



INITIATIVE TO COMBAT THE HEALTH IMPACT OF  
DOMESTIC VIOLENCE AGAINST WOMEN

**STAGE 2**

**REPORT**



## **Acknowledgements**

Crime Prevention Strategy Queensland

Queensland Health Women's Health Team

Domestic Violence Initiative Reference Group and participating sites

*This is an internal working document of the Queensland Health Domestic Violence Initiative.  
A final evaluation report will be produced on completion of the Initiative.*

## **Contents**

<b>PART A: EXECUTIVE SUMMARY OF EVALUATION FINDINGS</b> .....	<b>1</b>
<b>A1. Background to the Domestic Violence Initiative</b> .....	<b>1</b>
<b>A2. Key Findings of the Stage 2 Evaluation of the Domestic Violence Initiative</b> .....	<b>3</b>
<b>A3. Key Recommendations from the Evaluation of Stage 2 of the Domestic Violence Initiative</b> .....	<b>4</b>
<b>PART B: OVERVIEW OF THE DOMESTIC VIOLENCE INITIATIVE</b> .....	<b>6</b>
<b>1.0 Rationale for the Domestic Violence Initiative</b> .....	<b>6</b>
<b>2.0 Project Summary and Update of DVI Activities</b> .....	<b>7</b>
<b>2.1 Stage One Implementation of the DVI</b> .....	<b>7</b>
2.1.2 <i>Key Findings of the Evaluation of Stage 1 of the DVI</i> .....	<i>7</i>
2.1.3 <i>Key Recommendations from the Evaluation of Stage 1 of the DVI</i> .....	<i>8</i>
<b>2.2 Stage 2 Implementation of the DVI</b> .....	<b>8</b>
2.2.1 <i>Stage 2 Objective and Strategies</i> .....	<i>8</i>
2.2.2 <i>Stage 2 Report and Update</i> .....	<i>10</i>
<b>PART C: STAGE 2 EVALUATION OF THE DOMESTIC VIOLENCE INITIATIVE</b> .....	<b>16</b>
<b>3.0 Evaluation of DVI Screening</b> .....	<b>16</b>
<b>3.1 Background</b> .....	<b>16</b>
<b>3.2 Methodology</b> .....	<b>16</b>
<b>3.3 Results</b> .....	<b>17</b>
3.3.1 <i>Screening</i> .....	<i>17</i>
3.3.2 <i>Disclosure Rates</i> .....	<i>19</i>
<b>3.4 Discussion</b> .....	<b>23</b>
<b>3.5 Emergent Issues arising from chart audits</b> .....	<b>24</b>
3.5.1 <i>Record Keeping</i> .....	<i>24</i>
3.5.2 <i>Antenatal repeated screening</i> .....	<i>24</i>
3.5.4 <i>Verbal Screening</i> .....	<i>25</i>
3.5.4 <i>Client Decline of Assistance</i> .....	<i>26</i>
<b>3.6 Recommendations</b> .....	<b>26</b>
<b>4.0 Client Evaluation</b> .....	<b>28</b>
<b>4.1 Goals and objectives</b> .....	<b>28</b>
<b>4.2 Background</b> .....	<b>28</b>
4.2.1 <i>Development of the client survey screening tool</i> .....	<i>29</i>
<b>4.3 Methodology</b> .....	<b>30</b>
<b>4.4 Results</b> .....	<b>30</b>
4.4.1 <i>Reasons for not accepting help</i> .....	<i>31</i>
4.4.2 <i>Helpful Services and Facilities</i> .....	<i>34</i>
4.4.3 <i>Other Helpful Factors</i> .....	<i>36</i>
4.4.4 <i>Additional comments</i> .....	<i>37</i>
<b>4.5 Discussion</b> .....	<b>38</b>
<b>4.6 Recommendations</b> .....	<b>39</b>

References .....	40
Appendices .....	42
<b>Appendix A: Screening forms used by the Domestic Violence Initiative .....</b>	<b>43</b>
<b>Appendix B: Detailed Results of the Chart Audit.....</b>	<b>45</b>
Table B1: Stage 2 Evaluation Chart Audit Results: Screening Rate.....	45
Table B2: Stage 2 Evaluation Chart Audit Results: Domestic Violence Screening Status ..	46
Table B3: Stage 2 Evaluation Chart Audit Results: Acceptance of help.....	47
Table B4: Stage 2 Evaluation Chart Audit Results: Type of Abuse.....	48
Table B5: Type of violence and acceptance of help.....	48
Table B6: GP Link by Site (Antenatal Clinics only) .....	49
Table B7: GP Link by Type of abuse.....	49
<b>Appendix C: Client Questionnaire Survey Form, Procedure and Flow-Chart .....</b>	<b>50</b>
<b>Appendix D: DVI Presentations .....</b>	<b>53</b>
<b>Appendix E: DVI Sites .....</b>	<b>54</b>
<b>Appendix F: Summary of Stage 2 Evaluation Strategy and Status .....</b>	<b>55</b>

## **PART A: EXECUTIVE SUMMARY OF EVALUATION FINDINGS**

### **A1. Background to the Domestic Violence Initiative**

The Queensland Health Domestic Violence Initiative was commenced in 1998 through funding from the Queensland Government's Crime Prevention Strategy to develop and trial an effective method for identifying women who have experienced domestic violence for use in antenatal and emergency departments.

Domestic Violence is widespread in Australia. The Australian Bureau of Statistics reports that 23% of Australian women who have ever been married or in a de facto relationship experienced violence by a partner at some time during the relationship, with 1.1 million Australian women experiencing violence from a partner (ABS, 1996). A survey of women presenting at the Emergency Department of the Royal Brisbane Hospital showed that 23.6% of women indicated a history of domestic violence. A survey at the Royal Women's Hospital's Antenatal Clinic revealed that 29.7% of pregnant women reported a history of abuse, with 8.9% experiencing abuse during their pregnancy (Webster, 1994).

Domestic violence is defined as:

*Violent, abusive or intimidating behaviour carried out by an adult against a partner or former partner to control and dominate that person. It is most often violent, abusive or intimidating behaviour by a man against a woman.*

(NSW Health, 1999; p19)

Domestic Violence is being increasingly recognised as a health issue. The effects of domestic violence on women's health and well-being are pervasive, and can impact significantly on physical, emotional and mental health. The client incidence of domestic violence is important information for health care providers to incorporate into the appropriate provision of diagnoses, treatment and care for clients.

The experience of domestic violence causes health problems for women, and poor obstetric and reproductive outcomes for pregnant women. Research has shown that women who have experienced violence are more likely to have a greater number of hospital admissions during pregnancy, to smoke, to use both pharmaceutical and illicit drugs, to have a higher incidence of asthma and epilepsy, and deliver a preterm or low birth weight baby (Webster, 1996). Abuse during pregnancy is more prevalent than other routinely screened complications of pregnancy (such as pre-eclampsia, gestational diabetes) with resultant health consequences impacting on women and their children (Parker et al, 1994).

The Domestic Violence Initiative seeks to incorporate screening for domestic violence into routine history taking protocols, as a component of core clinical practice. This entails the health service provider asking the client 2 –3 additional questions relating to domestic violence as part of the routine client history taking procedure. This small change in the process of routine history taking could result in significant

improvement in the diagnosis and provision of health services and information to women who experience domestic violence. The outcomes anticipated from the Domestic Violence Initiative include raised awareness about domestic violence amongst health care professionals and the wider community; increased communication between stakeholders in the area of domestic violence; and the development of a standardised method of identification for women who have been subjected to domestic violence.

Stage 1 of the Domestic Violence Initiative involved trialing a screening tool at 8 pilot sites: Antenatal clinics at Mt Isa Base Hospital, Cairns Base Hospital, Kirwan Hospital for Women and the Mater Misericordiae and the Royal Women's Hospital in Brisbane; the gynaecology outpatient department at the Royal Women's Hospital; the emergency department of the Mater Adults' Hospital, Brisbane; and the emergency department (primary care unit) at the Royal Brisbane Hospital. The evaluation of Stage 1 revealed that most women (83%) presenting to the antenatal or gynaecology outpatient services were screened for domestic violence, with approximately 6.5% disclosing some form of domestic violence. Of those women who screened positive for domestic violence, approximately 10% accepted an offer of immediate help. Screening women for domestic violence was overwhelmingly perceived by clients as a good idea, with 97% of surveyed women supporting screening. Service providers and staff also reported satisfaction with the screening process.

Stage 2 of the Domestic Violence Initiative has seen a continuation and extension of the previous Stage, to include the original pilot sites, as well as the addition of 11 new sites. It was of particular interest to examine possible changes in screening rates over the implementation of Stage 1 and Stage 2 of the DVI, as previous research in domestic violence screening in the health care setting has indicated that there is a decline in screening rates over time (Fanslow et al, 1998).

The current report summarises the activities of the Domestic Violence Initiative during the implementation of Stage 2, and examines the results of the Stage 2 Evaluation, including reporting of screening rates, client screening status, and a client evaluation.

## A2. Key Findings of the Stage 2 Evaluation of the Domestic Violence Initiative

1. Across all sites, 82% of presenting women were screened for domestic violence. 7% of all women screened disclosed some form of domestic violence. The rate of women screening positive to domestic violence has slightly increased from the Stage 1 result of 6.5%.
2. Most (89.2%) women presenting to the antenatal services were screened for domestic violence. This compares favourably to the Stage 1 result, where 86.5% of women were screened. Of the women who were screened at the antenatal sites, 6.8% of them disclosed some form of domestic violence.
3. More than 23% of women presenting to an emergency department were screened for domestic violence. This is a substantial increase in the screening rate from only 7.6% in Stage 1. Of the women screened at the emergency department, 8.5% disclosed abuse.
4. More than 45% of women presenting to the Gynaecology Outpatients Department were screened, with 12.4% of women screening positive for domestic violence. This compared to a Stage 1 result of a screening rate of 67.3%, with a positive screening rate of 1.6%.
5. Approximately 13% of women disclosing violence at all sites accepted an offer of help at the time of screening. This has increased since Stage 1, where 10% of women who disclosed abuse accepted help at the time of screening. The Stage 2 evaluation also revealed that the proportion of women accepting help at the antenatal sites at the time of screening was 14%.
6. Despite 10.8% of all women screened disclosing abuse at the emergency and gynaecology outpatients sites, no women who were screened at these sites accepted help at the time they were screened.
7. Women who screened positive to domestic violence reported in a survey that fear, embarrassment or shame, and the hope that the situation will resolve itself were barriers to accepting help at the time of screening. Women who participated in the survey also reported that support of family and friends, counselling, and police and agency responses were helpful factors when experiencing abuse.

### **A3. Key Recommendations from the Evaluation of Stage 2 of the Domestic Violence Initiative**

1. The universal routine screening for domestic violence in public sector health facilities should continue and expand to other sites.
2. A protocol documenting screening procedures, including record keeping should be distributed and implemented statewide.
3. Negotiations with sites and medical records staff should continue regarding the incorporation of DVI screening forms in all female patient charts, onto routine history forms.
4. Data on domestic violence should be incorporated into existing health databases such as the Queensland Perinatal Data Collection.
5. Core screening skills training should be available to new DVI sites. Refresher and train-the-trainer training should be available at all sites, with the intention of self-sustaining training of staff at all sites.
6. The Domestic Violence Initiative should continue to work with the Child and Youth Family Unit to integrate the DVI and the Early Intervention for Safe and Healthy Families Initiative.
7. Stage 3 evaluation should incorporate an evaluation of the process of notification of domestic violence to a General Practitioner when a patient is engaged in shared antenatal care.
8. Screening for domestic violence should be rolled out during Stage 3 to additional emergency department sites across the state.
9. Further examination of the impact of domestic violence training on staff attitudes and practices should be undertaken as part of Stage 3 evaluation.
10. The client evaluation should be trialed in additional sites, with particular emphasis on sites with a higher proportion of rural and remote and Indigenous populations.
11. Client evaluations should be considered in the development and modification of new and existing services and facilities for women and families who have experienced domestic violence.
12. Case studies of clients' service utilisation histories after disclosure of violence, and an investigation into their satisfaction with their experiences of accessed resources should be incorporated as a component of the evaluation of Stage 3.
13. Obtaining demographic data of women who disclose violence should be investigated as a possible strategy for the Stage 3 evaluation.



14. The findings of this evaluation should be incorporated into staff development and training addressing the health impact of domestic violence.
15. The findings of this evaluation should be disseminated to relevant government, non-government and community health and welfare services that address domestic violence.

## **PART B:**

# **OVERVIEW OF THE DOMESTIC VIOLENCE INITIATIVE**

### **1.0 Rationale for the Domestic Violence Initiative**

Violence was identified as a priority health issue by the many women consulted in the development of the National Women's Health Policy (1989). Over the last two decades a significant body of evidence has established a strong association between domestic violence and a range of physical and mental health risk factors and disorders. Victims of violence are likely to be heavy users of health care, and there are high costs of violence to the economy, for example through absenteeism, and reduced opportunity to obtain or retain employment. There is a growing recognition of the impact of violence on obstetric outcomes, including increased miscarriage, substance abuse, smoking, inadequate prenatal care, anxiety and depression, and reproductive health, with more frequent generalised gynaecological disorders.

The *Queensland Crime Prevention Strategy: Building Safer Communities* is a whole-of-Government approach that includes strategies to address various aspects of domestic violence. The strategy identifies five key goals, including reducing violence and supporting families, children and young people. Queensland Health's contribution to the Queensland Crime Prevention Strategy is the minimisation of the health impact of domestic violence. Funding of \$1.05 million over four years has been provided for the Queensland Health Domestic Violence Initiative (DVI) by the Queensland Crime Prevention Strategy.

Queensland Health's Corporate Plan 1999-2004 includes *practices in antenatal and emergency clinics to address the impact of violence against women* as an explicit health goal and the DVI began to work towards this goal in November 1998.

The DVI is based on evidence synthesised in the section on Violence in the draft Queensland Women's Health Outcomes Plan, which aims to provide medium to long term strategic directions to address priority health issues. In spite of the pervasive impact of violence on women's health, there have been few systematic attempts to address this, largely because violence is seldom queried by service providers or disclosed by clients, and thus remains a hidden health risk. Evidence indicates that screening to enable women to disclose violence in a health care setting is essential in order to enhance the capacity of the health care system to provide accurate diagnoses and appropriate interventions for victims of domestic violence.

The DVI has introduced screening for domestic violence in some antenatal clinics as a component of the routine history taking procedure for each client. The screening tool is comprised of a series of direct questions regarding physical, emotional and threatened abuse, and fear of partner. The health care provider verbally asks these questions of the client during the first "booking-in" visit to the antenatal clinic. In addition, there is a check box on the form to record if help was offered to the client and if it was accepted.

Five sites - Mt Isa and Cairns Base hospitals, Kirwan Hospital for Women in Townsville and the Mater Misericordiae and Royal Brisbane Hospital campuses in Brisbane - across the State were invited to participate in Stage 1 of the project. They

were selected because of a demonstrated interest in innovation for women's health and the capacity to provide a representative demographic and environmental sample. During the implementation of Stage 2, nine additional sites have joined the Domestic Violence Initiative.

The DVI is guided by a reference group comprised of participants from each site, as well as representatives from relevant government and non-government agencies and academic institutions. The DVI is jointly managed by the Principal Policy Advisor (Women's Health) in the Health Outcomes Unit of Corporate Office, Queensland Health and the Nursing Research Director at the Royal Women's Hospital, Brisbane. A project co-ordinator and a data and evaluation officer also assist the implementation of the DVI.

## **2.0 Project Summary and Update of DVI Activities**

### **2.1 STAGE ONE IMPLEMENTATION OF THE DVI**

Stage 1 of the DVI began in November, 1998. Five District Health Services which had been involved in the development of the Women's Health Outcome plan were invited to work on the development, trial and evaluation of a screening instrument for domestic violence. The participating sites were the Royal Women's Hospital (antenatal and gynaecology outpatient clinics), Royal Brisbane (primary care unit of the emergency department), the Mater Mothers' and Mater Adult's Hospitals, Mt Isa and Cairns Base Hospitals, and Kirwan Hospital for Women in Townsville.

The screening instruments (attached as Appendix A) were developed by the DVI Reference Group. A standard four-hour training package for service providers was developed under the guidance of a training co-ordinator.

Piloting of the screening instrument began in July 1999. A process evaluation began eight weeks later with results showing that clients overwhelmingly supported the screening process.

#### **2.1.2 Key Findings of the Evaluation of Stage 1 of the DVI**

1. Most (97%) women presenting for care supported screening for domestic violence, particularly in the antenatal clinics.
2. Most (98%) women being screened for domestic violence were comfortable with the method in which they were asked.
3. Approximately two thirds of the women surveyed for the evaluation expressed a preference for a nurse/midwife or a general practitioner to ask questions about domestic violence.
4. Most (83%) women presenting to the antenatal or gynaecology outpatient services were screened for domestic violence.

5. Less than 10% of women presenting to the emergency departments were screened for domestic violence.
6. Approximately 7% of the women screened disclosed some form of domestic violence.
7. Approximately 10% of women disclosing violence accepted an offer of immediate help.
8. Staff screening women for violence gained confidence and competence in screening with training and experience over time.
9. Staff screening women for violence benefited from initial and ongoing training on domestic violence and related issues.
10. Staff screening women for violence benefited from explicit role clarification – ie- clear, expressed identification of what is expected of service providers, other agencies and clients.
11. Data and feedback on screening practices and follow up were identified as important sources of experiential learning and maintaining staff commitment.

### **2.1.3 Key Recommendations from the Evaluation of Stage 1 of the DVI**

The Stage 1 Evaluation recommended that actions listed below were implemented during Stage 3:

1. The universal, routine screening for domestic violence in public sector health facilities should continue and expand.
2. The issue of domestic violence should be raised at subsequent visits, particularly in antenatal services. Women screening negative should be re-screened at a later interval. Women disclosing violence should be given the opportunity to talk further about their situation.
3. Agreed standards should be developed to provide guidelines and standards of practice for domestic violence screening practices.
4. Evaluation findings should be incorporated into ongoing staff development and training.
5. Evaluation of the agreed link with general practitioners should be redesigned, trialed and evaluated.

## **2.2 STAGE 2 IMPLEMENTATION OF THE DVI**

### **2.2.1 Stage 2 Objective and Strategies**

1. To initiate a quality improvement management approach in universal screening for domestic violence.

- Continuation of screening at all Stage 1 sites, supported by training and resources. Expansion to include new sites.
  - The development of site-specific protocols detailing rights, roles and responsibilities of all health service providers concerned with the care of women who have experienced violence.
  - Collaboratively develop an audit instrument for use in monitoring of participating sites.
  - To examine the needs of women who disclose violence, including the action women take in relation to violence following disclosure, and access to, and satisfaction with services.
  - To plan and stage a two day forum in March 2001 to showcase the DVI achievements and to explore current and future issues for the Initiative.
2. To integrate screening results into medical records and existing data bases such as the Queensland Perinatal Data Collection.
    - To coordinate negotiations with medical records departments at participating sites to incorporate screening instruments and information into the patient medical chart.
    - To negotiate with the Health Information Centre for the inclusion of screening information into core Queensland Health data collections such as the Queensland Perinatal Data Collection.
  3. To pilot and evaluate a system to link the screening system with general practitioners involved in shared obstetric care.
    - To liaise with Divisions of General Practice to facilitate communication about the process of information sharing between hospital and general practitioners.
    - To develop evaluation methodology in collaboration with key stakeholders involved in the process of screening women for domestic violence.
    - To evaluate linkages with general practitioners, document and provide feedback about results to the Management and Reference Groups for discussion, decision making and wider dissemination.
  4. To liaise with relevant professional bodies and academic institutions to have domestic violence included in curriculum for basic nursing and medical education.
    - To work with representatives from the six Queensland hospitals teaching midwifery to develop strategies to include issues related to violence against women into core curricula.

- To negotiate with the Queensland Nursing Council on the inclusion of the inclusion of a domestic violence of a domestic violence component in undergraduate nursing curriculum.

A summary of Stage 2 objectives, strategies and status is attached as Appendix F.

### **2.2.2 Stage 2 Report and Update**

#### ***Expansion into new sites***

During Stage 2 implementation of the DVI, 9 additional sites have joined the DVI. These sites are:

- Bayside Health Service District (Family Health Service, Bayside Hospital and Wynnum Hospital)
- Central West Health Service District (Longreach Hospital Antenatal Clinic; Miles Hospital, Tara Hospital, Chinchilla Hospital)
- Northern Downs Health Service District – (Jandowae Hospital, Accident & Emergency)
- Redcliffe-Caboolture Health Service District
- Townsville Hospital (Accident & Emergency)
- Gold Coast Hospital (Antenatal Clinic)
- South Burnett Health Service District
- Nambour Hospital (Antenatal Clinic)
- Mackay Hospital

#### ***Development of site specific protocols***

The Royal Women's Hospital Quality Improvement Unit has produced a policy and procedure for screening antenatal clients and surgical gynaecology outpatients for domestic violence. This policy also incorporates an audit tool for use in the antenatal setting. It is anticipated that this policy will be adapted for Statewide circulation in 2001.

- ❖ It is recommended that all Queensland hospital antenatal sites implement the policy and procedure for screening antenatal clients for domestic violence, pending endorsement by the General Manager, Health Services.

#### ***Incorporation of screening instruments into medical records***

The introduction of routine domestic violence screening into hospital clinical practice has involved the integration of screening information into existing client record systems. The DVI screening instruments have been incorporated into patient medical record systems at all participating DVI sites. In most sites, this has involved the

incorporation of a separate sheet of paper containing the DVI screening form, which is included in the patient chart immediately following the patient history notes. However, the inclusion of the form into patient medical records has not been universal at all sites, and some client records do not contain the DVI screening form.

- ❖ It is recommended that the DVI screening form be incorporated into all female patient charts.
- ❖ It is recommended that negotiations with sites regarding the incorporation of the DVI screening form into existing patient history forms continue during Stage 3 of the DVI.

### ***Incorporation of results into the QLD Perinatal Data collection***

If routine screening for domestic violence into hospital clinical practice is to be sustained, it must be integrated into existing clinical information systems such as the client's medical record, clinical electronic reporting systems and appropriate databases that will enable monitoring of the prevalence of domestic violence (as disclosed by the client). The integration of the screening forms into the client's medical record has been achieved at the pilot sites, however there has been limited progress in the incorporation of the data into corporate information systems such as the Queensland Perinatal Data Collection.

- ❖ It is recommended that domestic violence data be included in the Queensland Perinatal Data Collection.

### ***Communication with Divisions of General Practice***

Training of medical staff regarding domestic violence, its health impact, and screening has been recognised as imperative to the provision of quality health care services to women who have experienced violence. Initial discussions regarding the training needs of general practitioners in relation to domestic violence occurred with the Divisions of General Practice during Stage 2 of the DVI. A training package which has a Continuing Medical Education (CME) component has been discussed, although the design and delivery of the package are yet to be finalised. Auditing of domestic violence screening and practices is to be self-administered by the general practitioners.

- ❖ It is recommended that communications with the Divisions of General Practice continue, to finalise a domestic violence training package for general practitioners (GPs).

### ***General Practitioner (GP) Link***

Approximately 40% of pregnant women in Queensland participate in shared antenatal care programs, where the antenatal care of the woman is shared between her nominated GP and the hospital antenatal clinic. As the experience of domestic violence is important information for a woman's antenatal care, and ongoing health care, the DVI has included a provision for seeking consent to share domestic violence screening information with a client's GP.

In October 1999, discussions with senior hospital staff and representatives from the Divisions of General Practice were held regarding the safe and appropriate transmission of domestic violence screening results to general practitioners. The importance of sharing information about the results of the domestic violence screen was discussed and three areas of concern emerged:

1. the safe and confidential transfer of the screening results from the hospital to the GP;
2. the consent of the client for the screening clinic to provide her domestic violence information to her GP; and
3. training for GPs to heighten awareness of the health impact of domestic violence and to increase their capability to assist clients.

It was agreed that after informed consent was provided by the woman, a confidential letter posted to her nominated GP is the optimal method of disclosure to a third party. The following procedure for notifying a GP of a client's domestic violence status was trialed and evaluated in pilot areas:

1. A woman screens positive for domestic violence at the hospital site;
2. Consent to share this information with a GP of her choice is provided by the woman;
3. A form letter and a photocopy of the domestic violence screening form are posted to the GP nominated by the woman. This should be done on the same day as the screening is conducted by hospital staff, and hospital protocols should include reference to the importance of timely communication of this information. A client-held record must not be used to communicate the screen results because of the potential risk to the client in terms of confidentiality.

Notification of a GP was trialed at Antenatal sites during Stage 2. Results are presented in Chapter 4.

- ❖ It is recommended that the evaluation of Stage 3 includes a component which investigates the procedure for sharing domestic violence information with a client nominated GP.

### ***Collaboration with universities and QLD Nursing Council***

The Queensland University of Technology (QUT) has reorganised its clinically-focused post-graduate nursing courses. The Graduate Certificate, Graduate Diploma and Masters of Nursing courses include a women's health stream, which includes subjects on violence against women, and social and reproductive health. The DVI Reference Group had been invited to participate in the consultative process in the development of these courses at QUT.

Discussions have commenced with the Qld Nursing Council to progress the inclusion of material on the impact of violence on women's health into undergraduate nursing curricula.

In October 2000, Queensland Health extended an invitation for tender offers for the design and delivery of a distance education training package for midwives regarding the health impact of domestic violence. The training package will incorporate a flexible delivery model, and will allow for self-directed learning. The training material being developed will include an interactive video and workbooks.

- ❖ It is recommended that collaborations with other Queensland universities that offer degree courses in nursing continue, to place domestic violence and women's health in nursing curricula.

### ***Accolades***

During 2000, the DVI was recommended for some prestigious awards. In May 2000, the DVI won the Domestic Violence Prevention Award, sponsored by Families, Youth and Community Care Queensland, and the Queensland Domestic Violence Council. In August 2000, the DVI won the Queensland Health Director General's Silver Award for Excellence in Policy and Outcomes. In November 2000, The DVI won a Certificate of Merit in the Australian Violence Prevention Award by the Australian Heads of Government 2000, sponsored by the Minister Assisting the Prime Minister for the Status of Women. A grant of \$10 000 provided to the DVI with this award has been reserved for further research into the health impact of domestic violence.

### ***Publications and Dissemination of Information***

The DVI publishes a newsletter every month, updating DVI information and progress, and discussing issues concerned with violence, screening and women's health. The DVI newsletters are also available on the DVI website at <http://www.health.qld.gov.au/womhlth/home.htm>. In addition, to support ongoing education in this area, current articles related to health care and violence are circulated with the newsletter.

The DVI has been active in the dissemination of information and presentation of research findings. A publications and presentations list is in Appendix D. In addition, the DVI has been featured in a number of publications and newsletters, including the Queensland Health publication *Health Matters*, and the *Domestic Violence Clearinghouse Newsletter*.

### ***Continuation of Inservice DVI Training***

Training of health service providers increases the identification of domestic violence and improves the responses to those who experience domestic violence. A four-hour DVI training program is available for health care professionals at DVI sites. This program addresses the health impact of violence on women, practical issues associated with screening, and potential responses to the identification of domestic violence. Core inservice training, refresher training, and train-the-trainer courses are available at no cost to participants or sites. This training program is accompanied by resources which include research articles on domestic violence, screening forms and procedures, and a list of Queensland domestic violence resources. Training is conducted at all sites prior to the implementation of screening, and on-going and refresher training is available for participants on a needs basis.

During Stage 2, the following sites participated in training:

- Cairns Base Hospital
- Chinchilla Hospital
- Dalby Hospital
- Gold Coast Hospital
- Miles Hospital
- Redland Bay Hospital
- Royal Women's Hospital
- Wynnum Hospital

Feedback forms were obtained from participants at all training sessions. Participants reported satisfaction with all aspects of the training module, and reported an increase in their self assessed knowledge of domestic violence following the training session.

### ***Early Intervention for Safe and Health Families***

Family violence frequently coexists with child abuse and neglect, and there are substantial deleterious effects of living with family violence on children's health and well-being. Children may be primary victims of violence, subjected to violence by one or both care-givers or they may be secondary victims of violence and suffer significant psychological effects and poor health outcomes from witnessing their mothers' experience of violence. Furthermore, the intergenerational cycle of violence may be perpetuated, as boys who witness violence against their mothers are more likely to abuse their female partners when they are adults than boys from non-violent homes.

The Family CARE Nurse Home Visiting Program and the Domestic Violence Initiative have the common goal of seeking to reduce the impact of domestic violence, and have been integrated to form the Early Intervention for Safe and Healthy Families Initiative (EISHFI) at four Queensland sites. The Family CARE Program is an evidence-based nurse home visiting service that targets families with newborns at risk for poor health and social outcomes due to a range of key risk factors, including the presence of family violence (EISHFI Project Plan, 2000). The current EISHFI sites are:

- Sunshine Coast Health Service District
- Logan & Beaudesert Health Service District
- Gold Coast Health Service District
- Cairns Health Service District



Expansion of the EISHFI into other Queensland sites is planned for 2001. The identification of family violence is one criterion for admission into the Family CARE home visiting program. An evaluation plan for EISHFI is being developed collaboratively with the DVI, and will incorporate data collection at the four EISHFI sites, as well as ongoing program monitoring and evaluation.

## ***PART C:***

# **STAGE 2 EVALUATION OF THE DOMESTIC VIOLENCE INITIATIVE**

## **3.0 Evaluation of DVI Screening**

### **3.1 BACKGROUND**

An important component of the evaluation is determining screening compliance of sites, as well as the screening status of clients at participating sites. This data provides essential feedback to sites regarding the prevalence of domestic violence in their target population, and could also serve to inform hospital policy and practices.

### **3.2 METHODOLOGY**

An audit of a representative sample of patient charts from randomly selected Stage 1 and Stage 2 sites was used to ascertain the proportion of all women presenting at these departments who were screened. Results of the routine screen are retained in the women's hospital record. Permission to access medical charts was received from the Medical Superintendent or equivalent of all public facilities and the Chief Executive Officer of the Mater Misericordiae Hospitals.

At the selected antenatal sites and the Royal Women's Hospital gynaecology outpatients department, all charts available for at least three complete months were audited. The charts for one week of admissions were audited at the Emergency Department at Mater Adult's Hospital.

All information used or recorded in the evaluation was de-identified. The Mater Mothers' Hospital captured the Domestic Violence Screen electronically and frequency counts from the Clinical Record System were used to collect the required information.

A standard data collection form was used to audit each patient chart. The form was used to collect information regarding:

- (1) whether the DVI screening form was present in the chart,
- (2) whether the DVI screening form had been completed,
- (3) the client's responses to each DVI question,

(4) if the woman was offered assistance if required; and

(5) if the woman accepted referrals or other assistance.

At the antenatal clinics, an additional question seeking the client's approval to share domestic violence screening information with the woman's GP was included. Demographic information was not collected.

Overall, 3546 charts were audited - 3097 from the antenatal sites, 254 from the Mater Adult Emergency Department and 195 from the Royal Women's Hospital Gynaecology Outpatients Department.

### 3.3 RESULTS

#### 3.3.1 Screening

The overall screening rates across all participating sites was 82%. The highest rate of screening occurred at the antenatal sites, as shown in Figure 3.1.

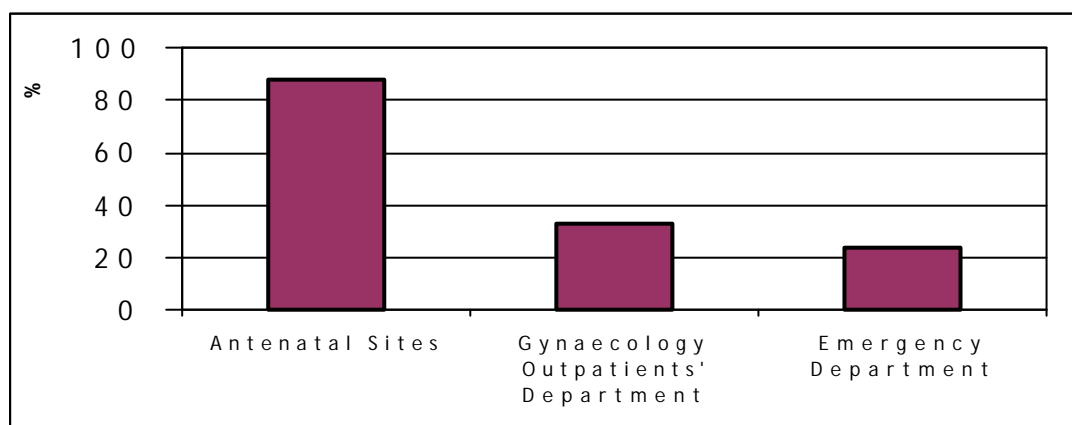


Figure 3. 1: Proportion of women screened by type of site.

#### *Stage 1 Antenatal sites*

The selected antenatal sites recorded the highest rates of screening activity of any participating department, with an overall screening rate of 89.2%. This screening rate compares favourably with the audit of Stage 1, which reported a screening rate of 86.5% for the antenatal clinics. For Stage 2, the proportion of all women screened at antenatal sites ranged from 32.3% at Kirwan Hospital for Women to 96.6% of patients who were screened at the Mater Mothers' Hospital.

In comparison to Stage 1 evaluation results, screening rates increased at Mater Mother's and Cairns Base Hospitals but fell significantly at Kirwan Hospital for Women, as shown in Figure 3.2. Slight declines in the screening rates were experienced at Mt Isa Base Hospital and the Royal Women's Hospital.

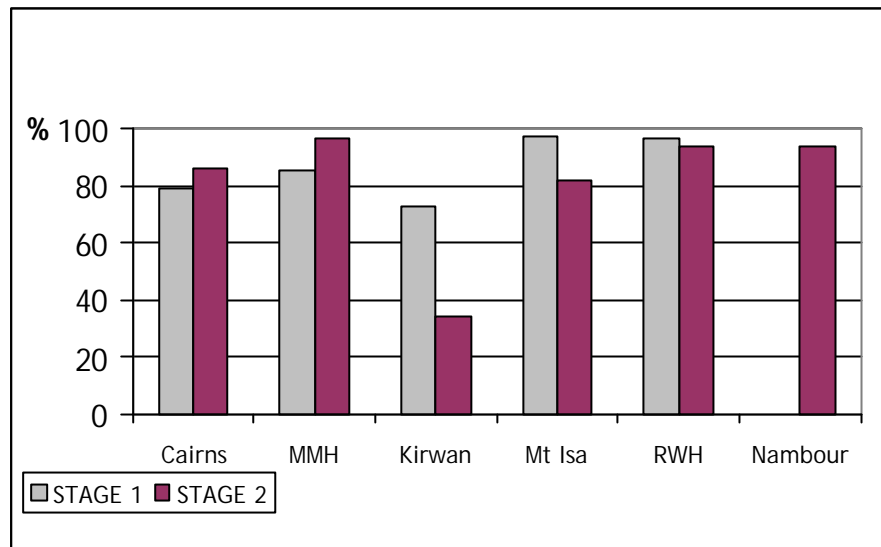


Figure 3.2: Screening rate by audited site.

**Stage 2 Antenatal Site**

Nambour Hospital Antenatal Department commenced DVI screening in June, 2000. The chart audit demonstrated a screening rate of 94% which is a high initial compliance rate, compared to evaluation results in pilot antenatal sites in Stage 1, which averaged 86.5%.

**Emergency department**

Although the screening rate for the Mater Adults' Hospital Emergency Department remains low in comparison to the antenatal sites, it has increased significantly since the evaluation of Stage 1. At the Stage 1 evaluation, the rate of screening was 7.7%. In Stage 2, the proportion of all women who presented to the Emergency Department who were screened increased to 23.2%. This is displayed in Figure 3.3.

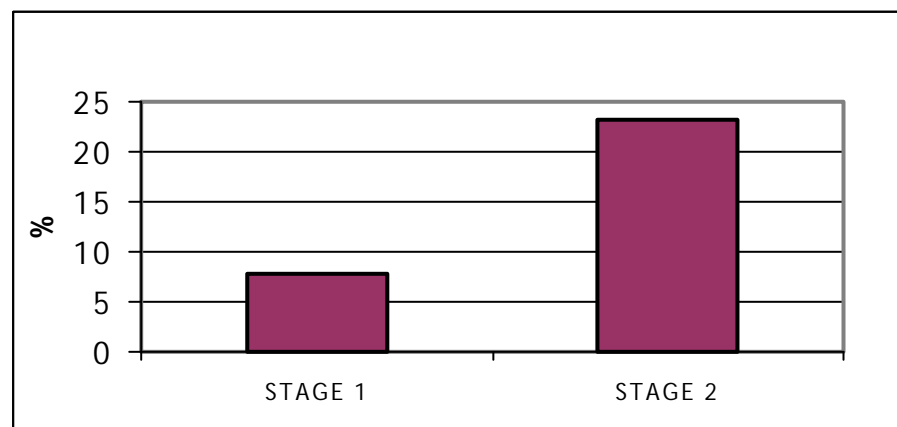


Figure 3.3: Proportion of women screened at the emergency department, Mater Adults' Hospital in Stage 1 and Stage 2.

**Gynaecology Outpatients Department**

At the Stage 2 Evaluation, the Gynaecology Outpatients Department (GOPD) of the Royal Women's Hospital experienced a decline in the rate of screening since the

Stage 1 evaluation. During Stage 1, the proportion of all women who presented to Royal Women's Hospital GOPD who were screened for domestic violence was 67.3%. The screening rate decreased to 45.6% for Stage 2. This decline occurred despite the inclusion of the DVI screening tool in the Core Assessment Form, which was trialed as an inclusion in the charts of patients undergoing gynaecological surgery requiring theatre admission.

It is important to note that the Stage 1 evaluation data sample consisted of patient visits for a single week, whereas the Stage 2 evaluation data consisted of all charts available for three complete months. The Stage 2 data might be considered more representative of the screening compliance at the Gynaecology Outpatients Department due to the larger sample size.

The Clinical Nurse Consultant of the GOPD suggested that a possible reason for the decreased screening rate is that partners and family often accompany women when they are admitted to the department. In addition, administrative changes, including amalgamation of the medical records systems with the Royal Brisbane Hospital, have been cited as possible reasons for the decline.

### 3.3.2 Disclosure Rates

The overall rate of disclosure of all types of domestic violence at all sites was 7.0%. This compares to the disclosure rate of Stage 1 of 6.5%. Disclosure rates during Stage 2 varied from 0% at Mt Isa Base Hospital to 14.6% at Kirwan Hospital for Women. The Stage 1 evaluation revealed a range of disclosure from 3.9% to 11.0%, as shown in Figure 3.4.

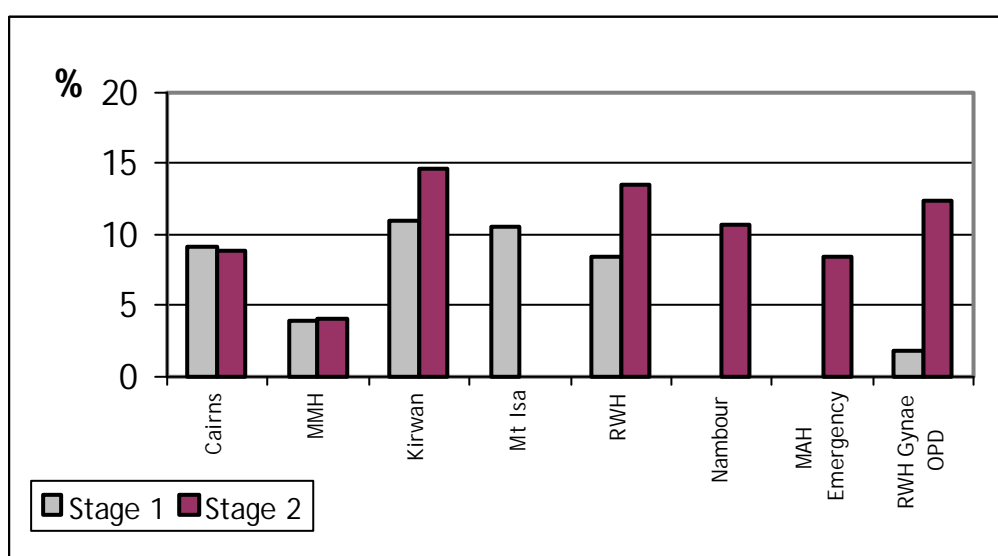


Figure 3.4: Disclosure Rates by site for Stage 1 and Stage 2

Mt Isa Base Hospital reported the lowest rate of disclosure of all sites, decreasing from 10.7% during Stage 1 to 0% at Stage 2. It was evident from information available in the patient chart that the low rate of disclosure at Mt Isa Base Hospital was not reflective of the true domestic violence status of some clients, as emergency department records revealed admissions for injuries due to domestic violence.

Discussions with the antenatal department of the Mt Isa Base Hospital suggested that the unique client population at Mt Isa, with a high proportion of Indigenous and rural and remote clients might affect the disclosure rate, however this was not experienced at this site during Stage 1. As they were statistical outliers, and not reflective of true client domestic violence status, the results from Mt Isa Base Hospital were excluded from further analysis in this report.

The next lowest rate of disclosure in the antenatal sites (4.1%) occurred at the Mater Mothers' Hospital where data is entered directly into an electronic records system. The Mater Mothers' Hospital also reported the lowest rate of disclosure during the Stage 1 evaluation. The electronic recording of patient information and the data-entry terminals allow little flexibility in the environment where women are screened and the mandatory fields and limited response options prevents staff from recording that a partner was present and that it was unsafe to screen. In addition, practical issues, such as typing of information into a keyboard may impede the building of rapport between service provider and client, and discourage clients from disclosing abuse.

While the Mater Mother's Hospital had the highest screening rate with the lowest disclosure rate, Kirwan Hospital for Women had the highest disclosure rate with the lowest screening rate. There was no evidence at Kirwan to indicate that staff were selectively screening according to perceived risk. Screening practices appeared to be more associated with clinic days, suggesting that some staff were screening routinely while others were not screening at all. This highlights the need for continued availability of training for all staff.

The screen results also indicated that in comparison to Stage 1 findings, a slightly increased proportion of all women screened positive to at least one form of violence (7.0% compared to 6.5% in Stage 1). Emotional abuse was the most widely disclosed form of abuse, with 79.4% of all women who screened positive for domestic violence disclosing emotional abuse. Physical abuse had a prevalence of 43.7% among those women who screened positive, and 38.2% of women who screened positive reported threatened abuse. Some women experienced more than one form of abuse so totals are greater than 100%.

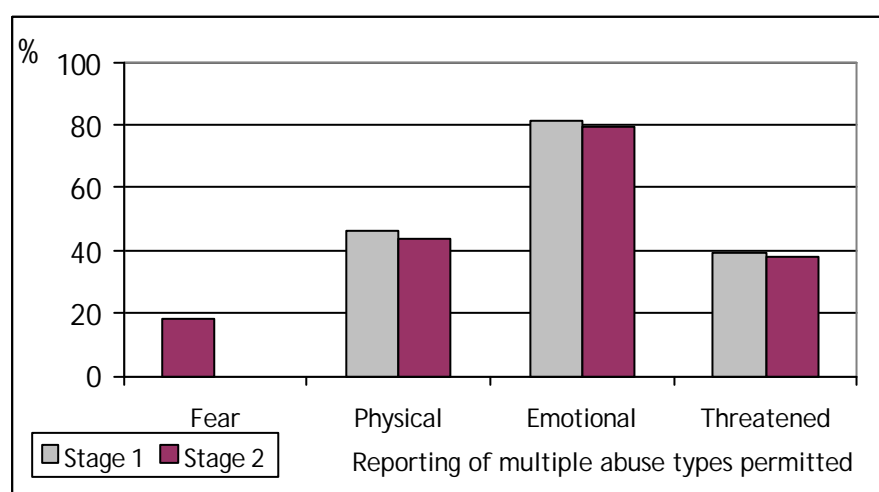


Figure 3.5: Type of abuse disclosed

The proportion of women accepting offers of immediate assistance increased from 10.7% in Stage 1 to 12.9% in Stage 2 (Figure 3.6). Of the 2912 charts at all participating sites that had evidence of screening activity, 199 women screened positive and 33 accepted help at the time of screening (Figure 3.6). It is important to note that the number of women accepting help is small, with only 1% of women who were screened at all sites accepting an offer of help. Despite a comparatively high rate of disclosure of abuse, no women accepted offers of help at the emergency department, Mater Adults' Hospital or the gynaecology outpatients department at the Royal Women's Hospital.

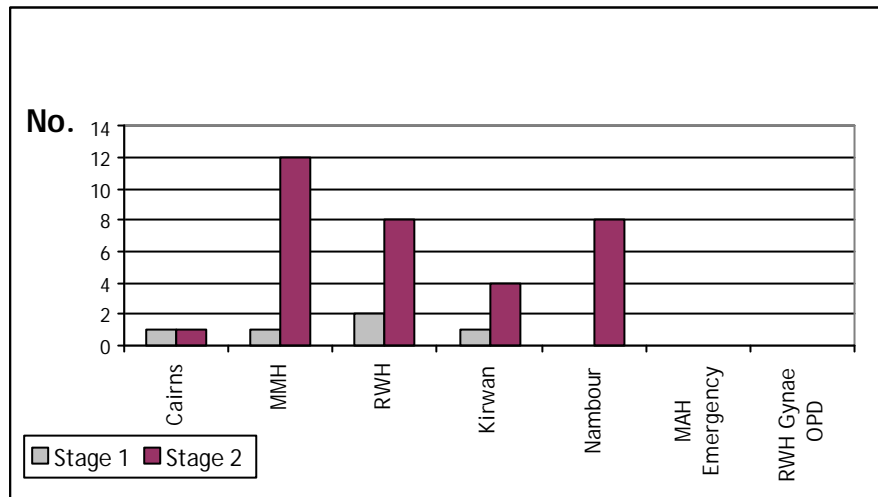


Figure 3.6: Number of women accepting assistance by sites

Of particular interest was the relationship between the type of abuse and client uptake of assistance. Women disclosing threatened abuse were slightly more likely than those disclosing physical abuse to accept offers of help, with 29.7% of women who disclosed threatened abuse accepting help, compared to 27.9% of those disclosing physical abuse accepting help. Women disclosing emotional abuse were least likely to accept offers of help, with 17.4 % accepting help at the time of screening (Figure 3.7). Reporting of more than one type of abuse was permitted.

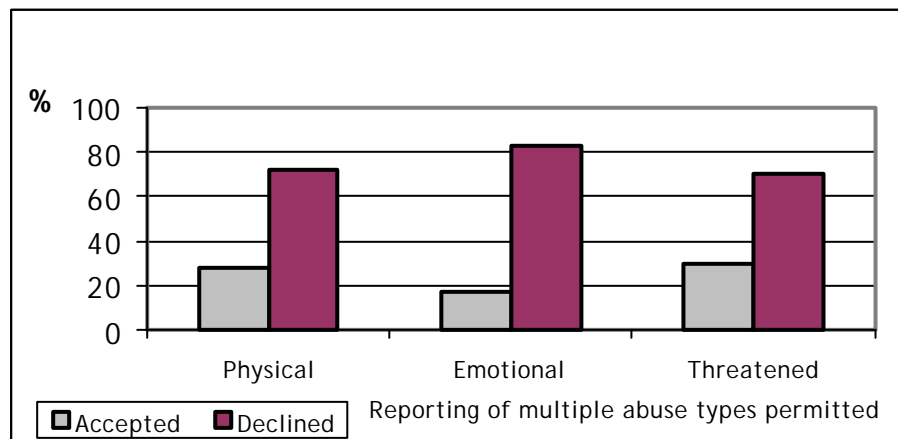
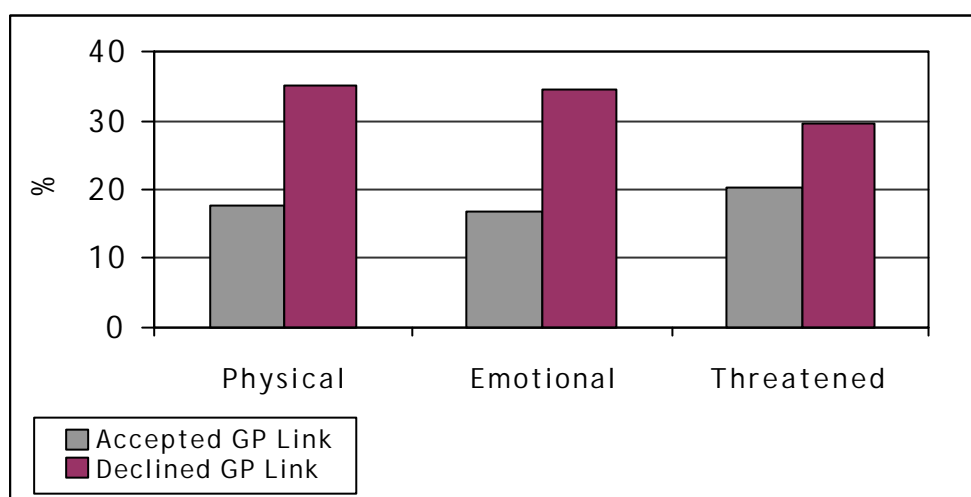


Figure 3.7: Type of abuse disclosed by uptake of assistance

The disclosure of domestic violence is important information for a woman's ongoing health care. Women who screened positive for any form of domestic violence at antenatal clinics and at the RWH Gynaecology Outpatients Clinic were asked whether

information regarding her disclosure of abuse could be shared with her nominated GP. Overall, 13.4 %, of women who disclosed any form of violence agreed to share their domestic violence information with their GP.

Figure 3.8 shows that women who disclosed threatened abuse were most likely to agree to share domestic violence information with their GP (20.2%) than those who disclosed other forms of abuse. Of those women who disclosed some form of violence, 17.6% who disclosed physical violence and 16.6% of those who disclosed emotional abuse agreed to share their domestic violence information with their GP. It is important to note that this data involves a small number of clients, with only 26 clients agreeing to share domestic violence information with their GP.



**Figure 3.8: Type of abuse and acceptance of GP Link**

Client response to the notification of a nominated GP was discussed at a meeting with senior hospital staff and representatives of the Divisions of General Practice. Several possible reasons were identified that may inhibit women disclosing domestic violence information to a GP. These included:

- women at most risk of violence may not choose shared antenatal care;
- clients may be concerned about confidentiality when informing a GP who also cares for the partner;
- there may be concerns about judgemental attitudes from the GP;
- the woman, who is screened at the antenatal booking in clinic, may not yet have engaged with a GP and may have concerns about communication, rapport and trust with someone she has not met before;
- the woman may already have established community support, which may include her GP; and
- the violent situation may have been resolved.

### 3.4 DISCUSSION

The generalised increase in the rate of screening across combined participating sites demonstrates a definite trend of continued commitment to the DVI, and to women's health in general, by the staff and management at participating sites. In particular, the sustained screening rates suggest that the ongoing training and support available to participating sites has maintained a high level of commitment to DVI screening. In addition, the implementation of the DVI has coincided with a growing recognition of the importance of the social origins of health and its impact on the provision of adequate medical care, which may account for the continued support for the implementation of this initiative.

It is of particular interest to note that the DVI has countered the trend reported by similar screening programs, of a decline in the screening rate over time. (Fanslow et al, 1998; Wiist & McFarlane, 1999).

The increased screening rate at the Mater Adult's Hospital Emergency Department is an encouraging result, particularly as various studies indicate that domestic violence accounts for a significant number of emergency department admissions (Valente, 2000). In addition, emergency departments experience significant challenges to screening, including staffing, patient loads, and work environmental factors (eg patients often do not present alone).

The chart audit highlighted the importance of formally integrating the screen results into the medical record. The use of a standard form stored in a designated and consistent area of the chart (eg. immediately following the related history forms) remains an important component of an effective screening system. It is possible that some health service providers do not record screening status if the patient screens negative to domestic violence. If this is the case, then the actual screening rate would be underestimated as there would be an incomplete record of the screening process.

It has been suggested that incorporating the DVI screening tool onto the standard medical history form would increase screening rates. However, due to space limitations, this is not practical in every clinic setting. The Royal Women's Hospital Gynaecology Outpatients Department trialed the incorporation of the DVI screening tool into a Core Assessment Form used for surgical patients who required theatre admission. In January 2001, this practice was discontinued due to concerns over the confidentiality of patient disclosure, as the Core Assessment form was no longer retained in the patient chart, but kept by the patient's bed.

The chart audit revealed that at all sites a proportion of charts did not retain the DVI screening form. In addition, when the form was present in the chart, this was not universally completed. This emphasises the importance of developing a methodology for inclusion of the standard form universally for all patients, and facilitating the completion of the forms by health service providers. Ongoing training and routine reminders would be advantageous in this regard. In addition, Medical Records

departments of sites may be able to assist by including the DVI form when compiling new patient charts and preparing charts for new admissions.

### **3.5 EMERGENT ISSUES ARISING FROM CHART AUDITS**

#### **3.5.1 Record Keeping**

The chart audits revealed that a significant number of blank forms were present in client charts. It is possible that health service providers are implementing the screening process, but not completing the necessary documentation in the patient medical chart, particularly for women who screen negative to domestic violence. It was also mentioned in one site that loose DVI screening forms are filled out, but the patient charts are not retained at the site, and forms are sometimes delayed in being returned to the patient chart. These issues would affect the screening rate, and the chart audit results, including screening compliance rate and client screening status for that site. In addition, it is possible that the loose DVI screening form is not included in the patient's chart when she presents with a partner or others present. Although the presence of a partner or others would exclude the women from being screened at that visit, it is essential to include the form in the patient chart and to note on it that the woman was not screened at that visit due to the presence of others during the health care interview.

- ❖ It is recommended that all sites implement strategies to ensure the inclusion of the DVI screening form in all patient charts prior to the commencement of the clinic. This would facilitate universal record-keeping for all clients.
- ❖ It is recommended that the correct completion of the appropriate documentation be emphasised through training and follow-up support.
- ❖ It is recommended that an amendment to the screening form to include a tick box to record if the partner was present and a box in which to record the date be trialed during the implementation of Stage 3.

#### **3.5.2 Antenatal repeated screening**

Although pregnancy can be a protective factor against domestic violence for some women, abuse may actually begin during pregnancy, at any stage of gestation. Women who are experiencing domestic violence during their pregnancy may not be ready to disclose on their first visit, but are more likely to disclose after developing a rapport with their service provider. Although repeated screening at intervals throughout the pregnancy is not a component of the DVI protocol, these issues highlight the need for repeated screening throughout the pregnancy. A health service provider may use the DVI screening tool at any visit throughout the pregnancy, any number of times. Repeated screening may facilitate disclosure and acceptance of assistance by women who are suspected of experiencing abuse (Gazmararian et al, 1996). It is important to note that asking questions at the booking-in visit may be an intervention in itself, by making the woman aware that the hospital does care about the woman and her experience of abuse. By asking the questions, the service

provider is giving the woman knowledge of where to seek help if she does experience abuse at some time in the future.

- ❖ It is recommended that in-service training highlights the possibility of the beginning of violence during a woman's pregnancy and emphasises the use of the service provider's discretion in administering repeated screening at various stages throughout the pregnancy.
- ❖ It is recommended that repeated screening at the 36 week visit, and/or after delivery is trialed during the implementation of Stage 3.

### 3.5.4 Verbal Screening

The chart audit also revealed that some service providers do not administer the DVI screening tool verbally, but provide the woman with the form to read and complete on her own. The DVI protocol states the importance of asking the screening questions verbally during the routine history-taking procedure. The DVI screening form was designed to be a component of the confidential medical record of a patient, to be retained in the patient chart for health and medical use only. However, some service providers use the screening form as a patient self-administered questionnaire, providing the client with the form to complete herself. This was apparent from service providers' written comments on otherwise blank forms such as "declined to fill in" and "refused to fill out". Other indications that women were filling in the forms themselves included written comments by the clients.

Research literature reports that women are more likely to disclose an experience of violence if they are asked the screening questions by a caring professional than to self-disclose (Little, 2000). In addition, questionnaire screening excludes women with low levels of literacy and from non-English speaking backgrounds.

It may be endangering the woman to provide her with a form which her partner or family or friends might see. This practice also breaches the commitment by the Health Service Districts to ensure that domestic violence information is kept confidential.

Discussion with service providers indicated that one reason for providing the woman with the form is the concern that the screening questions will be overheard by the partner, family or other clinic patients. The questions should be asked in an environment where confidentiality can be maintained. This can be difficult to accomplish if the woman is accompanied by family members. The health service provider may need to conduct part of the health care interview in private. If it is not possible to ask the woman the DVI screening questions on her own, without partner or others present, then she should be excluded from screening on that visit and screened on a subsequent visit.

It is also noted that the DVI screening form component which enables the recording of action when a woman screens positive (the bottom half of the form) instructs that that particular section is to be completed by staff (See Appendix A). This may imply that staff should fill out that section only, and not the entire form. This is misleading and implies that someone other than staff (ie the client) is to complete the other component of the form (ie the screening questions).

- ❖ It is recommended that the verbal component of the screening process be emphasised in the development of the protocols for domestic violence screening in Queensland hospitals.
- ❖ It is recommended that the requirement for privacy during screening is a consideration in determining clinic accommodation.
- ❖ It is recommended that the verbal component of screening is continued to be emphasised during DVI in-service training, with a discussion of potential barriers to verbal screening and possible solutions incorporated into the training curriculum.
- ❖ It is recommended that the instruction “to be completed by staff” be removed from the action component of the form, and some specific instructions regarding verbal screening and completion of the entire form by staff be placed at the top of the screening form.

### 3.5.4 Client Decline of Assistance

Women who report domestic violence to health service providers are likely to refuse assistance at the time they are asked the screening questions. This pattern is supported by the Stage 1 and 2 evaluation results of the DVI. This pattern is frequently reported as a source of professional frustration for service providers. It is important to note, however, that assistance is sought by women when they perceive they are ready, and when it is safe to do so. Indeed, if help leads to the woman leaving the relationship, violence may increase, and she is more likely to be killed by her partner at this stage (Valente, 2000). Gerbert (et al, 1999) reported that interviews with women revealed that questioning by a health care professional had “planted a seed” in recognising their situation of abuse and seeking help for it.

- ❖ It is recommended that DVI training continues to emphasise that clients are most likely to refuse assistance with their domestic violence situation when they disclose abuse.

## 3.6 RECOMMENDATIONS

- 3.6.1 That universal routine screening for domestic violence in public sector health care facilities should continue and expand to additional sites.
- 3.6.2 That DVI screening forms are incorporated into patient charts as a component of medical history notes.
- 3.6.3 That incorporating the DVI screening tool onto routine history forms for all female patients is considered at all sites.
- 3.6.4 That screening for domestic violence continues to be administered verbally, with the woman on her own during the screening interview.

- 3.6.5 That the DVI screening form is modified to include instructions regarding verbal screening and the completion of the entire form by staff.
- 3.6.6 That staff training continues at all sites on a regular basis with additional training available for sites that experience high staff turnover.
- 3.6.7 That train-the-trainer sessions are implemented for all sites with the goal of the self-sufficiency of sites.
- 3.6.8 That sites liaise with medical records staff to incorporate DVI screening form in new patient charts.
- 3.6.9 That screening is trialed in additional emergency department sites.
- 3.6.10 That demographic information of positively screening clients is collected as part of the Stage 3 evaluation.
- 3.6.11 Further examination of the impact of domestic violence training on staff attitudes and practice should be undertaken as part of Stage 3 evaluation.
- 3.6.12 The findings of this evaluation should be incorporated into staff development and training on addressing the health impact of domestic violence.

## 4.0 Client Evaluation

### 4.1 GOALS AND OBJECTIVES

#### *Goal*

To assess client satisfaction with existing mechanisms of help following disclosure; to ascertain what women screening positive for violence want or need in the way of help; and to identify why most women screening positive for violence decline offers of assistance.

#### *Objectives*

- To develop a survey form to address the strengths and weaknesses in the screening process
- To develop a survey form to address the strengths and weaknesses, from the client's perspective in the offering and the provision of assistance.
- To establish possible reasons for the low rate of acceptance of help for women who screen positive for domestic violence.
- To determine barriers and facilitating factors for the acceptance of help for women who experience domestic violence.
- To provide the opportunity for client input in the discussion and development of improvements to existing and alternative forms of assistance available to women who experience domestic violence.

### 4.2 BACKGROUND

The evaluation of Stage 1 revealed that the majority of women who screened positive for domestic violence declined offers of help with their situation at the time of screening. Overall, only 10.7% of women who screened positive to domestic violence accepted help from the interviewer, in the form of the provision of a help-line number, referral to a social worker or other domestic violence resource, or domestic violence information. The evaluation of Stage 2 showed an increase in the proportion of women accepting help, with 12.7% of positively screened women accepting help. Despite the slight increase, this figure remains low, with the overwhelming majority of women continuing to decline assistance at the time of screening.

The evaluation of Stage 1 revealed that service providers have identified this low uptake of assistance as a source of professional and personal frustration. The

following comments were obtained from focus group discussions with service providers as part of the Stage 1 evaluation:

- *It's hard when they say yes [to DV questions] ...but they don't want any help.*
- *A lot of them refuse the help, but you feel like you should still give them something.*

The low rate of uptake of assistance experienced in Stage 1 and Stage 2 of the DVI is reflected in the international literature (Fanslow et al, 1998; Gerbert et al, 1999; Wiist & McFarlane, 1999). Patients who report domestic violence to health service providers frequently refuse assistance with their situation at the time they are screened (Hotch et al, 1995). A recent Australian phone-in survey revealed that the main reasons for women not seeking help include feelings of embarrassment and shame, feeling responsible for the violence, fear of ending the relationship and not knowing who to contact for help (Bagshaw et al, 2000).

Possible reasons why women who experience domestic violence decline help at this point have not been explored in any systematic way in the Australian context, and this issue has remained largely unexplored in the international literature. Few studies exist that have examined clients' perspectives on their experiences of disclosing abuse in health care settings (Gerbert et al, 1999). The identification of possible reasons for refusal of assistance would be of great value in the development of improvements to existing and alternative support services and facilities available to the population of women who experience domestic violence. The DVI recognised the opportunity to gain client input into the assessment and evaluation of the screening system and a client evaluation was incorporated in Stage 2 DVI implementation.

#### **4.2.1 Development of the client survey screening tool**

The aim of the client evaluation survey was to increase our understanding of what women who experience domestic violence would find helpful in terms of currently available and potentially available services and facilities. Four open-ended questions were designed to ascertain clients' perspectives on the reasons women who screen positive to domestic violence decline assistance, to gain women's reports on the positive attributes of current services and facilities, and to elicit women's ideas on services and facilities that they would find useful in their domestic violence situation. The questions are:

1. Why do you think some women who have experienced abuse do not want help at the time they are asked the questions?
2. Thinking about what is currently available, what helps women who have experienced domestic violence?
3. What else do you think would help?
4. Any other comments?

A copy of the client survey form, instructions and flow chart for administration are attached as Appendix C.

### 4.3 METHODOLOGY

Six antenatal sites participated in the client evaluation – Royal Women's Hospital, Nambour Hospital, Mt Isa Base Hospital, Kirwan Hospital for Women, Cairns Base Hospital and the Mater Mothers' Hospital. The client survey was implemented for a period of 12 weeks, during November and December, 2000 and January and February 2001.

Women who presented to a participating antenatal clinic at their 36 week visit, who had screened positive to domestic violence on an earlier visit, were eligible for inclusion in the client evaluation. The 36 week visit was identified as the opportune time for client evaluation, due to the transference of shared antenatal care from the GP to the hospital midwifery staff at this stage of the pregnancy.

Antenatal staff members were required to check each day's bookings for clients who had screened positive for domestic violence on a previous visit. When such a woman was identified, a client evaluation form was placed in the patient chart in readiness for her visit.

The client evaluation form was provided to the woman when she presented to clinic. If the woman was accompanied by small children, this did not preclude her from obtaining the form, however, the presence of another adult rendered the woman ineligible for the client evaluation. The woman was also provided with a reply paid addressed envelope, which was sealed by the woman before returning it with the completed form inside to the nurses' desk for dispatch.

If it was identified that a client had not been screened on a previous visit to the clinic, then this provided an additional opportunity for screening. Following screening, if the woman screened positive, then the client survey form was to be provided.

If a woman who had screened positive had not been provided with a client survey form for any reason at the 36 week visit, opportunities to provide the woman with the form were presented at subsequent visits.

It was noted in the chart when a woman was provided with a client survey form to avoid repeated requests to the woman on subsequent visits.

### 4.4 RESULTS

Forty-four completed forms were returned to the Evaluation Officer during the 12 week period of implementation of the client evaluation. 30 responses were received from the Royal Women's Hospital, 10 from Cairns Base Hospital, 1 from Mater Mothers' Hospital, and 3 from Nambour Base Hospital. No responses were received from Kirwan Hospital for Women.

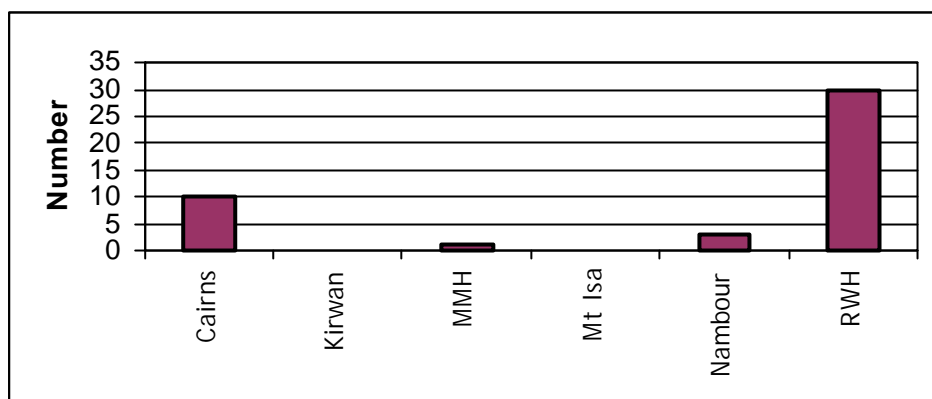


Figure 4.1 - Client evaluation response from participating antenatal sites

The client response rates were not reflective of the disclosure rates at sites. It was expected that sites with higher rates of disclosure would recruit a greater number of respondents, but this did not occur. Staffing changes over the holiday period was cited as a reason for this discrepancy. The client survey is being continued for an extended period at Kirwan Hospital for Women due to the low response rate. Mt Isa Base Hospital experienced a low rate of disclosure of domestic violence (0%) during Stage 2 evaluation, therefore a low response rate for the client survey was expected.

Examples of client responses have been grouped below into themes. Some responses have been edited to aid comprehension.

#### 4.4.1 Reasons for not accepting help

All respondents answered the first question " Why do you think that women who experience abuse do not want help at the time they are asked the questions?"

##### *Fear*

Of all respondents, 36% reported fear as a barrier to accepting help when it is offered. For some respondents, this was the fear of the partner, or the fear of the consequences of telling someone, or fear of ending the relationship:

- *For fear of the consequences of asking or receiving help*
- *Because they are scared*
- *Too scared of repercussions if partner found out*
- *Fear of reprisal and social beliefs*
- *Because they are usually scared of the abuser finding out they have told someone and do not want repercussions. They probably also think they do not want to be a bother to other people*

- *Sometimes they are too scared to say what is happening to them*
- *Fear of retribution from the partner if he learns of disclosure of information*
- *Fear*
- *They may think the problem will get worse with interference*
- *Some women feel frightened until someone offers help*
- *Fear, distrust of the system*
- *Maybe scared*
- *They are frightened of the consequences that may arise if the other finds out*
- *They may be afraid*
- *Scared and afraid of what might happen*
- *They may fear that breaking away from their situation leaves them with more limited opportunities eg financial disadvantage etc.*
- *Worried about others being involved and the consequences*

#### ***Hoping that the domestic violence situation will resolve itself***

Some respondents reported the hope of the resolution of the domestic violence situation, in the hope that things would improve, or the perpetrator would change his violent behaviour:

- *Often if there is a good family and wide circle of friends, additional help is not required*
- *Hoping things work out when you are having a child together*
- *They can handle it, hoping things will get better*
- *Because they don't want to deal with the fact they have a problem*
- *They probably think its going to get better*
- *Due to hoping things will sort themselves out*
- *Living in hope (denial)*
- *Hoping abuse will pass or is a result a stress; [the hope that] if he sees it upsets you, he will stop*
- *Just want to forget about the violence, do not want to talk about it*

One respondent found that reporting her husband's abusive behaviour to the service provider at the time of screening was a sufficient intervention in itself, which led to a decrease of abuse:

- *In my case the abuse decreased ... when I told my husband I reported his behaviour. It helped me significantly to report the problem and telling my husband as a warning. I believe he tried to control himself more.*

### **Embarrassment**

Many respondents reported feeling embarrassed or ashamed about their experience of violence:

- *Embarrassment is a big issue. While at home you are dealing with it alone. I feel to ask for help could be an inconvenience and you risk having people judge you*
- *They are embarrassed*
- *Pride*
- *Too embarrassed*
- *Embarrassment, thinking it reflects poorly on them as a person*
- *Have buried their feelings and do not want to bring up emotions*
- *Because they feel embarrassed*
- *Embarrassment*

### **Self blame, feeling responsible for the violence**

Some respondents reported that they felt responsible for the violence and this prevented them from reporting the abuse, or accepting help:

- *At the time of the abuse you would feel powerless and to blame. I think the self blame would probably account for most of this problem.*
- *Personally it comes down to thinking it's your fault and you deserve it and that no one really believes you anyway*
- *Because most of the time some feel it's only happened because of them*
- *They probably think they deserved it ... and don't want to make a fuss*

### **Actual resolution of domestic violence situation**

In some cases, respondents reported that a situation of domestic violence might have been resolved at the time of screening, which could be a reason for refusing assistance at the time of screening. The screening questions refer to the client's experience of abuse within the previous 12 months; therefore it is possible for retrospective reporting of abuse from previous or current relationships. It is also important to note that cessation of abuse is sometimes apparent although it is only a component of the cycle of abuse, and violence may re-occur at a later stage. Responses in this category included:

- *They are no longer experiencing DV*
- *Situation may have changed*
- *Perhaps the situation in question has been resolved or they have already had assistance*

### **Other**

- *They are still realising it's not normal treatment*
- *Not sure they really need help*

- *Feelings of hopelessness, that nothing practical can be done*
- *Because they have no control over the situation at hand*
- *Wanting to seek help when they want to in the future*
- *Torn loyalties*
- *Because they don't want help or aren't ready for help*

#### **4.4.2 Helpful Services and Facilities**

All respondents answered question 2: "thinking what is currently available, what helps women who have experienced domestic violence?"

##### ***Family and friends***

36% of respondents reported that the support of family and friends is helpful in a domestic violent situation. The support of family and friends was categorised separately from comments that related to general support, which may have been obtained from family, friends, health service providers, counsellors and other agencies:

- *Their friends and family*
- *They just need to know there is someone who will listen*
- *Good support system ..., friends and family*
- *A lot of help from family and friends*
- *Talking and comfort, someone that understands*
- *Friends and family willing to help when the need arises*
- *The knowledge that ... they have someone to listen when needed*
- *Support of family and friends*
- *Talking to a good friend*
- *Talking to someone about it*
- *Talk to mother about it*

One respondent reported that support from family and friends led to the resolution of her domestically violent situation:

- *Often if there is a good family and wide circle of friends, additional help is not required which is the case in my situation.*

##### ***Counselling and Group Support***

Some respondents identified counselling as a helpful factor available to women who have experienced violence:

- *Positive constructive advice relating to their circumstances*
- *Counselling that leads into all areas, eg drug addiction*
- *A lot of women's help lines*

- *Counselling*
- *To talk to someone about the choices and help they can receive*
- *Someone to listen and explain alternatives*
- *Counselling for both partners*

Some respondents suggested that group support is a helpful factor available for women who experience domestic violence:

- *Group involvement with other women to show them they are not alone*
- *Knowing that there are others who have experienced the same*
- *Awareness that it happens to other people*
- *Talking about it with other people who understand, or who have experienced it themselves. Having someone tell them its not their fault*
- *Group support*
- *Going to a group and speaking about it*
- *Talking to other women who have experienced domestic violence*

#### ***Police / legal / welfare response***

Some respondents suggested that police response and legal support are helpful factors for women who have experienced domestic violence:

- *Quick response of police*
- *Protection order*
- *Domestic violence orders really help; if broken they go to jail*
- *Welfare and housing options*
- *Safe houses, financial support*
- *Domestic violence units, boarding houses, social workers*
- *Shelter/accommodation is needed, as it is often hard to get somewhere comfortable to stay long-term while you get on your feet, especially while pregnant*
- *If there is some form of housing women can get into*
- *Safe areas/ accommodation*
- *Help to leave situation eg women's refuge and counselling*

#### ***Hospital***

- *If you are willing to discuss it, I know the staff at the hospital will help you. I have requested help and great measures are being taken.*
- *Having someone to talk to and listen to problems helps; being able to openly relate to the midwives caring for her.*

### 4.4.3 Other Helpful Factors

32 respondents (72.7%) answered question 3: "What else do you think would help?" These are categorised below.

#### ***Counselling***

Some respondents identified that counselling would be a helpful factor for women who had experienced domestic violence. Some respondents indicated the need for counselling should be available for both partners:

- *Free counselling for both partners and understanding of individual cases*
- *I found it difficult to find a person [counsellor] for my husband to talk to about his problem (why he did this to me)... perhaps a counsellor at the hospital for the abuser would help*
- *Communication and care for each other*
- *Counselling of spouse*
- *Regular counselling of a positive and constructive nature*
- *To talk about it*
- *Meet with a counsellor*
- *More "obvious" [ie accessible] help and support groups*
- *Counselling/separation (especially when children are involved)*
- *People persevering with the woman's problem, and not giving up on helping them*

#### ***Education***

Some respondents suggested community education and publicity about domestic violence would be helpful:

- *To inform children at school level about what is acceptable behaviour from peers, parents and relatives*
- *More publicity that no one deserves to be treated abusively at any time. There is nothing you could ever possibly do to condone being abused in any form*
- *More advertising on the problem and promotion of current services available*
- *More awareness about domestic violence in schools etc could possibly help*
- *Maybe education of men to discourage them from violence, or offer alternatives*
- *Advertising*
- *More awareness of what defines abuse. I find it hard to understand the definition of emotional abuse*

#### ***Discussion/support groups***

Some respondents suggested that support groups, which enable discussion between women who have been in domestically violent situations, would be helpful:

- *Discussion groups help heaps and for people just to say kind words or offer help in a small way seems to make a big difference*
- *Support groups*
- *Talking to people who have been through the same situations*
- *Women talking about it and not letting it happen*
- *Alcohol programs [for perpetrator]*

### **Practical Issues**

- *Asking the mother if she has any close friends who can be present at the birth. Abusers are normally nice in public so it might relax the mother.*
- *More stable financial circumstances*

### **Follow-up review**

One respondent made the suggestion of a follow-up contact after disclosure of domestic violence. It is unclear whether the respondent intended this follow-up to be implemented after a counselling session:

- *Review/report at 1 or 3 months – just a phone call for progress*

### **Supportive family and friends**

Many respondents highlighted the importance of supportive family and friends as an additional helpful factor:

- *Supportive family*
- *That extra help and support from everyone*
- *Benefit of the doubt before judging them*
- *Positive role models who can encourage and inspire women out of their situation*

#### **4.4.4 Additional comments**

Question 4 provided space for additional comments. These responses are not grouped into themes as they represent diverse experiences and beliefs:

- *I feel some women's self worth stems from childhood experiences and what was tolerated by their role models*
- *I had to learn to self-talk positively and the most work to be done was ME not giving the opportunity for it to happen and to cut him off [ie terminate relationship] – this was HARD!!*
- *I thank you for the support you offered me and I believe it helped me at home, my situation has improved greatly.*
- *Until a decision is made to deal with it, nothing will change.*
- *I felt the question on the original questionnaire relating to verbal harassment was possibly threatening to women who may experience criticism or relationship differences which aren't anything more than the reality of an active relationship.*

- *Letting people know there are things that can be done. I had to ask and follow through. If someone is shy, it may be harder for them.*
- *My situation has improved but it helps knowing there is always someone to talk to for support if need be.*
- *I believe that intervention is sometimes needed with abusers. Anyone who abuses needs help, not just the person being abused.*

#### 4.5 DISCUSSION

The results demonstrated that the most widely reported barrier to women accepting help at the time of screening is fear. This may be fear of the consequences of disclosing, fear of the abuser discovering the disclosure, or fear of worsening the abuse by disclosure.

Another significant barrier to the uptake of assistance is shame or embarrassment about their domestic violence situation. Self-blame also emerged as a significant barrier, reported by 6 respondents.

In addition, the acceptance of the abuse as a part of the relationship, and the hope that the situation will “sort itself out” emerged as factors which inhibit client acceptance of assistance.

Furthermore, some respondents suggested that decline of offers of assistance may be due to the actual resolution of the domestic violence situation (which in fact may be a part of the progression of the cycle of violence), the termination of the relationship, or that assistance has already been provided by other agencies.

A recent Australian phone-in survey revealed that reasons for not seeking help included feelings of embarrassment or shame, feeling responsible for violence, fear of ending the relationship and not knowing who to contact or being unable to make contact (Bagshaw et al 2000). The current findings regarding women's acceptance of help revealed similar reasons for declining help when it is offered.

With respect to currently available services and facilities, the client survey revealed that the support of family and friends emerged as the most significant helpful factor reported by client respondents. Advice and support in the form of help-lines, talking and counselling were also identified as helpful factors. Positive comments regarding the helpful nature of interventions by police, welfare, housing and health agencies also emerged.

Suggestions for help for abuse women included community education and publicity, counselling for abusers, discussion and support groups for women who have experienced domestic violence, case reviews and follow-up.

Additional comments included women's recounting of their own experiences, attitudes and beliefs, and reflections on the effects that the abuse has had on them.

Although this component of the evaluation aimed to focus on client satisfaction with the screening process and response to disclosure, many comments reflected client experience with subsequent actions from agencies other than the health services.

From the data collected, it is difficult to ascertain the type and level of interventions used by the respondents. In particular, the services women need, and the outcomes of use of these services have been identified as a gap in the knowledge about domestic violence (Davidson, King, Garcia & Marchant, 2000). Few studies have documented the steps following disclosure of abuse, including treatment, support and referrals to other agencies. Indeed, links between the health care setting and other services need to be investigated to ensure clients are experiencing a supportive and smooth transition between agencies. Data on client service use and satisfaction was not obtained during Stage 2, but it suggested that this become a component of the evaluation of Stage 3.

It is recognised that the sample of women who participated in the client evaluation may not be representative, as this is a self-selected sample. In addition, it is acknowledged that a self-administered questionnaire excludes the participation of women from non-English speaking backgrounds, and women with low levels of literacy.

In addition, the sample of women who responded to the client survey was not equally distributed across all sites that participated in this component of the evaluation. Although demographic data was not collected, it is apparent from the response rates of sites that there were very few respondents from rural and remote areas, or from Indigenous backgrounds.

Despite these limitations, it is suggested that the responses indicate a strong mandate for the continuation of screening for domestic violence in the antenatal setting, and indeed, the expansion of screening into other health settings. Furthermore, these responses may provide direction for the development of new and existing services for women who have experienced, or are experiencing violence.

## **4.6 RECOMMENDATIONS**

- 4.6.1 That the client survey is continued in existing sites and is expanded to include other departments and sites, with particular emphasis on rural and remote areas and Indigenous populations.
- 4.6.2 That strategies designed to increase response rates in rural and remote sites are implemented.
- 4.6.3 That client responses are considered in the development and modification of new and existing services and facilities for women and families who have experienced domestic violence.
- 4.6.4 That client survey results are reported to health and welfare service providers, including domestic violence facilities and support services.
- 4.6.5 That case studies of clients' service histories and satisfaction with service use after disclosure of abuse are incorporated into the evaluation of Stage 3.

## REFERENCES

- Australian Bureau of Statistics (1996). *Women's Safety Australia*. Australian Bureau of Statistics, Commonwealth of Australia.
- Bagshaw, D. , Chung, D. , Couch, M. , Lilburn, S. , & Wadham, B. (2000). *Reshaping responses to domestic violence: Final report*. University of South Australia.
- Davidson, L. , King, V. , Garcia, J. & Marchant, S. (2000). *Reducing domestic violence...what works? Health Services*. Policing and Reducing Crime Briefing Note. Policing and Reducing Crime Unit: London.
- Fanslow, J. L. , Norton, R. N. , Robinson, E. M. , & Spinola, C. G. (1998). Outcome evaluation of an emergency department protocol of care on partner abuse. *Australian and New Zealand Journal of Public Health*, 22, 598 – 603.
- Furbee, P. M. , Sikora, R. , Williams, J. , & Derk, S. (1998). Comparison of domestic violence screening methods. *Annals of Emergency Medicine*, 31 (4), 495 – 501.
- Gazmararian, J. A. , Lazorick, S. , Spitz, A. M. , Ballard, T. J. , Saltzman, L. E. & Marks, J. J. (1996). Abuse during pregnancy: Effects on maternal complications and birth weight in adult and teenage women. *Obstetrics and Gynaecology*, 84 (3), 323 – 328.
- Gerbert, B. , Abercrombie, P. , Caspers, N. , Love, C. , Bronstone, A. (1999). How health care providers help battered women: The survivor's perspective. *Women and Health*, 29, 115 – 134.
- Hotch, D. , Grunfeld, A. F. , Mackay, K. , Cowan, L. (1996). An emergency department-based domestic violence intervention program: Findings after one year. *Journal of Emergency Medicine*, 14, 111 – 119.
- Kaplan, S (2000). Family violence. *New Directions for Mental Health Services*, 86, 49 – 62,
- Little, K. J. (2000). Screening for domestic violence: Identifying, assisting and empowering adult victims of abuse. *Postgraduate Medicine*, 108 (2), 135 – 141.
- NSW Health (1999). *Review of Domestic Violence Policy: Discussion paper*. NSW Health Department. Available: [HTTP://WWW.HEALTH.NSW.GOV.AU](http://www.health.nsw.gov.au)
- Parker, B. , McFarlane, J. , & Soeken, K. (1994). Abuse during pregnancy: Effects on maternal complications and teenage women. *Obstetrics and Gynaecology*, 84 (3), 323 – 328.
- Queensland Health Child & Youth Health Unit. (2000). *Early Intervention for Safe and Healthy Families Project Plan*. Unpublished document: Queensland Health.
- Queensland Health Domestic Violence Initiative (2000). *Initiative to combat the health impact of domestic violence against women: Stage 1 evaluation report*. Unpublished document: Queensland Health.

Valente, S. M. (2000). Evaluating and managing intimate partner violence. *The Nurse Practitioner*, 25 (5), 18 – 33.

Webster, J. , Sweet, S. & Stolz, T. A. (1994). Domestic violence in pregnancy: A prevalence study. *Medical Journal of Australia*, 161, 466 – 470.

Wiist, W. H. & McFarlane, J. (1999). The effectiveness of an abuse assessment protocol in public health prenatal clinics. *American Journal of Public Health*, 89 (8), 1217 – 1221.

## APPENDICES

## Appendix A: Screening forms used by the Domestic Violence Initiative

### Domestic Violence Initiative ANTENATAL DEPARTMENT

*(Questions below can be introduced in a conversational style).*

In this hospital we are concerned about your health and safety, so we ask **all** women a few questions.

**Whatever you reply will remain strictly confidential**

(Please circle correct answer)

- |   |                              |   |                             |
|---|------------------------------|---|-----------------------------|
| 1. Are you afraid of your partner?  | <input type="checkbox"/> Yes | — | <input type="checkbox"/> No |
| 2. In the last year, has anyone at home hit, kicked, punched or otherwise hurt you?   | <input type="checkbox"/> Yes | — | <input type="checkbox"/> No |
| 3. In the last year, has anyone at home often put you down, humiliated you or tried to control what you can do?                           | <input type="checkbox"/> Yes | — | <input type="checkbox"/> No |
| 4. In the last year, has anyone at home threatened to hurt you?   | <input type="checkbox"/> Yes | — | <input type="checkbox"/> No |
| 5. Would you like help with any of this now?  | <input type="checkbox"/> Yes | — | <input type="checkbox"/> No |
| 6. (If any answers are yes) This could be important information for your health care. May we send a copy of this form to your own doctor? | <input type="checkbox"/> Yes | — | <input type="checkbox"/> No |

Name of Doctor: ..... Signature of patient

Address .....  
 ..... Post code .....

(To be completed by staff)

Action:

- |  |                          |
|--|--------------------------|
| Woman answered 'No' to question 5      | <input type="checkbox"/> |
| Woman declined assistance at this time | <input type="checkbox"/> |
| Referred to Social Work Department     | <input type="checkbox"/> |
| No referral required                   | <input type="checkbox"/> |
| Other – please indicate .....          |                          |
| .....                                  |                          |

Provided with:

- |   |                          |
|---|--------------------------|
| Woman declined information at this time | <input type="checkbox"/> |
| No information required                 | <input type="checkbox"/> |
| Help line number                        | <input type="checkbox"/> |
| Information about domestic violence     | <input type="checkbox"/> |
| Other – please indicate .....           |                          |
| .....                                   |                          |

Date: --/--/--

**Domestic Violence Initiative**  
**OUTPATIENT/EMERGENCY DEPARTMENT**

In this hospital we are concerned about your health and safety, so we ask all women a few questions.

(Please circle correct answer)

**Whatever you reply will remain strictly confidential**

1. Do you have problems with anyone at home who makes you afraid?

Yes       No

*If no then no further questions*

*If yes then continue with the following questions*

A. Would you like to talk about it?

Yes       No

B. Would you like some help now?

Yes       No

(To be completed by staff)

Action:

Woman answered 'No' to question 3	<input type="checkbox"/>
Woman said it was unsafe to accept referral at this time	<input type="checkbox"/>
Referred to Social Work Department	<input type="checkbox"/>
No referral required	<input type="checkbox"/>

Other – please indicate .....

.....

.....

Provided with:

Woman said it was unsafe to take information at this time	<input type="checkbox"/>
No information required	<input type="checkbox"/>
Help line number	<input type="checkbox"/>

## Appendix B: Detailed Results of the Chart Audit

TABLE B1: STAGE 2 EVALUATION CHART AUDIT RESULTS: SCREENING RATE

Site	Screened		Not screened		Total charts audited	
	No.	%	No.	%	No.	%
<i>Antenatal clinic sites</i>						
Cairns Base Hospital	281	85.9	46	14.1	327	100.0
Kirwan Hospital for Women	82	34.5	156	65.0	238	100.0
Nambour Base Hospital	280	94.0	18	6.0	298	100.0
Mater Mothers' Hospital	1150	96.6	41	3.4	1191	100.0
Mount Isa Base Hospital	54	81.8	12	17.4	66	100.0
Royal Women's Hospital	917	93.6	63	6.3	980	100.0
<b>Total antenatal sites</b>	<b>2764</b>	<b>89.2</b>	<b>336</b>	<b>10.8</b>	<b>3100</b>	<b>100.0</b>
<i>Other sites</i>						
Mater Adult Hospital: Emergency Department	59	23.2	195	76.8	254	100.0
Royal Women's Hospital: Gynaecology Outpatients	89	45.6	106	54.4	195	100.0
<b>Total other sites</b>	<b>148</b>	<b>33.0</b>	<b>301</b>	<b>67.0</b>	<b>449</b>	<b>100.0</b>
<b>Total all sites</b>	<b>2912</b>	<b>82.0</b>	<b>637</b>	<b>17.9</b>	<b>3549</b>	<b>100.0</b>

**TABLE B2: STAGE 2 EVALUATION CHART AUDIT RESULTS: DOMESTIC VIOLENCE SCREENING STATUS**

Site	Positive		Negative		Total women screened	
	No.	%	No.	%	No.	%
<i>Antenatal clinic sites</i>						
Cairns Base Hospital	25	8.9	256	91.1	281	100.0
Kirwan Hospital for Women	12	14.6	70	85.4	82	100.0
Mater Mothers' Hospital	47	4.1	1103	95.9	1150	100.0
Mount Isa Base Hospital	0	0	54	100.0	54	100.0
Nambour Base Hospital	30	10.7	250	89.3	280	100
Royal Women's Hospital	69	7.5	848	92.5	917	100.0
<b>Total antenatal sites</b>	<b>183</b>	<b>6.8</b>	<b>2527</b>	<b>93.2</b>	<b>2710</b>	<b>100.0</b>
*Mt Isa excluded						
<i>Other sites</i>						
Mater Adult Hospital:						
Emergency Department	5	8.5	54	91.5	59	100.0
Royal Women's Hospital:						
Gynaecology Outpatients	11	12.4	78	94.4	89	100.0
<b>Total other sites</b>	<b>16</b>	<b>10.8</b>	<b>132</b>	<b>93.7</b>	<b>148</b>	<b>100.0</b>
<b>Total all sites</b>	<b>199</b>	<b>7.0</b>	<b>2659</b>	<b>93.0</b>	<b>2858</b>	<b>100.0</b>

**TABLE B3: STAGE 2 EVALUATION CHART AUDIT RESULTS: ACCEPTANCE OF HELP**

Site	Accepted help		Declined help		All women screening positive	
	No.	%	No.	%	No.	%
<i>Antenatal clinic sites</i>						
Cairns Base Hospital	1	4.0	24	96.0	25	100.0
Kirwan Hospital for Women	4	33.3	8	66.7	12	100.0
Nambour Base Hospital	8	26.7	22	73.3	30	100.0
Mater Mothers' Hospital	12	25.5	35	74.5	47	100.0
Mount Isa Base Hospital	0	0	0	0	0	100.0
Royal Women's Hospital	8	6.5	116	93.5	124	100.0
<b>Total antenatal sites</b>	<b>33</b>	<b>13.8</b>	<b>205</b>	<b>86.1</b>	<b>238</b>	<b>100.0</b>
<i>Other sites</i>						
Mater Adult Hospital:						
Emergency Department	0	0	5	100.0	5	100.0
Royal Women's Hospital:						
Gynaecology Outpatients	0	0	11	100.0	11	100.0
<b>Total other sites</b>	<b>0</b>	<b>0</b>	<b>16</b>	<b>100.0</b>	<b>16</b>	<b>100.0</b>
<b>Total all sites</b>	<b>33</b>	<b>12.9</b>	<b>221</b>	<b>87.0</b>	<b>254</b>	<b>100.0</b>

**TABLE B4: STAGE 2 EVALUATION CHART AUDIT RESULTS: TYPE OF ABUSE**

	Physical Abuse		Emotional abuse		Threatened abuse		Total women screening positive	
	No.	%	No.	%	No.	%	No.	%
<i>Antenatal clinic sites</i>								
Cairns Base Hospital	10	40.0	22	88.0	7	28.0	25	100.0
Kirwan Hospital for Women	7	58.3	12	100.0	7	58.3	12	100.0
Nambour Base Hospital	18	60.0	28	93.3	14	46.7	30	100.0
Mater Mothers' Hospital	23	48.9	31	66.0	15	31.9	47	100.0
Royal Women's Hospital	26	37.7	58	84.1	31	44.9	69	100.0
<b>Total All Sites</b>	<b>84</b>	<b>45.9</b>	<b>151</b>	<b>82.5</b>	<b>74</b>	<b>40.4</b>	<b>183</b>	<b>100.0</b>

\* cumulative responses permitted

**TABLE B5: TYPE OF VIOLENCE AND ACCEPTANCE OF HELP**

Type of violence	Accepted Help		Declined Help		Total Type of Abuse	
	No.	%	No.	%	No.	%
Physical	24	27.9	62	72.1	86	100.0
Emotional	27	17.4	128	82.6	155	100.0
Threatened	22	29.7	52	70.3	74	100.0
<b>Total All Sites</b>	<b>73</b>	<b>23.1</b>	<b>242</b>	<b>76.8</b>	<b>315</b>	<b>100.0</b>

**TABLE B6: GP LINK BY SITE (ANTENATAL CLINICS ONLY)**

	GP Link Accepted		GP Link Declined		Not clear		Total Screening +ve	
	No.	%	No.	%	No.	%	No.	%
<i>Antenatal clinic sites</i>								
Cairns Base Hospital	0	0.0	18	72.0	7	28.0	25	100.0
Kirwan Hospital for Women	3	25.0	4	33.3	5	41.7	12	100.0
Nambour Base Hospital	9	30.0	8	26.7	13	43.3	30	100.0
Royal Women's Hospital	14	20.3	31	45	24	35	69	100.0
<b>Total All Sites</b>	<b>26</b>	<b>14.2</b>	<b>61</b>	<b>33.3</b>	<b>49</b>	<b>26.7</b>	<b>183</b>	<b>100.0</b>
*MMH excluded								

**TABLE B7: GP LINK BY TYPE OF ABUSE**

Type of abuse	GP Link Accepted		GP Link Declined		Not clear	
	No.	%	No.	%	No.	%
Physical	15	17.6	30	35.3	40	47.1
Emotional	25	16.6	52	34.4	74	49.0
Threatened	15	20.3	22	29.7	37	50.0

**Appendix C:  
Client Questionnaire Survey Form, Procedure and Flow-Chart**

**DOMESTIC VIOLENCE INITIATIVE**

**Reason for this survey**

*In this clinic we are concerned about your health and safety so we ask ALL women a few questions about physical and emotional abuse.*

We have found that while some women who have experienced abuse want help when we ask, others do not. To improve the way we can help women who experience domestic violence we need to know more about what women want. It would help us if you would answer the following questions.

**Please note your name is not required and your answers will remain anonymous.**

1. Why do you think some women who have experienced abuse do not want help at the time they are asked the questions?

---

---

---

2. Thinking about what is currently available, what helps women who have experienced domestic violence?

---

3. What else do you think would help?

---

4. Any other comments ?

---

---

Please place in envelope and leave in box provided.

THANK YOU FOR YOUR HELP

Feel free to write on the back of this page if you need more space.

## DOMESTIC VIOLENCE INITIATIVE

### STAGE 2 EVALUATION

#### Client Survey Procedure

As part of the Stage 2 evaluation of the Domestic Violence Initiative, we need your help in surveying women who have disclosed violence at an earlier visit. The evaluation of Stage 1 showed that most women do not accept help at the time of screening. This survey is designed to increase our understanding of what women who experience violence would find helpful.

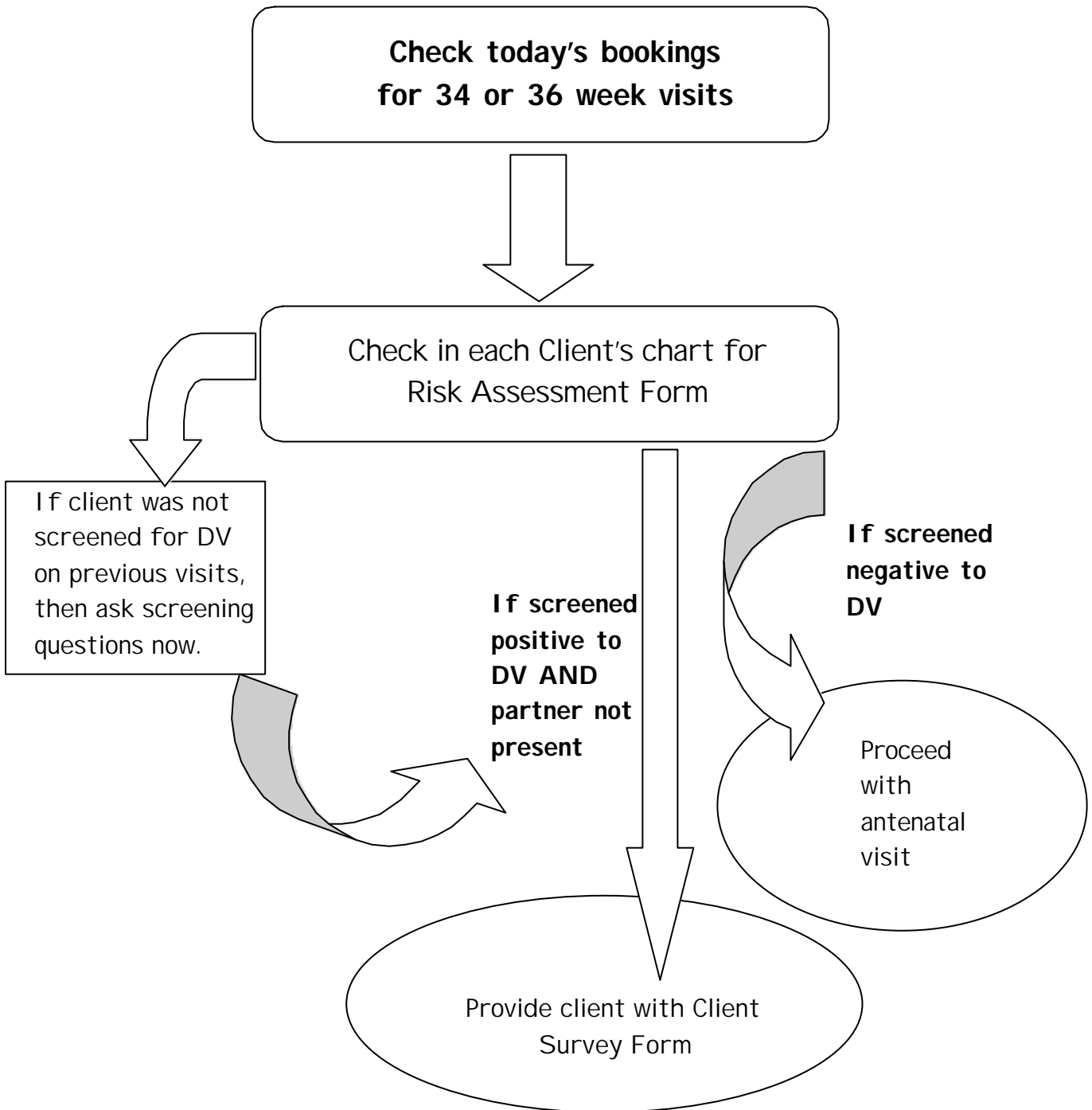
The CLIENT SURVEY FORM is to be presented to women at their 34 or 36 week visit IF they have screened positive to any type of violence at a previous antenatal visit.

NB: This may be an additional opportunity to provide referrals or follow-up to women who previously refused help. If this is the case, provide referrals and support as required, note in the patient's chart, and give her the CLIENT SURVEY FORM.

#### Process for Client Evaluation

- ❖ Before each clinic, ascertain which women are attending for their 34 or 36 week visit.
- ❖ Look in these charts for the Risk Assessment Form for screening of domestic violence.
- ❖ If the client answered "YES" to any of the questions on this form, then insert a CLIENT SURVEY FORM in her chart. If the client answered "NO" to all questions, then proceed with the antenatal visit.
- ❖ If there is no Risk Assessment form in the chart, or she was not screened on any previous visit, then ask the screening questions at this visit as per protocol. If the woman screens positive at this stage, provide her with the CLIENT SURVEY FORM.
- ❖ During the visit, provide the client with the CLIENT SURVEY FORM, ONLY IF she can complete the form without partner or family (apart from small children) present. The woman is expected to fill in the form on her own, but assistance with literacy or understanding may be offered if needed.
- ❖ If necessary, reassure the woman that her participation is entirely anonymous and her responses cannot be identified.

**DOMESTIC VIOLENCE INITIATIVE  
FLOWCHART FOR CLIENT SURVEY**



## Appendix D: DVI Presentations

### CONFERENCE PRESENTATIONS

1. Webster J, Roberts G, Mc Murray A, Harris M, Stratigos S, Wagner L. Screening for domestic violence in pregnancy: an evaluation of women's responses. *Proceedings from the 4<sup>th</sup> Annual Perinatal Society of Australia and New Zealand*. Brisbane, 2000
2. Webster J. The health impact of domestic violence on pregnancy. *Proceedings from the Domestic Violence Initiative Forum*, Brisbane, 2000
3. Stratigos S, Webster J. Screening across multiple sites: putting research into sustainable practice. *Proceedings from the 10<sup>th</sup> International Nursing Conference Ending Violence Against Women*. Vancouver, 2000
4. Webster J. Maternal consequences of domestic violence in pregnancy. *Proceedings from the Evidence-based Postnatal Care Seminar* Brisbane, 2000
5. Webster J. Screening for domestic violence in pregnancy: what do women think? *8<sup>th</sup> International Conference for Maternity Care Researchers*. Glasgow, 2000
6. Webster J. Does domestic violence affect pregnancy health outcomes? *Proceedings from the Herston Campus, Health Care Symposium*. Brisbane, October 2000
7. Webster J, Roberts G, McMurray A, Harris M, Stratigos S, Wagner L. Screening for domestic violence in pregnancy: do women think it is appropriate? *Proceedings from the Herston Campus, Health Care Symposium*. Brisbane, October 2000
8. Stratigos, S. , Webster, J. , & Grimes, K. (2000). Violence and pregnancy: *Partnerships Against Domestic Violence Conference*. Melbourne, April 2000

### PUBLICATIONS

1. Webster J. Opening closed doors: assessing for abuse in pregnancy *Birth Issues* 1999; 8: 92-93 (I)
2. Webster J, Stratigos S, Grimes K. Women's responses to screening for domestic violence in health care settings (2000 submitted to *Midwifery*)

## **Appendix E: DVI Sites**

### **STAGE 1 DVI SITES**

- Antenatal Clinic at the Royal Women's Hospital, Brisbane
- Antenatal Clinic at the Mater Mother's Hospital, Brisbane
- Antenatal Clinic at Kirwan Hospital for Women
- Antenatal Clinic at Cairns Base Hospital
- Antenatal Clinic at Mount Isa Base Hospital
- Gynaecology Outpatient Clinic at Royal Women's Hospital, Brisbane
- Emergency Department (Primary Care Unit) at Royal Brisbane Hospital, Brisbane
- Emergency Department at Mater Adult's Hospital, Brisbane

### **STAGE 2 DVI SITES**

- Bayside Health Service District (Family Health Service, Bayside Hospital and Wynnum Hospital)
- Central West Health Service District (Longreach Hospital Antenatal Clinic; Miles Hospital, Tara Hospital, Chinchilla Hospital)
- Northern Downs Health Service District – (Jandowae Hospital, Accident & Emergency)
- Redcliffe-Caboolture Health Service District
- Townsville Hospital (Accident & Emergency)
- Gold Coast Hospital (Antenatal Clinic)
- South Burnett Health Service District
- Nambour Hospital (Antenatal Clinic)
- Mackay Hospital

## Appendix F: Summary of Stage 2 Evaluation Strategy and Status

Objective	Strategies	Evaluation Questions	Evaluation Strategy	Evaluation Status
To integrate a quality improvement management approach in universal screening for domestic violence.	Continuation of screening at all stage one sites, supported by training and resources. Expansion to include new sites.	<ol style="list-style-type: none"> <li>1. Did all Stage One sites continue screening?</li> <li>2. Did training and resources support all Stage One sites?</li> <li>3. Did the Initiative expand into new sites?</li> </ol>	<ol style="list-style-type: none"> <li>1. Chart audits from selected sites to establish screening practices, particularly in the new sites. Internal auditing will be endorsed and supported.</li> <li>2. Written report from Steering Committee about progress and experience.</li> </ol>	<ol style="list-style-type: none"> <li>1. Chart audit revealed that all Stage 1 sites continued DVI screening, with an overall increase in screening rates across sites.</li> <li>2. DVI expanded into 11 new sites.</li> <li>3. Training was continued at Stage One and Stage 2 sites.</li> </ol>
	Site specific protocols detailing rights, roles and responsibilities of all care providers concerned with the care of women experiencing violence.	<ol style="list-style-type: none"> <li>1. Were site-specific protocols developed at each site?</li> </ol>	<ol style="list-style-type: none"> <li>1. Copies of site-specific protocols forwarded by each site.</li> </ol>	<ol style="list-style-type: none"> <li>1. RWH Domestic Violence Screening Protocol to be distributed for Statewide implementation pending endorsement of General Manager, Health Services.</li> </ol>
	Collaboratively develop an audit instrument for use in auditing of participating sites.	<ol style="list-style-type: none"> <li>1. Was an audit instrument developed?</li> </ol>	<ol style="list-style-type: none"> <li>1. Copy of audit instrument to be included in evaluation report.</li> </ol>	<ol style="list-style-type: none"> <li>1. Audit instrument is attached to RWH Domestic Violence Screening Protocol which is to be distributed for Statewide implementation pending endorsement of General Manager, Health Services.</li> </ol>
	To investigate follow-up information on women who disclose violence, for example, what women do about violence following disclosure, access to and satisfaction with services and what they want.	<ol style="list-style-type: none"> <li>1. What do women who screen positive want/need after the screening?</li> <li>2. Why do so few women want an intervention at the time of screening?</li> </ol>	<ol style="list-style-type: none"> <li>1. Questionnaire developed from literature review and expert opinion.</li> </ol>	<ol style="list-style-type: none"> <li>1. Client evaluation trial completed. Extension of client evaluation intended for Stage 3.</li> <li>2. Case study data on client service use and satisfaction planned for Stage 3.</li> </ol>

Objective	Strategies	Evaluation Questions	Evaluation Strategy	Evaluation Status
To integrate screening results into medical records departments and existing databases such as the Queensland Perinatal Database.	To negotiate with medical records departments at participating sites to incorporate screening instruments and information into the medical chart.	1. Were screening instruments and information incorporated in the medical records charts at each site?	1. Report from Steering Committee on the inclusion of screening instruments and information into medical charts.	1. Inclusion of screening forms in majority of charts, but not universal. 2. Trial of inclusion of screening forms in RWH gynaecology outpatients history form.
	To negotiate with the Health Information Centre for the inclusion of screening information into the Queensland Perinatal Data Collection.	2. Was screening information incorporated into the Queensland Perinatal Data Collection?	1. Written report on the progress of this strategy, commenting on the inclusion of the screening information into the Queensland Perinatal Data Collection and the electronic reporting system – OBICARE	1. Negotiations with the Health Information Centre continue during Stage 3. 2. Domestic Violence screening questions incorporated into OBICARE electronic form in February, 2001.
To pilot and evaluate a system to link the screening system with GPs involved in shared obstetric care.	To liaise with Divisions of General Practice to facilitate communication about the process of information sharing between hospital and GPs.	1. Was a GP link process established in conjunction with the Divisions of General Practice?	1. Written report from Steering Committee about progress and experience.	1. GP link established, but low acceptance amongst clients.
	To develop evaluation methodology in collaboration with key stakeholders involved in the process of screening women for domestic violence.	1. Was an evaluation methodology developed collaboratively?	1. Report on the development of evaluation methodology	1. Evaluation methodology including questionnaire for GP to be implemented during Stage 3.

Objective	Strategies	Evaluation Questions	Evaluation Strategy	Evaluation Status
<p>To liaise with relevant professional bodies and academic institutions to have domestic violence included in curriculum for basic nursing and medical education.</p>	<p>To work with representatives from the six Queensland universities teaching midwifery to develop strategies to embed issues related to violence against women into core curricula.</p>	<ol style="list-style-type: none"> <li>1. Were the six Queensland Universities involved in developing the midwifery curricula to include issues related to domestic violence?</li> <li>2. Did the curricula change to include issues related to domestic violence?</li> </ol>	<ol style="list-style-type: none"> <li>3. Formal report from the Steering Committee regarding the progress and activity of this strategy.</li> </ol>	<ol style="list-style-type: none"> <li>1. Communications with nursing schools to continue during Stage 3.</li> <li>2. Curricula inclusion of the health impact of violence against women at Queensland University of Technology (QUT) at post-graduate level.</li> <li>3. Tender for Midwifery training package was filled in December, 2000. To be implemented during Stage 3.</li> </ol>
	<p>To negotiate with the Queensland Nursing Council on the inclusion of a domestic violence component in undergraduate nursing curriculum.</p>	<ol style="list-style-type: none"> <li>2. Did the Queensland Nursing Council support the inclusion of domestic violence in nursing curricula?</li> </ol>	<ol style="list-style-type: none"> <li>3. Written report from the Steering Committee regarding the progress of this strategy</li> </ol>	<ol style="list-style-type: none"> <li>1. Tender for Midwifery training package was filled in December, 2000. To be implemented during Stage 3.</li> <li>2. Communications with QNC to continue during Stage 3.</li> </ol>



Domestic Violence Initiative March 2001