Acknowledgments

The Domestic Violence Screening Pilot was an initiative of the Department of Health funded by the Commonwealth Government under Partnerships Against Domestic Violence and the NSW Women’s Health Public Health Outcome Funding Agreement.

Many thanks go to the members of the working party for South East Sydney Area Health Service who included:

- Pauline Foote, Director, Women’s Health Unit (Chair)
- Michelle Bonner, Project Officer, Domestic Violence Screening Pilot, Women’s Health Unit
- Gary Fuller, Nurse Unit Manager, Sutherland Hospital Emergency Department
- Annette Griffin, Acting Nurse Unit Manager, Maternity and Women's Health, St George Hospital
- Joan Hobbs, Manager, Social Work Department, Sutherland Hospital
- Maria Hole, Domestic Violence Project Officer, Women’s Health Unit
- Carol Jones, Nurse Unit Manager, Delivery Suite and Antenatal Services, Sutherland Hospital
- Lesley Jordan, Nurse Unit Manager, Maternity and Women's Health, St George Hospital
- Murray Lean, Acting Divisional Nurse Manager, Maternity, Child and Family Health Services, Sutherland Hospital
- Lee Love, Manager, Sutherland Alcohol and Other Drugs Service
- Josephine Pancia, Social Worker, Emergency Department, Sutherland Hospital
- Clair Ramsden, Clinical Nurse Consultant, Emergency Department, Sutherland Hospital
- Kay Vine, Director of Child, Youth and Family Services, Sutherland Hospital
- Denise Wood, Divisional Nurse Manager, Maternity, Child and Family Health Services, Sutherland Hospital

Acknowledgment and thanks to the health staff who participated in the training and undertook the screening and to all the women who agreed to be screened.

This report was compiled and produced by South East Health Women’s Health Unit.
## Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Executive summary</td>
<td>1</td>
</tr>
<tr>
<td>Recommendations</td>
<td>2</td>
</tr>
<tr>
<td><strong>1. Background</strong></td>
<td>3</td>
</tr>
<tr>
<td>Aims</td>
<td>4</td>
</tr>
<tr>
<td>Objectives</td>
<td>4</td>
</tr>
<tr>
<td>Resources</td>
<td>4</td>
</tr>
<tr>
<td>Evaluation</td>
<td>5</td>
</tr>
<tr>
<td><strong>2. The Pilot Project in South East Health</strong></td>
<td>5</td>
</tr>
<tr>
<td>Area Commitment</td>
<td>5</td>
</tr>
<tr>
<td>Training</td>
<td>5</td>
</tr>
<tr>
<td>Resources</td>
<td>6</td>
</tr>
<tr>
<td><strong>3. Participating services</strong></td>
<td>6</td>
</tr>
<tr>
<td>Sutherland Hospital Antenatal Services</td>
<td>6</td>
</tr>
<tr>
<td>Sutherland Hospital Emergency Department</td>
<td>6</td>
</tr>
<tr>
<td>Sutherland Alcohol and Other Drugs Service</td>
<td>7</td>
</tr>
<tr>
<td>St George Hospital Antenatal Services</td>
<td>8</td>
</tr>
<tr>
<td>Area Women's Health Nurses</td>
<td>9</td>
</tr>
<tr>
<td><strong>4. Identification of domestic violence</strong></td>
<td>10</td>
</tr>
<tr>
<td><strong>5. Issues raised during the pilot project</strong></td>
<td>11</td>
</tr>
<tr>
<td>Interviewing alone</td>
<td>11</td>
</tr>
<tr>
<td>Time</td>
<td>11</td>
</tr>
<tr>
<td>Training</td>
<td>11</td>
</tr>
<tr>
<td>Social work role</td>
<td>11</td>
</tr>
<tr>
<td>Child at risk concerns</td>
<td>12</td>
</tr>
<tr>
<td>Casework relationship</td>
<td>12</td>
</tr>
<tr>
<td>Appropriateness of male health staff asking the questions</td>
<td>12</td>
</tr>
<tr>
<td>Participation and commitment of medical staff</td>
<td>12</td>
</tr>
<tr>
<td><strong>6. Protocol and policy developments</strong></td>
<td>12</td>
</tr>
<tr>
<td><strong>7. Feedback from women screened</strong></td>
<td>13</td>
</tr>
<tr>
<td><strong>8. Discussion</strong></td>
<td>13</td>
</tr>
<tr>
<td><strong>9. Conclusion</strong></td>
<td>14</td>
</tr>
<tr>
<td><strong>References</strong></td>
<td>16</td>
</tr>
<tr>
<td><strong>Appendices</strong></td>
<td>17</td>
</tr>
<tr>
<td>Appendix 1</td>
<td>17</td>
</tr>
<tr>
<td>Appendix 2</td>
<td>18</td>
</tr>
</tbody>
</table>
Executive summary

Domestic violence is now recognised as an important public health issue that can adversely affect the physical and emotional health of women and their children. Despite the existence of both the state and area domestic violence policies and training programs, domestic violence has not been identified and addressed adequately or consistently by health services.

In 1999, the Department of Health reviewed the 1993 Domestic Violence Policy and included a recommendation for routine screening. This recommendation received a positive response from Area Health Services. The Commonwealth Partnerships Against Domestic Violence (PADV) agreed to fund NSW Health to pilot routine screening in South East Health (SEH) and Macquarie Health Service (MHS) in 2000 to 2001 with the long term aim of implementing screening across the state. The Violence Prevention Unit in Health Services Policy (now Primary Health and Community Care) was responsible for the coordination and management of the NSW Pilot Project. The Education Centre Against Violence (ECAV) developed and produced the resources and training manual for the project. The Department of Social Work, Social Policy and Sociology at the University of Sydney (now the School of Social Work and Policy Studies) undertook an evaluation of the pilot project. Approval was obtained from three ethics committees: the University of Sydney, SEH and MHS.

In SEH, the pilot was coordinated by a project officer managed by the Women’s Health Unit. A working party of participating services was convened throughout the pilot. The participating services included:

- Sutherland Hospital Antenatal Services (including the Antenatal Clinic and Menai Service)
- Sutherland Hospital Emergency Department
- Sutherland Alcohol and Other Drugs Team
- St George Hospital Antenatal Services (including the Antenatal Clinic, Birth Centre and Rockdale and Hurstville Outreach Midwifery Program (STOMP))
- Area Women’s Health Nurses

The goal of the project was to contribute to improved health outcomes for women and children. The aim of the domestic violence screening pilot was to improve health services’ response to domestic violence.

The domestic violence screening pilot initiated a number of practice changes in participating health services. For example, the Antenatal Clinics recognised the need for women to have time on their own during their visits to discuss and disclose personal social and medical histories, Sutherland Hospital Emergency Department developed a protocol and training program on elder abuse following concern from nursing staff about this issue. The domestic violence screening pilot enhanced health staff’s confidence around child protection and reporting risk of harm. There was also greater awareness and knowledge among health staff of domestic violence as a possible health issue for women presenting to their services. This resulted in increased referrals to the social workers and requests for further information, resources and training.
Health services involved in the screening project expressed a range of views about undertaking screening. These included a reluctance to ask what were perceived as personal questions, a fear that disclosures of domestic violence would open a ‘Pandora’s box’ and therefore take up too much of a clinician’s time and a belief that the women and/or their partners would become angry with the health worker for asking the questions. Staff in the Emergency Department and Alcohol and Other Drugs Service found it difficult to implement the screening into their current work practices due to privacy issues, lack of time and the belief it was inappropriate. The midwives and nursing staff in the Antenatal and Well Women Clinics also struggled with time issues but found the screening to be complementary to the interventions they were already undertaking with women.

Limited time and resources to undertake the necessary training prior to screening was an issue for all health staff and services. Training was recognised as essential but enabling health staff to access it was challenging.

Overall, health staff agreed that domestic violence was an important health issue. However, they varied in their response as to which health staff they believed should undertake the screening or even which service was the most appropriate to screen. For screening to be successful, there are a number of things that are essential to its implementation in health services. These are:

- support and commitment of management
- adequate and appropriate training for health staff to develop skills and confidence in managing domestic violence
- clear referral paths and protocols
- available resources and information
- links with both government and non-government agencies and services.

**Recommendations**

To successfully implement screening for domestic violence, it is essential health services:

a) recognise and acknowledge domestic violence as a serious health issue affecting the physical, sexual and emotional health and well being of women and children.

b) accept responsibility for the early identification and prevention of domestic violence.

c) recognise the need to support health staff in screening for domestic violence. This can be provided through formalised debriefing, case discussions and case management procedures, ongoing training and inservices and access to the Employee Assistance Program.

d) provide or access flexible training and inservice programs on domestic violence for health staff on an ongoing basis. These should include information about how domestic violence is defined and understood, its impact on women’s and children’s health, current health policy concerning intervention such as the domestic violence screening and information on referral procedures and pathways.

e) develop and implement localised domestic violence protocols, including referral pathways. These must be based on the 2003 NSW Health Department Domestic Violence Policy and Procedures for identifying and responding to domestic violence.
1 Background

In 1999, the NSW Department of Health undertook a review of its 1993 NSW Domestic Violence Policy. The review proposed that the updated policy include a provision for routine standardised assessment for domestic violence of women presenting to emergency departments, attending antenatal, mental health and drug and alcohol services. These services were targeted as research shows women who are victims of domestic violence are high users of these services. Local and overseas research also highlighted low rates of identification of domestic violence by health services, a high incidence of domestic violence in NSW and a positive response by victims to direct questioning about violence (NSW Health Department 2000).

In 1999 the Commonwealth Partnerships Against Domestic Violence (PADV) agreed to fund NSW Health to pilot routine screening, with the long term aim of implementing it across the state. Two Area Health Services (AHS) were selected as the pilot sites: Macquarie Health and South East Health. Project officers were employed in 2000 in each AHS through the Women’s Health Coordinators to coordinate the pilot project including training health staff, developing resources, collating and analysing the data collected.

The Violence Prevention Unit in Health Services Policy (now Primary Health and Community Care) of the NSW Department of Health was responsible for the coordination and management of the NSW Pilot Project. Funding and Performance Agreements were negotiated with the participating AHS and the Education Centre Against Violence (ECAV).

The Violence Prevention Unit convened the NSW Domestic Violence Screening Pilot Project Working Party with membership from the two AHS and ECAV. The group met monthly during the course of the project from 1999 to 2001 to advise on all aspects of the screening project and collaborated on project components including background research, screening questions, protocol, development of training module contents and training schedules.

A NSW Interagency Reference Group was also established to consult with and inform the other key stakeholders in domestic violence policy and services. Membership included the working party members and representatives from the NSW Centre for Mental Health, NSW Drug Programs Bureau and Nursing Branch. The government signatories to the Violence Against Women Strategy, NSW Attorney General’s Department, NSW Police Service and the NSW Department for Community Services (DoCS) were members. The community sector was represented by two key non-government organisations (NGOs), the NSW Women’s Refuge Referral and Resource Centre and the Domestic Violence Advocacy Service.

Three editions of an information bulletin, *Routine Screening for Domestic Violence in NSW Health*, were produced by NSW Health in 2000 to provide basic information and give progress reports to the participating services, management and health staff and to other agencies.

The Screening Pilot involved health services routinely screening all women 16 years old and over who attended their service over a 12 week period. Prior to undertaking the screening, health staff attended training which covered domestic violence health issues, the screening protocol and opportunities to practice delivering the screening questions. The project officer provided additional support and resources throughout the pilot and assisted services in developing screening and referral pathways.
Aims

The overall aims of the NSW pilot project were to:

- ameliorate the effects of and reduce the incidence of domestic violence through early identification and appropriate provision of information, support and referral for victims of domestic violence and accompanying children
- identify experiences of domestic violence early in the health care response
- prevent victimisation or re-victimisation of children
- promote help-seeking behaviour in victims of domestic violence and to prevent the escalation of violence
- enhance intra-health responses to victims of domestic violence presenting to NSW health services and increase awareness amongst health practitioners about domestic violence
- enhance an integrated whole-of-government response by the NSW Police Service, DoCS and community agencies to victims of domestic violence and accompanying children presenting to NSW health services.

Objectives

The specific project objectives were to:

- conduct a six month pilot of procedures to routinely screen whether female patients of accident and emergency, antenatal, drug and alcohol and mental health services experience domestic violence
- enhance referral procedures to appropriate services
- develop and conduct training and information strategies tailored to health staff of each of the participating services in the pilot and implementation stage
- develop model routine screening procedures, forms and data collection methods within pilot services to:
  - refine, introduce and ensure appropriate use of the screening tool
  - provide participating health staff with clear guidance about their role in routinely screening patients for domestic violence
  - develop model localised interagency protocols between the AHS, the NSW Police Local Area Command, and the local DoCS Community Service Centre, in accordance with NSW Health policy on domestic violence and child protection, where serious injury of adults and certain child protection matters must be referred to NSW Police and DoCS respectively
  - ensure appropriate referrals to appropriate health services, DoCS, NSW Police and other community agencies
  - ensure appropriate documentation of patients'/clients' experiences of domestic violence and action taken upon disclosure
  - promote and assist state-wide implementation of the routine screening models in Early Childhood Services, Emergency Departments, Antenatal, Drug and Alcohol, Community Health, and Mental Health Services
  - promote the results of the pilot in each of the 17 AHS in NSW.

Resources

The Education Centre Against Violence, (NSW Health’s specialist training and resource unit for domestic violence, child protection and sexual assault), developed and produced the resources for the project. These include a training manual with a four-hour training program, screening protocols and flowchart for health staff and a statewide domestic violence resource card with key contact numbers for all participating women.
Evaluation

The Department of Social Work, Social Policy and Sociology at the University of Sydney (now the School of Social Work and Policy Studies) undertook an evaluation of the pilot project. This evaluation included questionnaires and follow-up telephone interviews with women about the screening process and questionnaires and focus groups with health staff about the training and their experience of the screening project.

2  The Pilot Project in South East Health

Area commitment

South East Health's commitment for participation in the Domestic Violence Screening Pilot Project was secured firstly through consultation with identified service managers who gave in-principle agreement, followed by consultation with the senior executive at the Area Health and Sector (facility) levels. In November 1999 memorandums were sent to senior management informing them of the project and providing them with a project description.

The director of the SEH Women’s Health Unit (WHU) held overall management responsibility for the project. In July 2000 a project officer was employed in the WHU to coordinate the project including training health staff, developing localised resources, collating and analysing data collected for the NSW evaluation and providing feedback to services.

The pilot was managed through a working party; terms of reference were developed and membership consisted of representatives from participating services. The SEH working party met on a number of occasions throughout 2000 to 2001 and provided feedback to the NSW Domestic Violence Screening Pilot Project working party.

The participating services within SEH were:

- Sutherland Hospital Antenatal Services (including the Antenatal Clinic and Menai Outreach Service)
- Sutherland Hospital Emergency Department
- Sutherland Alcohol and Other Drugs Team
- St George Hospital Antenatal Services (including the Antenatal Clinic, Birth Centre and Rockdale and Hurstville Outreach Midwives Programs (STOMP))
- Area Women’s Health Nurses

To enable the project officer to assist in managing the implementation process and according to service readiness, each site commenced screening on different dates in 2000.

Training

The domestic violence screening protocol required all health staff to attend a four-hour training session prior to participating in the pilot. For the pilot project this was facilitated by the ECAV trainer or the project officer. However, it soon became clear during the pilot that this would not be possible for a number of services because of the associated costs such as back filling positions and staff replacement as well as the possible need for health staff to attend in their own time. These concerns were raised at the pilot project working party and the Women’s Health Unit agreed to subsidise staff replacement/release. This allowed attendance at the four-hour training sessions and ensured health staff would receive sufficient information and preparation to implement the questions and develop skills in responding appropriately.
A problem solving approach was taken to rolling out the health staff training. Commitment to training sessions was negotiated with each of the service managers. The content and length of the training sessions varied according to capacity of the services to release health staff for the training sessions.

Resources

A resource folder containing information about domestic violence, the screening protocols and a list of resources and referral services was provided to each service. The referral lists contained local as well as statewide services, so were site specific. The domestic violence resource cards were available to be given to all participating women if they wished to accept them. Flowcharts depicting screening pathways were put up in each facility for health staff reference.

3 Participating services

Sutherland Hospital Antenatal Services

The Antenatal Services (including the Hospital Antenatal Clinic and Menai Outreach Service) attempted to screen all women, 16 years old and over, who were attending for their first visit interview with the midwife. Women who went straight to the delivery suite as unbooked patients without any antenatal care were also screened.

All antenatal midwives and other key maternity staff including the community liaison nurse and the maternity social worker attended a four-hour training session. A presentation was given to five of the obstetric medical staff including Visiting Medical Officers (VMOs), Senior Registrars and Resident Medical Officers (RMOs).

During the pilot period, 199 women attended first visit interviews at which 159 women (80%) were screened for domestic violence.

Among the 159 women who were screened, 17 women (10.7%) disclosed previous or current domestic violence. Of these women:

- four women accepted further assistance when offered by the midwives and were referred to the maternity social worker
- nine women did not want further assistance, however all were given information. Three women were additionally referred to the social worker and two women also discussed their options and received support from the midwife
- in four instances it was not documented whether the woman wanted or accepted further assistance when offered by the midwives. However, information was given to all the women and one woman was also referred to the social worker.

The main reason given by the midwives for not screening was the presence of the woman’s partner or family members.

Sutherland Hospital Emergency Department

The Emergency Department attempted to screen all women, 16 years old and over, who presented to the Department. The attending nurse or medical staff screened the women as part of the medical/social history assessment. Screening was not undertaken at triage. Due
to the nature of Emergency Department presentations, it was expected that some women would not be able to be screened eg women with serious injuries.

The Emergency Department reported experiencing a nursing shortage in each shift and found there was little capacity for nursing staff to attend a training program. The training sessions were therefore held at nursing staff changeover time and varied between 20 and 45 minutes. In addition, three informal information sessions were held with nursing staff at changeover before the training began. Three sessions of two hours were then held with eight key nursing staff. Training of thirty minutes was provided to the two permanent nursing night staff. The social worker attended a four-hour training session at St George Hospital. Eight of the medical staff (including medical students, interns, RMOs and the staff specialist) attended training from twenty to forty-five minutes. Contact was made and information given to the weekend social worker and the weekend senior registrar.

During the pilot period, 2,446 women over the age of 16 years attended the Emergency Department during the pilot period. Of these, 245 women (11%) were screened for domestic violence.

Of the 245 women who were screened for domestic violence, 36 women (15%) disclosed previous or current domestic violence. Of these women:

- eight women wanted further assistance when offered by health staff. Seven of the women were given information and four were additionally referred to the social worker. With two women, health staff also discussed options and gave support and for another two women, the police were either already involved or notified.

- twenty-three women did not want further assistance when offered by health staff. However, the health staff gave sixteen of these women information and one woman was additionally given support, her options were discussed and a referral to social work was made. Three women refused information and for two women any action taken was not documented.

- one woman was unclear if she wanted further assistance (written on the form by health staff). However, the action taken by health staff included providing information, giving support, discussing her options, referring to the social worker and documentation that the police were already aware.

- one woman disclosed being hit, slapped or hurt in other ways by her son and did not want further assistance and refused information. One woman disclosed being hit, slapped or hurt in other ways and frightened by her father and wanted further assistance and received information.

- in four instances, it was not documented if the woman did or did not want further assistance. However, information was given to all of the women and two women were additionally referred to the social worker.

The main reasons documented by the health staff for not screening were: the woman was not well enough to answer the questions (this included both physical and mental health concerns), the presence of partner or family members and in a few cases an inability to book an interpreter.

**Sutherland Alcohol and Other Drugs Service**

Sutherland Alcohol and Other Drugs Service attempted to screen all female clients, 16 years old and over, who were new to the service during the pilot period. This included clients who
were referred to the hospital liaison worker and the outreach worker at Engadine Community Health Centre. All caseworkers were involved in the screening.

One four-hour training session was provided to five staff. Two of the staff members were unable to attend.

During the pilot period, 46 women were seen as new clients and 10 women (22%) were screened for domestic violence.

Of the 10 women who were screened for domestic violence, four women (40%) disclosed previous or current domestic violence. Of these women:

- two women did not want further assistance when offered by health staff. One woman refused information however the other woman was given information, support and her options were discussed.
- it was not documented for two women whether they did or did not want further assistance. However, health staff gave information to both women.

The main reason documented for not screening was that health staff considered the screening to be inappropriate for a number of reasons including; the client was a young adolescent, the client had attended because of her child’s drug use and the client was an adolescent not in a relationship.

St George Hospital Antenatal Services

St George Hospital Antenatal Clinic
The Antenatal Clinic attempted to screen all women all women, 16 years old and over, who were attending for their first visit interview with the midwife. All first visits are for half an hour. An Arabic and Cantonese interpreter are available on set days each week for the clinic. The first visit interview time of half an hour was not changed during the pilot period.

One four-hour training session was provided to seven nursing staff including the nurse unit manager, the ethnic obstetric liaison officer, the community liaison officer and maternity social worker. Brief information sessions were also held on three occasions with nursing staff in the Antenatal Clinic as they had been unable to attend the training. The nurse unit manager presented to the obstetric medical staff about the screening pilot. One, one-hour session, was held with student midwives who would be involved in the pilot.

During the pilot period, 356 women attended first visit interviews of which 230 women (65%) were screened for domestic violence.

Of the 230 women who were screened, 11 women (5%) disclosed previous or current domestic violence. Of these women:

- two women accepted further assistance when offered by health staff. Assistance provided by the health staff included support, discussion of available options, information and referral to the maternity social worker.
- nine women did not want further assistance, however health staff provided information to eight of the women and one woman refused the information.

The main reason documented by health staff for not screening was overwhelmingly the presence of the woman’s partner.
St George Hospital STOMP
The outreach midwives programs attempted to screen all women, 16 years old and over, who attended for booking in visits. The outreach services were located in St George Hospital and Rockdale Child and Family Health Centre.

Three two-hour training sessions were held for ten midwives from the two outreach clinics and the Birth Centre. These were provided at the staff changeover time.

During the pilot period, 46 women attended booking in visits during the pilot and 33 women (72%) were screened for domestic violence.

Of the 33 women who were screened, two women (6%) disclosed previous or current domestic violence. Of these women:

- one woman did not want further assistance when offered by midwives. Midwives, however, still provided her with information, support and discussed her options.
- it was not documented whether the other woman did or did not want further assistance and the action taken was also not documented.

Midwives documented on only one occasion the reason for not screening and this was due to the woman refusing to answer the questions.

St George Hospital Birth Centre
The Birth Centre midwives attempted to screen all women, 16 years old and over, who attended the centre for their first visits during the pilot period. The Birth Centre is located within St George Hospital.

During the pilot period, 69 women attended the Birth Centre for first visits during the pilot period. Seven women (10%) were screened for domestic violence. Of these, no woman disclosed previous or current domestic violence.

The main reason documented by midwives for not screening was the presence of the woman’s partner.

Area Women’s Health Nurses
The two Area Women’s Health Nurses attempted to screen all women, 16 years old and over, who attended their Well Women’s Clinics during the pilot period. The Clinics are held at Sutherland Hospital, St George Hospital, a General Practitioner (GP) Practice and Caringbah Women’s Health and Information Centre. Both Area Women’s Health nurses attended a two-hour training session.

During the pilot period, 58 women were seen at the Well Women’s Clinics and 36 women (62%) were screened for domestic violence.

Of the 36 women screened, one woman disclosed previous domestic violence. This woman did not want further assistance when offered but was given information.

The main reasons documented for not screening was the presence of the woman’s partner and the lack of time for the Women’s Health Nurses to ask the screening questions.
4. Identification of domestic violence

Attempts were made by the project officer to collect baseline data from participating services to identify the number of domestic violence presentations and referrals for a period of three months prior to the commencement of screening.

Across the Area, the collection of data relating to domestic violence is inconsistent, with services using a variety of methods and measures for collection. As a result, providing a baseline of data for domestic violence was difficult. Each service decided how they would provide this information and what it would be based on. Sutherland Hospital Emergency Department and the Sutherland and St George Hospital Antenatal Clinics agreed to audit referrals to their social workers (women who are victims of domestic violence are routinely referred to the social worker). The Alcohol and Other Drugs Service, St George Hospital Birth Centre and STOMP were unable to provide any baseline data on domestic violence. The Area Women’s Health Nurses audited their client records and found they had no recorded disclosures of domestic violence prior to the screening pilot. This baseline information is summarised for each service in Table 1 with comparative data from the pilot screening period.

From the pre-and post-screening data, it appears that there was an increase in identification of domestic violence during the screening pilot from both the Antenatal Clinics and the Emergency Department.

Table 1: Identification of domestic violence (baseline and pilot screening data)

<table>
<thead>
<tr>
<th>Service</th>
<th>Pre-pilot baseline DV identifications</th>
<th>Pilot screening DV identifications</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>June - August 2000</td>
<td>September - November 2000</td>
</tr>
<tr>
<td>Sutherland Hospital Antenatal Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Women attending the service</td>
<td>242</td>
<td>199</td>
</tr>
<tr>
<td>Social Work referrals for domestic violence</td>
<td>1 (0.4%)</td>
<td>5 (2.5%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sutherland Hospital Emergency Department</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Women attending the service</td>
<td>2608</td>
<td>2446</td>
</tr>
<tr>
<td>Social Work referrals for domestic violence</td>
<td>8 (0.3%)</td>
<td>14 (0.6%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>St George Hospital Antenatal Clinic</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Women attending the service</td>
<td>435</td>
<td>356</td>
</tr>
<tr>
<td>Social Work referrals for domestic violence</td>
<td>12-18 (2.8%-4.1%) #</td>
<td>30-42 (8.4%-11.8%) #</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Area Women’s Health Nurses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Women attending the service</td>
<td>67</td>
<td>58</td>
</tr>
<tr>
<td>Disclosures of domestic violence</td>
<td>0</td>
<td>1</td>
</tr>
</tbody>
</table>

# these numbers were estimates provided by the maternity social worker
5 Issues raised during the pilot

Each service raised a number of issues in regard to implementation or practice during the domestic violence screening pilot.

Interviewing alone

To ensure they could screen the woman alone, midwives had to consider changing their practice of inviting the partner or family and friends to attend the whole interview. This practice change also allowed the midwives to obtain a more complete medical history from women as they were able to gain information about sensitive issues such as miscarriages, terminations and sexually transmitted infections. Achieving this practice change however was difficult. Some midwives attempted to separate the partner at the beginning of the interview but often found it difficult if the couple were already walking together to the interview room. Midwives expressed their lack of confidence in requesting time alone with a woman.

Time

Sutherland Hospital Antenatal Clinics held one hour first visit interviews. For the pilot, these interviews were extended to 1½ hours to accommodate the screening. However, during and following the pilot it was decided by the clinic that one hour was in fact sufficient. The majority of health services were concerned about the extra time they felt the screening would take in their already pressured history taking/assessment interviews.

Training

Organising medical staff from the Emergency Department to attend training sessions was problematic due to a lack of time for medical staff to attend and the perception that domestic violence was not their area of concern. Senior staff agreed that it was difficult to get medical staff to attend training as the medical staff argued they were tired, overworked and already pushed to attend training for routine medical procedures. Medical staff indicated they would be more likely to attend if the training was mandatory or structured into their orientation week.

Nursing staff in the Emergency Department were unable to commit to four hours training due to the lack of replacement staff available. The majority of training provided was for 20 to 45 minutes at staff changeover time which nursing staff also used to have a break, get refreshments, debrief and to hand over. These short training sessions often did not give staff sufficient time to become comfortable with the questions or to be confident in how they would respond when women screened positive to the questions.

The cost and time involved in the training was a significant issue for all services. Although staff who received the four hours training found it beneficial, the practicalities of cost and time remained a barrier for many services.

Social work role

Nursing staff and midwives were particularly concerned about the amount of work the screening may create for the social worker attached to their unit, whom they often felt was already overwhelmed with referrals. Despite this concern, all the social workers were committed to the pilot and did not want the possible increase of referrals to jeopardise undertaking the pilot.
Child at risk concerns

The Alcohol and Other Drugs Team decided they needed to better specify in the preamble that if a woman disclosed any information about children being at risk, they would need to report this information to DoCS. The team were concerned that if they were not clear about this possibility at the beginning, then it could harm any future working relationships with the client. It is unclear if the team undertook this during the pilot.

Casework relationship

Caseworkers felt the screening was inappropriate when clients were attending the service to speak about a partner or child’s drug and alcohol issue. The caseworkers believed the domestic violence screening changed the focus of the interview to the presenting person, rather than the person the client wished to discuss. There were also concerns by the case workers that clients were requesting assistance with drug and alcohol issues not domestic violence and therefore may become upset by the questions.

Appropriateness of male staff asking the questions

While supporting the screening project in principle, some male nursing staff felt it was inappropriate for males to be asking women about domestic violence. They were concerned that women would feel uncomfortable and that partners may become upset or angry.

Participation and commitment of medical staff

Securing the commitment and participation of medical staff in the screening project was a challenge. Medical staff identified the reasons for this as lack of time to ask the questions, lack of training, appropriateness/relevance of asking the screening questions whilst taking a medical history and a lack of confidence in the value of the screening.

6 Protocol and policy developments

Following completion of the screening pilot a number of developments occurred as a direct result of either implementing the domestic violence screening or as a result of an increased awareness of, and commitment to, domestic violence.

A number of services developed domestic violence protocols. These included Sutherland Hospital Emergency Department and the Antenatal Clinic. A draft domestic violence protocol for St George Hospital Antenatal Clinic, STOMP and Birth Centre was developed. Sutherland Hospital Emergency Department also developed an elder abuse protocol and updated their sexual assault protocol.

Both St George and Sutherland Hospital Antenatal Services continued screening for domestic violence following completion of the pilot in 2000. Sutherland Hospital Antenatal Services re-designed their clinic card to incorporate the domestic violence preamble and screening questions. St George Hospital Antenatal Services developed a screening form within the hospital guidelines to be included in the medical notes.

In 2001, the Area Women’s Health Nurses incorporated the screening questions into their clients clinical history and documentation and continued screening after the completion of the pilot.
In 2002, Sutherland Hospital Emergency Department designed an early identification and intervention model including flowcharts, to assess women for domestic violence on presentation to the department. This flowchart outlined the intervention procedures recommended when domestic violence was disclosed or suspected and also detailed referral points and documentation procedures.

Sutherland Hospital Drug and Alcohol Service began screening for domestic violence in 2003.

7 Feedback from women screened

The NSW Health report, *Unless they’re asked: Routine screening for domestic violence in NSW Health - An evaluation report of the pilot project*, provides a comprehensive evaluation of the domestic violence screening pilot. This report details the responses from women screened who completed a questionnaire on the screening and/or responded to the follow-up telephone interview by the University of Sydney.

Overall, the majority of women screened for domestic violence were positive about the process with 97% indicating they felt ‘OK’ or ‘relieved’ about being asked questions about abuse. Women commented that they were happy with the questions and that the direct approach worked best. The majority of women screened (95%) also believed that the health service they were attending should ask questions about domestic violence (NSW Health, 2000):

‘It is a difficult thing to ask, so I feel any health professional in an appropriate situation should be able to ask.’

‘….being straightforward and direct helps.’

‘There is no easy way to ask these questions, the person asking can only ask in the most gentle way possible and hope that they will be responded to positively.’

8 Discussion

Staff involved in the screening pilot project expressed a variety of views about undertaking the screening and the impact on their service. Generally, midwives and social workers were supportive of the screening. Midwives had already begun to recognise domestic violence as an issue for women attending their antenatal clinics, but were unsure how to raise and address the issue with them. Many midwives in the screening pilot expressed the view that the screening questions now gave them the appropriate tool to do this.

The social workers involved in the pilot discussed how the screening enabled case management to begin much earlier with their clients. This was due to disclosure occurring a lot earlier which allowed the social worker more time to develop case plans and avoid a crisis situation. One of the social workers stated that the screening assisted in her communication about domestic violence with midwives as she found they now had a greater understanding and comprehensive background of the issue. As a result this assisted to further build and establish links and relationships between midwives and social work.

Other health staff, however, were hesitant about asking the screening questions when the women had come in for a different health issue. These staff believed the screening completely changed the purpose of the visit for the client eg the client was attending for a drug and alcohol issue and the staff were asking about domestic violence. Staff were
concerned that the client worker relationship would suffer because of this and so believed it was inappropriate to ask the screening questions.

The Emergency Department nursing staff raised particular concerns around limited privacy in the department while all services mentioned the pressure on time to ask the screening questions. Overall, the staff in the Alcohol and Other Drugs Team believed they already adequately identified domestic violence in their casework through assessment procedures. The Team did not believe the domestic violence screening questions were compatible with developing a casework relationship. However since 2003 the Alcohol and Other Drugs Team have implemented the screening.

Male health staff from across the services and professions were extremely reluctant to undertake the screening in the pilot. The reasons for this were unclear but generally centered on feeling uncomfortable about being male and asking a female about male violence. There was a widely held belief amongst male staff that a female client may be offended and feel that the male staff member was being intrusive and perhaps ‘overstepping boundaries’ by asking about male violence. There was also a belief that male partners may then take offence to their partner being asked about violence. This area requires further research around the underlying beliefs held by male staff and to garner the views of the female clients.

Limited time, resources and available staff to undertake the necessary training prior to screening was an issue for all health staff and services. Training was recognised as essential but enabling staff to access it was challenging eg one service could allow the time for staff to attend training but had no staff to cover those who would be at the training. Overall, medical staff did not recognise domestic violence as their responsibility and so were extremely reluctant to attend any training. It was clear the medical staff viewed domestic violence mainly as a ‘nursing issue’ whilst nursing staff clearly saw it as both a medical and nursing responsibility.

9 Conclusion

During and following the domestic violence screening pilot, the majority of health staff acknowledged that domestic violence was an issue that had an impact on women and children’s lives. However, health staff were unclear about their, and/or their service’s role and responsibility in relation to domestic violence. Some health staff did not see identification and intervention in domestic violence as their role and were more inclined to see other health professionals as being responsible. Some health staff did not see identification and intervention in domestic violence as a responsibility of their service at all.

The screening was more successfully implemented in the antenatal services and well women’s clinics. Although health staff of these services expressed some concern and reluctance in undertaking the screening, overall it was seen as complementary to these services and their holistic approach to care.

For the screening to be successfully implemented in health services, there needs to be a demonstrable belief in and commitment to the project by management whilst at the same time providing support for health staff undertaking the screening. Domestic violence must be acknowledged by both management and health staff as the responsibility of all staff, whether they are nursing, medical or social work, male or female. This needs to be reflected in attendance at training, inservices, development of protocols and an acceptance and willingness to identify and intervene with domestic violence.
Both managers and health staff viewed training on domestic violence and the screening as essential, however finding available time for staff to attend proved difficult for all the services. Facilitating domestic violence training on a consistent basis throughout the year in established mandatory training programs and inservice calendars would enable a more sustainable approach to training across the Area. This would also ensure domestic violence stays on the health services ‘agenda’.

To successfully maintain the screening and provide support for health staff, an ongoing change management program must be implemented alongside the domestic violence screening. This program should include training, inservices, audits, resource development, partnerships with other health services and non-government agencies, reviews of protocols and policies, and provision of information and resources.
References


NSW Health Department (2001) Unless they’re asked: Routine screening for domestic violence in NSW Health, NSW Health, Sydney

South Eastern Sydney Area Health Service (1996) Domestic Violence Policy and Protocol, SESAHS
### Appendix 1

**Summary of training sessions**

<table>
<thead>
<tr>
<th>Service</th>
<th>No. of sessions</th>
<th>Total health staff attending</th>
<th>Attendance by service provider</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Nursing staff</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>staff</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Sutherland Hospital</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Emergency Department</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Antenatal Services</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Alcohol and Other Drugs Service</td>
</tr>
</tbody>
</table>

- **Sutherland Hospital**
  - **Emergency Department**
    - 3 (information sessions)
      - 12 (20-45min)
      - 3 (2hrs)
    - 17 (45 min)
    - 45 (12 hrs)
    - 8* (3 hrs)
    - 17
    - 34
    - 7
    - 0
    - 0
    - 0
  - **Antenatal Services**
    - 3
    - 1 (30 mins)
    - 22
    - 5
    - 0
    - 2
    - 0
    - 5
  - **Alcohol and Other Drugs Service**
    - 1
    - 5
    - 0
    - 5
    - 0

- **St George Hospital**
  - **Antenatal Clinic**
    - 2
    - 15#
    - 13
    - 2
    - 0
  - **Outreach Programs/Birth Centre**
    - 3 (2 hrs)
    - 11+
    - 11
    - 0
    - 0

* includes 1 Women’s Health Nurse
# includes 3 health staff from Sutherland Hospital
+ includes 1 Women’s Health Nurse

Unless otherwise stated, training sessions were held for four hours and facilitated by either ECAV, the Domestic Violence Screening Pilot project officer or the Area Domestic Violence project officer.
Appendix 2

Screening procedure and protocol

All health staff at the sites were expected to screen women 16 years of age and over for domestic violence during the three months of the pilot. The screening was incorporated as part of the normal routine assessment or intake procedure for each service. Nursing and medical staff and social workers screened women for domestic violence.

The screening questions were asked when the woman was alone, without the presence of partners, family, friends or children over the age of three years. The screening was pre-empted by a preamble explaining the pilot. This was then followed by the three screening questions.

Preamble
In this Health Service, we have begun a new project to routinely ask all women the same questions about violence at home.

This is because violence in the home is very common and can be serious and we want to improve our response to women experiencing domestic violence.

You don’t have to answer the questions if you don’t want to.

All your answers to the questions will remain confidential to the Health Service except where you give us information that indicates that you or your children are at immediate risk of serious harm. We would discuss this with you.

Also, we are interested to know how women feel about being asked these questions, so afterwards we give you a brief survey to fill out and leave in a box at the front desk. Your answers to this will be completely anonymous.

Domestic violence screening questions

1. Within the last year, have you been hit, slapped or hurt in other ways by your partner or ex-partner?

2. Are you frightened of your partner or ex-partner?

3. Are you safe to go home when you leave here?

If domestic violence has been identified in any of the above questions, continue to Question 4. If domestic violence has not been identified, give the information card to the woman and tell her: Here is some information that we are giving to all women about domestic violence.

4. Would you like some assistance with this?

If YES, refer to Protocol for response. If NO, Health worker still needs to consider safety concerns raised in answer to Questions 2 and 3. Refer to protocol for response.