

HOSPITAL FAMILY VIOLENCE SERVICES

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QUESTION

What is the available evidence for family violence services delivered in a hospital setting?

RESULTS

ONLINE RESOURCES

AUSTRALIAN GUIDELINES

The Royal Children's Hospital Melbourne. (2021). **Clinical Practice Guidelines: Family Violence**. [Link](#).

- Guidelines for recognising family violence and subsequent management.

The Royal Women's Hospital. (2020). **Strengthening hospital responses to family violence**. [Link](#).

- The aim of the Strengthening Hospital Responses to Family Violence Project is to support public Victorian hospitals and health services to implement a whole-of-organisation response to family violence.
- This edition is designed to enhance work already undertaken and focuses on supporting Victorian public health services to align to the Family Violence Multi-Agency Risk Assessment and Management Framework.

Australasian College for Emergency Medicine. (2020). **Family and domestic violence and abuse**. [Link](#).

- This document is a policy of the Australasian College for Emergency Medicine and relates to the identification, screening, treatment and support of patients who present to the emergency department and are experiencing family and domestic violence and abuse.

The Royal Women's Hospital. (202x). **Screening for Family Violence in Antenatal Clinics – Clinical Practice Guideline**. [Link](#)

- This clinical practice guideline outlines expectations and processes for staff mapped at the identification and screening level of response who will undertake routine screening for family violence in antenatal clinics only.

UK GUIDELINES

Royal College of Nursing. (2023). **Domestic Abuse Guidance**. [Link](#).

- This guide has been developed in response to the recognition by the RCN of the need for nurses, midwives, registered nursing associates and health care support workers and all health care professionals to have an understanding of the impact of the domestic abuse of patients, clients, and colleagues.

NHS Trust Royal Cornwall Hospitals. (2025). **Domestic Abuse and Sexual Violence Clinical Guideline for Maternity Staff**. [Link](#).

- This guideline aims to support maternity staff to screen women for domestic abuse and sexual violence. Routine enquiry should be used to enable identification and management of women who may be experiencing Domestic Abuse, Sexual Abuse or Sexual Exploitation.

NHS Department of Health and Social Care (2017). **Domestic Abuse: A resource for health professionals**. [Link](#).

- This resource looks at how health professionals can support adults and young people over 16, and dependent children, who are experiencing domestic abuse.
- It will help staff to identify potential victims, initiate sensitive routine enquiry, and respond effectively to disclosures of abuse.

INTERNATIONAL GUIDELINES

European Society for Emergency Medicine. (2019). **Guidance for domestic abuse and violence in the Emergency Department**. [Link](#).

- These recommendations aim to help Emergency Physicians detect and identify domestic abuse and violence in relation to children, intimate partners, and elders.

Washington State Department of Health. (2019). **Best Practice Guidelines for Trauma Center Recognition of Child Abuse, Elder Abuse, and Intimate Partner Violence**. [Link](#).

- This guideline seeks to help the trauma practitioner identify victims of abuse that present with physical injury and to initiate treatment and reporting.

PEER-REVIEWED JOURNAL ARTICLES – MOST RECENT FIRST

Articles are grouped by theme:

- Training for Recognising Domestic and Family Violence
- Implementing Domestic and Family Violence Services
- DFV in Maternity Services
- DFV in Emergency Department

- DFV in Mental Health

Each article summary contains excerpts from the abstract and an online link.

TRAINING FOR RECOGNISING DOMESTIC AND FAMILY VIOLENCE

Dheensa, S., et al. (2025). **Experiences of supporting primary and community healthcare workers affected by domestic abuse in the United Kingdom: A cross-sectional survey.** *The European journal of general practice*, 31(1): 2571600. [Link to full text.](#)

Healthcare workers are expected to identify and respond to domestic abuse among patients. However, research has neglected healthcare workers' own experiences of domestic abuse. Focusing on UK primary and community healthcare workers with formal support roles (e.g. line managers, human resources, employee assistance professionals), this exploratory study aimed to illustrate workplace support offered to healthcare colleagues affected by domestic abuse. Despite several limitations, including substantial missing data, our work highlights that primary and community healthcare workplaces should explore the implementation of practical and emotional support measures; healthcare-based domestic abuse advocates with staff support; and training on supporting colleagues. Further pan-European comparative research should surface good practice and foster cross-learning.

Dheensa, S., et al. (2025). **Identifying and responding to domestic abuse in cancer care: A mixed methods service evaluation of a training and support intervention.** *European journal of oncology nursing : the official journal of European Oncology Nursing Society*, 74(100885136): 102724. [Link to full text.](#)

This article reports on a service evaluation of a domestic abuse intervention for hospital-based cancer professionals in two sites. The core component was a training and monitoring process, which hospital-based domestic abuse coordinators led. This role was adapted from a generic hospital role to be cancer specific. Pre-training preparedness to identify and respond to domestic abuse, domestic abuse identifications, and changes ~6 months post-training are presented. We used an explanatory sequential design including a survey pre-training (Time 1), immediately post-training (Time 2) (with follow-up semi-structured interviews) and ~6 months post-training (Time 3). Sites were asked to share domestic abuse identification numbers pre- and post-coordinator hire. Our evaluation contributes further evidence of the benefit of hospital-based domestic abuse coordinator roles; contributes new evidence for the feasibility of adapting the role for a specific context; and illustrates the need for a domestic abuse response in the cancer setting.

Troy, K., et al. (2025). **Impact of a 3-year transformational change project in family violence clinical response: Qualitative evaluation of the depth and breadth of knowledge in hospital clinicians by training level.** *Women's health (London, England)*, 21(101271249): 17455057241305264. [Link to full text.](#)

This study aimed to investigate the impact of different levels of training in family violence (no training, some training, clinical champions), on the clinician knowledge of key family violence response skills, using qualitative, survey obtained text-box responses. A cross-sectional, online, survey of hospital clinicians in a major trauma hospital was conducted. The Assisting Patient/Clients Experiencing Family Violence: Royal Melbourne Hospital Clinician Survey tool was utilised and open for clinicians to complete, anonymously over a 6-week period. Free-text survey responses were analysed using an inductive thematic analysis approach. Providing some training in family violence

yields a higher degree of family violence knowledge in clinicians, relative to no training. However, the extra resourcing required to train and maintain a clinical champions model in family violence provides demonstrable benefits, via a more sophisticated and nuanced understanding of indicators, enquiry and disclosure response skills, that align with best practice guidelines.

Schalk, D., et al. (2024). **How Health Professionals Identify and Respond to Perpetrators of Domestic and Family Violence in a Hospital Setting: A Scoping Review**. *Trauma, violence & abuse*, 25(4): 3405-3418. [Request full text.](#)

There is heightened awareness that a whole-of-systems approach to perpetrator responses is key to addressing domestic and family violence (DFV). This paper reports on the findings from a scoping review which mapped the international literature on how health professionals identify and respond to perpetrators of DFV within a hospital setting. The review did not identify any mandated or formal procedures for identifying and/screening or responding to perpetration of abuse in hospitals. Rather, responses to perpetrators are inconsistent and rely on the motivation, skill, and self-efficacy of health professionals rather than an embedded practice that is driven and informed by hospital policy or procedures. The literature paints a picture of missed opportunities for meaningful work with perpetrators of DFV in a hospital setting and highlights a disjuncture between policy and practice.

Takov, V., et al. (2023). **Evaluation of a Community Hospital-Based Residencies' Intimate Partner Violence Education by a Domestic Violence Shelter Expert**. *International journal of environmental research and public health*, 20(9). [Link to full text.](#)

Intimate partner violence, or IPV, is estimated to affect an estimated 10 million Americans. From 2015-2017 our community hospital-based residencies trained first-year residents to improve education in recognizing and screening for IPV. This retrospective cohort study's goal was to analyze the longitudinal effectiveness of the educational program. The education was based on a curriculum created by Futures Without and the United States Office on Violence Against Women. The curriculum was taught by Turning Point, the local county provider for victims of domestic and sexual violence, and involved five hours of training. Physician Readiness to Manage Intimate Partner Violence Survey was used as the assessment tool. Residents were measured pre-, post immediate, and one-year post-education. Measures that include perceived knowledge and perceived preparation improved post immediate and one year after the training ($p = 0.0001$). Actual knowledge increased significantly post immediate but decreased after one year ($p = 0.0001$). The proportion of residents who screened patients and the proportion of patients who were screened increased post-intervention. The educational training provided by our local shelter improved residents' performance in several of the categories tested, but most importantly, improved IPV practice post immediate and generally one year after.

Forsdike, K., et al. (2018). **An Australian hospital's training program and referral pathway within a multi-disciplinary health-justice partnership addressing family violence**. *Australian and New Zealand journal of public health*, 42(3): 284-290. [Link to full text.](#)

An innovative health-justice partnership was established to deliver legal assistance to women experiencing family violence who attended an Australian hospital. This paper reports on a multifaceted response to build capacity and willingness of health professionals to identify signs of family violence and engage with referral pathways to on-site legal assistance. The program built capacity and willingness of health professionals to identify signs of, and respond to, family violence.

Increase in referral rates to legal assistance was not shown. Potential improvements include better data capture and greater availability of legal services. Implications for public health: Strong hospital system supports and reliable recording of family violence referrals need to be in place before introducing such partnerships to other hospitals.

IMPLEMENTING DOMESTIC AND FAMILY VIOLENCE SERVICES

Andrews, P., et al. (2025). **Facilitating best clinical practice in domestic violence work with hospital social workers.** *Social work in health care*, 64(1-3): 18-33. [Link to full text.](#)

Domestic and family violence (DFV) is a major public health issue mainly affecting women and children. Health services are an important site in the identification and initial response to DFV. Social Workers often lead the psychosocial response to DFV. This study aimed to explore the experiences of internal referrers to a hospital-based social work led DFV Service. A social work-led hospital-based DFV Service has benefits for the practice of hospital and health social workers who identify and provide the initial response to DFV. Implementation of such models in practice provides opportunities for increased awareness, assessment and responsiveness to the complex needs of people experiencing DFV.

Hansen, K., et al. (2025). **Virtual emergency departments and domestic violence: A new frontier in healthcare and safety.** *Emergency medicine Australasia : EMA*, 37(2): e70023. [Link to full text.](#)

Emergency Departments (ED) are critical components of the healthcare system, providing immediate care for acute conditions, injuries and trauma. Individuals who experience domestic violence (DV) face barriers accessing care in traditional EDs. These include fear of retaliation from an abuser, shame, isolation, logistical challenges. Virtual Emergency Departments (VED) have emerged as potential solutions to these challenges. Providing emergency care through telehealth offers an innovative way to meet the needs of patients who may otherwise hesitate or be unable to seek help. This article explores the intersection of VEDs and DV, examining the potential benefits and challenges of using telemedicine to support DV victim-survivors, as well as the ethical, legal and clinical considerations. By focusing on this emerging field, this opinion piece seeks to highlight how VEDs could enhance the way DV victim-survivors access care and the broader implications for healthcare delivery.

Elvey, R., et al. (2022). **A hospital-based independent domestic violence advisor service: demand and response during the Covid-19 pandemic.** *BMC health services research*, 22(1): 865. [Link to full text.](#)

Recent UK policy has focussed on improving support for victims of domestic violence and abuse (DVA), in healthcare settings. DVA victims attending hospital are often at highest risk of harm, yet DVA support in hospitals has been inadequate. A targeted service supporting high risk DVA victims, was implemented at a hospital Trust in North West England. The service was provided by Independent Domestic Violence Advisors (IDVAs). This paper assesses the activity in the hospital-based IDVA service during the COVID-19 pandemic and addresses the research questions: What was the demand for the service? How did the service respond? What facilitated this response? The hospital-based IDVAs provided an efficient, flexible service during the COVID-19 pandemic. Referrals increased during the first lockdown and subsequent relaxing of restrictions. Locating the IDVAs within a team working across the organisation, and building good working relationships facilitated an effective disclosure and referral route, which endured through social restrictions. The IDVAs supported high-risk victims who may otherwise not have been identified in traditional community-based DVA settings during the pandemic. Hospital-based IDVA services can broaden access by supporting vulnerable, at risk populations whose needs may not be identified at other services.

Dheensa, S., et al. (2020). **"From taboo to routine": a qualitative evaluation of a hospital-based advocacy intervention for domestic violence and abuse.** *BMC health services research*, 20(1): 129. [Link to full text.](#)

Health services are often the first point of professional contact for people who have experienced domestic violence and abuse. We report on the evaluation of a multi-site, hospital-based advocacy intervention for survivors of domestic violence and abuse. Independent Domestic Violence Advisors (IDVAs), who provide survivors with support around safety, criminal justice, and health and wellbeing, were located in five hospitals in England between 2012 and 2015 in emergency departments and maternity services. We present views about IDVAs' approaches to tackling domestic violence and abuse, how the IDVA service worked in practice, and factors that hindered and facilitated engagement with survivors. Hospital-based IDVAs offer a unique and valued way to respond to domestic violence and abuse in a healthcare setting. Further work must now be done to explore how to implement the service sustainably.

Halliwell, G., et al. (2019). **Cry for health: a quantitative evaluation of a hospital-based advocacy intervention for domestic violence and abuse.** *BMC health services research*, 19(1): 718. [Link to full text.](#)

Domestic violence and abuse (DVA) damages the health of survivors and increases use of healthcare services. We report findings from a multi-site evaluation of hospital-based advocacy services, designed to support survivors attending emergency departments and maternity services. Hospital IDVAs worked with survivors less visible to community IDVA services and facilitated intervention at an earlier point. Hospital IDVAs received higher referrals from health services and enabled access to a greater number of health resources. Hospital survivors were more likely to report greater reductions in and cessation of abuse. No differences were observed in health outcomes for hospital survivors. The odds of safety increased two-fold if hospital survivors received over five contacts with an IDVA or accessed six or more resources / programmes over a longer period of time. Six months preceding IDVA intervention, hospital survivors cost on average 2463 each in use of health services; community survivors cost 533 each. The cost savings observed among hospital survivors amounted to a total of 2050 per patient per year. This offset the average cost of providing hospital IDVA services. Hospital IDVAs can identify survivors not visible to other services and promote safety through intensive support and access to resources. The co-location of IDVAs within the hospital encouraged referrals to other health services and wider community agencies. Further research is required to establish the cost-effectiveness of hospital IDVA services, however our findings suggest these services could be an efficient use of health service resources.

DFV IN MATERNITY SERVICES

Branjerdporn, G., et al. (2023). **Australian women's perspectives of routine enquiry into domestic violence before and after birth.** *BMC pregnancy and childbirth*, 23(1): 44. [Link to full text.](#)

Peripartum women are vulnerable to experiencing intimate partner violence (IPV). Interactions with health practitioners during maternity care provide a unique opportunity to detect and respond to women who are experiencing IPV. The aim of this study was to explore women's experiences of IPV screening at an Australian maternity service. The nine women expressed three major themes, and six sub-themes, surrounding clinician approaches (communication and support, asking about IPV, and following disclosure), system considerations (fear of child safety involvement, continuity of care, and environmental considerations), and education. All participants supported screening and highlighted beneficial or detrimental approaches to screening and care, and recommendations for

improvement. This research points to the benefit of trauma-informed frameworks in hospitals to support women experiencing IPV.

Forbes, C., et al. (2023). **A survey and stakeholder consultation of Independent Domestic Violence Advisor (IDVA) programmes in English maternity services.** *BMC pregnancy and childbirth*, 23(1): 404. [Link to full text.](#)

Healthcare-based Independent Domestic Violence Advisors (hIDVA) are evidence-based programmes that provide emotional and practical support to service users experiencing domestic abuse. hIDVA programmes are found to improve health outcomes for service users and are increasingly delivered across a range of healthcare settings. However, it is unclear how hIDVA programmes are implemented across maternity services and the key facilitators and barriers to their implementation. The aim of this study was to identify; how many English National Health Service (NHS) Trusts with maternity services have a hIDVA programme; which departments within the Trust they operate in; what format, content, and variation in hIDVA programmes exist; and key facilitators and barriers of implementation in maternity services. Despite hIDVA programmes role in improving the health outcomes of service users experiencing domestic abuse, increased funding and staff training is needed to successfully implement hIDVA staff in maternity services. Integrated Care Board commissioning of acute and mental health trust services would benefit from ensuring hIDVA programmes and clinician DVA training are prioritised.

Arora, S., et al. (2019). **Effectiveness of a counselling intervention implemented in antenatal setting for pregnant women facing domestic violence: a pre-experimental study.** *BJOG : an international journal of obstetrics and gynaecology*, 126(Suppl 4): 50-57. [Link to full text.](#)

To assess the effectiveness of a counselling intervention in antenatal care settings for pregnant women who report domestic violence. Pre-experimental study with pretest-posttest design. Two public hospitals in Mumbai, India. Routine enquiry and counselling for domestic violence during pregnancy are effective in improving women's ability to cope, safety, and health.

Eustace, J., et al. (2016). **Midwives' experiences of routine enquiry for intimate partner violence in pregnancy.** *Women and birth : journal of the Australian College of Midwives*, 29(6): 503-510. [Link to full text.](#)

Reducing violence against women is a national public health priority in Australia. Routine antenatal intimate partner violence screening by a skilled midwife is essential for assessment, support and appropriate referral, but can be challenging to implement. To explore midwives' experiences of routine enquiry, perceptions of facilitators and barriers, and suggested strategies to improve practice. Routine enquiry about IPV is a valuable and important midwifery role. Midwives described frustration and fear when women disclosed violence. The perceived level of support from health services varied according to practice contexts and needs to be improved.

DFV IN EMERGENCY DEPARTMENT

Allen, D., et al. (2024). **Enabling Emergency Department Staff to Support Domestic Violence Victims of Strangulation.** *Australian Social Work*, 1-15. [Link to full text.](#)

The study reported here investigated what enables emergency department (ED) staff to support domestic violence victim-survivors of strangulation, which poses potentially life-threatening medical and psychosocial risks. Informed by Appreciative Inquiry, interviews were conducted with twelve staff from eight emergency departments in New South Wales, Australia. Doctors, nurses, and social workers with experience in supporting victim-survivors of domestic violence-related strangulation were interviewed. De-identified transcripts were analysed using inductive thematic analysis. Themes identified from the data were the importance of recognising strangulation injuries, that understanding experiences of violence improves ED staff's responses to victim-survivors of strangulation, the value of social work in multidisciplinary response, and that informal support sustains staff in this work. These themes highlight the need for emergency department staff education in identifying and responding to domestic violence and strangulation, which enables informed responses, positive patient engagement, and effective multidisciplinary care. Multidisciplinary care for health and safety assessments are essential for domestic violence victim-survivors of strangulation presenting to emergency departments. 24-hour access to social workers in emergency departments facilitates safety planning and may mitigate the risks of escalating violence. Strangulation and domestic violence education is essential for emergency department staff. There is an evident need for increased social work roles in EDs, especially in rural hospitals, to support victim-survivors and to apply a social work approach to train ED staff to respond appropriately. Formalising supportive structures through enhancing social work and domestic violence education in emergency departments whilst encouraging informal support networks for staff may enhance safety for victims-survivors and maximise staff emotional wellbeing.

Kurbatfinski, S., et al. (2024). **The Evaluation of a Domestic Abuse Response Team Program in an Emergency Department.** *Journal of Family Violence*, 39(8): 1473-1486. [Link to full text.](#)

Domestic abuse (e.g., family violence) occurs globally and increases the risk for lifelong adverse health outcomes for all members involved. Although victims of domestic abuse often refrain from seeking support due to various reasons (e.g., fear), health centers such as emergency departments (EDs) can serve as outlets for assistance. The Domestic Abuse Response Team (DART) is a program working collaboratively with a regional hospital center in Alberta, Canada, uniquely providing immediate, expert, and patient-oriented services (e.g., safety plans) to domestic abuse victims within the ED. This study aimed to evaluate the DART program by: (1) using administrative data to characterize ED and DART patient characteristics and (2) examining staff perceptions about DART's operations, effectiveness, challenges, and improvements. The DART program offers valuable support to domestic abuse victims. Staff reported that DART is effective in providing victims with immediate care and services while also supporting ED staff.

Butala, N., et al. (2023). **Child safety assessments during a caregiver's evaluation in emergency departments after intimate partner violence.** *Academic Emergency Medicine*, 30(1): 23-31. [Link to full text.](#)

Physical abuse of children is reported to occur in 30%-60% of homes with intimate partner violence (IPV). IPV in adult victims presenting to emergency departments (EDs) represents a critical opportunity to evaluate for child safety. The primary objective was to determine the frequency of child safety assessments (CSAs), defined as any documented inquiry about the presence of children in the household, when adults presented to EDs for IPV. The secondary aims were to assess (1) the impact of demographic factors, ED type, and social work (SW) involvement on the likelihood of CSAs; (2) the nature of children's exposure; and (3) the frequency of child protective services (CPS) reports.

CSAs were omitted in one-fifth of encounters for IPV. Given the high prevalence of children involved in IPV episodes, ED encounters for IPV represent an opportunity to improve the safety of children.

Moore, S., et al. (2023). **Family and domestic violence policy discourses and narratives: implications for Emergency Departments and communities in rural Australia.** *International journal for equity in health*, 22(1): 65. [Link to full text.](#)

Australian data has indicated that the frequency and severity of family and domestic violence (FDV) tends to increase with remoteness. Rural communities rely on Emergency Departments (ED) within public hospitals for general health and safety needs. Public health departments within Australia are strongly influenced by Government policies which can define 'health problems' and limit institutional responses to patients presenting with FDV. The current study therefore aimed to critically examine FDV Australian Government policies to explore how policy meanings could potentially impact on ED staff and individuals within rural communities. Foucauldian Discourse Analysis and Policy Narrative Analysis were used to examine 9 policy documents which represented national, state/territory and clinical practice levels. Publication dates ranged from 2006 to 2020. The results reflected a transition in the meaning of FDV within Australian society and over the past decade, with policies trending away from Deficit Subject Narratives and towards Object Oriented or Societal Narratives. Institutional systems, sociohistorical context and broader societal movements may have shaped this transition by stagnating policy meanings or introducing new insights that expanded the possibilities of understanding and action. Narratives produced assumptions which significantly altered the relevance and agency of individuals and groups when applied to a rural ED setting. As FDV was moved out of the clinical space and into the public domain, the agency of health professionals was reduced, while the values and strengths of FDV subjects and rural communities were potentially recognised. Later policies provided contextual specificity and meaning fluidity that could benefit diverse groups within rural areas; however, the expectation for ED staff to learn from their communities and challenge institutionalised approaches to FDV requires careful consideration in relation to rural hospital systems and resources.

Brignone, L. and A. M. Gomez (2022). **Access to domestic violence advocacy by race, ethnicity and gender: The impact of a digital warm handoff from the emergency department.** *PLoS ONE*, 17(3 March): e0264814. [Link to full text.](#)

Racial/ethnic minority survivors of domestic violence (DV) referred from emergency departments (EDs) face barriers connecting with advocacy services due to systemic inequities. This study assesses the impact of Domestic Violence Report and Referral (DVRR), a digital mandatory reporting compliance system with integrated direct-to-advocacy referrals sent with patient consent, on survivors' likelihood of receiving advocacy by race/ethnicity and gender. Direct-to-advocacy ED referrals facilitated by eHealth technology improve access to advocacy care for all survivors in this sample; marginalized racial and ethnic groups most often victimized by DV appear to have the highest rates of connection to advocacy.

DFV IN MENTAL HEALTH

Gillespie, K., et al. (2023). **Domestic violence screening in a public mental health service: A qualitative examination of mental health clinician responses to DFV.** *Journal of psychiatric and mental health nursing*, 30(3): 472-480. [Link to full text.](#)

Mental health clients experience higher estimated rates of domestic violence, yet mental health services are less likely to screen for domestic violence. This paper qualitatively explores the

perspectives and experiences of mental health practitioners in inpatient and community teams in a publicly funded hospital and health service (i.e. public mental health service). Mental health practitioners described a lack of domestic violence training, as well as a lack of knowledge of domestic violence and support mechanisms for victims, when domestic violence is disclosed by clients. The paper highlights the unique difficulties and barriers experienced by clinicians in screening for domestic violence while also dealing with clients suffering a mental health crisis. The paper sheds more light on the issue of domestic violence in mental health in terms of screening, and identifies avenues for improvement in mental health services; particularly the need for staff training and education. Education, attitudes and resources relating to domestic violence are major factors that should be addressed for the successful screening and treatment of clients in mental health. This paper informs services of the gaps in knowledge and care around domestic violence and mental health. A less medicalized approach to the treatment of mental health should be adopted, and domestic violence training introduced for all healthcare practitioners, to improve client outcomes.

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APPENDIX

SEARCH METHODOLOGY

A systematic search was conducted for literature. The results were screened by librarians using [Covidence](#).

SEARCH LIMITS

- English-language
- Published within the last 10 years

DATABASES SEARCHED

- Medline – index of peer reviewed articles across health sciences and medicine.
- Embase – index of biomed and pharmacological peer reviewed journal articles.
- Emcare – index of nursing, allied health, critical-care medicine and more.

- PsycINFO – index of psychology and psychiatry peer review journal articles and book chapters.
- Grey literature – Google, Google Scholar, Trip database, Biomed Central Proceedings.

MEDLINE SEARCH STRATEGY

This search strategy was conducted on 28/01/2026 and translated to other databases, as relevant. Searches in each database were conducted on the same day.

- 1 Domestic Violence/pc [Prevention & Control]
- 2 ((family or domestic or interpersonal or partner or spousal or marital) adj2 (violence or abuse) adj3 (service* or support or manage* or department* or unit* or outreach or advocacy or advocate* or team*)).ti.
- 3 1 or 2
- 4 (hospital* or health service* or tertiary care or health network* or health system*).tw,kf.
- 5 exp hospitals/
- 6 4 or 5
- 7 3 and 6
- 8 limit 7 to (english language and last 10 years)

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PRISMA CHART

Identification of studies via databases and registers

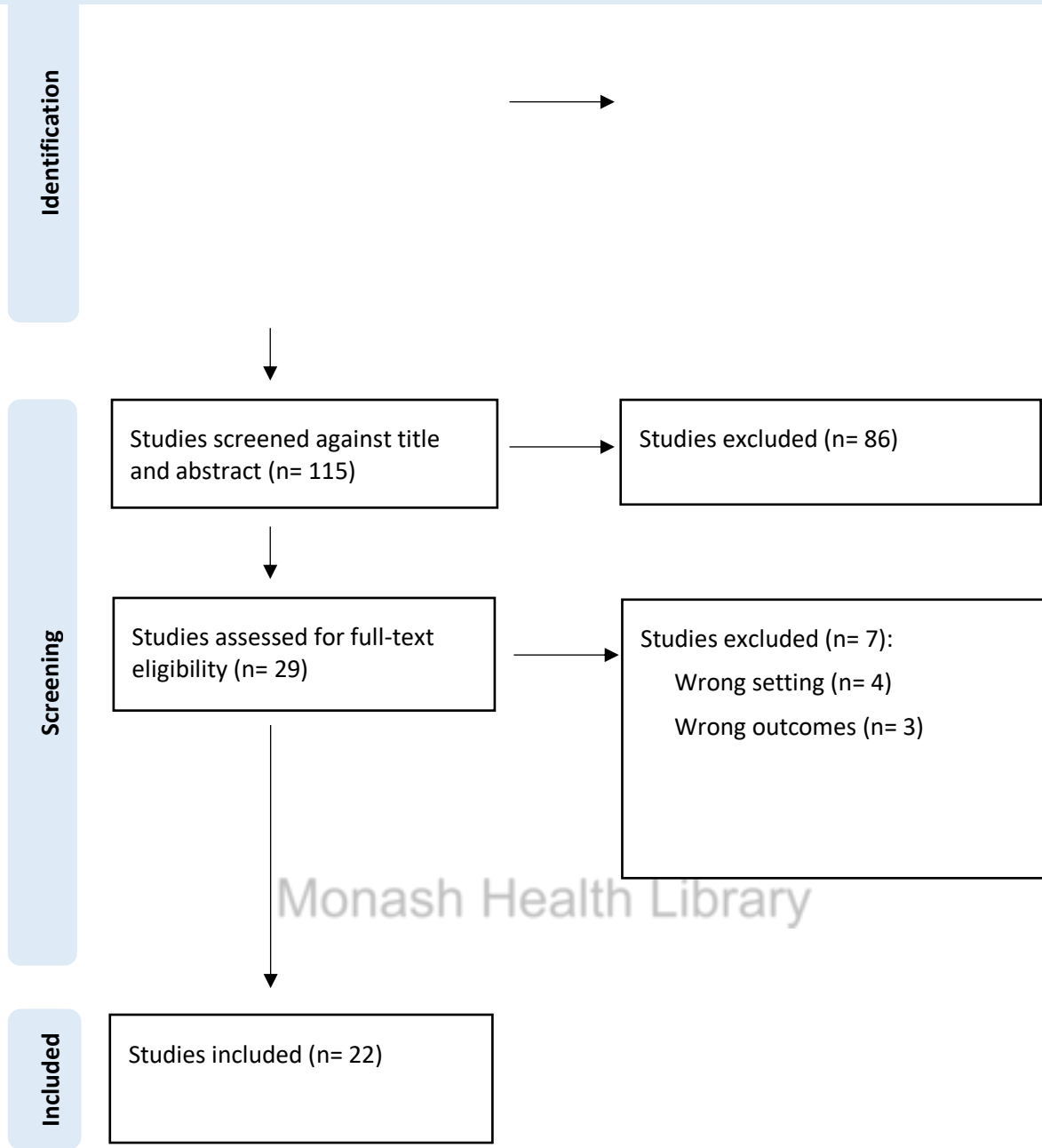
References imported for screening (n= 188):

- Medline (n= 82)
- Embase (n= 47)
- Emcare (n= 42)
- PsycINFO (n= 17)

Studies removed before screening:
Duplicate studies removed (n= 73)

11





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