to equity-oriented and trauma- and violence-informed care. Such a change is reflective of the prioritization of DV at a system-level such that even the dissemination of knowledge to providers extends beyond individual risk factors and appreciates that violence is strongly related to health inequity, social determinants of health, and social justice (Ford-Gilboe et al., 2018; Varcoe et al., 2014). Overall, improving the DV response in general service provision will require a broadening of the lens beyond that of the individual practitioner and towards the system at large.

Limitations

This study should be reviewed in the context of its limitations. Although all informants hailed from general health and mental health services, there was significant variability in their specific roles, their experiences, and the populations with which they work. Some informants reported working at multiple agencies, either presently or in the past; thus, their answers may have reflected prior experiences. Furthermore, the present sample included informants from both health and mental health sectors–settings which may present with inherent differences in barriers, attitudes, and practices. In considering sample selection, it is also important to acknowledge that informants who agreed to participate in this study may have been more motivated to take part in work addressing violence relative to those who did not agree to participate and who may otherwise have lower engagement with the issue of DV. Most informants also reported working in Ontario, limiting the generalizability of these findings to service provision across Canada. With regard to the present methodology, interviews were conducted by several graduate research assistants who likely varied in interviewing technique and may have differed with respect to the amount of prompting used, adherence to the interview script, and the type of information they elicited from informants. Despite the anonymous nature of interviews, it is also plausible that some informants may have wanted to present their agency in a positive light and minimized shortcomings. For example, nearly all informants described adhering to mandatory reporting regulations whenever they became aware of children in the context of DV. Yet, data has suggested that despite often being the first professional line of

contact for many clients, a very low percentage of overall referrals to child protective agencies come from general health services (Huecker et al., 2021).

Future Directions

Future work should take care to sample a larger population that more evenly captures the perspectives of practitioners across Canada. Given that calls for improved knowledge and responses to DV extend to subsectors that were not included in the present sample, including but not limited to dentistry, optometry, occupational therapy, and physiotherapy (Ontario DVDRC, 2019), it will also be important to explore the DV-related practices within these areas. Considering the need for a multisectoral response to DV, it will furthermore be critical to determine key competencies that are expected (and present) in generalist versus specialist work. Creating efficient and effective cross-system collaboration will require specific knowledge of each sector's roles, responsibilities, and expertise. Further research in Canada's general health and mental health sector is also required to isolate the role of facilitating factors such as institutional policies and on-site DV advocates in the implementation and success of DV referral processes as a response to DV (Catallo et al., 2012). Regarding future directions in practice and education, it has been noted that current rates of inclusion of DV content in the Canadian medical and allied health professional curricula are low (Stewart et al., 2013). There is a need for systemwide uptake of DV education that should be provided early in the training of medical, nursing, psychology, public health, and other general care professionals. Beyond the improvement of individual-level knowledge, future work should consider alternate ways in which to assess effective multisectoral responses to DV, such as by examining the degree of collaboration between agencies and the effectiveness and efficiency of information sharing processes in high-risk cases (Hanson et al., 2016). Finally, informants' uncertainty when asked about referral pathways relevant for perpetrators, children, newcomers, and Indigenous clients reflects a need for more community services geared specifically towards these populations.

Conclusions

In sum, individuals experiencing and perpetrating DV are frequently in contact with the general healthcare system, which must be prepared to respond. Shedding light on current practices of general health service in this area reveals that providers are motivated to help individuals experiencing DV but frequently lack the organizational direction for an effective response. Individual knowledge-building alone will not suffice in improving general service

responses to DV; what is needed is system-level change. It is our hope that greater institutional prioritization of DV, in addition to improved collaboration and integration of generalist and specialist services, will result in improved DV outcomes.

References

Ahmad, I., Ali, P. A., Rehman, S., Talpur, A., Dhingra, K. (2017). Intimate partner violence screening in emergency department: A rapid review of the literature. *Journal of Clinical Nursing, 26*(21), 3271-3285. https://doi.org/10.1111/jocn.13706

Alshammari, K. F., McGarry, J., & Higginbottom, G. M. A. (2018). Nurse education and understanding related to domestic violence and abuse against women: An integrative review of the literature. *Nursing Open, 12*(5), 237-253. https://doi.org/10.1002/nop2.133

Arias, L., & Corso, P. (2005). Average cost per person victimized by an intimate partner of the opposite gender: A comparison of men and women. *Violence and Victims, 20*, 379–391. https://doi.org/10.1891/0886-6708.20.4.379

Austin, S., & Sutton, J. (2014). Qualitative research: Getting started. *Canadian Journal of Hospital Pharmacy, 67*(6), 436-40. https://doi.org/10.4212/cjhp.v67i6.1406

Basu, S., & Ratcliffe, G. (2014). Developing a multidisciplinary approach within the ED towards domestic violence presentations. *Emergency Medicine Journal, 31*(3), 192-5. http://dx.doi.org/10.1136/emermed-2012-201947

Beynon, C. E., Gutmanis, I. A., Tutty, L. M., Wathen, N., & MacMillan, H. L. (2012). Why physicians and nurses ask (or don't) about partner violence: A qualitative analysis. *BMC Public Health, 12*(473). https://doi.org/10.1186/1471-2458-12-473

Bonomi, A. E., Holt, V. L., Martin, D. P., & Thompson, R. S. (2006). Severity of intimate partner violence and occurrence and frequency of police calls. *Journal of Interpersonal Violence, 21*, 1354-64. https://doi.org/10.1177/0886260506291656

Brownridge, D. A., Taillieu, T., Afifi, T., Chan, K. L., Emery, C., Lavoie, J., & Elgar, F. (2017). Child maltreatment and intimate partner violence among Indigenous and non-Indigenous Canadians. *Journal of Family Violence, 32*, 607-619. https://doi.org/10.1007/s10896-016-9880-5

Burns, S. C., Kogan, C. S., Heyman, R. E., Foran, H. M., Smith Slep, A. M., Dominguez-Martinez, T., Grenier, J., Matsumoto, C., & Reed, G. M. (2020). Exploring mental health professionals' experiences of intimate partner violence-related training: Results from a global survey. *Journal of Interpersonal Violence*, 1-27. https://doi.org/10.1177%2F0886260520908020

Burns, S. C., Kogan, C. S., Heyman, R. E., Foran, H. M., Smith Slep, A. M., Dominguez-

Martinez, T., Grenier, J., Matsumoto, C., & Reed, G. M. (2021). Evaluating the relationship between intimate partner violence-related training and mental health professionals' assessment of relationship problems. *Journal of Interpersonal Violence*. https://doi.org/10.1177%2F08862605211005154

Campbell, J. C. (2002). Health consequences of intimate partner violence. *The Lancet, 359*(9314), 1331-1336. https://doi.org/10.1016/S0140-6736(02)08336-8

Canadian Centre for Justice and Community Safety Statistics (2020). *Police-reported crime statistics in Canada, 2019.* Retrieved from: https://www150.statcan.gc.ca/n1/pub/85-002-x/2020001/article/00010-eng.htm

Canadian Women's Foundation (2016). *Fact sheet: Moving women out of violence.* [Fact sheet]. Retrieved from: https://canadianwomen.org/wp-content/uploads/2017/09/FactSheet-VAWandDV_Feb_2018-Update.pdf

Catallo, C., Jack, S. M., Ciliska, D., & MacMillan, H. L. (2012). Minimizing the risk of intrusion: A grounded theory of intimate partner violence disclosure in emergency departments. *Journal of Advanced Nursing, 69*(6), 1366-76. https://doi.org/10.1111/j.1365-2648.2012.06128.x

Charmaz, K. (2006). *Constructing grounded theory: A practical guide through qualitative analysis.* Sage Publications.

Dawson, M., Sutton, D., Jaffe, P., Straatman, A., Poon, J., Gosse, M., Peters, O., & Sandhu, G. (2018). *One Is Too Many: Trends and Patterns in Domestic Homicides in Canada 2010-2015*. Guelph, ON: Canadian Domestic Homicide Prevention Initiative with Vulnerable Populations.

Delara, M. (2016). Mental health consequences and risk factor of physical intimate partner violence. *Mental Health in Family Medicine, 12*, 119-25. https://doi.org/10.1177/1077801208319283

Dowrick, A., Kelly, M., & Feder, G. (2020). Boundary spanners: Negotiating connections across primary care and domestic violence and abuse services. *Social Science & Medicine, 245*. https://doi.org/10.1016/j.socscimed.2019.112687

Eisner, E. W. (1997). The promise and perils of alternative forms of data representation. *Educational Researcher, 26*)6, 4-10.

Feder, G., Hutson, M., & Ramsay, J. (2006). Women exposed to intimate partner violence:

Expectations and experiences when they encounter health care professionals: A meta-analysis of qualitative studies. *Archives of Internal Medicine, 166*(1), 22-37. https://doi.org/10.1001/archinte.166.1.22

Flick, U. (2009). *An Introduction to Qualitative Research* (4th ed.). Sage Publications.

Fontana, A., & Frey, J. H. (2003). The interview: From structured questions to negotiated text. In N. K. Denzin & Y. S. Lincoln (Eds.) Collecting and interpreting qualitative materials. California: Sage Publications.

Ford-Gilboe, M., Wathen, C. N., Varcoe, C., Herbert, C., Jackson, B. E., Lavoie, J. G., Pauly, B., Perrin, N. A., Smye, V., Wallace, B., Wong, S. T., & Browne, A. J. (2018). How equity-oriented health care affects health: Key mechanisms and implications for primary health care practice and policy. *The Milbank Quarterly, 00*(0), 1-37.

Garcia-Moreno, C., Hegarty, K., Lucas d'Oliveira, A. F., Koziol-McLain, J., Colombini, M., & Feder, G. (2015). The health-systems response to violence against women. *The Lancet, 385*, 1567-1578. https://doi.org/10.1016/s0140-6736(14)61837-7

Garcia-Moreno, C., & Watts, C. (2011). Violence against women: An urgent public health priority. *Bulletin of the World Health Organization, 89*(1). https://doi.org/10.2471/blt.10.085217

Garcia-Moreno, C., Zimmerman, C., Morris-Gehring, A., Heise, L., Amin, A., Abrahams, N., Montoya, O., Bhate-Deosthali, P., Kilonzo, & Watts, C. (2015). Addressing violence against women: A call to action. *The Lancet, 385*(9978), 1685-95. https://doi.org/10.1016/s0140-6736(14)61830-4

Guillery, M. E., Benzies, K. M., Mannion, C., & Evans, S. (2012). Postpartum nurses' perceptions of barriers to screening for intimae partner violence: A cross-sectional survey. *BMC Nursing, 11*(2). https://doi.org/10.1186/1472-6955-11-2

Gutmanis, I., Beynon, C., Tutty, L., Wathen. N., & MacMillan, H. L. (2007). Factors influencing identification of and response to intimate partner violence: A survey of physicians and nurses. *BMC Public Health, 7*(12), 1-11. https://doi.org/10.1186/1471-2458-7-12

Hanson, M. D., Wathen, N., & MacMillan, H. L. (2016). The case for intimate partner violence education: Early, essential and evidence-based. *Medical Education, 50*, 1087-1093.

Huecker, M. R., King, K. C., Jordan, G. A., & Smock, W. (2021). *Domestic violence. StatPearls Publishing.* Retrieved from: https://www.ncbi.nlm.nih.gov/books/NBK499891/

Kitching, G. T., Firestone, M., Schei, B., Wolfe, S., Bourgeois, C., O'Campo, P., Rotondi, M.,

Nisenbaum, R., Maddox, R., & Smylie, J. (2020). Unmet health needs and discrimination by healthcare providers among an Indigenous population in Toronto, Canada. *Canadian Journal of Public Health, 111*, 40-49. https://doi.org/10.17269/s41997-019-00242-z

Lengler, R., & Eppler, M. J. (2007). *Towards a Periodic Table of Visualization Methods for Management.* IASTED Proceedings of the Conference on Graphics and Visualization in Engineering (GVE 2007), Clearwater, FL.

Leppakoski, T., Flinck, A., & Paavilainen, E. (2014) Assessing and enhancing health care providers' response to domestic violence. *Nursing Research and Practice, 4*. http://dx.doi.org/10.1155/2014/759682

Lockhart, L. L., & Mitchell, J. (2010). Cultural competence and intersectionality: Emerging frameworks and practical approaches. In L. L. Kockhart & F. S. Danis (Eds.) *Domestic Violence: Intersectionality and Culturally Competent Practice* (pp. 1-28). Columbia University Press.

Macy, R. J., Ferron, J., & Crosby, C. (2009). Partner violence and survivors' chronic health problems: Informing social work practice. *Social Work, 54*, 29-43. https://doi.org/10.1093/sw/54.1.29

Marchand, K., Palis, H., & Oviedo-Joekes, E. (2015). Patient perceptions of prejudice and discrimination by health care providers and its relationship with mental disorders: Results from the 2012 Canadian community health-mental health survey data. *Journal of Community Mental Health, 52*, 294-301. https://doi.org/10.1007/s10597-015-9949-2

Nelson, S. E., & Wilson, K. (2018). Understanding barriers to health care access through cultural safety and ethical space: Indigenous people's experiences in Prince George, Canada. *Social Science & Medicine, 218*, 21-27. https://doi.org/10.1016/j.socscimed.2018.09.017

Okeke-Ihejirika, P., Yohani, S., Muster, J., Ndem, A., Chambers, T., & Pow, V. (2018). A scoping review on intimate partner violence in Canada's immigrant communities. *Trauma, Violence, & Abuse, 21*(4), 788-810. https://doi.org/10.1177%2F1524838018789156

Olive, P. (2007). Care for emergency department patients who have experienced domestic violence: A review of the evidence base. *Journal of Clinical Nursing, 16*(9), 1736-48. http://dx.doi.org/10.1111/j.1365-2702.2007.01746.x

Ontario Domestic Violence Death Review Committee (DVDRC). (2019). *Domestic Violence*

Death Review Committee 2018 annual report. Toronto, ON: Office of the Chief Coroner. Retrieved from: https://www.mcscs.jus.gov.on.ca/english/Deathinvestigations/OfficeChiefCoroner/Public ationsandreports/DVDRC2018Report.html

Reif, K., Jaffe, P., Dawson, M., & Straatman, A. (2020). Provision of specialized services for children exposed to domestic violence: Barriers encountered in Violence Against Women (VAW) services. *Children and Youth Services Review, 109,* 1-10. http://dx.doi.org/10.1016/j.childyouth.2019.104684

Rose, D., Trevillion, K., Woodall, A., Morgan, C., Feder, G., & Howard, L. (2011). Barriers and facilitators of disclosures of domestic violence by mental health service users: Qualitative study. The British Journal of Psychiatry, *198*, 189-194. https://doi.org/10.1192/bjp.bp.109.072389

Rutherford, A., Zwi, A. B., Grove, N. J., & Butchart, A. (2007). Violence: A priority for public health? (Part 2). *Journal of Epidemiology and Community Health, 61*(9), 764-770. https://dx.doi.org/10.1136%2Fjech.2006.049072

Saldana, J. (2011). *Fundamentals of qualitative research*. Oxford University Press.

Scott, K., Oliver, C. L., & Cheng, P. (2020). Perpetrator mental health: Depression and suicidality as risk factors for domestic homicide. In P. Jaffe, K. Scott, & A. Straatman (Eds.) *Preventing Domestic Homicides: Lessons Learned From Tragedies* (pp. 137-158). Academic Press.

Shorey, R. C., Febres, J., Brasfield, H., & Stuart, G. L. (2012). Prevalence of mental health problems in men arrested for domestic violence. *Journal of Family Violence, 27*, 741-748.

Statistics Canada. (2018). *Family violence in Canada: A statistical profile, 2016: Section 3: Police-reported intimate partner violence.* Juristat, Statistics Canada Catalogue no. 85-002-X. Retrieved from: https://www150.statcan.gc.ca/n1/pub/85-002-x/2018001/article/54893/03-eng.htm

Statistics Canada. (2021). *Family violence in Canada: A statistical profile, 2019.* Juristat, Statistics Canada Catalogue no. 85-002-X. Retrieved from: https://www150.statcan.gc.ca/n1/en/catalogue/85-002-X202100100001

Stewart, D. E., MacMillan, H., & Kimber, M. (2021). Recognizing and responding to intimate

partner violence: An update. *Canadian Journal of Psychiatry, 66*(1), 74-109. https://doi.org/10.1177%2F0706743720939676

Stewart, D. E., MacMillan, H., & Wathen, N. (2013). Intimate partner violence. *The Canadian Journal of Psychiatry*, *58*(6), 1-15. https://doi.org/10.1177%2F0706743713058006001

Symes, L., Maddoux, J., McFarlane, J., Nava, A., & Gilroy, H. (2014). Physical and sexual intimate partner violence, women's health and children's behavioural functioning: Entry analysis of a seven-year prospective study. *Journal of Clinical Nursing, 23*, 2909-18. https://doi.org/10.1111/jocn.12542

Symington, A. (2004). Intersectionality: A tool for gender and economic justice. *Women's Rights and Economic Change, 9,* 1–8.

Tower, L. E. (2006). Barriers in screening women for domestic violence: A survey of social workers, family practitioners, and obstetrician-gynecologists. *Journal of Family Violence, 21*, 245-257. https://doi.org/10.1007/s10896-006-9024-4

Turner, W., Hester, M., Broad, J., Szilassy, E., Feder, G., Drinkwater, J., Firth, A., & Stanley, N. (2017). Interventions to improve the response of professionals to children exposed to domestic violence and abuse: A systematic review. *Child Abuse Review, 26*(1), 19-39. https://doi.org/10.1002/car.2385

Varcoe, C., Browne, A. J., & Cender, L. M. (2014). Promoting social justice and equity by practicing nursing to address structural inequities and structural violence. In P. N. Kagan, M. C. Smith & P. L. Chinn (Eds.), *Philosophies and Practices of Emancipatory Nursing: Social Justice as Praxis* (pp. 266–284). Routledge.

VEGA Project. (2019). Recognizing and responding safely to family violence. McMaster University. Retrieved from: https://vegaproject.mcmaster.ca

Verdinelli, S., & Scagnoli, N. I. (2013). Data display in qualitative research. *International Journal of Qualitative Methods, 12*, 359-381.

World Health Organization (2013). *Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines.* Geneva: World Health Organization. Retrieved from: https://www.who.int/reproductivehealth/publications/violence/9789241548595/en/

Wathen, N. (2012). *Health impacts of violent victimization on women and their children.* Research and Statistics Division, Department of Justice Canada. Retrieved from: https://www.justice.gc.ca/eng/rp-pr/cj-jp/fv-vf/rr12_12/rr12_12.pdf

Appendix A: Interview Guide

Canadian Domestic Homicide
Prevention Initiative

Section A: Setting up the interview

Hello. My name is __.

Thank you for agreeing to participate in this research interview regarding domestic violence risk assessment, risk management and safety planning. This interview is being conducted as part of the Canadian Domestic Homicide Prevention Initiative with Vulnerable Populations. The Co-Directors are Dr. Peter Jaffe and Dr. Myrna Dawson, and the local Co-Investigator is __.

This interview asks about your knowledge and use of risk assessment, risk management, and safety planning strategies and tools, focusing on four populations identified as experiencing increased vulnerability for domestic homicide: Indigenous, immigrants and refugees, rural, remote, and northern populations, and children exposed to domestic violence. I will be asking you about risk factors, barriers to effective risk management and safety planning, and strategies currently being used with these vulnerable groups and the communities in which they live. Some questions I will ask may have you focus on specific cases you have dealt with in your work and may trigger emotional responses. Do you have a colleague or supervisor that you can debrief with if this does occur?

Before we begin, I want to make sure we've walked through the informed consent and that you have had an opportunity to have any questions addressed. Have you received and read the Information Letter and Consent form for Interview? Do you have any questions at this time?

Along with the informed consent, we sent you our definitions of risk assessment, risk management, and safety planning to review. Do you happen to have the definitions in front of you as we will ask for feedback later in the interview?

With your permission, I am going to audio record this interview for transcription purposes only. The audio recording will be destroyed at the end of the study. Do I have your permission to record this interview? This interview will take about 30 minutes to complete. You are free to withdraw from the interview at any time. If we run out of time, and you wish to complete the interview, do I have your permission to contact you at a later date to complete the interview?

Section B: Questions

Now I would like to ask you a few questions about where you work and the kind of work you do.

1. What province or territory of Canada do you work in?
2. Which sector do you work in? (e.g., VAW, family law, police, victim services, health, education, settlement services)
3. What is the name of the agency or organization that you work for?
4. Where is your agency/organization located? [Please note your agency will not be named in any reports].
5. What is your job title?
6. What does your role as [job title] entail?
7. How long have you been doing work related to domestic violence?

Risk Assessment

I'm now going to ask you some questions about risk assessment. We define risk assessment as involving an evaluation of the level of risk a victim of domestic violence may be facing including the likelihood of repeated or lethal violence. It may be based on a professional's judgment based on their experience in the field and/or a structured interview and/or an assessment tool/instrument that may include a checklist of risk factors.

8. Do you have any feedback on our definition of risk assessment? For example, is this a definition that you would use in the context of your work?
9. In your role, do you conduct risk assessments as we described? *If no*, who does (e.g., referral to another organization, frontline professionals in the organization)? *If yes:*
   a) Do you use your professional judgment in risk assessment? Please explain.
   b) Do you use a structured interview? If yes, please describe the structured interview.
   c) Do you use a structured tool/instrument? *If yes*, what tool(s) do you use?
   d) Did you receive training on this tool(s)? *If yes*, who conducted the training?
      How many trainings did you receive? (e.g., refresher training)
10. Is conducting a risk assessment mandatory or optional in your organization/role? (e.g. only done when charges are laid)
11. If someone is deemed to be high risk, what happens next in terms of information sharing and interventions?
12. Are there any written documents/directives (e.g., policies, protocols) that guide risk assessment within your organization? Please elaborate.
13. Are the victim's perceptions of safety considered in the risk assessment? Please elaborate.
14. If children are present, is there an automatic referral to child protection? Please elaborate.
15. Are children included in the risk assessment? Please elaborate.

16. Do you collaborate with other organizations when assessing risk? *If yes*, which ones?

Risk Management

I'm now going to ask you some questions about risk management. Our definition of risk management refers to strategies to reduce the risk presented by a perpetrator of domestic violence such as close monitoring or supervision and/or counselling to address the violence and/or related issues (e.g., mental health, addictions).

17. Do you have any feedback on our definition of risk management? For example, is this a definition that you would use in the context of your work?
18. In your role, do you engage in risk management strategies? *If no*, who does (e.g., referral to another person in agency or another agency)? *If yes…*
   a) What are the strategies you use?
   b) Did you receive training in risk management? *If yes*, who conducted the training?
      If yes, how many trainings did you receive? (e.g., refresher training)
19. Are there any written documents/directives (e.g., policies, protocols) that guide risk management within your organization? Please elaborate.
20. Do you collaborate with other organizations regarding risk management? *If yes*, which ones?

Safety Planning

I'm now going to ask you some questions about safety planning. We define safety planning as finding strategies to protect the victim that may include such actions as educating victims about their level of risk, a change in residence, an alarm for a higher priority police response, a different work arrangement and/or readily accessible items needed to leave the home in an emergency including contact information about local domestic violence resources.

21. Do you have any feedback on our definition of safety planning? For example, is this a definition that you would use in the context of your work?
22. In your role, do you provide safety plans for victims? Please elaborate. *If no*, who does so (e.g., referral to another agency, frontline professionals in the organization)? *If yes…*
   a) What are the strategies you use?
   b) Did you receive training on safety planning? *If yes*, who conducted the training? How many trainings did you receive? (e.g., refresher training)
23. Are there any written documents/directives (e.g., policies, protocols) that guide safety planning within your organization? Please elaborate.
24. Are children included in the safety plan? Please elaborate.
25. Do you collaborate with other organizations around safety planning? If yes, which ones?

Unique Challenges for Vulnerable Populations

26. Do you work with individuals who fit into one or more of the following groups: Indigenous people; immigrants and refugees; rural; northern and remote communities; children exposed to domestic violence? If yes, how do you become involved with these clients? (e.g. referral; community outreach; voluntary; mandatory)

[Note to interviewer: For each vulnerable population identified in question 26, ask the following questions. If none identified, skip to question 28.

27. You indicated that you work with (name all that apply):
    o   Indigenous people
    o   immigrants and refugees
    o   rural, northern and remote communities
    o   children exposed to domestic violence

[Note to interviewer – for each of the follow up questions, prompt participant to address the population(s) they have the most experience with and then address the others if there is more time – when discussing multiple populations some answers may overlap, some will be different.]

    a) What are the challenges dealing with domestic violence within these particular populations?
    b) What are some unique risk factors for lethality among these populations?
    c) What are some helpful promising practices? (Including specific risk assessment tools, risk management and safety planning strategies that address vulnerabilities.)

28. Do you know of any agency or government policies or guidelines and/or academic papers related to risk assessment, risk management and safety planning particularly among vulnerable populations? If yes, what are they?

29. Without using names, do you know of any case illustrations (synopses) where interventions (risk assessment, risk management, and/or safety planning) may have saved a life? If yes, can you tell me about this?

30. Has there been a domestic homicide from your region profiled in the media recently? Did the media coverage offer any insights to risk factors, or risk assessment, management or safety planning strategies that would be helpful for others to know about? If so, can you tell me about it? Are you able to provide the names of the parties involved?

That is the end of the interview questions. Do you have any other comments you would like to make?

Thank you very much for participating in this interview. Your answers have been very helpful. More information about this research study is available on our website at www.cdhpi.ca

If you have any questions about the study, please contact Dr. Jaffe or Dr. Dawson.

Appendix B: Codebook

Parent Code	Child Code	Sample Excerpts
Risk Assessment, Risk Management, and Safety Planning6	Accumulating domestic violence knowledge	"I wouldn't say that I have necessarily had formal training in risk management it's more of something that I've kind of come by informally through my time at volunteering at changing ways and the child development institute and my post graduate studies talking these issues in consultation with a supervision over time and reading research its really been I would say more of an informal kind of learning process it might be valuable for those starting out in the field or even those in the field currently if there was a formal risk management process developed to offer that to agencies and service providers and therapists who are working with couples. I think that would be useful." –Inf. 5 "You know what specifically with for DV no like I have done my own kind of different risk assessment tools and actually going to that's where I start to feel like we really have a gap. It has been quite a while since I was specifically looking at DV and the risk factors involved I feel like we really could use some more training around that just to like bring our awareness to that again." –Inf. 8
	Comfort with, and knowledge around, domestic violence issues	"…I would say the average counsellor wouldn't know those things […] we're not specifically interpersonal violence informed." –Inf. 10 "I know how important the risk assessment is so I do it a lot but I don't think that everybody else does necessarily understand. So when you asked if I've received training I said no and I don't think anybody does. So for people who haven't worked in the field before they maybe don't know how important it is to do that. I would say I make it mandatory for myself but I don't think anyone really checks up on it." –Inf. 16
	Barriers to service	"In healthcare, because it is so medically focused sometimes I find that they are really just focused on treating the patients, the client, so I am talking more on an acute care lens, so sometimes they don't, they being, other professionals aren't paying attention to some of the signs or symptoms or information that might be happening to the family or the system. It is more focused on this individual, the patient who is in front of them and how they need to treat him or her." –Inf. 17

		"That's where I find my job really difficult. I mean the work itself is hard enough as it is because it's so trauma-based but it's the systems that are so challenging. Access to court, access to lawyers, access to doctors… there's so many people in this city who don't have a doctor. Those things really frustrate me […] I think that our mental health, we're not doing such a very good job." –Inf. 11 "That was one of the issues we had with asking these questions in an initial interview because families don't trust and have not developed a relationship with you." –Inf. 9
	Using professional judgment	"It's the grey areas where you have to use your gut feeling and your judgment […] 'cause what if you think that something is going on but they're denying it? That's when you have to use your professional judgment and kind of investigate a little bit more. Is there history of abuse in the relationship? Are you fearful? Has he hurt you in the past? Does he drink? You know, these things that would be more of a red flag. Health care is an interesting place because you get to see people when they're at their worst – they're worried. So is that male partner – and I'm going to be using violence against women rights – is the male partner following her into the operating room out of concern or is she afraid that she's going to say something as soon as he's out of earshot? So those kinds of things. I think professional judgment comes into with experience too. And as you get older you kind of know what a healthy relationship is too." –Inf. 3
	Engaging with the perpetrator – How are men seen and talked about?	"I know I have a perpetrator on my caseload. So I will often ask questions on what's happening at home, but that's not really within my scope of practice and I don't do counselling, like I'm not monitoring or supervising the perpetrator." –Inf. 10 "Unfortunately, I don't do a lot of work with perpetrator. I guess my major feedback would be not enough work do work with perpetrators there aren't enough services for perpetrators." –Inf. 16
	Engaging with the perpetrator – What do they do with men who harm?	"If they are threat to themselves or others then asking more questions. Looking at anger management, looking at how they are coping overall with stress." –Inf. 1 "I don't know where I would refer them for management. I think I would consult with their probation officer but you know it's an interesting thing, when you ask the question, who does indeed do the monitoring?" –Inf. 7

		"I would probably just say maybe [refer to] the police. I think just a referral […] not really a collaboration." –Inf. 16
	Working with women – Knowing about and listening for risk factors	"I have seen women, it is all hidden under their clothing. Unless they have their head smashed in or they have a lot of head trauma, then you have the protruding eyes and the crooked jaws. But usually, physical abuse is all under your clothes. But there are all sorts of things, if a woman lowers her center of gravity to below her knees, how come they can't recognize that that is a sign that she is either torn or very hurt? If a victim of abuse continually apologizes, that is a form, that right away is an indicator that they are abused; somebody who continually apologizes for a very small thing." –Inf. 15
		"I base that on what the women's narrative have brought me. Is there alcohol involved with her partner is she herself judging herself at risk, where is it that she is living. If she when I need her is living in a shelter I am not as concerned and I know they are doing safety planning but if she is living at her mother's I am a bit more concerned. Is there extra vulnerabilities that she has? Does she have alcohol involved, drugs involved this sort of thing has there been repeated occurrences of this violence, has there been repeated separation of the couple. Is he a hunter here the problem is in a very rural community everybody is got guns. Have the police taken those guns away if they were involved in the violence. That sort of thing. Where the guy is now is he awaiting bail. Those are the things that I look at." –Inf. 7
	Working with women – Safety Planning	"I'll often refer to the shelter. I'm constantly - I'll refer them to the people who can help them all the time 'cause I also have to do addiction counselling. So I'll often refer to a couple of our resources here in the city." –Inf. 10
		"We do lots of education and encouragement and, you know, just take a lot of time with our clients because obviously it takes time to build trust…it also takes time for people to get ready to think about leaving. So, we are very aware of that and so we follow up." –Inf. 14
		"We do it–the safety–in terms of having some discussions with her. Talking to her, making sure that she is able to open up in a safe environment." –Inf. 4

		"Then looking at some of the immediate stuff, what to do if he comes home and he is drunk or he is really angry – so not to back themselves in a room with no or only one exit, making sure that they have money stored away, they have their own legal documents that they are planning or anticipating something might happen. Do they have a contact person that knows what is going on that they can call at any time of the day or night. Do they know where the shelters are, have they called police, have they got a restraining order. So if they're thinking of leaving knowing how to leave quickly" –Inf. 1
	Working with women – Considering women's knowledge about their own risk	"My experience is that the majority of women underestimate the harm to themselves. The majority of women. Only about 10-20% correctly estimate the danger to themselves. The majority is underestimating. They will say "I told him, if he hits me once again, I will leave him forever". They don't realize that yes, you told him but that doesn't mean he has bought into it." –Inf. 4 "Her perceptions are probably 90%, if I was going to put a percent on it, because I think that women are either very accurate or they undervalue how at risk they are. I haven't run across a lot of women and I work in mental health and I haven't worked with a lot of women that I thought, oh she is over the top… I find them quite accurate or a bit understated." –Inf. 7 Safety again is a very - that whole word is a complicated and complex tool. We are assuming that people know what it means to be safe when we do a safety assessment and I don't believe that's true at all. I think that we have to be careful about using that word, you know. I think a lot of times we say "are you safe?" Well what does that even mean? So I'm really careful about the language that I use and these women and children have been keeping themselves from danger as best as they can for sometimes decades, so I would argue they're the experts in this." –Inf. 11
	Processes, protocols, and guidelines	"The thing that sticks out – and I sound like I'm bragging about our hospital, but maybe I am – the higher up, like the management feels that this is important and so they encourage it, they are always thankful of the small committee but mighty committee that we've had for so many years and so there are posters around our hospital with the CEO saying "violence is a health care issue" and "please reach out if you need help", and "we do not tolerate violence." So I think that's impressive, it's not

		everywhere you see the CEO with violence on a poster on the elevator. And we do the White Ribbon campaign every year and the year we almost didn't do it, I got flak from the men – "No, I need to stand at the door and hand out white ribbons," I know it's little, but it's in their mind that it's important and some of the male staff bring their little kids to do it too." –Inf. 3
		"…for me on my team, the assessment-directed therapy team, we don't have a set risk assessment. We don't have anything that is standardized or structured […] we have structured risk assessments for suicidality however, in terms of domestic violence, I don't have anything structured that we use […] that's where I start to feel like we really have a gap." –Inf. 8
		"I guess the screen can be classified as a structured interview …] like I said I don't use it my current position, so I don't have the sheet with me so I don't have the questions in front of me nor do them there […] it's not something that's required by the health region." –Inf. 16
Vulnerable Populations– Inward Focused	Building relationships	"I guess I would say again making things more visible, helping to reach out to the immigrant population right from the get-go in their own languages, that's something else we lobby all the time is to have our various brochures and resources translated so that if they come seeking some help for a child that's anxious we can give them something that's written in their own language that they can understand and help put them into touch with someone who can help them within their own culture and language and that is something I would like to really see a lot more of, it is again as things are more visible there's more money, so we just need to keep it up front." –Inf. 13
	Collaboration with community supports	"In [local city], we've got the [cultural community resource centre] and that's a long term initiative; it's been about collaborating with the [community centre] about the services that they want and feel like they need and so I think that that's, you know, a really great shining example of what we need more of in terms of engaging immigrant and refugee communities to help them get organized to have community centers to help them feel like its okay for them to get together and celebrate their cultures […]" –Inf. 5
	Recognizing stigma or	"When you go to emergency, sometimes you can be left in the waiting room as a great big blubbering idiot, there

	perpetrating racism	is no – they somehow manage to catch that person and put them aside because everybody looks at them, everybody wonders why…I also go there as part of my job and I see people, and I go, why aren't they treated with dignity? Why are they allowed to be re-traumatized by people going, "oh what happened? How come you couldn't hit him?" It's really stupid. And, if I say anything to the nurses, they will just start–they are overworked also." –Inf. 15 "Indigenous–It's all the cultural stigmas–I can't even say the words it hurts me too much, you know, "the drunk Aboriginal", you know, "oh well, they were drunk" or "they're back again…" so it enrages me and bothers me to the point where people know not to talk about that when I'm around, which I love, I don't mind, so as long as I can make small changes that way. And it enables you to remind people of Canada's past and where we still need to move forward and treat everybody respectfully regardless of whether they were intoxicated." –Inf. 3
	Competency with vulnerable populations	"I think you are talking about intersectionality in terms of just the complexity of the nuances of different circumstances and people's lives and the layers of identities that can contribute to privilege or oppression or marginalization. As I said I haven't had formal training in those things its really been kind of something that I've been kind of working on myself in terms of educating myself and talking with colleagues and having conversation with the supervisors and so there is pieces of this that I have been picking up over the years I think it's a complex kind of thing so I'd like to think that that's part of it. Kind of case by case basis as you know." –Inf. 5 "Like I said, we are just doing it slow because we can't–our normal process is out the window with this population. We are trying to figure out how we can show them that we are a support service and not the police. It is a lot slower." –Inf. 9
Vulnerable Populations–Outward Focused	**Recognizing greater vulnerability** –Indigenous populations	"For them to know that some of this is not ok. Past trauma. Addiction, mental health issues are often some of the challenges. Mistrust of some of the mainstream resources that are available but may not necessarily meet their needs. Often it is small communities, everybody knows everybody, so confidentiality is significant issue." –Inf. 1

		"I would say that it's so common that it is almost is normalized is one of the things we noted. Obviously, addictions are a huge problem. Trauma…generational trauma. There are so few resources for them. So few resources that they may actually trust. Isolation is an issue hugely. Poverty is an issue." –Inf. 14
	Recognizing greater vulnerability – Newcomer populations	"Certainly with immigrants and refugee language can be a huge barrier, cultural practices and norms can be a barrier just because of the way in particularly women and children are treated in some societies, its ingrained right into them and into men, what their place is and that can be very difficult to help them feel empowered enough to make step away from that and again I would say money, employment, those are also barriers to getting the kind of help they need, they don't know where to turn or how to get there. The trauma of war…" –Inf. 13
	Recognizing greater vulnerability – Rural and remote populations	"The challenge is that most of the resources are centralized and if you're living out in the country, you know, it's going to be a heck of a lot harder to access all of these resources […] Do you have access to a vehicle? So that could be a barrier sometimes […] so geography definitely and access to resources. Usually, the smaller a place, or the more remote, the less options there are. And small communities, people know each other so there could be a fear of divulging because of the fact that everybody knows everybody." –Inf. 2
Children	How are children seen and talked about?	"What I have learned is that it isn't always on the hospital's radar…we don't often work directly with children and that is one of the things that I think is one of the challenges in health care" –Inf. 17 "Here [at addictions services] we wouldn't do with the child. It's not our role because, specifically, we're only working with the mom…and the child is more just here at the appointment, just child minding." –Inf. 10
	Working with children –Kids as additional risk information	"The difficulty with other women is around children. She is falling apart but "he loves my children, he doesn't love me but he is very close to my children and they are looking to me [for the father], they keep on asking me 'where is Dad, when is Dad going to come back?'" That is a risk that we want to educate her on what it means to minimize her own risk for the sake of working around the children." –Inf. 4
	Working with children – Mandatory reporting	"We would call CAS. We are hoping in that situation, as they say, "bring the hammer" and let them know that is not okay." –Inf. 9

		"And if I felt that the mother wasn't appropriately or unable to – for whatever reason – help protect the kids, then definitely Children's Aid." –Inf. 3
	Working with children – Other ways children are involved	"We wouldn't safety plan with the children directly, but we would assist the adult in considering safety plans for their children, yeah." –Inf. 6

"In some cases, parents are not as aware of the need to protect their children from exposure to their conflict and escalation and so, in those cases, it's kind of a treatment of ours to kind of educate them on that." –Inf. 5 |

Appendix C: Narrative Summaries of Codes

Risk Assessment/Risk Management/Safety Planning

Accumulating knowledge and competency

All but one informant spoke about the manner in which they accumulated (or did not) the knowledge necessary to address clients and cases around concerns of domestic violence (DV). Informants, for the most part, suggested that they had not received formal training in conducting risk assessments, risk management, and safety planning at their organizations:

> […] specifically for domestic violence, no […] and that's where I start
> to feel like we really have a gap. It has been quite a while since I was
> specifically looking at domestic violence and the risk factors involved.
> I feel like we really could use some more training around that […].

Instead of referencing formal experiences, informants described the informal ways in which they have accumulated this knowledge throughout their careers, such as by "picking up" the skills to effectively address DV concerns in their work: "I haven't had formal training–it's something that I've been working on myself, in terms of educating myself, talking with colleagues, having conversations with the supervisors…there are pieces of this that I've been picking up over the years […]." A few informants alluded to the additional learning they have personally pursued in order to learn more about how to respond to concerns of violence: "Over the years I have also done a fair bit of reading of the literature and trying to incorporate that into my practice," and "it means staying on top of any changes in legislation, policies, and programs in the city, staying on top of that." Other informants described participating in informal "lunch-and-learns" and other events by community organizations as a pathway to gain more knowledge.

Several informants described prior clinical placements–in all cases referring to experiences occurring early on in their careers or throughout their schooling–as key opportunities for learning how to respond to DV. One informant reflected on their experience:

> As a social worker, when you're going through your schooling, you
> have mandatory placement. One of the ones I did was with a Sexual
> Assault and Domestic Violence Care Centre based out of a hospital, so
> through the assessments, work, and research I did there, I have been
> exposed to a lot of victim reports and a lot of the risk assessment tools
> and such that are out there.

Relatedly, the supervision of more experienced clinicians was described as a key source of DV-related knowledge, over and above formal training. Informants described how DV specialists and more senior members of their organizations served as key references whenever DV concerns arose. As one informant put it, their learning happened through "watching my supervisors and seeing how they've handled things." In this way, specialized knowledge about DV was described as being passed down from clinician to clinician within an organization instead of through formal trainings: "What we have done instead is that, those people, we get them to train other people. If there is a case someone thinks is high risk, then we usually get the staff to go to them and consult with them." In addition to learning from other clinicians, informants described "learning on the job." One informant stated that "a lot of [my knowledge] is based on experience and previous relationship with my clients," while another said that "You learn a lot as you go […] I'm still learning. Like 'that's a first, I haven't had the abuser in the taxi while you're calling the crisis line' […] you're constantly encountering situations you've never seen before."

Finally, with regard to accumulating knowledge, a few informants espoused that they did receive some formalized training related to responding to DV over the course of their careers, "Yes, I've received all kinds of training over the years. Some of it I don't even remember […] yeah, I've received training, much training, over my years of practice." Nevertheless, those few reports of formalized training are vague in description and seem isolated to brief "refreshers" mandated at the beginning of a new job, "You can probably say I've had a refresher every time I sort of move from one position to another so I would say maybe five different refreshers over the years."

Comfort and knowledge around issues of DV

Accumulating the knowledge and skillset to serve victims and perpetrators of DV violence is related to, but quite different, from feeling comfortable (and being competent) when responding to DV. Informants overall described having general discomfort when responding to cases in which DV was a concern. One informant commented that, "[…] it doesn't matter how long you work, this is anxiety provoking […]," while several others suggested that a client's experience may drastically vary depending on the specific professional they are working with: "It's really clinician to clinician and what they're comfortable doing." These varying levels of comfort were indeed linked to differences in training and knowledge:

> Not everyone has an analysis of woman abuse and not everyone has a
> feminist analysis of woman abuse […] I think there's probably a need

for better training to be offered for all therapists because we see these people […] and there is a need, an ongoing need. We're graduating people on a regular basis, I think we just need to make sure that everybody has an analysis of woman abuse in my opinion.

Another informant expanded upon this idea by describing their difficulty keeping up with the knowledge of existing services and policies that would allow them to best serve their clients: "[…] we may not, I may not, know all of what's available. […] and that's the problem, is that things change […] I feel a bit removed from those processes." One informant, who works at an addictions and mental health centre, noted that even though a majority of their clients have experienced violence in some manner, their organization's approach to service did not take this into account: "we all know trauma, so we're very much trauma-informed, but we're not specifically interpersonal violence informed." Yet another informant commented on the lack of comfort and knowledge towards DV that they generally witness within their field: "I go by memory and just on my own know what to ask, but I would say the average counsellor wouldn't know those questions." Lastly, one informant suggested that their lack of specialist knowledge and expertise in the area of DV meant that they were not suited to working with patients that presented with these concerns: "I'm not going to spend a lot of time when there are other people who are much more expert in the area than me to give them better information."

Barriers to Service

Many informants discussed barriers that prevented them from providing an effective response to DV. Barriers were related to individual factors, organizational factors, and systemic factors. With regard to individual factors, several informants commented on their inability to help client who did not desire help, even if they believed the client was at risk of harm: "If the person feels that they are safe, I can't do anything–assuming that they're competent […]." Another informant suggested that their hands were tied if a client chose not to pursue or formally report an incident of abuse: "[…] they're usually there for a health reason and not directly because of the violence, but also because of the consequences physically. If they present for that but they choose not to report to anybody, then I'm solo with them." Some informants suggested that a lack of trust between clients and clinicians made it difficult to query for risk. This trust, often essential for the disclosure of abuse, was described as difficult to build during a single, short, and initial healthcare visit. Another informant commented on the lack of trust based on potential consequences of disclosing abuse: "One of the issues we had was with asking these

questions in an initial interview…because families don't trust and have not developed a relationship with you. Families don't want to say these things because it is reportable."

More frequently discussed by informants were barriers related to the context of working in a general healthcare setting that prioritizes other concerns (i.e., physical health) and necessitates quick and efficient treatment. One informant, who works in an emergency room, commented on having too little time to address all the needs that a woman may present with in the context of DV: "It's not that I don't want to…it's just time." Another explained that querying for risk would not be feasible due to the extra effort that this requires: "We wouldn't be able to do a domestic violence questioning because our job, it takes us up to two hours to do an intake on a client. To have another layer of paperwork would be far too much." Additional limitations centred around the structure of service provision within an organization. One informant elaborated, "It's tricky – they have to be a patient of the hospital. We've had cases where it's been disclosed that the partner is abusing and they're there, but we can't do anything unless they're a patient. So that's a challenge." Finally, the context of emergency healthcare in particular was described as a difficult setting in which to determine whether DV was a concern at all, "You get to see people when they're at their worst–they're worried. So, is that male partner following her into the operating room out of concern, or is he afraid that she's going to say something when he's out of earshot?" Another informant, a social worker working in a hospital setting, provided an explanation for why they felt that general healthcare often neglects to assess the whole person within their relationships and environment:

> As a social worker, I am trained and should be looking at the person in their environment. So, you may be my client, but I am looking at you and your systems; who is involved with you; who do you live with; who do you get support from; who fills you up, and who doesn't. However, in healthcare, because it is so medically-focused, sometimes I find that they are really just focused on treating the patients–on an acute care lens–so other professionals aren't paying attention to some of the signs or symptoms or information that might be happening to the family or the system. It is more focused on *this* individual–the patient who is in front of them–and how they need to treat him or her.

Finally, with regard to organizational barriers, a few informants commented that their agencies were simply unable to provide the services and supports that clients experiencing DV truly needed. For example, one informant who works in a setting that offers couples counselling explained, "Sometimes couples have been referred by CAS to get couples counselling. Maybe

they had a domestic [dispute]…our challenge is couples counselling may not be the most appropriate service for them even though they were recommended to get that…" Another informant described a situation in which the client, a woman, was not eligible for services due to having prior charges related to a domestic dispute: "The woman herself had charges–she was considered a perpetrator–and was not eligible for service with [community organizations…] she got swapped up in charges that really belong to her husband […] She still remains at risk from him."

When it came to systemic barriers, many informants noted that their organizations are lacking the resources to fund the training related to DV, "it's too expensive to train everybody because you have to pay their time to be present, so it's impossible to get doctors…it's getting more and more impossible to get nurses." Another informant suggested that even though their organization stresses the importance of its staff being trained in responding to DV, such training is difficult to implement, "the institution believes in training staff around violence… it's just figuring out how to do it now in the new budgetary way." Yet another informant, working in a community mental health centre, elaborated that DV-related programs are typically not prioritized in budgets or additional funding opportunities:

> We neither have the expertise, the staff, nor the money […] so that's where we are the weakest, we do not have it […] and the programs that we run, we run them on our own–we are not funded by the Ministry. That's another thing. So, we do not have a violence against women counsellor…we fundraise every year, we fundraise for these propositions, to run the PAR program, and to run the women's program.

Lastly, informants discussed their own distrust in existing systems as a barrier to addressing DV concerns in a competent manner. One informant described the ever-changing resources for women, which makes it difficult for them to best support clients who present with these concerns, "I may not know all of what's available […] the problem is that things change […] I feel a bit removed from those processes […] I'm limited in my role [and the knowledge I have]." Another informant expressed their worry that the current systems are not coordinated or organized and therefore inadequate to truly help women at all. They described working with a woman who was failed by the current systems:

I'm very cynical. If I report, I'm pretty sure nothing much is going to happen because it has to be extreme before something happens. I had someone say to me–she had left an abusive situation–she said 'they tell women to leave abusive situations. I did with my child, and now I am being further abused by the court system because he's got the money and he's taking me to court and he's saying all these things and I have no recourse because I can't afford the legal counsel […].' So, I think the whole system in this area has to be much improved and victim-based […] I think the whole of culture has to come to grips with this issue because it is impacting us hugely.

Thus, the difficulty of navigating the greater system–not only for women, but for service providers and informants–was depicted as a barrier, "I wish they'd make it easier […] I need to walk [women] through it [to access services] and have to get higher authorities involved before they can access. It's a brick wall and red tape […] the system is overloaded."

Using professional judgment

When it came to conducting risk assessments, a majority of informants spoke to their reliance on using professional judgment in order to determine an individual's level of risk. This judgment was often described as a "gut feeling," "spidey sense," or the result of "reading between the lines." One informant described how these intuitive feelings can be useful when identifying aspects of unhealthy or violent relationships:

You have those spidey senses, those feelings that something's just not right […] I always say 'go with them' because they're usually speaking to something–whether it's lethal violence or just an unfit relationship. But there's something going on there and you might as well respond to it within reason.

These feelings were differentiated from structured risk assessment forms or tools. For example, one informant noted that "in my health region position, it would be more based on experience rather than a structured interview." Another reported that "the risk assessment […] is more based on gut feeling and clinical background than on a form of any kind." Yet another informant explained their perspective that although formalized tools can be helpful, professional judgment is necessary for an accurate assessment: "[it is important to recognize] that tools are not diagnostic […] and that they rely on self-reporting, so there is a need for a professional to also use their discretion and their own expertise." One informant reflected that DV is not always

apparent and described their use of professional judgment in a hospital setting to explore for hidden risks:

> […] it's the grey areas where you have to use your gut feeling and your judgment […] if you think that something is going on but they're denying it, that's when you have to use your professional judgment and kind of investigate a little bit more. Is there history of abuse in the relationship? Are you fearful? Has he hurt you in the past? Does he drink? You know, these things that would be more of a red flag. Health care is an interesting place because you get to see people when they're at their worst – they're worried. So, is that male partner following her into the operating room out of concern or is he afraid that she's going to say something as soon as he's out of earshot? Those kinds of things. I think professional judgment comes with experience too. And as you get older you kind of know what a healthy relationship is, too.

In this way, professional judgment seems to be linked not only with an accumulation of professional experience, but also personal knowledge and one's own idea of what a healthy relationship entails.

Engaging with the perpetrator

When asked about their work with perpetrators of DV, there was an overwhelming consensus that informants did not, in fact, work with perpetrators at all: "it's just that we're not really dealing with the perpetrator." Several informants implied that, even when men were explicitly identified as perpetrators of violence, the services they provided to these men would nevertheless not address these concerns. One informant elaborated, "I know I have a perpetrator on my caseload. I will often ask questions on what's happening at home, but that's not within my scope of practice. I don't do counselling, and I'm not monitoring or supervising the perpetrator." Another informant, who works in a hospital setting, explained, "We don't get an awful lot of opportunity to work with perpetrators […] we wouldn't be focusing on that, we would be more focused on their healthcare needs." Only one informant, a social worker, discussed considerations around how their work with perpetrators of DV can have an impact on the safety of the perpetrator's partner:

> If I happen to have a man who has come to me for psychiatric issues,
> but there has developed a domestic violence situation […] even if we

are done with other matters, I am going to hang on to him…because

it's going to increase that woman's safety.

Though this individual did not describe addressing the perpetrator's violence directly through their work with him, they acknowledged their role in managing his risk to reoffend. Likewise, whereas several informants acknowledged that perpetrators of violence require more readily-accessible services, they concluded that they themselves did not have the skills or knowledge to work with these men: "As much as I work with survivors, we know the current research is saying that we need to make sure that we are thinking about [perpetrators] as well […] I don't have much information about [what to do with] men." One informant stated, "These guys…I don't think we have the clinical skills to [address their issues]. Our group program is not going to do justice by this guy." Taking this into account, numerous informants agreed that there is a need for more programs and organizations oriented specifically towards addressing the needs of perpetrators: "We need more education and more programs for perpetrators."

When informants did report taking steps to respond, address, and work with perpetrators around concerns of DV, the vast majority indicated that they refer these men to other services. One informant stated that, "If we had a perpetrator who came […] and was open to one of our programs and […] was wanting help to deal with this particular part of his life, then we would be making referrals for them." Unlike when referring women to external services, informants did not frequently reference or provide the names of specific services that they would refer to. Instead, most informants spoke generally about "encouraging patients to seek treatment," "directing people towards things and resources," and "involving other agencies." Only a handful of informants spoke about engaging with the perpetrator directly regarding their violence. This involved working on management and coping skills related to the de-escalation of the perpetrator's emotions: "Looking at anger management, looking at how they are coping overall with stress […] giving them the coping skills to better manage their anger." One informant explained their approach to helping perpetrators become more aware of this escalation by focusing on bodily cues: "What we will do is […] find the signs, triggers, for escalation. For some clients, when they turn red that is an indicator […] we'll say, 'what's happening to your body and how can we calm your body right now?'" Finally, three informants, all who work in community mental health and addictions organizations, also discussed directly working with perpetrators–not by addressing their violence, but by addressing parallel issues such as substance abuse. One informant explained their process, "Our focus would be treatment planning to

identify the relationship between their substance use and violent behaviour, or to identify the underlying reasons for both. So, to assist the individual to address those reasons and help them increase their self-efficacy…" Another suggested that any work addressing the perpetrator's violence may in fact be less effective without also addressing parallel issues–such as substance abuse or depression–first: "In cases where we identify depression in men, that is a high risk. We need to alleviate it. Our [domestic violence work] is not going to do anything, unless we address this issue of depression within this guy." In conclusion, most informants reported that they did not work with perpetrators of DV around assessing or addressing their violence. Many noted a need for additional specialist services for men who harm. The few informants who did report taking actionable steps with perpetrators of DV most frequently referred these men to other services. Only a few described working directly with perpetrators, which typically involved a focus on building coping skills around anger management or attempting to address parallel mental health concerns.

Working with women

When informants discussed their interactions with women in cases in which DV was a factor, they described knowing and listening for risk factors that signaled increased likelihood of harm to the woman. Frequently, informants listed the questions that they typically ask clients to determine the presence of specific risks. One informant provided an example:

> Is there alcohol involved with her partner? Is she herself judging herself at risk? Where is it that she is living? If she, when I see her, is living in a shelter, I am not as concerned and I know they are doing safety planning. But, if she is living at her mother's, I am a bit more concerned. Is there extra vulnerabilities that she has? Does she have alcohol involved, drugs involved…this sort of thing. Has there been repeated occurrences of this violence? Has there been repeated separation of the couple? Is he a hunter? […] Where the guy is now; is he awaiting bail? Those are the things that I look at.

Informants also reported exploring risks around the patient's relationship with the perpetrator of violence: "[…] it's exploring their fears, worries and more about the history […] any things that might increase risk, like around offender's mental health, if the offender has breached any of their conditions in the past, if they've been trying to contact." Whereas most of the informants discussed explicitly asking about these risk factors, a few also described examining the

behaviours and physical states of women. One informant, who works at a pregnancy care centre, noted that, "We're observing if they're coming with a boyfriend, if he's overly friendly or if he's seeming quite aggressive or not wanting her to go in alone, […] if she's very late in her pregnancy and hasn't had any care." Another, drawing from their own personal experience with violence, spoke to the need to be alert to subtle signs that a woman may be a victim of violence:

> […] usually, physical abuse is all under your clothes, but there are all sorts of things: if a woman lowers her center of gravity to below her knees […] that is a sign that she is either torn or very hurt. If a victim of abuse continually apologizes, that is a form, that right away is an indicator that they are abused. somebody who continually apologizes for a very small thing.

Similarly, the client's environment was flagged as an important consideration when assessing risk: "[…] we rely heavily on not only what the victim is telling us, but we also rely on—with whom is she surrounding herself with and what are they saying about the extent of violence that she has undergone." Other relevant factors, such as a woman's current living situation, support system, and previous family history also played a role: "Poverty is probably the biggest risk: lack of safe housing, isolation in the community…I'm amazed at how many people have absolutely no one, especially when you come from a family where you were abused." Overall, in this way, informants demonstrated a knowledge of the factors that increase the likelihood of violent victimization.

A critical aspect of risk assessment and safety planning is working directly with women and asking them about their circumstances, perspectives, and needs. The value of listening to what a woman has to say about her own situation was described by several informants as "the most important thing. They are the ones that have been victimized. They are the ones that know whether they are feeling safe or what's going on, so I think it's really important to hear them out […]." Another informant explained that the client's assessment of their own safety trumps one's clinical experience:

> I've been doing this 20-years and I learn from people sitting in front of me. They teach me what in the system doesn't work and why it doesn't work and what's working in the system, because again, that continues to change. And I learn so much from them and I think that's what we – we often think that they're not the experts in their own life…but they

are, so we need to be really mindful of that […] I'm not a professional
who purports that I have all the answers, 'cause I don't.

In this sense, this informant described the value of considering the woman's beliefs regarding her current situation, her risks, and her perception of safety. However, contrary to this view, several informants questioned the reliability of a woman's knowledge about her own situation. For example, some informants insisted that clients minimize or underestimate their own level of risk: "with repeated violence, they begin to undermine their own wisdom or their intuition about what might happen. The perpetrators blame them and make them feel like it's their fault […] so they might not think it's a big deal." Relatedly, the understanding of risk and safety was described to vary between women depending on their lived experiences: "[Does the] woman know what it means to be safe? […] a lot of these women have […] never known what it means to be safe. If you don't know what it means to be safe, then you don't necessarily know danger." Further elaborating, this informant noted the need to reconsider the language, terms, and tools that clinicians use when working with vulnerable populations and woman who have experienced violence:

We are assuming that people know what it means to be safe when we do a safety assessment, and I don't believe that's true at all. I think that we have to be careful about using that word, you know. I think a lot of times we say 'are you safe?' Well, what does that even mean? I'm really careful about the language that I use. These women and children have been keeping themselves from danger as best as they can for, sometimes decades, so I would argue they're the experts in this.

Lastly, when it comes to taking concrete, actionable steps to help women in the context of DV, informants described their reliance on several key strategies. By far the most common action, endorsed by all informants, involved connecting women to external services or professionals that could provide them with specialized support. One informant explained their thought process and listed the range of services that they might refer to when working with a woman:

I would definitely want to reach out to just really make sure this plan is going to happen. Is she going to get into a violence against women counselling clinic? What's their waitlist time? Is she really going to get into that family or women's shelter as opposed to going to the central

intake? So, it's not just giving the information; I would definitely be
calling out to the community to make sure that the plan is feasible
before I felt comfortable releasing her, discharging. Sometimes you
have these great plans but then there's the 6-month waitlist and then
your plan is really for nothing […] it's really now explaining what the
process will be: 'do you want to call the police?', 'do you want to do it
on your own?' This kind of thing.

The above description suggests that this informant takes a more involved role in making sure that
their clients are connected to appropriate services. Other informants detailed a more removed
referral process that involved simply providing women with the information for other existing
services in their area: "Referring…I would say any of the Violence Against Women shelters or
the Women's Centre […] I would suggest to call them and ask what's available" Similarly, some
informants described providing women with printed pamphlets that include the phone numbers
for community resources: "I have those available […] resources in the city available for our
clients […] We have sheets and we'll have them printed out for our clients so if they need go
somewhere, they have the numbers on hand right away." The services and organizations that
informants mentioned with regard to referrals included "the violence against women agencies,
mental health services, victim services." Furthermore, "it might be important to consult with
family doctors or psychiatrist, if there is one or if the person has a current open file with CAS
and that seems appropriate." Other relevant services named by informants included shelters,
advocacy centres, police services, sexual assault centres, specialized counselling and mental
health services, and "anyone else who works with victims of violence."

In addition to external referrals, a few informants described educating women about their
level of risk. This ranged from reviewing risk factors with women and "[…] helping the patient
identify the degree of risk," to conducting role plays of their client bumping into her perpetrator
to "mentally prepare her that these kinds of situations can emerge […] and give her as much
information as possible in terms of preparing her for the eventuality if it ever comes." Some
informants relied on basic safety planning with women which included:

[…] things like not informing their partner if they're planning to leave;
we can copy important documents; opening up a separate bank account;
not talking to the children about the move as they may make a mistake
and disclose; hiding some money away; keeping telephone

communications confidential; calling the local shelters; being prepared
to call police […] if they recently left their partner; seeking legal
assistance; considering additional safety measures for the home such as
installing peepholes-–those kinds of things.

Safety planning strategies were described as being limited by the short amount of time that informants had with women and thus pertained to more immediate safety goals. For example, an informant who was "speaking from an emergency department setting," noted that the safety plans that they implement cannot always be thorough: "yes, there might be 15 things that we need to do but, today, we're only going to be able to do one or two, and what's the biggest priority? What're we going to do tonight to keep you safe?" Finally, a handful of informants mentioned implementing short counselling and therapy sessions. One informant explained that this involved a "conversation with the victim, our client…trying to find out where she's at […] start small about what she's open to considering […] then a bit further with her being open to moving, then with not going back home." Others described their attempts to involve the family of the woman, if possible, in an attempt to increase the amount of support for their client, but noted that this required a nuanced and sensitive approach depending on the needs and circumstances of the woman: "I encourage the person to talk with neighbours, let neighbours know, let family members know what's going on. Often, they don't want to do that. There is so much shame involved, and risk, so, yeah, it's just a dynamic process."

Processes, protocols, and guidelines

Interviews were examined holistically and contextually to determine whether informants identified a formal process that guided their services when it came to responding to concerns about DV. Interviews were grouped into one of three categories based on the depth of each professional's description of the policies, procedures, guidelines, and tools–or lack thereof–that guided their response to DV. Informants either a) described a well-defined process, b) described a process that was inconsistent or unclear, or c) seemingly did not have any process in place.

A Formal Process. Of the 17 interviews with informants, three conveyed the existence of a clear, well-defined process that is consistently used to guide staff as they respond to queries about DV. One informant explained their organization's procedure when responding to a woman who discloses her experience of DV:

Every woman must have a risk assessment done the moment she says
'my husband beats me,' or 'my in-laws are beating me,' or 'I think I

am being mistreated.' The moment she uses the word abuse, […] we will do a formal assessment with her […] with the ODARA screening tool; assessment with the family members; then the frontline worker will sit with the supervisor and the case will be discussed. The level of intensity will be discussed. Is she at risk? What is her risk level? Is she at a low level of risk? A medium level? Is she at a high level of risk? And then the interventions would be settled appropriately: low, medium, and high. […It is] very structured. First, half an hour will be just sitting down, giving her a cup of tea, talking about it, and letting her share her experiences that will be for us to get to know her. […] After about a half an hour, we start asking her some precise questions. And at the end of the interview we tell her what the next steps are. So, we prepare her and give her the reasons for the questions. If we determine it is high risk, we say her life is in danger, [and ask her] 'what would you like us to do?' So, we tell her that she has an option of a shelter, going to a family member, outside of this area, and we give her a safety plan. […] And everything has to be properly documented. We have a mental health manual, a domestic violence manual, we have an addictions manual: those are the protocols that one has to follow.

This informant, serving as the CEO of a community mental health agency, was able to describe the systematic process that their organization uses, including their use of specific risk assessment tools, documented and manualized protocols guiding the intake and assessment of risk, and the safety planning process. This individual further described their organization's formal and close partnerships with other agencies in their goal to provide well-rounded care and support for women: "We have a close relationship with [victim services]. We ask our clients to go there [for information on] bail hearings, has he been let go, what the next stages are. She, as our client, can become a client of theirs." The informant's position as the CEO of their organization depicts a top-down approach to highlighting DV as a key issue requiring a systematic and coordinated response. These sentiments are highlighted by the two additional informants who describe a well-defined process for responding to DV. One informant, working in a hospital setting, explained that their organization established a specific committee to raise awareness and promote education for all staff around these issues:

> I chair our Violence Against Women Awareness Committee […] which is pretty unique to this hospital. […] It's a committee that was created out of a case where a patient was killed by her husband many years ago. The focus is to continue education for staff in the hospital around violence against women and constantly raising awareness of the issues and constantly training staff to know what to do. You know, with disclosures and suspicions of abuse, just to keep it present as it's an important health care issue.

The final informant described a well-defined process and highlighted the role that their prior (specialist) experience had in implementing specific tools and policies related to DV at their current organization:

> What we have done, because myself and [my coworker] were previously child welfare workers and we were both in management in child welfare at one point, is we use a lot of the child welfare tools. We adapted them from the *Asking When There Has Been an Abuse and Responding to an Abuse Disclosure Screening Protocol* and we also adapted the *Critical Connections for Women Abuse and Child Safety Intersect*. We use the *Power and Control Wheel,* as well. A lot of our therapists use that.

Those informants that described well-defined processes around screening, assessing, and responding to DV were thus those that work in organizations in which upper-level management understands, values, and promotes DV as a key healthcare issue. This top-down influence was reflected in their descriptions of organized and clear guidelines.

Inconsistent Process. Six informants described what seemed to be an inconsistent, unclear, or uncomprehensive process when it came to responding to DV. For example, informants may have described knowing about the *existence* of specific tools, but did not implement them themselves:

> We've informally like google researched different risk assessment tools. A number of us, because we've been doing this work for a number of years, are familiar with tools like ODARA or B-safer but familiar in the sense of, 'we know that they exist, we've talked to other

agency staff who use them, we've maybe seen some of the questions,'

but don't at all feel like that is something we are formally doing.

These informants reported using some screeners that query for basic information around risk of harm to the self or to others, but these were usually not specific to DV concerns: "We have policies that outline the specific things to screen for when it comes to screening for risk of suicide or homicide […] but with regard to domestic violence risk assessment, there isn't anything written in our policies or protocols." Some informants alluded to the existence of a procedure for responding to cases of DV, but they were unfamiliar with the specifics, unable to provide many details about it, or mentioned that they did not use these procedures: "Well, like I said, I don't use it in my current position so I don't have the sheet with me. I don't have the questions in front of me. It's not something that's required by the health region." Thus, although there seemed to be some semblance of a procedure in place, it did not seem to be consistently understood, known, or followed in a systematic way.

No Apparent Process. Finally, eight informants were otherwise unable to speak to any existing procedures or policies at their organization that were relevant to specifically addressing concerns of DV. One informant explicitly mentioned that they would prefer to have something more structured in place: "No [we don't have procedures], and that is what I'd like to have […] we've got to get more structured on this." This perspective was echoed by others:

> After going to conferences, I come back with a lot of information to share with my agency. We have structured risk assessments for suicidality, however in terms of domestic violence we don't have anything structured that we use. I actually feel that it might be helpful […] to speak with someone that manages […] because for me, on my team, we don't have a set risk assessment, and we don't have anything that is standardized or structured.

When asked to discuss existing guidelines, these informants were unable to provide any clarity, suggesting a lack of comfort and familiarity with procedures: "There's a flow chart for instance when answering the phone. Just–I guess there's a checklist of things for intake which include safety planning. Um…there's documentation that you have to do, certain questions you ask, certain timelines around those questions." Thus, when it comes to a systematic response to DV, the prevailing sentiment is one of, "there's really no protocols."

Vulnerable Populations

When informants described working with distinct populations–that is, with immigrants, refugees, or newcomers to Canada, Indigenous persons, or individuals living in rural, remote, or Northern communities–they did so in one of two ways: as it related to their own beliefs, actions, and knowledge (i.e., inward-focused statements), and as it related to the characteristics of the specific population that they were serving or factors external to their organization (i.e., outward-focused statements).

Inward-focused

Inward-focused statements were related to four subthemes: building relationships and connecting with clients from vulnerable populations; collaborating with culturally sensitive community supports; issues relating to competency when it came to working with vulnerable populations; and recognizing–or perpetrating–bias, stigma, and stereotypes against these populations.

Some informants described ways in which they tried to foster relationships with individuals from different communities and backgrounds. They noted the importance of respecting the unique histories of individuals from vulnerable populations, acknowledged that it would take more time to build trust with these clients, and provided resources to clients in their own language whenever possible. For example, it was noted that work with vulnerable populations should be completed "on their terms" since "there is a danger of trying to force people to where we're at rather than giving them time and process." Learning and taking the lead from their clients was suggested as a way to better understand an individual's unique needs and thus tailor services accordingly:

> Tell me the story. Tell me your survival story. How is it you keep fighting? We try to build up their strengths first and build a relationship of trust before we go into the problems…things we would think is a problem–like kids stealing–for them, it was a survival strategy to live in a refugee camp.

A few informants also emphasized that building a foundation of trust is critical when working with vulnerable populations but that this requires time and patience: "It definitely takes a lot longer. We're not asking the women these tough questions right away […] because they still don't even feel safe and we want people to feel safe and secure. We're just trying to develop some stability." Finally, a handful of informants reported that their organizations had taken steps to connect with clients from vulnerable populations by providing services and information in

different languages, "even if they can understand English, sometimes they don't get the meaning of the words in the same way […] the ability to give them things in their own language is wonderful." Similarly, a few informants indicated that their organizations had hired clinicians who hailed from similar backgrounds as their clients as a way to foster better connections with these communities: "[…] the fact that we'll have somebody who is Indigenous–out of a collaboration between our agency and the local nations who they'll be working with–I think that's very promising, in terms of breaking down those barriers."

Informants also described the manner in which their organizations collaborated–or did not–with cultural community resources to support vulnerable populations. For example, it was suggested that collaborations with cultural community centres helped to foster a sense of trust and understanding within the community about DV-related services:

> The biggest piece is the education, because [vulnerable populations] are so afraid [and do not understand the system] and we are trying to reassure them […]. That is why we like working with [the cultural community centre]. They will do some individual work with [these individuals] just to educate them.

However, although many informants supported the role that cultural centres had in fostering a sense of acceptance for vulnerable populations within the community, they noted that the extent of their work with these services was to receive referrals from them. In this way, although there is a potential for successful collaboration with cultural centres, the majority of general service providers continue to be disconnected from these organizations: "Again that's just where all of us in various agencies need to be aware of what one another does. I don't think we're very good at that either, I think we're pretty siloed, all of us."

Four informants expressed doubt regarding their ability to understand and consider the multiple and intersecting identities of their clients when it came to working with vulnerable populations:

> […] just the complexity of the nuances of different circumstances and people's lives and the layers of identities that can contribute to privilege or oppression or marginalization…As I said, I haven't had formal training in those things. It's really been kind of something that I've been working on myself in terms of educating myself.

One informant suggested that their background–different from that of the clients they serve–made it difficult to understand these complex intersections, "it's hard for me to know all the

layers because I am not Indigenous." Nevertheless, these informants noted some internal training initiatives intended to improve cultural competencies related to working with Indigenous and newcomer communities specifically, "As an agency, we did Indigenous culture safety training recently. We work hard to try and engage the Indigenous community. We've had [individuals] from [these] communities give a talk about what they need about engaging their community and supporting them."

When referring to working with vulnerable populations, informants frequently recognized or described instances of racism, bias, and stereotyping that they had witnessed or experienced throughout the course of their career. One informant reported on the range of cultural sensitivity within their organization, "We do have staff that still revert back to that stigmatizing way, but we also have great staff that have move forward and see every patient regardless of systemic views." Another expressed their despair at the stigmatizing comments that they have heard from fellow clinicians and staff:

> I can't even say the words, it hurts me too much: 'the drunk Aboriginal'
> [or] 'oh well, they were drunk,' or 'they're back again.' It enrages me
> and bothers me to the point where people know not to talk about that
> when I'm around, which I don't mind, so as long as I can make small
> changes that way. And it enables you to remind people of Canada's past
> and where we still need to move forward and treat everybody
> respectfully."

Yet another informant described racist comments that they've heard within their organization, "the other thing I'm hearing too is the people who grew up here and lived here and [are] struggling with the fact that they think that refugees are coming here and taking up jobs and funding."

It is important to consider how general service providers' own biases and beliefs can impact their ability to provide competent and effective services. While several informants reported racism and stigma towards vulnerable organizations being perpetuated by others within their organizations, evidence of informants' biased beliefs towards these populations were also evident within their descriptions of vulnerable populations. For example, one informant described their initial reaction to newcomer clients:

> Whenever I hear 'immigrant' or 'refugee,' I immediately go to that day
> when they don't have interim federal health anymore, and now they're

> going to be spending time in the emergency department and they're
> going to get a huge bill […] as soon as I hear that population, I think
> 'Oh my gosh, they are coming to a hospital and they can't afford the
> bill' regardless of what the issue that they're coming for.

Several others attempted to recognize differences between cultures but instead seemed to convey their biased beliefs, "We see that there's a tradition of patriarchy, a challenge for those communities in terms of a tradition of seeing girls and women as less valuable or more deserving of physical abuse or requiring protection. It's like a mafia racquet." Another informant provided a blanket statement to explain away DV and homicides within newcomer populations:

> We've come across this before: the honour killing. So, just that in the
> family […] there's a strong belief that it is the right thing to do; this
> woman dishonoured me and so this is now what we must do. So that
> puts them at very high risk because they're not afraid of the
> consequences […].

These types of statements suggest that biased perspectives and stereotyped beliefs persist among general healthcare practitioners and have consequences for the quality of care that vulnerable populations receive: "I worry that's what people blame it on as opposed to responding to the violence." However, several informants also described the steps their organizations have taken to combat these beliefs. For instance, one informant remarked that they were "pleased when our CEO fired those people who made the racial slur […] that's the kind of action we need so that Indigenous people see we do want to make things different and we're going to make steps towards that." Yet another explained their perspective on challenging these beliefs and believing their patients regardless of their history or background:

> […] you've got to process your assumptions and stick them in a jar
> somewhere and close that jar and work where the patient is and believe
> the patient regardless if they have been here 14 times intoxicated and
> today they are coming and telling you they were abused – we are
> believing them and going with what they're telling us. And I see that
> as a move forward with staff is that we are a place where we're believed
> more so than not.

Overall, informants recognized and described instances of racism and stigma towards vulnerable populations within their organizations. Several informants projected their own biases towards these populations within their descriptions of their work.

Outward-focused

When discussing their work with vulnerable populations, every informant recognized and discussed characteristics that placed these communities at higher risk for both experiencing DV and having more difficulty accessing supports and services. For example, informants who reported having worked with newcomers to Canada recognized many factors related to an individual's or family's newness to the country that might result in greater risk for victimization or perpetration of violence:

> [There are] language barriers, and cultural differences. So, sometimes they don't know that the abuse doesn't have to happen, especially if they're new to this country, because there's certain rules that they have within their family that's based on their own traditions and cultural practices. The laws may be different in some of their countries, so they're still learning the laws here. There may be a fear of police, and not understanding child protective services or poor experiences with both already in Canada.

Another informant suggested that newcomers often "don't know what they don't know," noting that this unfamiliarity with Canadian systems can be a barrier that contributes to a lack of trust towards community supports and prevents individuals from seeking help. Another risk factor for newcomers included the increased likelihood of being isolated or lacking social support networks: "[They are] somewhat isolated, depending on where they're coming from and who's in their new community…whether they're living with other newcomers who may practice or have similar beliefs, or whether they're more in a Canadianized community […]." Language familiarity and financial resources were also depicted as barriers to accessing resources. These were described as risk factors particularly for women who may be dependent on their abusers for income or support:

> I think financial barriers…often you have immigrant families that are refugee families. They likely don't have jobs; they are still learning English as a second language…and, in a way, they may be reliant on that individual–the offending individual–so it changes a lot in terms of

> that kind of power and control over, and the shame in terms of whether
>
> or not to leave [the perpetrator].

Relatedly, an individual's culture, past experiences, and expectations around relationships were discussed as factors that service providers must consider when working with newcomers. One informant described how shame and embarrassment can prevent women from reaching out for formal support: "One of the things that I've primarily noticed is the shame factor around anyone in the community finding out and fear of the impact on their reputation, how that would change the supports and the connections that they do have." Another elaborated on how these factors also impact men who are perpetrators:

> Depending on the cultural context around what it means to leave a
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> relationship and the shame that might put on the whole family…in
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> terms of mental health. I mean, already for men there is much more
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> stigma around accessing therapeutic services than there might be for
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> women and so that might be a big barrier to accessing any supports
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> prior to things escalating.

Finally, informants considered risks related to an individual's prior experiences in their country of origin or journey to Canada. Particularly for refugee populations, prior trauma was discussed as a factor adding to the complexity of responding to DV: "I see trauma as a being a big driver of a lot of things…of mental health…of addictions…violence. So, I think trauma really has a ripple effect." One informant commented on the connection between trauma and DV, "I see how someone would be triggered to that extreme because that's the only way they've been able to cope in the past…going into those automatic-traumatic responses that are hard-wired into them because of the level of trauma they've experienced." Overall, informants were aware of and able to describe numerous factors that place immigrant and newcomer individuals and families at higher vulnerability with regard to DV.

Informants also spoke about increased vulnerability and specific risk factors related to Indigeneity. Those factors brought up most frequently included concurring addiction and mental health concerns, intergenerational trauma, and a lack of culturally appropriate resources. For example, several informants expressed that the impact of colonialism is evident across generations of individuals in their "fear of engaging services by white community members," uncertainty regarding "how they are going to be treated," and "layers of trauma of family members who were at residential schools," or "trauma by parents or caregivers through neglect

or abuse." These were referred to as layers of risk for which "colonialism certainly played a big part." One informant described how these layers might result in the "normalization of violence" and reflected on how they try to address these concerns in their work with Indigenous communities:

> There is normalization of violence within the community–peer-to-peer, family violence–it's just built right in […] It's almost become an accepted part of the culture because they haven't had the opportunity to learn anything else. So, one of the biggest challenges is helping them to put a context around their violent behaviour […] we're trying to make particularly children and adolescents aware of intergenerational trauma and the impact that has on ability to parent and ability to regulate emotion and those kinds of things in the hopes that we can start to make a dent in that cycle that seems to go on and on and on.

This individual further reflected on how the abundance of barriers and risks can result in a situation that seems hopeless and insurmountable:

> You add to that substance abuse–another big problem on the reserves, [and] neglect–the number one reason kids go into care […] it's often parents that just don't know how to parent and they don't realize that they are putting their child at risk sometimes. Another challenge is a lack of resources…huge lack of resources. They don't have the same health care, they don't have the same child and family services, they don't have the same policing, they don't have same justice system, and all they have is less than what the rest of us have. So, it can be extremely difficult to find out who to go to about what. […] Just a lot of compounding problems and in general [leads to] what I would call loss of self. They don't see themselves as having any personal power at all and so to try and make a change just feel totally foreign and insurmountable.

Related to these histories of trauma and colonialism, several informants described the mistrust of mainstream resources by Indigenous persons as a barrier to their accessing services: "A trust of outsiders. That's huge. Takes a long time to build enough trust to actually have that conversation." Finally, one informant commented on the challenge of connecting with

Indigenous communities given that they themselves were not Indigenous: "…me being a different race–that probably gets in the way. I think racism is huge […] through our culture, they are seen as less than, and that is a huge risk factor because they're not taken as seriously."

Informants furthermore described a number of risk factors that were relevant to Indigenous individuals living on reserves. Many of these overlapped with the risks for rural, remote, and Northern communities, such as increased isolation, difficulty accessing resources, poverty, and a lack of confidentiality in smaller communities:

> We are talking about isolated communities out here so when are doing some safety planning say with a woman and her children, she can't necessarily change residences. […] the communities are very small; they are very intimate; there is not the same level of anonymity and resources that you would get in a city, so we have to be very creative […] and everybody knows everything within two seconds, so just being able to support some of that privacy.

Informants also emphasized the lack of resources in these northern, isolated communities: "They don't have the resources to get help. There's a psychiatrist here who goes once a week…some counsellors that might go once a month. In one hour, you don't have time to talk about your issues, let alone do anything." Other relevant risk factors noted by informants included increased access to weapons, delayed response times in emergency situations, and a lack of cell phones to call for help.

Finally, when it came to outward-focused statements, several informants mentioned promising practices–that is, positive practices or events that served to address some of these heightened risks–that were not necessarily happening within their own organizations but instead more generally within the community. One informant expressed, "We're seeing real trends of Indigenous people getting more education and rising above the intergenerational trauma, engaging in legal advocacy, protests, and really taking back pride of their identity, ancestry, heritage, cultural practices, their language. I'm hopeful for that process." Another discussed improving advocacy within the immigrant and newcomer communities:

> …within the cultural communities in which [domestic violence] is becoming an issue–so, some of the more informal social groups, the churches, the mosques, the places where there are English as a second language classes…they're starting to recognize that there's a an

information gap, there is a knowledge gap–and they're trying to address
it.

A few informants reported on the existence of specialized services geared specifically for vulnerable populations: "I find that specialized groups often [have] their own places where they'll go, which is a good thing in some respects. So, the special native services […] I make sure that anybody with status, who is Indigenous, has those…" Finally, one informant mentioned the beneficial use of technology in the mental health sector to provide safe and confidential resources to individuals who may otherwise have difficulty accessing services: "Technology is going to be a huge factor. Just being able to access other resources that don't require being there in person and don't require you to have to walk away with handouts that could potentially be [identified by the perpetrator]."

Children

How are children seen and talked about?

A majority of informants described that they rarely, if ever, included considerations of a client's child(ren) in the context of DV. For example, one informant explained, "we don't really work with children [...] I don't worry about anything other than the patient in my bed." Another expressed, "we wouldn't [work] with the child, it's not our role because, specifically, we're only working with the mom, and the child is more just here at the appointment." Some informants implied that this exclusion of children was, in part, due to a lack of knowledge regarding appropriate steps to take when children are involved. They described they are "not trained to consider them," and that they "don't have that knowledge…it takes someone with a very specific skillset to have that conversation about a child and to know exactly how to deal with that and we don't have that training." One informant suggested that children are simply "forgotten" in the process: "people forget about the children […] say a woman goes to the hospital because the man beats the hell out of her and nobody in adult mental health or the hospital was asking, 'where are the children?'" For informants who did describe working with children directly, their accounts suggested that what was happening in the home (i.e., DV) was not taken into account, highlighting once again a disconnect in which the impact of domestic violence on children was not considered. For example, one informant highlighted, "there's very few resources and services for the kids who are exhibiting trauma reactions. They might get diagnosed with attention deficit and then be medicated for that, but they're not actually receiving counselling for what's happening at home." Yet another informant spoke about the paradox of addressing DV concerns

in health services but neglecting to consider the children in the situation: "we're not putting the resources towards the most vulnerable in the whole domestic violence [situation]. It's very hard to get appropriate resources, almost impossible to get counselling resources."

Informants held various views with regard to the impact of DV on children. One informant suggested that DV occurring in the home may *not* impact children, "Sometimes, the abuse doesn't involve the child at all." Another informant similarly suggested that staff members at their organization often misunderstand the impact that DV on children:

> What I hear in my work is that they didn't get hurt […] so what is the big deal? They were sleeping, they were in the other room…that minimization about the impact that domestic violence can have on children and on their emotional development, on their physical development.

Other informants, however, acknowledged that although they may not work with children directly, the impact of DV on children is indeed profound: "Obviously, children are impacted and traumatized by domestic violence and people don't realize it and people don't realize that a child–even an infant seeing or hearing, even if they're preverbal–they will be impacted by it." Informants likewise discussed children in relation to their mothers. With regard to assessing risk of harm to children, one informant expressed that they "hope that the mother would be keeping them safe." Another implied that mothers should be responsible for their children's safety: "Children are included to the extent of the mother's ability to protect them." Yet another noted that they "haven't had to [include children] yet because, usually, the mum, they feel they have control of it, or the kids are too young to have the conversation so there are no other strategies." In contrast to these views, some informants referred to their prior training and experiences in the child sector to emphasize that a child's safety is often linked to their mother's safety:

> "[…] because I was in children's mental [health] and because I did a lot of training for people on the impact of woman abuse on children […] I think we need to be listening to mothers about what they do and what they're aware of and what their children need. We don't work with [children] directly, but what I would argue is that if you're working with a client with children, you are, in fact, working with the child because you need to. […] I think we need to get better at adult

mental health in ensuring we are at least having a conversation about children."

Finally, whereas most informants provided blanket statements that their work did not involve children at all, a few expressed that they would recommend clients with children to seek specialist services, since they themselves could not effectively address these concerns. One informant explained, "That's one of our weakest links […] we do not have a program for them. We can only make referrals to the Children's Centre […] and that is not going to undo a serious kind of trauma to the children." Another echoed this sentiment, "It's not as big of a focus of our work […] I would likely recommend that she go to […] a [women's community group] that is available for victims of domestic violence and for the children for their exposure." Thus, although these professionals did not work with children directly, they acknowledge the inherent danger to the children given the mother's risk.

Working with children

When describing responses to DV cases in which children were involved, every single informant mentioned, to some degree, their duty to report these instances to the Children's Aid Society (CAS). Several informants brought this up as their default plan of action if their client disclosed that children were present during the violent occurrence: "We don't necessarily have to assess the risk in those situations; we just need to have a reasonable suspicion and then we can make the referrals." Other informants explained that their decision to report depended on the mother's ability to protect her children: "And if I felt that the mother wasn't appropriately or unable to – for whatever reason – help protect the kids, then definitely Children's Aid," and "[…] mothers try their very best to keep their children safe but sometimes they can't so I call children's protective services quite often actually, at the risk of losing the client." In some cases, a more nuanced stance on reporting was described. For example, one informant explained that "there would have to be a phone call to child protection if the perpetrator is still living in the home–then I would have to call–but if they aren't still in the home I wouldn't call." The idea of a 'grey zone' in deciding to report to CAS in the context of DV was brought up by numerous informants. One informant explained, "It's mandatory to report if any child is suspected to be at risk–including witnessing domestic violence. If there are children who aren't present, for example, they were at a relative's house […] that becomes a sort of grey zone […]." Another stated, "You're trying to balance out risk to the individual and to family members […] and so a mandatory report with somebody who absolutely is terrified of what the repercussions

could be–that's why it's a bit of a grey zone, right?" Nevertheless, informants generally expressed their obligation to complete a report if children were involved, regardless of the consequences to their adult clients: "the challenge when you involve CAS is often you've alienated the mother. So, it becomes this really dicey situation but, you know, keeping in line our obligation, is to keep the children safe right?"

In addition to reporting to CAS, informants described querying for the presence of children in order to determine the degree of risk for their (adult) client. That is, information about children was often only collected as collateral information in the process of assessing risk. This information typically revolved around concerns relating to custody, access, and history of violence toward children. One informant listed several areas that query: "Custody, access to the child is a big risk factor, […] sometimes the child may try to contact the abuser and that could increase risk. They miss their parent." Another explained how they incorporate information about children to consider increased risks to women:

> It is harder if children are involved and also, depending on their age…so like where can you guys go; do they have enough room for all your children; what are the conversations you need to have with your kids; also to let them know that if he comes to the door then don't let him in or, if you see him when you're walking home from school, run and find an adult. Things like that.

In this way, information about children is collected to supplement the risk assessment process and guide safety planning for women.

Finally, children were, in some cases, used strategically as way to further education parents on DV. For example, "[…] a parent or a couple might bring their children for services and may be not aware that their escalation of the relationship is the thing that is leading to their child acting out." Informants described using these situations as opportunities to speak to the adults: "parents are not as aware of the need to protect their children from exposure to their conflict and escalation and so in those cases it's kind of a treatment of ours to kind of educate them on that." In line with this, one informant further explained how they might frame their services to parents:

> […] part of the lens is to look at, you know, some of the risks to children not in terms of imminent risks, but sort of the impact of domestic violence on children over time and trying to learn some of that to give

skills, to give safe coping skills to parents, to minimize or end that
intergenerational violence.

Children, in this way, are spoken about in terms of being an access point to provide parents with the necessary education and coping skills to minimize violence. Nevertheless, considerations around the specific needs of the children themselves continue to be absent in this response.