INITIATIVE TO COMBAT THE HEALTH IMPACT OF DOMESTIC VIOLENCE AGAINST WOMEN

STAGE I

EVALUATION REPORT

Queensland Government
Queensland Health

ACKNOWLEDGEMENTS

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This is an internal working document of the Queensland Health Domestic Violence Initiative which is being circulated for comment and discussion.

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KEY FINDINGS OF THE EVALUATION OF STAGE I OF THE DOMESTIC VIOLENCE INITIATIVE

1. Most (97%) women presenting for care support screening for domestic violence, particularly in the antenatal clinics.

2. Most (98%) women being screened for domestic violence were comfortable with the way 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 on 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 gain confidence and competence in screening with training and experience over time.

9. Staff screening women for violence benefit from initial and ongoing training on domestic violence and related issues.

10. Staff screening women for violence benefit 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.

1.0 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 considerable body of evidence has established a strong association between domestic and sexual violence and a range of physical and mental health problems and risk factors. There is a growing recognition of the impact of violence on obstetric outcomes and reproductive health. Victims of violence are likely to be heavy users of health care and studies in other fields are showing that the high costs of violence to the economy generally, for example through absenteeism, reduced opportunity to obtain or retain employment.

Crime Prevention Queensland is a whole - of - Government program that includes strategies to address various aspects of domestic violence. Queensland Health's contribution to this is the minimisation of the health impact of domestic violence and funding of $1.05 million over four years was provided for its Domestic Violence Initiative (DVI).

The DVI is based on evidence synthesised in the section on Violence in the Queensland Women's Health Outcome Plan which is currently being developed to provide medium to long term strategies directions to address priority health issues. In spite of the impact of violence on women's health, there has been little systematic attempt to address this, largely because the violence is seldom disclosed by clients or queried by service providers. The evidence indicated that screening to assist women to disclose violence was essential in order to enhance the capacity of the health care system to provide accurate diagnoses and appropriate interventions for victims of domestic violence.

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 in November 1998.

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 to provide a representative demographic and environmental sample.

The DVI is guided by a reference group made up of participants from each site. It is jointly managed by the Principal Policy Advisor (Women's Health) in the Health Outcomes Unit of Corporate Office and the Director, Nursing Research at the Royal Women's Hospital, Brisbane. In the interests of the long term sustainability of the work when the Initiative funding expires, only two time-limited positions were established centrally to assist in its implementation: a project co-ordinator and a data and evaluation officer. The DVI is an evidence based service modification initiative that is incrementally integrated into the core business of each facility.

By May 1999, a simple screening tool had been collaboratively developed for use in antenatal clinics (Appendix A), with a shorter version of it designed for emergency and gynaecology clinics (Appendix A).

The project design included evaluation of several aspects of the Initiative in each twelve-month period. In the first year it was essential to assess the feasibility of the DVI with particular reference to the effectiveness of the screening tool and the acceptability of the process to clients and service providers. The methodology was developed by a special working party of the Reference Group before implementation began.

Twelve-week trials began in July 1999. They were preceded by a four-hour training session for the staff involved. Evaluation, as described below, began about eight weeks later. At the end of the trials, the sites were unanimous in their conviction that routine universal screening for domestic violence should continue at all the trial sites. As the results and discussion below indicate, the process was not easy and in some ways the trials raised unforeseen questions and issues. Nor was any additional funding or resourcing provided, apart from training, materials and coordinated communication. The decision to continue was made at the sites before the evaluation was completed and indicates that the trial was an experiential learning experience that had a very positive impact.

Apart from the specific questions developed for the formal evaluation, a number of other issues raised in the literature or discussions demanded attention. Some of the questions appear to have been resolved in practice. For example, though time constraints were often raised as a barrier, those administering the short straightforward questionnaire as part of routine medical history taking found it only took a few minutes. On average only 7% of the women screened positive, and only 10% of these women wanted assistance at that point. The service providers clearly saw the value of any time devoted to this small group.

As a number of studies had suggested, the fear that women would not disclose or that their relationship with their caregiver would be undermined proved unfounded when put to the test. Any lingering doubts were dispelled when the preliminary results of the client survey were released.

Two thirds of the women surveyed for the evaluation gave their reasons for supporting routine screening. Their comments provide a moving and sophisticated rationale for routine screening for domestic violence and indicated a broad understanding of its impact on the health and wellbeing of women.

An initial tendency to see violence as an issue that could only be dealt with by social workers probably reflected professional roles and training that have changed considerably over the last decade. In fact few women wanted referral to the hospital social work department and a check across all sites at the end of the trial revealed that the increased workload flowing from the DVI has been within current capacity.

There was a similar concern that the screening would overload the specialised community based domestic violence services. While none took up the suggestion to collect specific data on referral from the DVI, there were no anecdotal reports of an increased service burden. This is not surprising, given the very small number of women who wanted a direct referral, although at most sites women were generally given details of how to contact these services among other general information handed out to them.

A related question focuses on the ethical implications of screening without sufficient services in the community to provide support for those who disclose violence. This concern is based on the assumption that the services currently available, or more like them, are what women want and need. There is no evidence available on this point and the low uptake of the offer of assistance that is built into the screening process may suggest a need to explore other models or pathways. There sometimes seems to be an implicit assumption that a woman who screens positive for violence should and could leave her partner. This is not borne out in the admittedly small body of evidence from women themselves. It is possible that staff may overlook the fact that the woman may not be ready to take action at this time or she may judge it unsafe to do so.

However, as a primary objective of this Initiative is to enhance the capacity of health professional to provide more accurate diagnosis of short and long term conditions associated with violence, the disclosure and recording of violence in a woman's medical record is important in itself.

There is also some qualitative evidence to suggest that asking women about violence and acknowledging the issue can be a positive intervention in itself. The 17% of clients in an emergency setting who reported “feeling relieved” when asked about violence supports this interpretation.

This report records the first of four planned formative evaluation processes. Some will be iterative. Others will investigate various aspects of the Initiative with a particular focus on its sustainability and, where possible, its outcomes for clients. All will now be firmly grounded in the mandate from women revealed in this report.

2.0 PROJECT SUMMARY

2.1 Recommendations

Processes and systems

1. The universal, routine screening for domestic violence in public sector facilities should continue and expand.

2. The issues 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. Such standards should include:

    - all women should be screened where safety permits;
    - standardised questions which must be asked in a conversational manner;
    - brief preamble must be given to women before screening;
    - training for all staff before they start screening women for violence;
    - screening women on their own, without their partners or others present;
    - clearly defined primary and secondary courses of action for staff;
    - dissemination of information about help and support on small business cards to all women;
    - screen results and response by staff incorporated in patient medical chart;
    - provision of immediate help if requested;
    - raising the issue of domestic violence on subsequent visits;
    - routine collection of screen results and dissemination of aggregated information as part of information flows and feedback loops to staff.

Staff development

4. The findings of this evaluation should be incorporated in initial and ongoing staff development and training on addressing the health impact of domestic violence. Feedback mechanisms should be established and maintained to provide information on screening rates, disclosure rates and acceptance of immediate assistance.

5. The rights, roles and responsibilities of the health care provider should be clarified in training programs.

6. Mechanisms to facilitate debriefing and ongoing learning in relation to domestic violence issues should be developed at all sites.

Screening instrument modification

7. Question 1 of the antenatal screening instrument should be removed. Clients do not relate to this ambiguous question.

8. Question 4 of the antenatal screening instrument, regarding threatened harm to the woman or her children, should be modified to resolve the possible ambiguity arising from raising two issues in one question.

2.2 Pilot sites

Antenatal Clinic at the Royal Women's Hospital, Brisbane
The Royal Women's Hospital is a tertiary referral hospital, providing inpatient and outpatient obstetric and gynaecological health services. It has a Level 3 Intensive Care Nursery. Approximately 3,800 women deliver at this facility each year. It is situated in an inner-city suburb on the north side of Brisbane. Key research in the area of domestic violence during pregnancy was conducted at this facility in 1994.

Antenatal Clinic at the Mater Mother's Hospital, Brisbane
The Mater Mother's Hospital is a tertiary referral hospital providing inpatient and outpatient obstetric health services. It has a Level 3 Intensive Care Nursery. Approximately 4,500 women deliver at this facility each year. It is situated in an inner-city suburb on the south side of Brisbane.

Antenatal Clinic at Kirwan Hospital for Women
Kirwan Hospital for Women in Townsville is a tertiary referral hospital providing inpatient and outpatient obstetric health services. It has a Level 3 Intensive Care Nursery. Approximately 1,800 women deliver at this facility each year. Over 10% of women delivering at Kirwan are reported as being Indigenous.

Antenatal Clinic at Cairns Base Hospital
The Cairns Base Hospital is a large regional hospital on the eastern coast of the State providing acute inpatient and outpatient health services. It has a level 2 Special Care Nursery and provides care for women evacuated to Cairns for delivery from remote northern areas. Approximately 1,700 women deliver at this facility each year. Approximately 25% of women delivering at Cairns Base Hospital are reported as being Indigenous.

Antenatal Clinic at Mount Isa Base Hospital
The Mount Isa Hospital is a major remote hospital providing inpatient and outpatient health services. Approximately 500 women deliver at this facility each year. It has a Level 2 Special Care Nursery and provides care for women who are evacuated to Mount Isa for delivery from remote northern areas. Situated less than 200km east of the Northern Territory border, almost one third of women delivering at Mount Isa Base Hospital are reported as being Indigenous.

Gynaecology Outpatient Clinic at Royal Women's Hospital, Brisbane
The Royal Women's Hospital is a tertiary referral hospital providing inpatient and outpatient obstetric and gynaecological health services. Approximately 450 women are seen at this clinic each week. All women booked for surgery are screened for domestic violence (approximately 160 clients per week). It is situated in an inner-city suburb on the north side of Brisbane.

Emergency Department (Primary Care Unit) at Royal Brisbane Hospital, Brisbane
The Royal Brisbane Hospital is a tertiary referral hospital providing inpatient and outpatient health services. The Primary Care Unit is part of the Emergency Department at the Royal Brisbane Hospital. Approximately 200 people, almost half (45%) of whom are women, are seen each week at this clinic by sessional general practitioners in private practice. The Royal Brisbane Hospital is situated in an inner-city suburb on the north side of Brisbane. Key research in the area of domestic violence was conducted at this facility in 1991.

Emergency Department at Mater Adult's Hospital, Brisbane
The Mater Adult's Hospital is a tertiary referral hospital providing inpatient and outpatient health services. Approximately 580 people present to the Emergency Department each week, most (56%) of whom are women. It is situated in an inner-city suburb on the south side of Brisbane.

2.3 Project goal and objectives

Goal: To minimise the physical and psychosocial harm to women associated with domestic violence.

Objectives – Stage I:

- To develop an appropriate method for identifying women who have experienced domestic violence.
- To trial the method for identifying women who have experienced domestic violence in both a rural and urban hospital accident and emergency department and antenatal care settings.
- To evaluate and document the methodology and make recommendations for the implementation of subsequent stages of the Initiative.

3.0 EVALUATION

3.1 Objective

The objective of the evaluation was to gather baseline data before implementation of the screening tool (eg identification rates, satisfaction of clients and staff with present practice) and post-implementation data.

3.2 Stage I Strategies

1. Develop an appropriate tool for identifying women victims/ survivors of domestic violence who present to rural, provincial or urban emergency and antenatal departments.

2. Document relevant practice and protocols.

3. Identify key personnel in the selected departments for the purpose of training, implementation, coordination and assistance with evaluation of the project.

4. Develop a plan for in-service training and on-site coordination prior to implementation of the tool.

5. Trial the selected screening tool for a trial period in emergency and antenatal departments which agree to participate in Stage I of the Initiative.

3.3 Methodology

The evaluation questions and approaches outlined in the Project Plan and summarised in Table 1 of this report have been used with some slight modification based on experience during implementation. For example, client focus groups were not used because the high response rate to the written surveys (Appendix D) and the very high level of positive and analytical comment they recorded. Staff questionnaires were used at three sites where focus groups were impracticable because of cost or time restraints. Some evaluation questions were also revised to better reflect the information was required (Table 1).

TABLE 1: SUMMARY OF EVALUATION STRATEGY AND STATUS

Issue	Evaluation question	Planned Approach	Actual Approach	Status
Project reach	Are all women who present at these departments being assessed?	Audit of charts from 1 week to 1 month	Audit of charts for 1 complete month at the antenatal pilot sites. Audit of charts for 1 week at emergency departments and gynaecology outpatient sites.	Completed at all sites.
Original: Consumer satisfaction *Revised:* Client attitudes	*Original question:* Are consumers satisfied with the process? *Revised question:* What do clients think of the process?	1. Client attitude questionnaire 2. Focus groups with clients	1. Client questionnaire 2. Client focus groups not held	1. Completed 2. Not required
Original: Staff satisfaction *Revised:* Staff attitudes	*Original question:* Are staff satisfied with the process? *Revised question:* What do staff think about the process?	1. Identify and liaise with key personnel in the respective departments 2. Staff training evaluation questionnaire 3. Training attendance records 4. Staff attitude questionnaire 5. Staff focus groups 6. Opinions of key personnel	1. Key staff identified and Training and Evaluation working groups formed. 2. Training evaluation questionnaire used 3. Staff attendance noted 4. Staff questionnaire used at gynaecology outpatient and emergency department sites 5. Staff focus groups used at all antenatal sites 6. Opinions of key personnel responded to as required. Minutes from Training and Evaluation meetings recorded and disseminated.	1. Completed 2. Completed 3. Completed 4. Completed 5. Completed 6. Completed
Implementation	Are all relevant staff administering the screening system?	1. Opinions of key personnel 2. Feedback from staff questionnaires and focus groups	1. Opinions of key personnel responded to as required. Minutes from Training and Evaluation meetings disseminated and filed 2. Staff questionnaires and focus groups used	1. Completed 2. Completed
Quality Control	Are all materials and components of the project of good quality?	1. Staff attitude measures 2. Client attitude measures	1. Focus groups and questionnaires 2. Client questionnaire	1. Completed 2. Completed

4.0 RESULTS

4.1 Evaluation of project reach

Question 1: Are all women who present at these departments being assessed?

4.1.1 Methodology

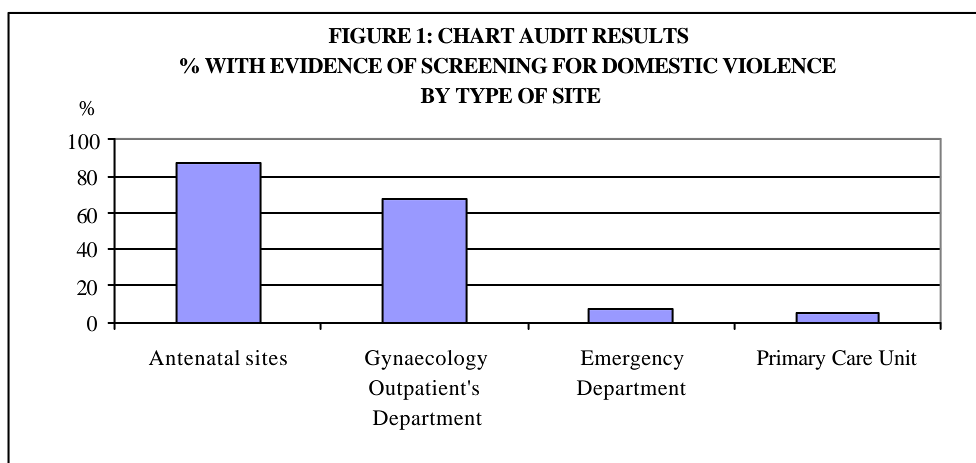
An audit of a representative sample of charts from the pilot sites was used to establish the proportion of all women presenting at these departments who were screened. Legal opinion was sought regarding the process for accessing the required information. Permission to access medical charts was received from the Medical Superintendent of all public facilities and the Chief Executive Officer of the Mater Misericordiae Hospitals.

At the antenatal sites all charts available a complete month's clinic were checked for the screening status of the client. The charts for a single week were audited at the emergency departments and gynaecology outpatient clinic. The shorter time frame was necessary because of the volume of clients presenting to the emergency department was much greater than at the other sites. No identifiable information was used in the evaluation. The Mater Mother's Hospital captured the Domestic Violence Screen electronically and frequency counts from the Clinical Record System were used to collect the required information.

Overall 1,279 charts were audited - 860 from the antenatal sites, 88 from the Primary Care Unit, 169 from the Mater Adult Emergency Department and 162 from the gynaecology outpatient department (Appendix B).

4.1.2 Results

The Antenatal sites and gynaecology outpatients department recorded the highest rates of screening activity (86.5% and 67.3% respectively). Less than 10% of charts audited at the Emergency Department and the Primary Care Unit had evidence of screening for domestic violence (Figure 1).



Antenatal sites

The proportion of all women screened ranged from 72% at Kirwan Hospital for Women to 97% at Royal Women's Hospital (Appendix B). The comparatively low screening rate at Kirwan Hospital for Women reflects the way the screening instrument was filed. Initially the screening forms were kept separately, however when staff recognised that it is essential to keep them with the client's chart in order to provide short and long term follow-up, the process was changed.

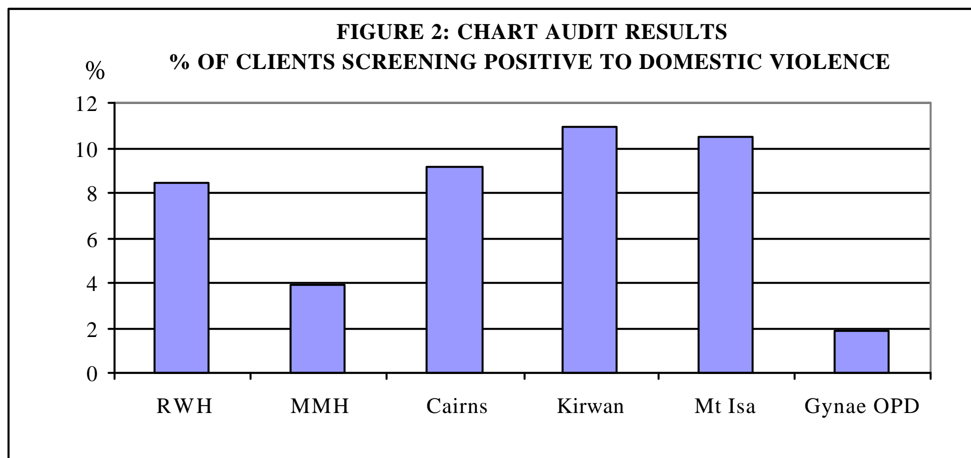
Emergency departments and gynaecology outpatient department

Most (67.3%) women presenting to the gynaecology outpatient department at Royal Women's Hospital, Brisbane were screened for domestic violence. Less than 10% of the charts audited from the Royal Brisbane Hospital's Primary Care Unit or the Emergency Department of the Mater Adult's Hospital, Brisbane had evidence of screening (Appendix B). The low screening rates in the Primary Care Unit may reflect the fact the instrument is administered by general practitioners in private practice who are working in the clinic on a sessional basis and who were unable to have more than one hour's training. The culture, work-flows and service environment in an emergency department raise particular challenges to screening. Neither service providers nor clients are accustomed to the idea of routine questions on for psychosocial matters in this environment.

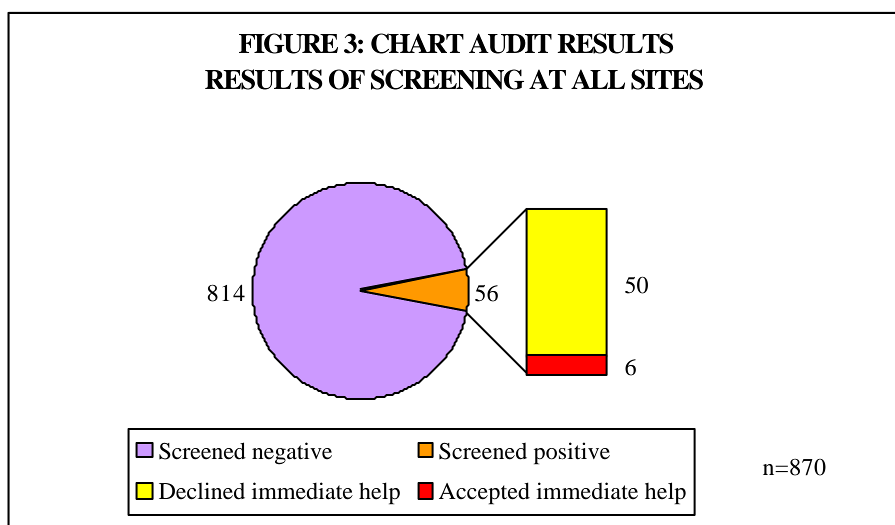
Discussion

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 consistent area of the chart and the use of a patient identification mechanism and date would have assisted greatly in the interpretation of the results. This was particularly important when women presented several times to the same site within a short period of time.

Although results of the screen were not required for the evaluation, all sites requested that this information be collected in order to provide staff feedback about site specific prevalence rates (Figure 2 & Appendix B). This additional data proved to be very valuable to the evaluation as it provided an opportunity to assess the relative effectiveness of different methods of data collection. For example the lowest rate of disclosure in the antenatal sites occurred at the Mater Mothers Hospital where data is entered directly into an electronic records system. The data-entry terminals allowed little flexibility in where mothers were screened and the mandatory fields and limited response options initially meant staff were unable to record that a partner was present and that it was unsafe to screen. For this reason data presented in this report should be interpreted with caution, as it is may not be an indication of prevalence.

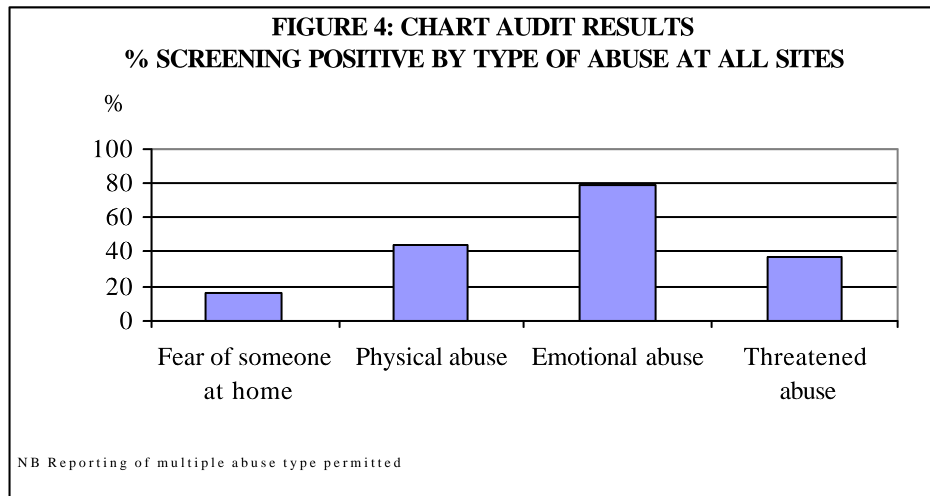


The screen results also indicated that whilst almost 6.5% of all women screen positive, answering yes to at least one of the questions, less than 11% of these women request help at that point of time (Figure 3 & Appendix B). Of the 870 charts that had evidence of screening activity, 56 women screened positive and 6 accepted immediate help (Figure 3).



It is important that this information is included in the preparation of staff prior to screening. Knowledge that women who screen positive may often refuse help will assist staff to adjust their expectations of the screening process. There was evidence in the audited charts that all of the clients requesting assistance received immediate help of one form or another. This was a significant issue that was frequently raised in the staff focus groups.

Of particular interest was the fact that not many women from the antenatal sites who disclosed physical, emotional or threatened abuse identified themselves as being afraid of anyone (Figure 4 & Appendix B) and indicates that the direct questions were more effective in assisting disclosure. This may have implications for the screening instrument used in the non-antenatal sites. Staff in these areas indicate that a previous history of abuse is more frequently disclosed than current abuse.



4.1.3 Recommendations.

A. Question 1 of the antenatal screening instrument should be removed. Clients do not relate to this ambiguous question.

B. The findings of this evaluation should be incorporated in initial and ongoing staff development and training on addressing the health impact of domestic violence. Feedback mechanisms should be established and maintained to provide information on screening rates, disclosure rates and acceptance of immediate assistance.

C. Agreed standards should be developed to provide guidelines and standards of practice for domestic violence screening practices. Such standards should include:

- screening women on their own, without their partners or others present;
- screen results and response by staff incorporated in patient medical chart;
- routine collection of screen results and dissemination of aggregated information as part of information flows and feedback loops to staff.

4.2 Evaluation of client attitudes

Question 2: ***What do clients think of the process?***

4.2.1 Methodology

A draft questionnaire was developed and reviewed by an expert panel of nurse researchers and members of the Domestic Violence Initiative Reference Committee (Appendix C). The population (n = 1,900) was a consecutive sample of women, from each of the 5 pilot sites (1,500 from antenatal clinics, 100 from the Primary Care Unit of an emergency department, 150 from the emergency department and 150 from the gynaecology outpatient clinic) who had been asked about domestic violence during a hospital visit. Sample size was determined by the estimated throughput of each site (outlined on page 9).

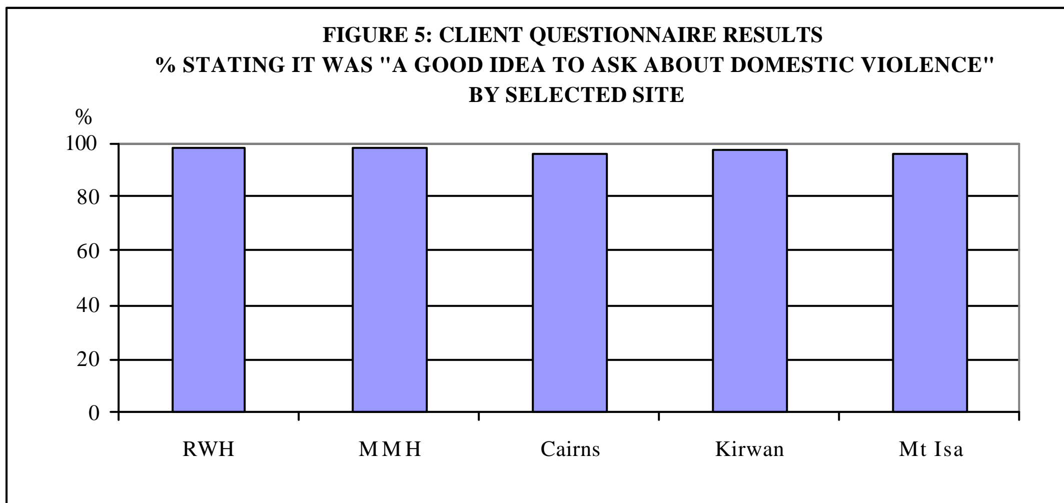
Women who had been asked questions about domestic violence at their antenatal booking-in visit were invited to complete the evaluation at their next hospital visit while they waited for their appointment. If women were going directly into shared obstetric care with a general practitioner for their next antenatal appointment, the evaluation was completed on the same day the questions were asked. A similar strategy was used for women screened at the Primary Care Unit, the emergency department and the gynaecology outpatient department.

Names were not required and a sealable pre-paid envelope addressed to one of the co-managers in Brisbane and 'posting box' were provided.

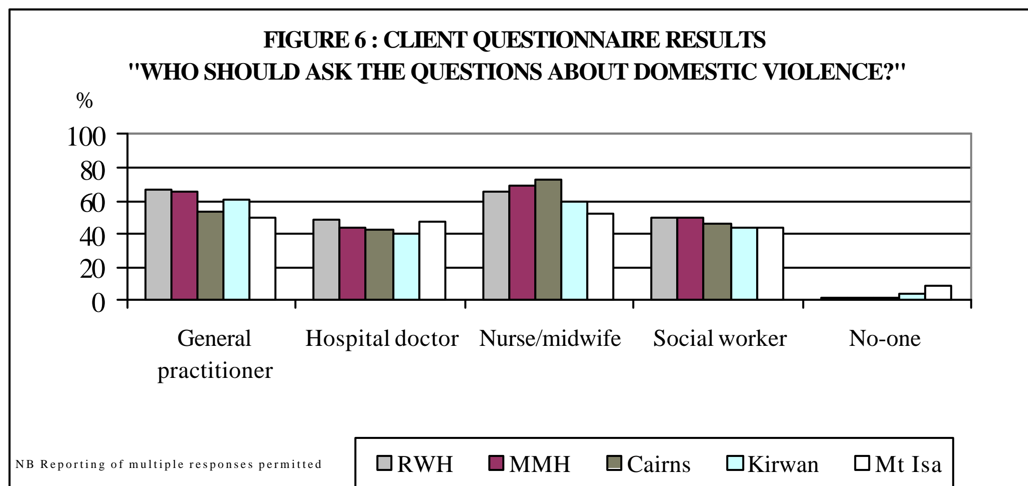
4.2.2 Results:

<u>Antenatal sites</u>

Thirteen hundred and thirteen (87.5%) useable questionnaires were returned from women attending antenatal clinics at the Royal Women's Hospital (Brisbane), the Mater Mothers' Hospital Brisbane, Kirwan Hospital for Women, Mt Isa Base Hospital and Cairns Base Hospital. Ninety-eight per cent of respondents stated that it was a 'good idea' to ask questions about domestic violence in a health care setting (Figure 5 & Appendix D). Only 30 women (2.3%) felt uncomfortable about being questioned on such a personal issue.



Midwives (66.6%) and general practitioners (62.7%) were nominated most often in response to the question "who should ask about domestic violence". Only 2.3% of the women thought no one should ask such questions (Figure 6 & Appendix D).



Two thirds of the women wrote an answer to the open-ended question "Why is it a good idea to ask about domestic violence?" Examples of their unedited responses have been grouped into themes:

- **Concerns for the baby**

  If the problem can be fixed it would be good to fix it before the baby had to suffer the consequences

  You also have the babies life to think about. They deserve a chance.

  It may make them speak out more if they wish to protect their child.

  If husband is violent it could be harmful for baby.

- **An opportunity for disclosure**

  Too many women are scared to come forward but if asked they feel people do care and there is help

  A lot of women don't know who to talk to. It makes it easier if someone else brings it up!

  Because you never know if it's happening & they can talk about it if they are going through it

- **A safe place to disclose**

  Most women are more open about their feelings while pregnant and open up more to professionals

  When they are away from their partners and feel safe they are more likely to open up and tell someone.

  It provides them with an opportunity to discuss their situation in privacy

- **To provide evidence in case of harm**

  In case of any injury to baby inflicted by blows/kicks from violence. Medical staff are then aware.

  For future reference if themselves or there children end up in hospital they have a record of it.

  A record is good for them if it happens to hurt them.

- **To assist with diagnosis**

  Possibility of this affecting health and reason for hospital visit

  The affect on their health, well-being, even if the abuse is only emotional

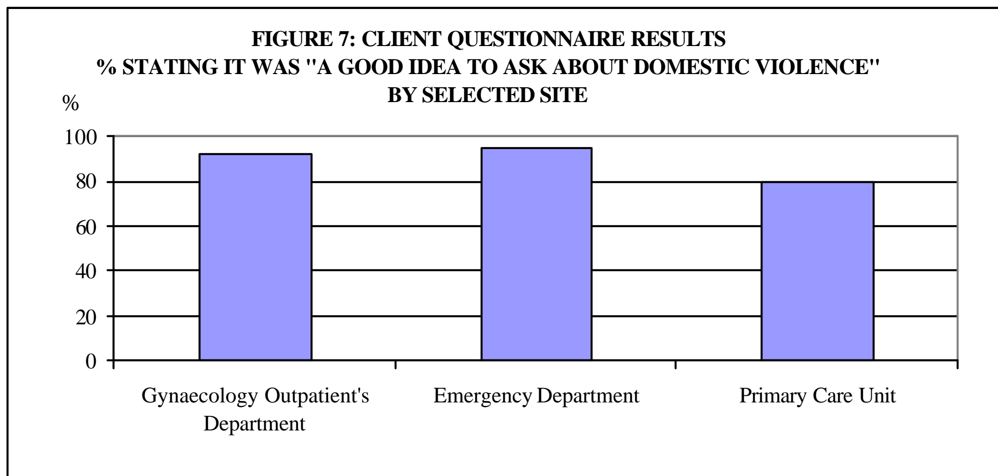
  To assist to assess patients problems

  As stated above, emotional well being affects general health

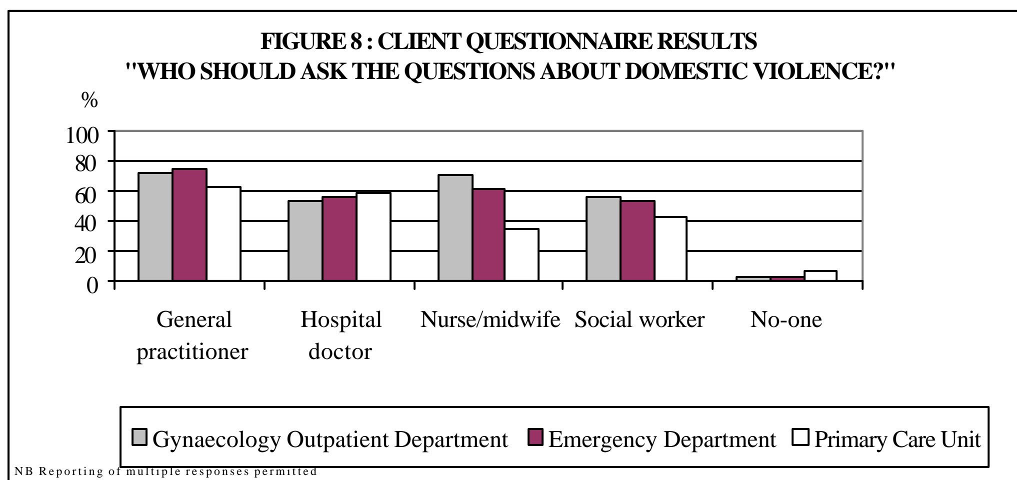
Emergency departments and gynaecology outpatient department

The overall response rate from the emergency departments and gynaecology outpatient department was marginally lower (82.5%) than from the combined antenatal sites, though still considerably higher than might have been expected. Fewer of these women agreed that it was a 'good idea' to ask questions about domestic violence (92.2%) but a similar number of these respondents felt uncomfortable about being asked the questions at their hospital visit (3.7%).

Women attending the Primary Care Unit at the Royal Brisbane Hospital responded in a different way to women at other sites when asked "how did you feel" about being asked the domestic violence questions. This was the only setting in which the screening system operated differently. In addition, providing the full 4-hour education component of the program to general practitioners was difficult and may partly explain the result.



General practitioners (70.3%) and nurses (58.7%) again, were most frequently named as being the most appropriate people to ask about domestic violence. Only 3.7% of these women believed no-one should ask about violence (Figure 8 & Appendix D).



Apart from the theme relating to safety of the baby, women from these sites provided similar responses to the open-ended question "why is it a good idea to ask about domestic violence" as women from antenatal sites.

All sites

When asked 'Is there a better way to ask about domestic violence?', 246 women responded. Two thirds of them appeared comfortable with the process, many specifically using phrases like *No, straight up is best* and *No point beating around the bush.*

Fourteen women (0.9% of all women) wrote that they would rather provide a written response. On the other hand, some of those who had been asked to complete the survey form themselves said, *a direct approach might be more personal.* They also suggested literacy could be a problem for some women. One woman wrote *I was required to read the question, some people may not be able to read and not be able to understand what is being asked.*

A number of women emphasised privacy, confidentiality and the importance of not asking questions about domestic violence when the partner was present. One woman pointed out that children are sensitive to stress and that they should not be present during screening.

Some responses were simply musings, reflections on the difficulty of addressing this sensitive issue. For example: *These are not easy questions to ask at any time* and *It is a difficult subject and difficult to decide on the best approach.*

The manner in which questions were asked was also important. Many respondents made remarks like *It was done well. I felt very comfortable with the midwife.* It seemed clear however, that some staff felt uncomfortable about asking the questions and this was felt by the women. Comments such as *I recall the questions being very direct, maybe some people would respond to a more gentle style,* another said *Always be considerate it is quite an embarrassing thing and an emotional time.*

A related issue concerned establishing trust before questions were asked, for example *After a few visits, a person may feel more comfortable to discuss issues with the midwife. Not at the first visit.* This is difficult without a continuous model of care maternity care but it is important for some women, perhaps particularly those in abusive relationships. Some women also suggested that the questions be asked at subsequent visits *More than once if staff are concerned as she may be too afraid first time asked.*

4.2.3 Discussion

Client safety and wellbeing is of prime importance when screening women for violence. It is essential that women be screened **on their own**, without their partners or others present.

Over 96% of women thought it was a "good idea to ask about domestic violence". This provides a strong mandate to continue screening and affirms the importance of viewing domestic violence as a health matter. The issue of domestic violence needs to be raised at subsequent visits, particularly for clients of antenatal services where continuity of care is more readily achieved. Some women, especially those in abusive relationships, need time to establish trust with care-givers. Providing further opportunities for these women to discuss violence may be of benefit.

It is important that the domestic violence screening questions are asked directly to women rather than giving them a screening form to complete. Literacy and other communication issues can present barriers. A brief explanation about the Initiative prior to screening may assist clients in the screening process. Education about violence, relevant resources and services and training in applying the questionnaire are essential before staff start screening. Such training should place particular emphasis on the manner in which the screening instrument is used.

4.2.4 Recommendations:

A. The universal, routine screening for domestic violence in public sector facilities should continue and expand.

B. The issue should be raised at subsequent visits, particularly in antenatal services.

C. Agreed standards should be developed for the Domestic Violence Initiative to provide guidelines and standards of practice for domestic violence screening practices. Such standards should include:

- standardised questions which must be asked in a conversational manner;
- brief preamble must be given to women before being screened;
- training for all staff before they start screening women for violence;
- screening women on their own, without their partners or others present;
- raising the issue of domestic violence on subsequent visits.

D. The findings of this evaluation should be incorporated in staff development and training on addressing the health impact of domestic violence.

4.3 Evaluation of staff attitudes

Question 3: What do staff think about the process?

4.3.1 Methodology

At least one staff focus group was conducted at each antenatal pilot site 12 to 16 weeks after the trial of the screening began. The focus groups consisted of student midwives, midwives and social workers. There was a variety of ages and experience. All but one of the participants were female. Participation in the focus groups was voluntary and some staff attended outside of their rostered hours. The focus groups were audio-taped and the transcripts analysed using Ethnograph version 4.0.

A semi-structured questionnaire derived from the focus group questions was used for the emergency departments and gynaecology outpatient department. Focus groups were not used because of the difficulties and costs of scheduling focus groups in these areas.

4.3.2 Findings

Staff were generally supportive of the Initiative. All sites indicated they would like to see it continued:

> *The screening is of value. Yes!*
>
> *I would like to see it continued in booking-in clinic and each client asked the questions and ….rolled out through birth suite and the gynae ward.*
>
> *The DV questions have to be part of the obstetric interview process. It can't stop now that we've implemented it. It has to be ongoing.*
>
> [It is of value?]*...most definitely! Because it was part of the women's health that we probably ignored because we never asked the questions and it's part of their life that we never addressed and it needs addressing.*
>
> *I just think it's been a good initiative…We're just surprised at the number and volume of women that come forward and say they're involved in a situation. It's unbelievable!*
>
> *I think at the end of the four years of the initiative we can't just then drop asking the questions. I think it should be carried on.*
>
> *Before we started this initiative we had a young girl come through the clinic…full of bruises…We didn't have any strategies to put in place although the midwife did say is there anything we can do to help you, are you safe at home? She said no I fell in the shower. I'm fine….The girl…*[was] *killed by her partner two weeks after she had left our clinic.*
>
> *I'd like to see it go everywhere…nationwide.*

There was some evidence that the screening process was assisting women, even those who refused help initially.

> *I had done the screening and she knew we were here…how we could help her. And she actually rang me…and burst into tears saying that her husband had tried to strangle her.*
>
> *A couple of weeks ago I did a history on a woman and she answered no to all the DV questions and then came back two weeks later without an appointment...to speak to us about the fact her husband was …abusive to her. She didn't know what to do. She couldn't ring the police because …she didn't speak English. So we got her...to see the social worker.*

Some staff noted that the screening process was important not just for the present but for the future of the women concerned, their families and the community:

> *And it's bringing it out in the open because a lot of people don't want to admit that it's happening to them. So it's opening doors for them. Just with this little initiative we've got here.*
>
> *…So I think we're turning light bulbs on.*
>
> *Well it's certainly making the public aware that we're on the ball...*
>
> *A large proportion of women are pleased that we are asking these, not so much for themselves but for the rest of the women in the community. They all say it is a good thing to ask*
>
> *A lot say: "Why wasn't this around ten years ago…?"*
>
> *I've had a couple of ladies and one particular I had last week... Had no problems with the interview...and I put this form in front of her…She was just staring and promptly burst into tears and started crying and I thought 'What have I done?', thinking that…she doesn't like this form... She calmed down and she said, 'See this form here... 'This should have been given to me five years ago. Why didn't yous have this form when I had my...when I was with my first husband?'*

Some staff recognised that while not all women will disclose violence, the screening process was of value to those that did:

> *I don't think it's quite fool proof,* [but] *at least if you can help at least one person then I think it's worthwhile.*
>
> *Well, certainly if it leads to a happy family environment and safety issues, well, its imperative that we continue.*
>
> *I think you've still got to continue because the ones that do say something, you know, it's still worthwhile.*

Some staff felt that support mechanisms in some hospitals and in the community should be considered further. There seems to be an implicit assumption that a woman who screens positive for violence should and could leave her partner. This is not borne out in the admittedly small body of evidence from women themselves.

> *It's good that women can tell us all this and we can put these strategies in to help them cope but it's so much for us to take on all at one time.*

> *We can only offer them those telephone numbers. To me, it defeats the purpose of asking the questions.*

> *It's a bit futile to do all this in depth chatting to the lady, gaining her confidence so that we can ask very personal questions; she's going to answer them truthfully and then you say, "Here's some phone numbers" that she can get out of the phone book. You've done nothing!*

> *Because we said that's what to do and the actual truth is there is nothing out there that's going to help. And it does worry me a little that maybe they won't talk to them again because they've tried it once.*

> *There's nothing wrong with the screening tool. The screening tool is alright. I just don't see a lot of point in screening where you can't offer help.*

> *I think we need to look at the safe care housing situation – what's the point in them wanting to leave if there's no safe place for them to go.*

Some staff indicated that they were unclear about what was expected of them in the process, what their role was in caring for women experiencing violence.

> *I thought it was difficult to know…how much do I delve into this myself? Like how much do I find out from her but I wasn't really the appropriate…I mean I could listen to her but I wasn't really the appropriate person to direct her.*

> *My first reaction was,"Oh this is a very private thing. Are we overstepping our boundaries or what?"*

> *…I mean one day I'm going to hit* [meet] *a lady and she's going to tell me she's in a terrible situation and what am I going to do?*

> *We can build up trust with the lady. We can build up a rapport with the lady and we can talk to her, but I'm not a professional counsellor.*

> *I'm worried about how I'm going to be if I get someone who really needs help. Like I don't mind asking the questions, but when it comes to the crunch…*

Having asked these questions, I expect to be able to follow on. I would like to be able to follow on.

Similarly, some staff had expectation of the woman who screened positive, particularly if she refused help at that time. It is possible that staff may overlook the fact that the woman may not be ready to take action at this time or she may judge it unsafe to do so.

Well you feel pretty helpless some of the time. Glad to want to help… you know. [But] *maybe they've not got to that stage.*

It's hard when they answer yes…but they don't want any help.

…You try and tell them that it's not a good situation. It's not an ideal situation to be in and you try to tell them that the help is there…

A lot of them refuse the help, but you feel like you should still give them something. Like they say: "I'm not ready for help." But it's almost like, what can we offer them?

Frustrated! 'Cause one girl said: "Well, its only when he drinks." But she didn't say how often he drinks and she didn't want help. I gave her the numbers for later down the track but...

Other staff had clearly defined boundaries for themselves and expectations of the women they encountered.

…My only thought is that as health care professionals you can only go so far to help a person – and only if they want to be helped. You can't force people to access the service that's provided and we all know that from working in the facility. So I think that as long as we bring up the subject, discuss it openly and provide support for the people that want it – I don't know how much further you can go. I think that people have to take a little bit of responsibility for themselves as well.

…I just respect their privacy and if they don't want to talk about it …

I think you have to respect their rights and support them.

Respect their rights and support, but again make them aware that there are avenues that if they need assistance we can help them with…and basically keep the door open so…they can come back or ring up or whatever. You know…if they change their mind…

Well once they say no they don't want any further help and we've given them the cards and the all the information we can give, unless we start intruding into their life,… that's where we should,

well I think we should stop. Once you start intruding you won't make any progress.

As long as we give them some way out…the rest will come from themselves.

4.3.3 Discussion

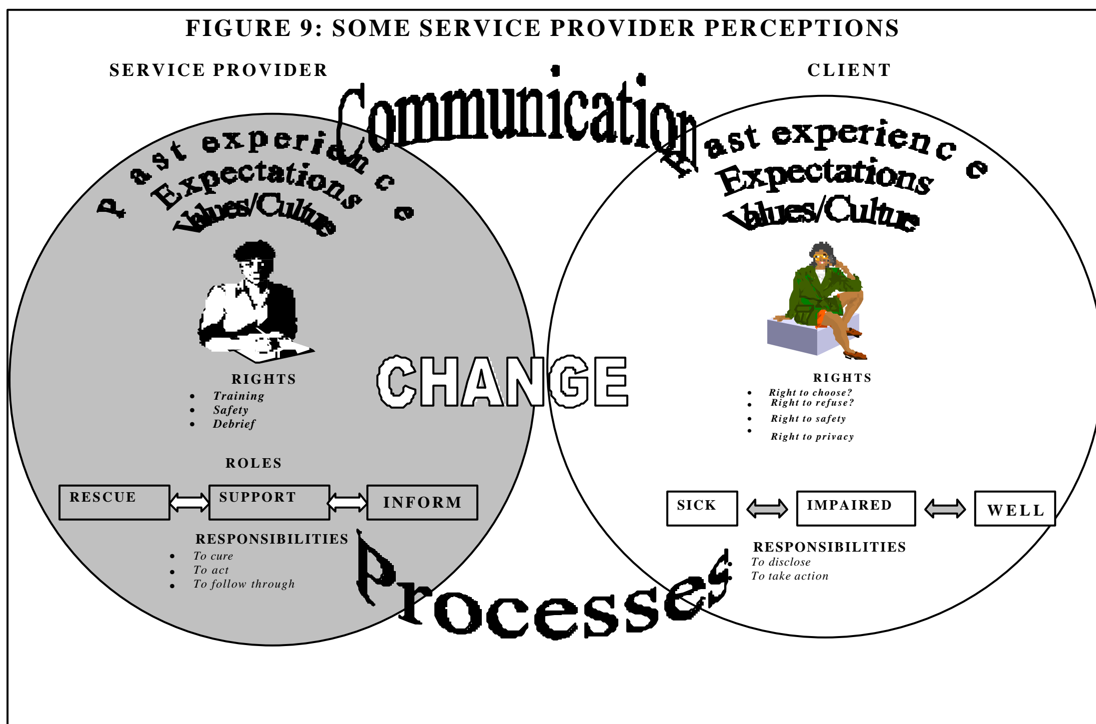
The screening result can shift staff perception of the woman's position on the continuum of health. If staff perceive the woman to be an informed client of health care services they will provide information and respect the woman's right to make a decision regarding her situation. However, if staff perceive the woman to be in a sick role they are more likely to respond to the woman in a protective, sometimes overly protective, manner. The tendency to do so, according to some literature, is likely to be related to the uncertainty and seriousness of the woman's situation. This is made more challenging by the fact that some women experiencing violence are indeed sick or are in need of immediate help – that is they have complicating medical diagnoses or are in grave risk in their current situation (Figure 9).

This dynamic influences the perceived rights, roles and responsibilities of the service provider and the client. For example, although some women may well come from less than healthy environments, they may not regard themselves, in this context, as sick and will not perceive a need to conform to the socially accepted role of the patient by accepting and complying with recommended courses of action. This may then contribute to feelings of frustration, sadness and helplessness in the care-giver with a concomitant risk of blaming the victim for their own circumstances or blaming themselves for their inability to resolve the client's problem (Figure 9).

The service provider is at a given stage in the change process in accepting, learning and supporting the screening of women for violence, bringing to the communication process a perspective influenced by past experience, expectations and values/cultural factors. The hospital setting operates processes such as systems of referrals inside and outside of its boundaries to provide continuums of care (Figure 9).

Similarly, the client is also at a given stage in the change process in accepting, learning about and resolving her situation and will also bring to the communication process a perspective influenced by past experience, expectations and values/cultural factors. The client operates in a community setting that has various networks, relationships and resources. These processes and resources are not necessarily always clear to either the client or to service providers (Figure 9).

FIGURE 9: SOME SERVICE PROVIDER PERCEPTIONS



Staff will be more comfortable with the screening process if there is clear definition the rights, roles and responsibilities of all staff involved and detailed procedures that provide a pathway for clinicians to respond to women who may be at varying stages of health and wellbeing. Adequate preparation and support for staff is important in reducing role conflict, role confusion and role overload which are well established precursors to burnout – a clear workplace health and safety issue.

Initial and ongoing staff development should be in place to support health care providers. It should include information on the continuum of health and the pervasive influence of values, culture and expectations in the communication process and delivery of care. The various roles of the pregnant woman should be explicitly addressed to promote realistic expectations of the care-givers. Similarly comparisons between a social model of health and a medical model should be discussed to emphasise the importance of the health care continuum in the support of women experiencing violence. Other topics which should be included in ongoing in-service training include: community resources, family dynamics, counseling techniques, crisis management, communication, cultural awareness, drug dependence, and information management (particularly with interrelated systems eg information flows between different clinical areas)

4.3.4 Recommendations

A. The screening for domestic violence in public sector facilities should continue and expand.

B. The issues 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.

C. Agreed standards should be developed to provide guidelines and standards of practice for domestic violence screening practices. Such standards should include:

- standardised questions which must be asked in a conversational manner;
- brief preamble must be given to be given to women before being screened;
- training for all staff before they start screening women for violence;
- screening women on their own, without their partners or others present;
- clearly defined primary and secondary courses of action for staff;
- dissemination of information on small business cards to all women;
- screen results and response by staff incorporated in patient medical chart;
- provision of immediate help if requested;
- raising the issue of domestic violence on subsequent visits;
- routine collection of screen results and dissemination of aggregated information as part of information flows and feedback loops to staff.

D. The rights, roles and responsibilities of the health care provider should be clarified in training programs.

E. The findings of this evaluation should be incorporated in initial and ongoing staff development and training on addressing the health impact of domestic violence. Feedback mechanisms should be established and maintained to provide information on screening rates, disclosure rates and acceptance of immediate assistance.

F. Mechanisms to facilitate debriefing and ongoing learning in relation to domestic violence should be developed at all sites.

4.4 Evaluation of implementation

Question 4: Are all relevant staff administering the screening system?

4.4.1 Methodology

The staff focus groups and questionnaires described in the previous section were also designed to capture information regarding the administration of the screening system.

4.4.2 Findings

At all antenatal sites the midwives were involved in screening women as part of the booking-in visit. While some midwives at some sites asked the women the questions, staff at other sites gave the screening instrument to the women to complete. Although staff were instructed to ask questions only if the woman was alone, this did not happen at some sites.

> *Often the partner's not taking any notice of what they're writing.* [But], *you know, if you're reading it out, he's listening. They can have this form in amongst the others and ...*
>
> *I had two husbands come in and I think …they both said she shared the form with him and the questionnaire too. It wasn't a big issue.*
>
> *Well, we ask all the women, pre-warn all the women, away from their partners, that we're going to ask them questions on domestic violence. And we give them the option of having their partner with them or not during the interview.*
>
> *Yes. It can work against you having the partner there, but by the same token…there's still quite a lot of husbands out there that want to participate in every part of the pregnancy…and you're supposed to be providing this really wonderful situation…and coming into the history is part of it.*

The safety of the woman and of the staff was raised:

> *But sometimes you can't separate the partner either. Cause I had a situation only a couple of weeks ago where the woman had told me she was in quite a severe domestic violence situation …So I went over to him and I told him we do the interview with the woman on her own and he just went ballistic! In front of everyone, swearing profusely at me and so in the end he had to come into the room…So he came in and when I asked questions about violence she just said no, no, no, no all the way through… And he just eye-balled me the whole time that I was asking the domestic violence questions.*

> [About home visiting] *…I suppose you've got to look at your own safety – and then what do you do?*

> *…We're broaching…subjects just through antenatal* [clinic] *and* [if] *it leads to a …separation or … a domestic violence issue in a court order…I don't think it has come to the point where we sort of feel targeted or anything.*

> *Its separating the partner from the process because we feel that the ones who are probably in those sorts of situations that would like to say 'yes' to us, he sticks to her like glue.*

> [About the woman's safety] *I guess that's …uppermost in all the responses that we do …not asking the questions in front of the partner…*

Most staff indicated that support and informal debriefing was important and that they would use peer support mechanisms rather than formal mechanisms for this:

> *Definitely support for staff is an important issue. Anybody who is continually asking these questions, and particularly if they are getting positive responses needs, that opportunity to debrief…*

> *But I think too, we try to support each other…especially for the students who are coming into the clinic…as new practitioners.*

> *I for one have found that the people here are usually involved and have current knowledge and I come and debrief with them.*

> *I think the reality here in this hospital is…we support each other. And I think that goes for most sort of things, you know, if we have a neonatal death…we support each other.*

> *I think you can debrief amongst yourselves and in the long term, yes, certainly your peers are the best ones to do it with.*

For some staff, screening gave them new insights into women's health and women's experiences in the community.

> *..and I guess I've been quite surprised about the people that openly admit there's domestic violence there and what they've done about it and what they haven't done about it.*
>
> *But it surprises me what people come out with...*
>
> *But the interesting thing is that they, sort of, appear to be dealing with it...*
>
> *I've been surprised that they've been happy to give us this information and they think it's a good idea...*
>
> *...And I hadn't thought of that area at all and I thought that is just appalling. And she said, 'No,no,no I'd rather struggle and have no money and no contact* [with ex-partner], *thank you.' which was quite an eye-opener for me.*

Some staff from the emergency departments and gynaecology outpatient sites raised issues of coordination with other care-givers and their role in the process:

> *I feel the medical and the nursing staff should have been introduced to the system at the same time because it became to be seen as the 'nurses' job'.*
>
> *Make the questioning of patients either a doctor's or a nurse's job/task.*
>
> *The <u>doctors</u> in the ED! I believe it is often more appropriate for them to ask as it could be included in their history. For us, we take observations and talk about their pain and then ask about domestic violence!*
>
> *The doctors in particular are very resistant to filling out the forms or assisting (by only calling the patient and not all the relatives) from the waiting room so that we can ask them.*
>
> *...medical staff's reluctance to be involved as they feel that the abused woman never takes the advice offered.*

There were also comments about the need to screen men as well as women for violence:

> *Many staff felt that it was unfair to only screen women and did not feel inclined to participate.*
>
> *I would like to see it implemented further to include men.*
>
> *Perhaps we could address issues for male victims*

A particular concern of the emergency departments and gynaecology outpatient sites was how to integrate the screening within their current service area:

> *Consideration of work- flows in an ED would improve compliance*
>
> *... it is a subject totally off track from gynae procedures but the more I did, the more comfortable I am now. On the whole the women were very supportive of being asked about DV.*
>
> *Time is a problem. I believe asking a question such as this you nee to be prepared to spend the time if the answer is yes. In an ED this is often not possible.*
>
> *Time – when its busy it is often difficult to ask such a question in a non-hurried manner. Confidentiality is also a problem – we have only curtains between cubicles.*

4.4.3 Discussion

Client safety is of prime concern. Women should not be screened in front of their partners or any other person. This is an important issue in the design and implementation of electronic information systems and associated processes. It is important that placement of data entry terminals and software design meet the requirements of the task.

The physical and emotional wellbeing of staff is also important. Whilst many staff prefer peer support in preference to formal counselling, all staff should be frequently reminded of formal mechanisms for staff support. New staff should be made aware of any boundaries to using peer support. Standard guidelines should be developed to advise staff of mechanisms in place to maintain their physical safety.

Feedback from staff at the emergency departments and gynaecology outpatient sites suggest two important issues influencing screening practices:

- Ownership of task by health care providers, particularly in areas where more than one service provider is involved in client care, and
- Assimilation of screening into existing procedures and practices.

It appears more challenging to introduce a screening modification relating to what may be a longer psychosocial health issue in areas that primarily focus on acute, physical issues.

Further exploration is needed to investigate whether or not there are particular groups of women who are more at risk of not being screened. This was beyond the scope of the evaluation however issues of language, age, culture, health status, and models of care (eg shared obstetric care) were raised by staff as potential barriers to screening.

4.4.4 Recommendations

A. Agreed standards should be developed to provide guidelines and standards of practice for domestic violence screening practices. Such standards should include:

- training for all staff before they start screening women for violence;
- screening women on their own, without their partners or others present;
- clearly defined primary and secondary courses of action for staff;
- dissemination of information on small business cards to all women;
- screen results and response by staff incorporated into patient medical chart;
- provision of immediate help if requested.

B. The findings of this evaluation should be incorporated in initial and ongoing staff development and training on addressing the health impact of domestic violence. Feedback mechanisms should be established and maintained to provide information on screening rates, disclosure rates and acceptance of immediate assistance.

C. The rights, roles and responsibilities of the health care provider should be clarified in training programs.

D. Mechanisms to facilitate debriefing and ongoing learning in relation to domestic violence issues should be developed at all sites.

4.5 Evaluation of quality control

Question 5: Are all materials and components of the project of good quality?

4.5.1 Methodology

The staff focus groups and questionnaires used to assess staff satisfaction and administration of the screening system were also designed to capture information regarding quality control.

4.5.2 Findings

In discussing the screening instrument, some staff felt unsure of their role or the processes involved should they encounter a woman who discloses child abuse. Other staff felt confronted when a small number of women identified themselves as the perpetrator of violence.

> *One of my biggest fears is somebody's going to identify that they're having problems and there's children involved. For me, if they're saying yes to that and no to any further help and considering there's a child involved then we've got to take it further.*
>
> *I think that is... I think we've all had a discussion about this and if they do say yes to child being involved ... in the questions – do we turn a blind eye even though one of us knows that there are problems?*

There was overwhelming support for the training sessions, particularly when it was presented along with and through role play, group work and information about local resources. Most staff who were screening had been trained beforehand although some sites found it particularly difficult to arrange this. For example staff turnover at Mount Isa and the use of sessional private sector general practitioners at Royal Brisbane Hospital.

> *…The training was good. It was very informative.*
>
> *I reckon the training opened my eyes to a lot more, a lot of things, and has helped me to look at things differently.*
>
> *At first* [when] *I heard this was happening …my initial reaction was: "Oh, this is a very private thing. Are we overstepping our boundaries or what?" But I think going to the domestic violence thing* [training] *I'm quite comfortable with it…I would be able to ask these questions now.*
>
> *When we did the role playing at… the four-hour inservice for domestic violence, we were quite amazed at the feelings that we had when we were asking each other in the role play.*
>
> *I thought the cross-cultural one that we had was really, really good. ..I could really understand why it was so difficult for her to get out of that situation because we had it explained to us…*

Staff gave feedback about the screening instrument based on their experiences in administering it:

> [of the questions] *Initially when they were being designed, I found them too blunt and too confronting. But now I've actually changed my mind.*
>
> *I just found the questions there were pretty blunt.*
>
> *One young one said to me one day to the question 'has anyone at home hurt you in the last year' or something…And I said 'Oh darling who's hurt you?' and she said 'Oh my mother…Yeah she growls at me'. This girl was fifteen and pregnant. ..So probably some questions could be more specific.*
>
> *There's nothing wrong with the screening tool. The screening tool is all right. I just don't see a lot of point in screening where you can't offer help.*
>
> *I'm happy. It's just that one question that I would like re-worded or changed somehow… Could they not ask separately* [about] *harm to the woman and harm to the child?*
>
> *The initial question seemed slightly ambiguous – I had one patient tell me that while her partner hit her she always hit him back. Therefore she was not afraid of him.*
>
> *Be more specific regarding violence …*
>
> *A lot of people have* [trouble] *with the 'put down, humiliated' question. Cause some …say (to their partners who are present) 'You do that to me all the time'…and then how do you interpret that? … Is it a cry for help or a jibe…?*
>
> *Another thing that surprised me about the questions is that … if they live with their brothers or their sisters or their family, they often say my brother does this.*
>
> *You know the questions say has anyone at home hit you…Some of the women are not living with their partners. Their partners are living separately …but they still come and bash them up.*
>
> *The communities are calling it 'Family violence' …because domestic violence is only a sample but there's a lot of family violence with other people, you know, bashing other people.*

The Initiative was guided by a Reference Group that met monthly by videoconference. It included representatives of all participating sites and three metropolitan universities. Teleconferencing was also used to communicate between sites. When discussing issues of project implementation, some staff felt that the communication methods used in the Initiative had improved with time and experience:

> *On the whole quite good…but there's a few sites around Queensland that need to know how to use teleconferencing facilities…There was a lot of in-house talking…*
>
> *I think a videoconference would be more relevant than a phone link-up…*
>
> *I think the videoconference is better.*
>
> *I guess it has improved the last couple of times…they've had someone from CITEC sit in and talk about the way in which the videoconference meetings were conducted.*
>
> *Yes I think more experience from all of us about just how we participate in videoconference meetings and particularly the large group in Brisbane.*
>
> *Well I think it's good to know where we're up to. I think if it hadn't been for them* [teleconferences]*… we wouldn't be where we're at now.*
>
> *I felt that other sites … would need to have a person with a very strong commitment to the project in order to speak up with suggestions or disagreements as it would be very easy to just go along with the main group.*

4.5.3 Recommendations

A. The rights, roles and responsibilities of the health care provider should be clarified in training programs.

B. Question 1 of the antenatal screening instrument should be removed. Clients do not relate to this ambiguous question.

C. Question 4 of the antenatal screening instrument, regarding threatened harm to the woman or her children, should be modified to resolve the possible ambiguity arising from asking two issues in one question.

5.0 INSERVICE TRAINING

5.1 Goals and objectives

5.1.1 Goal

To skill health care professionals in outpatient, emergency and antenatal care settings in the use of the method for identifying women who have experienced domestic violence

5.1.2 Objectives

- To develop an inservice training program that builds on existing skills in preparation for asking women questions related to domestic violence.
- To provide inservice training that uses a variety of teaching methods in the delivery of information related to domestic violence.
- To evaluate the content and usefulness of the inservice training program and material.
- To provide resource material and referral information.
- To encourage peer support mechanisms for staff.

5.2 Development of the inservice training program

5.2.1 Background

Although health professionals have skills in health care history taking, participation in this Initiative required further development of this skill. Screening for domestic violence requires particular sensitivity, knowledge and expertise. The health professional must feel confident and comfortable asking these questions in order to facilitate the woman's response.

Considering the incidence of domestic violence in the community, it is probable that participants in the inservice training may have personal experience of domestic violence. Therefore fostering a supportive, confidential and non-judgemental learning environment was essential.

The development of the inservice training program used human and material resources from metropolitan universities and community agencies. At the Brisbane sites, the delivery of the inservice program was enhanced by a team approach using two group facilitators with complementary professional backgrounds in social work and women's health. Sites in Northern Queensland were able to utilise the skills of experienced health educators, Indigenous health workers, midwives and social workers in delivering the training.

5.3 Inservice delivery

Statewide inservice training was essential in preparation for piloting the screening system from July 1999. Participants included registered nurses and endorsed midwives, medical officers, general practitioners, hospital security staff, officers of the Queensland Police Service.

Inservice training took place between June 1999 and December 1999 at the following sites. Generally training was prepared in a four-hour session, but a one-hour session was later developed for medical officers.

Fitting the training into tight staffing schedules was problematic at all sites. At the Royal Women's Hospital an antenatal clinic was cancelled to facilitate attendance. On the Mater campus Brisbane, strategies include cancelling clinics, backfilling positions from internal budgets and reduced medical staffing. At other sites some staff attended in their own time.

Staff at sites outside of Brisbane were not always able to attend a four-hour training session due to rostering difficulties. Training sessions with similar content but of varying length were developed to better accommodate the needs of the clinical areas. For example two two-hour sessions were used in Cairns and a three-hour session was developed in Kirwan.

5.3.1 Training sites

- Mater Mother's Hospital, Brisbane
- Mater Adults' Hospital, Brisbane
- Royal Women's Hospital, Brisbane
- Royal Brisbane Hospital
- Cairns Base Hospital
- Kirwan Hospital for Women, Townsville
- Mount Isa Base Hospital

5.4 Training evaluation methodology

The following table shows the number of inservice participants and the number of completed evaluation forms received at each site.

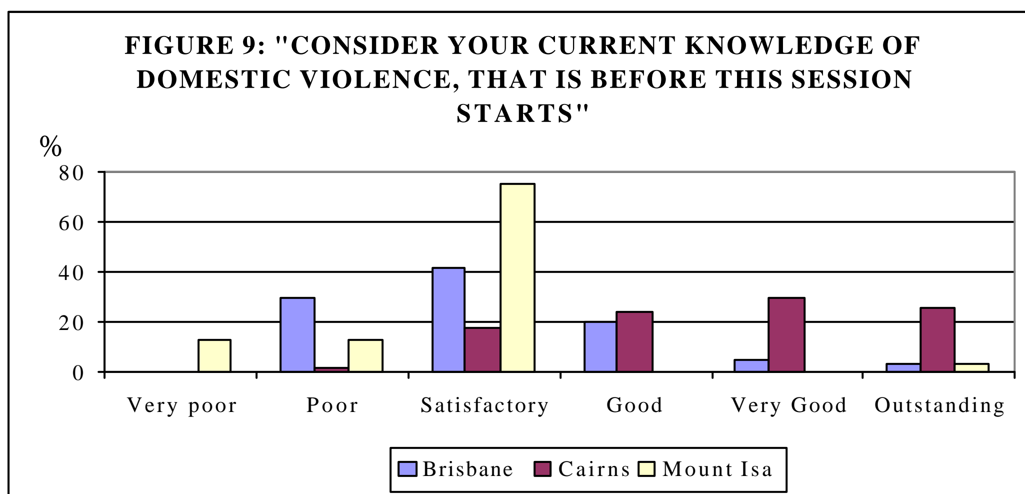
Site	**Number of particpants**	**Number of completed returns**	**Return rate**
Brisbane	110	81	74%
Mount Isa	16	16	100%
Cairns	59	45	76%
Kirwan	27	20	74%

At the Brisbane sites a Likert scale was used to gauge responses to a number of key evaluation questions. Qualitative data was also collected in the form of written comments. A similar methodology was used at Kirwan, Cairns and Mount Isa.

5.5 Results

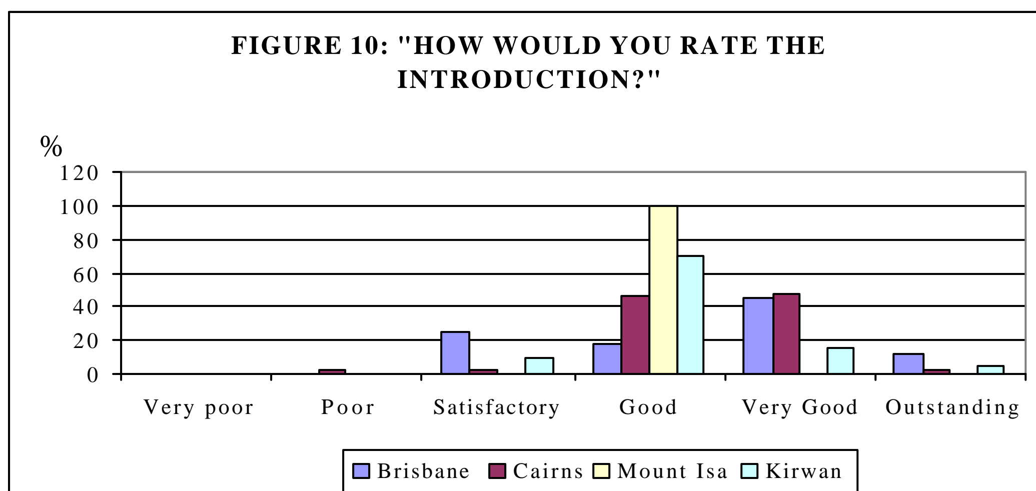
5.5.1 Self-assessed knowledge level on domestic violence prior to training

At the beginning of an inservice session, participants at all sites except Kirwan were asked to assess their current knowledge of domestic violence. Figure 9 illustrates that while many staff considered they had a satisfactory knowledge level, few indicated they had an outstanding knowledge level on this subject. This indicates the importance of adequate preparation of staff before screening women for violence.



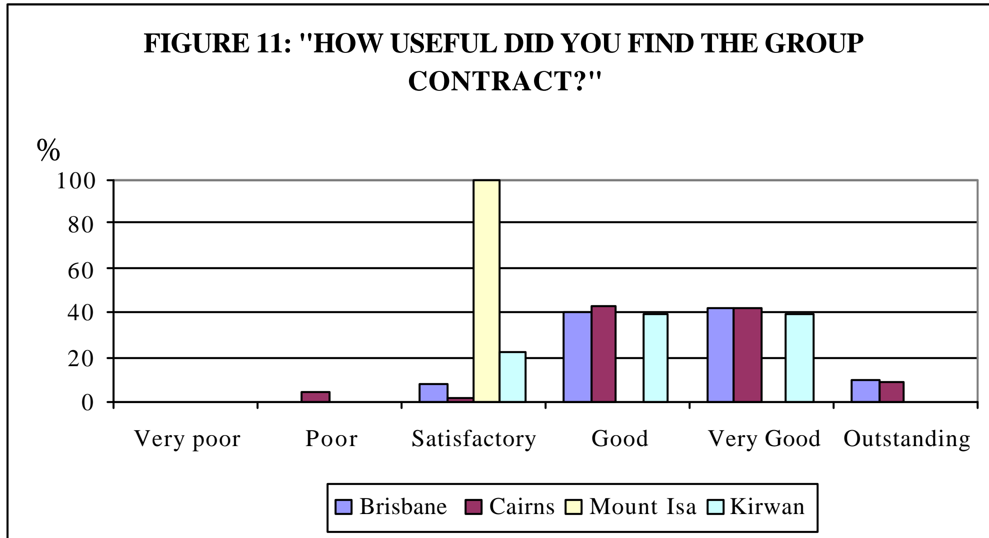
5.5.2 Introductory session

Participants were given an overview of the Domestic Violence Initiative that included familiarisation with some key staff of the Initiative (as they appeared on the project launch video). This was well accepted (Figure 10).



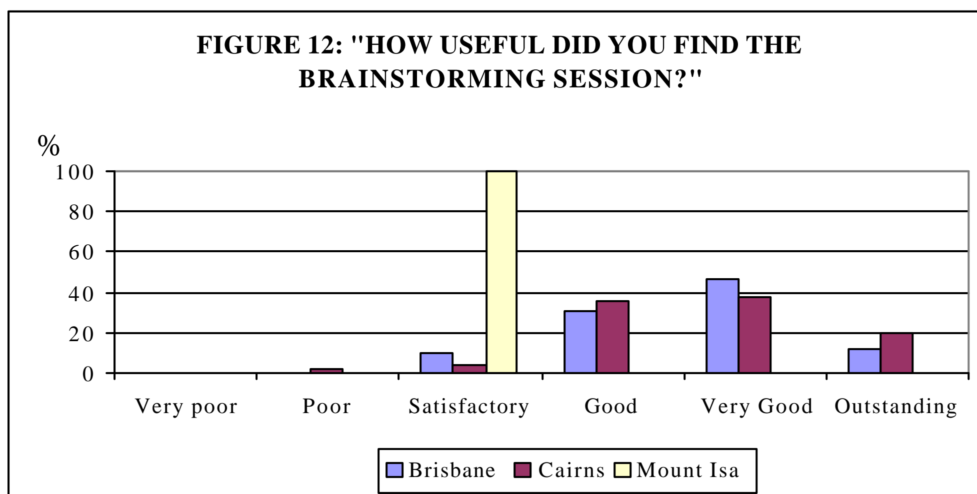
5.5.3 Group contract

A group contract was developed at the beginning of the session to ensure a safe environment for the participants. It emphasised a non-judgemental approach, keeping to time, one person speaking at a time, having fun, respect for other points of view and common personal and professional courtesies such as keeping any shared information confidential. Results indicate that a group contract was a useful strategy in providing information to health professionals about domestic violence (Figure 11).



5.5.4 Brainstorming session

At every session in Brisbane, Cairns and Mount Isa, participants generated examples demonstrating physical, emotional, financial and psychological abuse. Respondents indicated this was a useful exercise (Figure 12).

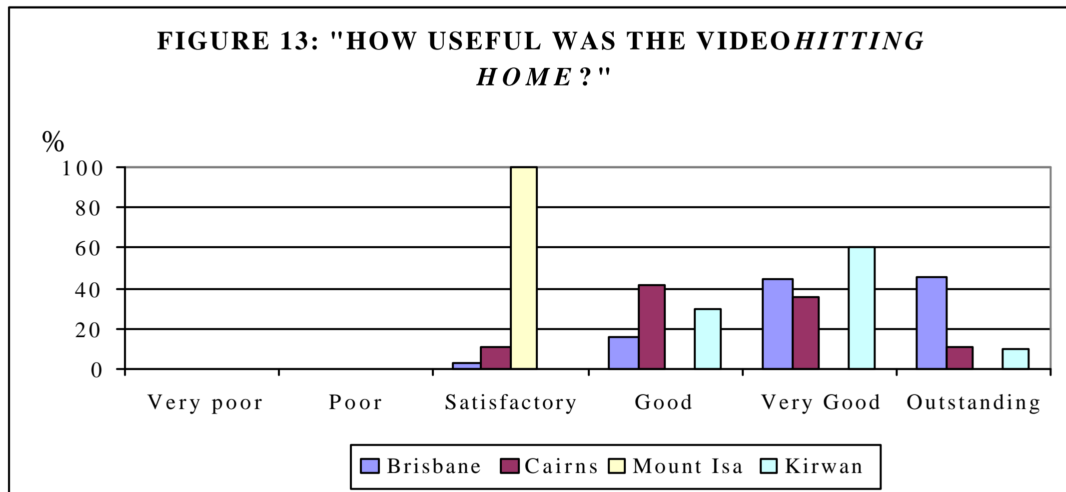


At Kirwan, a session entitled “Myths and Attitudes” was held to dispel common myths and to provide a better understanding of the effects of violence on women. This session was also well received by participants.

5.5.4 The "Hitting Home" video

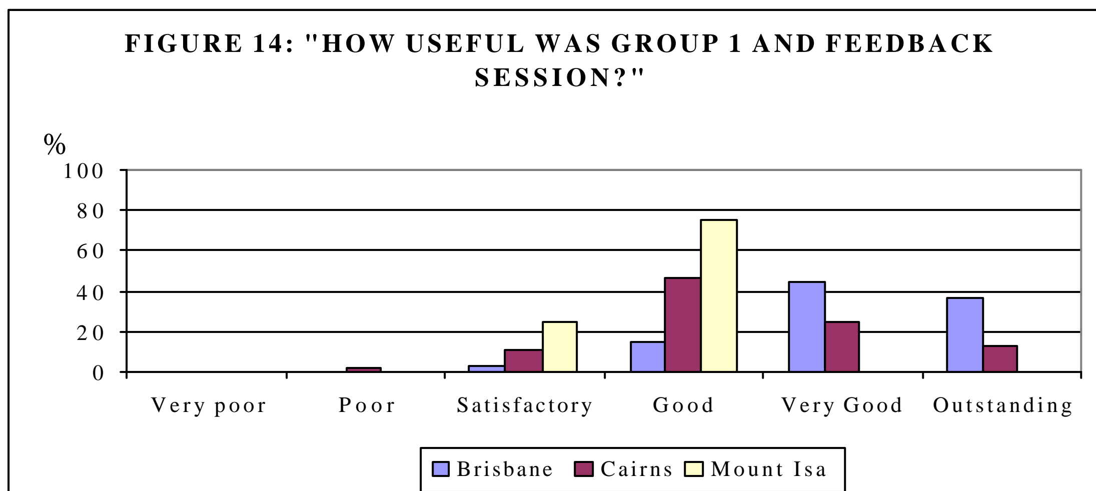
Hitting Home is a video produced for the Women's Health and Sexual Assault Unit, Western Sydney Area Health Service in 1994. It is set in a New South Wales public hospital emergency department.

After watching the video, midwives reacted with shock and disgust, whereas staff from the emergency departments found the video unremarkable. It was received very positively as a teaching tool (Figure 13) but some participants found it distressing.

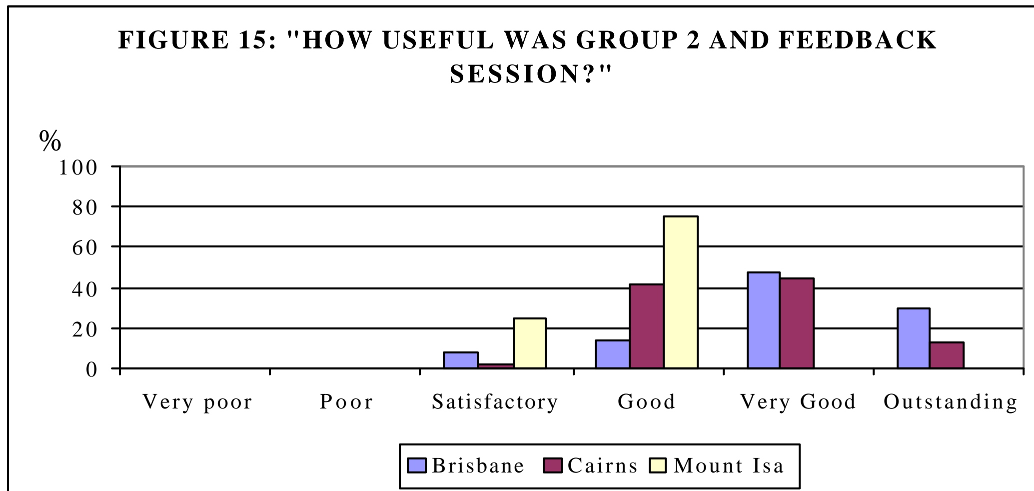


5.5.4 Group sessions

Two different group sessions were held during the program in Brisbane, Cairns and Mount Isa. During the first session participants were requested to work in groups of three to four, with staff members they did not know well. Groups were asked to respond on topics such as how they felt about the video *Hitting Home*, history taking and asking questions on domestic violence. This session was regarded well by participants (Figure 14).



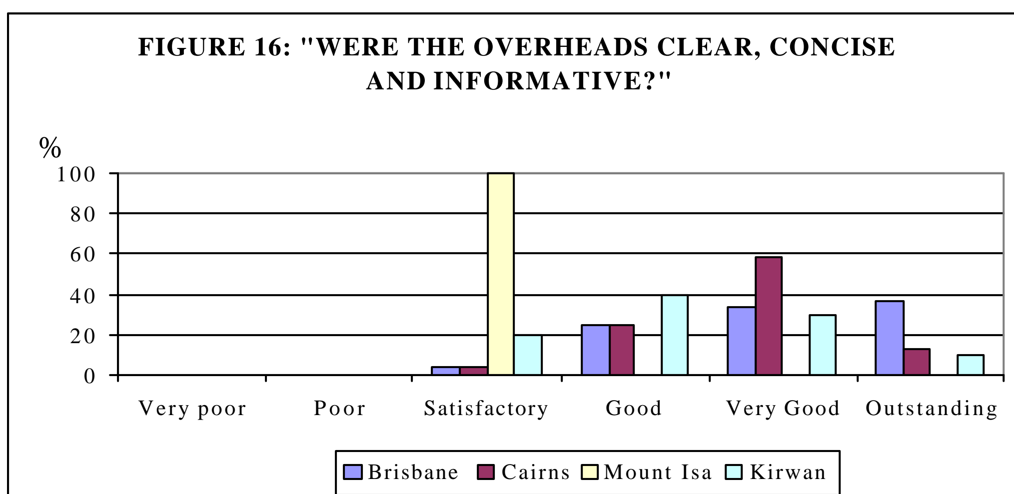
A second group session explored a variety of issues including emotional abuse, statistics on domestic violence, the cycle of violence, contributing factors, power and control, equality, reasons why women stay in violent relationships and planning for safety. This session used an overhead presentation and was positively received by staff (Figure 15).



At Kirwan, there were two sessions which focussed on the screening instrument practice and feedback time. Most staff indicated that these sessions were very useful to them.

5.5.5 Satisfaction with overhead transparencies.

Participants were asked if the overhead transparencies were clear, concise and informative. Responses indicated that participants were satisfied with the quality of the overhead transparencies.



5.5.6 The final session – drawing the major issues together.

The final session recalled the major themes of the presentation. Participants indicated a high degree of satisfaction with this session (Figure 17).

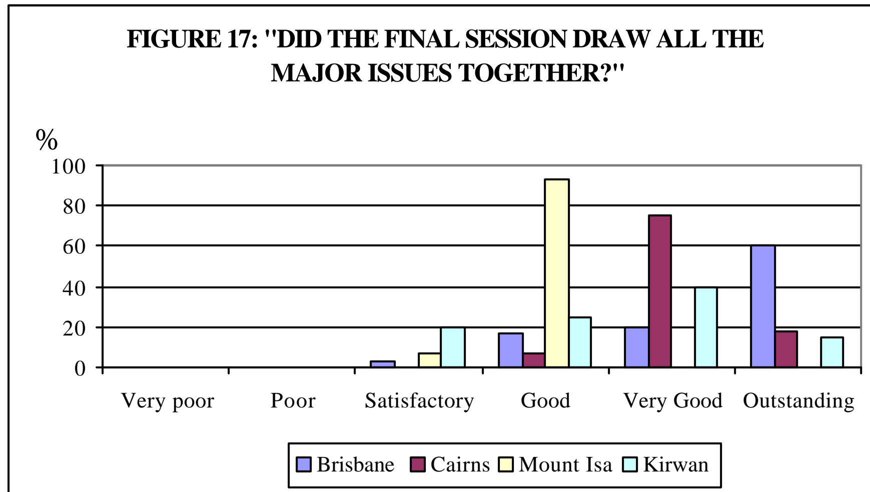


FIGURE 17: "DID THE FINAL SESSION DRAW ALL THE MAJOR ISSUES TOGETHER?"

5.5.7. Self-assessed knowledge on domestic violence after training

Participants in Brisbane, Cairns and Mount Isa indicated their self-assessed knowledge on domestic violence had improved after the training sessions (Figures 18-20). Participants in Kirwan also considered that their knowledge of domestic violence, awareness of resources and their role in dealing with the issues had improved following the inservice sessions.

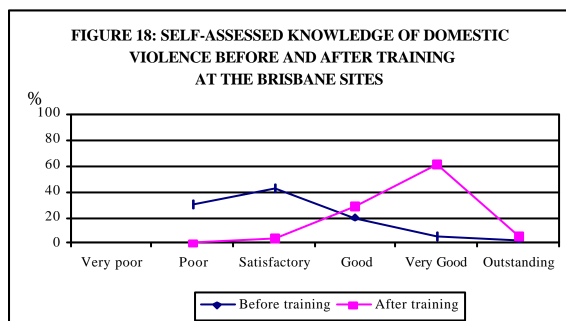


FIGURE 18: SELF-ASSESSED KNOWLEDGE OF DOMESTIC VIOLENCE BEFORE AND AFTER TRAINING AT THE BRISBANE SITES

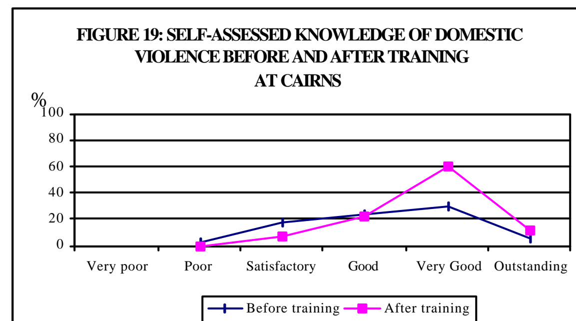


FIGURE 19: SELF-ASSESSED KNOWLEDGE OF DOMESTIC VIOLENCE BEFORE AND AFTER TRAINING AT CAIRNS

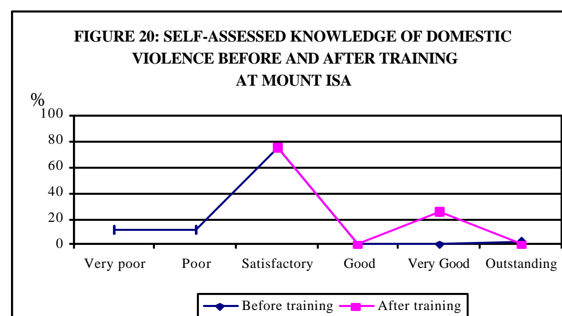


FIGURE 20: SELF-ASSESSED KNOWLEDGE OF DOMESTIC VIOLENCE BEFORE AND AFTER TRAINING AT MOUNT ISA

5.5.8. Comments from participants about the training

Participants commented on the widespread and often covert nature of domestic violence, particularly emotional violence and that health care professionals are in a position to make a difference in women's lives. Some staff felt frustration when women screen positive for domestic violence and refuse help. A perceived lack of skills to assist the woman was also mentioned. Working with health care professionals and other participants from different backgrounds (eg police) as well as survivors of domestic violence was viewed positively.

The participants saw the strengths of the information session to be group participation, brainstorming, the informal but informative approach, the material handed out, sticking to the time frame and the use of different teaching methods that met the needs of adult learners.

Suggestions for improving the information session included inviting a woman who is prepared to share her experiences of domestic violence, more time for participants to share their experiences, role plays to help asking the questions and supporting women in ways which enhance their self esteem.

The most valuable lessons from the session included:

- that nurses can assess approach and refer victims of domestic violence,
- statistics on the extent of the problem,
- methods of appropriate inquiry into domestic violence issues,
- expanding knowledge base and
- greater insight into what domestic violence means.

Participants said they would benefit from more time to practice answers to scenarios, for example on how to deal practically with situations, managing violent or aggressive partners, interviewing skills and more specific information on legal obligations and consequences.

At Kirwan and Cairns the inclusion of information about Indigenous culture, family dynamics and domestic violence was considered extremely important and very useful. Participants at Mount Isa expressed surprise that domestic violence is also a major issue for non-Indigenous women.

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)

Question		
A. Do you have problems with anyone at home who makes you afraid for your safety?	Yes	No
B. In the last year, has anyone at home hit, kicked, punched or otherwise hurt you?	Yes	No
C. In the last year, has anyone at home often put you down, humiliated you or tried to control what you can do?	Yes	No
D. In the last year, has anyone at home threatened to hurt you or your children?	Yes	No
E. Would you like help with any of this now?	Yes	No

(To be completed by staff)

Action:

- Woman answered 'No' to question 5 ☐
- Woman said it was unsafe to accept referral at this time ☐
- Referred to Social Work Department ☐
- No referral required ☐

Other – please indicate ……………………………………

……………………………………………………………………..

…………………………………………………………………….

Provided with:

- Woman said it was unsafe to take information at this time ☐
- No information required ☐
- Help line number ☐
- Information about domestic violence ☐

Other – please indicate ……………………………….…….

……………………………………………………………………..

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.

Whatever you reply will remain strictly confidential (Please circle correct answer)

F. 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 ☐

Woman said it was unsafe to accept referral at this time ☐

Referred to Social Work Department ☐

No referral required ☐

Other – please indicate ……………………………………

……………………………………………………………...

……………………………………………………………..

Provided with:

Woman said it was unsafe to take information at this time ☐

No information required ☐

Help line number ☐

Information about domestic violence ☐

Other – please indicate ……………………………………

……………………………………………………………...

……………………………………………………………..

Domestic Violence Initiative
GYNAECOLOGY OUTPATIENTS DEPARTMENT

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)

H. 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*

C. Would you like to talk about it? — Yes — No

D. Would you like some help now? — Yes — No

(To be completed by staff)

Action:

Woman answered 'No' to question 3 ☐

Woman said it was unsafe to accept referral at this time ☐

Referred to Social Work Department ☐

No referral required ☐

Other – please indicate ……………………………………

…………………………………………………………………..

………………………………………………………………..

Provided with:

Woman said it was unsafe to take information at this time ☐

No information required ☐

Help line number ☐

Information about domestic violence ☐

Other – please indicate ……………………………………

…………………………………………………………………..

………………………………………………………………..

APPENDIX B: DETAILED RESULTS OF THE CHART AUDIT

TABLE 1: EVALUATION OF THE DOMESTIC VIOLENCE INITIATIVE: RESULTS OF THE CHART AUDIT SCREENING STATUS BY PILOT SITE								
	Screened		Not screened		Not known		Total charts audited	
	No.	%	No.	%	No.	%	No.	%
Antenatal clinic sites								
Mater Mothers' Hospital	282	*85.2*	49	*14.8*	-	-	331	*100.0*
Royal Women's Hospital	248	*96.9*	2	*0.8*	6	*2.3*	256	*100.0*
Cairns Base Hospital	76	*79.2*	1	*1.0*	19	*19.8*	96	*100.0*
Mount Isa Base Hospital	38	*97.4*	-	-	1	*2.6*	39	*100.0*
Kirwan Hospital for Women	100	*72.5*	23	*16.5*	15	*10.9*	138	*100.0*
Total antenatal sites	**744**	***86.5***	**23**	***2.7***	**41**	***4.8***	**860**	***100.0***
Other sites								
Royal Brisbane Hospital:								
Primary Care Unit	4	*4.5*	-	-	84	*95.5*	88	*100.0*
Mater Adult Hospital:								
Emergency Department	13	*7.7*	1	*0.6*	155	*91.7*	169	*100.0*
Royal Women's Hospital:								
Gynaecology Outpatients	109	*67.3*	-	-	53	*32.7*	162	*100.0*
Total other sites	**126**	***30.1***	**1**	***0.2***	**292**	***69.7***	**419**	***100.0***
Total all sites	**870**	***68.0***	**2**	***0.2***	**333**	***26.0***	**1,279**	***100.0***

TABLE 2: EVALUATION OF THE DOMESTIC VIOLENCE INITIATIVE: RESULTS OF THE CHART AUDIT SCREEN RESULT BY PILOT SITE								
	Positive		Negative		Not known		Total women definitely screened	
	No.	%	No.	%	No.	%	No.	%
Antenatal clinic sites								
Mater Mothers' Hospital	11	*3.9*	271	*96.1*	-	-	282	*100.0*
Royal Women's Hospital	21	*8.5*	227	*91.5*	-	-	248	*100.0*
Cairns Base Hospital	7	*9.2*	69	*90.8*	-	-	76	*100.0*
Mount Isa Base Hospital	4	*10.5*	34	*89.5*	-	-	38	*100.0*
Kirwan Hospital for Women	11	*11.0*	89	*89.0*	-	-	100	*100.0*
Total antenatal sites	**54**	***7.3***	**690**	***92.7***	**-**	**-**	**744**	***100.0***
Other sites								
Royal Brisbane Hospital:								
Primary Care Unit	-	-	4	*100.0*	-	-	4	*100.0*
Mater Adult Hospital:								
Emergency Department	-	-	13	*92.9*	-	-	13	*100.0*
Royal Women's Hospital:								
Gynaecology Outpatients	2	*1.9*	107	*98.1*	-	-	109	*100.0*
Total other sites	**2**	***1.6***	**124**	***97.6***	**-**	**-**	**126**	***100.0***
Total all sites	**56**	***6.4***	**814**	***93.4***	**-**	**-**	**870**	***100.0***

TABLE 3: EVALUATION OF THE DOMESTIC VIOLENCE INITIATIVE: RESULTS OF THE CHART AUDIT								
ACCEPTANCE OF IMMEDIATE HELP BY PILOT SITE								
	Accepted help		Declined help		Not known		All women screening positive	
	No.	%	No.	%	No.	%	No.	%
Antenatal clinic sites								
Mater Mothers' Hospital	1	*9.1*	10	*90.9*	-	-	11	*100.0*
Royal Women's Hospital	2	*9.5*	19	*90.5*	-	-	21	*100.0*
Cairns Base Hospital	1	*14.2*	6	*85.7*	-	-	7	*100.0*
Mount Isa Base Hospital	1	*25.0*	3	*75.0*	-	-	4	*100.0*
Kirwan Hospital for Women	1	*9.1*	8	*72.7*	2	*9.0*	11	*100.0*
Total antenatal sites	**6**	***11.1***	**46**	***85.2***	**2**	***3.7***	**54**	***100.0***
Other sites								
Royal Brisbane Hospital:								
Primary Care Unit	n/a	n/a	n/a	n/a	n/a	N/a	n/a	N/a
Mater Adult Hospital:								
Emergency Department	n/a	n/a	n/a	n/a	n/a	N/a	n/a	N/a
Royal Women's Hospital:								
Gynaecology Outpatients	-	-	2	*100.0*	-	-	2	*100.0*
Total other sites	**-**	**-**	**2**	***100.0***	**-**	**-**	**2**	***100.0***
Total all sites	**6**	***10.7***	**48**	***85.7***	**2**	***3.6***	**56**	***100.0***

TABLE 4: EVALUATION OF THE DOMESTIC VIOLENCE INITIATIVE: RESULTS OF THE CHART AUDIT										
TYPE OF ABUSE BY PILOT SITE										
	Fear of someone at home		Physical Abuse		Emotional abuse		Threatened abuse		Total women screening positive#	
	No.	%	No.	%	No.	%	No.	%	No.	%
Antenatal clinic sites										
Mater Mothers' Hospital	2	*18.2*	4	*36.4*	9	*81.8*	3	*27.3*	11	
Royal Women's Hospital	2	*9.5*	6	*28.6*	20	*95.2*	7	*33.3*	21	-
Cairns Base Hospital	2	*28.6*	6	*85.7*	4	*57.2*	3	*42.9*	7	-
Mount Isa Base Hospital	-	-	2	*50.0*	3	*75.0*	1	*25.0*	4	-
Kirwan Hospital for Women	1	*9.1*	7	*63.6*	8	*72.7*	7	*63.6*	11	-
Total antenatal sites	**7**	***13.0***	**25**	***46.3***	**44**	***81.5***	**21**	***38.9***	**54**	**-**
Other sites										
Royal Brisbane Hospital:										
Primary Care Unit	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Mater Adult Hospital:										
Emergency Department	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Royal Women's Hospital:										
Gynaecology Outpatients	2	*100.0*	n/a	n/a	n/a	n/a	n/a	n/a	2	-
# Multiple responses recorded so numbers cannot be cumulated. Caution advised when interpreting small numbers.										

APPENDIX C: CLIENT QUESTIONNAIRE SURVEY FORM

DVI ANTENATAL SURVEY

Reason for this survey

At your first antenatal visit, we asked you some questions about anyone at home who hurt you physically or emotionally or who threatened to hurt you. We asked these questions because emotional or physical abuse may effect your health and possibly the health of your baby. What we don't know, is how women feel when talking about these issues with health care providers.

It would help us and other women having babies, if you would answer the following questions

(Please tick box)

1. Did you attend antenatal clinic at:

- The Royal Women's Hospital ☐
- The Mater Hospital ☐
- Kirwan Hospital ☐
- Cairns Base Hospital ☐
- Mt Isa Hospital ☐

2. Do you remember being asked questions about domestic violence at your first hospital antenatal clinic visit?

- Yes, I was asked questions ☐
- No, I wasn't asked questions ☐
- No, I wasn't asked, probably because my partner/husband was with me ☐
- I can't remember whether I was asked or not ☐

3. **Please tick how you felt when you were asked questions about domestic violence.**

- I felt OK about being asked ☐
- I felt relieved to be able to talk about my problems ☐
- I felt uncomfortable about being asked ☐
- Not Applicable ☐

Other feelings (please comment)………………

……………………………………………………

4. Do you think it is a good idea to ask women about domestic violence when they are pregnant?

Yes ☐ No ☐

Why

……………………………………………………………………

……………………………………………………………………

……………………………………………………………………

5. Who do you think should ask questions about domestic violence? (You may tick more than one box)

- My own GP ☐
- The hospital clinic doctor ☐
- The midwife in clinic ☐
- A social worker ☐
- No-one ☐

Other (please list name/s)……………………………..

6. Is there a better way to ask these questions? (You may use the back of the form if you wish)

……………………………………………………………………

……………………………………………………………………

……………………………………………………………………

7. Is there anything else we should ask about?

……………………………………………………………………

……………………………………………………………………..

8. **Did anyone help you to complete this form?** Yes ☐ No ☐

9. **If 'yes' who helped?** ……………………………………………………………………………………

10. When did you complete this questionnaire?

At my booking in visit ☐ At my next hospital visit which was ……. weeks later

Thank you for answering these questions.

Please place the form in the envelope and leave it in the box in the clinic.

Your name is not required; your answers are anonymous

DVI OUTPATIENT/EMERGENCY SURVEY

Reason for this survey

During your recent visit, we asked you some questions about anyone at home who hurt you physically or emotionally or who threatened to hurt you. We asked these questions because emotional or physical abuse may effect your health and possibly the health of your family. What we don't know, is how women feel when talking about these issues with health care providers.
It would help us, and possibly other women if you would answer the following questions.

(Please tick box)

4. Did you attend a clinic or the emergency department at:

- The Royal Brisbane Hospital ☐
- The Mater Hospital ☐
- Cairns Base Hospital ☐
- Mt Isa Hospital ☐
- Another hospital (please state) …………………… ☐

5. Do you remember being asked questions about domestic violence at that visit?

- Yes, I was asked questions ☐
- No, I wasn't asked questions ☐
- No, I wasn't asked, probably because my partner/husband was with me ☐
- I can't remember whether I was asked or not ☐

6. **Please tick how you felt when you were asked questions about domestic violence.**

- I felt OK about being asked ☐
- I felt relieved to be able to talk about my problems ☐
- I felt uncomfortable about being asked ☐
- Not Applicable ☐
- Other feelings (please comment)……………

……………………………………………………

5. Do you think it is a good idea to ask women about domestic violence when they visit hospital for medical care?

Yes ☐ No ☐

Why

……………………………………………………………………

……………………………………………………………………

……………………………………………………………………

6. Who do you think should ask questions about domestic violence? (You may tick more than one box)

- My own GP
- The hospital clinic doctor ☐
- The nurse in clinic ☐
- A social worker ☐
- No-one ☐
- Other (please list name/s)………………………….. ☐

8. Is there a better way to ask these questions? (You may use the back of the form if you wish)

……………………………………………………………………

……………………………………………………………………

……………………………………………………………………

9. Is there anything else we should ask about?

……………………………………………………………………

11. **Did anyone help you to complete this form?** Yes ☐ No ☐

12. **If 'yes' who helped?** ……………………………………………………………………

13. When did you complete this questionnaire?

At the same visit the questions were asked ☐ At my next hospital visit which was ……. weeks later

Thank you for answering these questions.
Please place the form in the envelope and leave it in the box in the clinic.
Your name is not required: your answers are anonymous

DVI GYNAECOLOGY OUTPATIENT SURVEY

Reason for this survey

During your recent visit, we asked you some questions about anyone at home who hurt you physically or emotionally or who threatened to hurt you. We asked these questions because emotional or physical abuse may effect your health and possibly the health of your family. What we don't know, is how women feel when talking about these issues with health care providers.
It would help usand, possibly other women, if you would answer the following questions.

(Please tick box)

7. Did you attend a clinic or the emergency department at:

- The Royal Women's Hospital ☐
- The Mater Hospital ☐
- Cairns Base Hospital ☐
- Mt Isa Hospital ☐
- Another hospital (please state) …………………… ☐

8. Do you remember being asked questions about domestic violence at that visit?

- Yes, I was asked questions ☐
- No, I wasn't asked questions ☐
- No, I wasn't asked, probably because my partner/husband was with me ☐
- I can't remember whether I was asked or not ☐

9. **Please tick how you felt when you were asked questions about domestic violence.**

- I felt OK about being asked ☐
- I felt relieved to be able to talk about my problems ☐
- I felt uncomfortable about being asked ☐
- Not Applicable ☐
- Other feelings (please comment)……………

…………………………………………………

6. Do you think it is a good idea to ask women about domestic violence when they visit hospital for medical care?

Yes ☐ No ☐

Why

………………………………………………………………………

………………………………………………………………………

………………………………………………………………………

7. Who do you think should ask questions about domestic violence? (You may tick more than one box)

- My own GP
- The hospital clinic doctor ☐
- The nurse in clinic ☐
- A social worker ☐
- No-one ☐
- Other (please list name/s)………………………….. ☐

10. Is there a better way to ask these questions? (You may use the back of the form if you wish)

………………………………………………………………………

………………………………………………………………………

………………………………………………………………………

11. Is there anything else we should ask about?

………………………………………………………………………

14. **Did anyone help you to complete this form?** Yes ☐ No ☐

15. **If 'yes' who helped?** …………………………………………………………………………………

16. When did you complete this questionnaire?

At the same visit the questions were asked ☐ At my next hospital visit which was ……. weeks later

Thank you for answering these questions.
Please place the form in the envelope and leave it in the box in the clinic.
Your name is not required; your answers are anonymous

APPENDIX D: DETAILED RESULTS OF THE CLIENT QUESTIONNAIRE

TABLE 1: EVALUATION OF THE DOMESTIC VIOLENCE INITIATIVE: EVALUATION OF CLIENT SATISFACTION

"REMEBERED BEING ASKED QUESTIONS ABOUT DOMESTIC VIOLENCE" BY PILOT SITE

	Yes - Asked		No - Not asked		No, Partner present		Couldn't remember		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%
Antenatal clinic sites										
Royal Women's Hospital	391	*91.4*	21	*4.9*	2	*0.5*	14	*3.3*	428	*100.0*
Mater Mothers' Hospital	356	*84.6*	47	*11.2*	2	*0.5*	16	*3.8*	421	*100.0*
Cairns Base Hospital	173	*87.8*	14	*7.1*	-	-	10	*5.1*	197	*100.0*
Kirwan Hospital for Women	134	*81.2*	22	*13.3*	-	-	9	*5.5*	165	*100.0*
Mount Isa Base Hospital	66	*75.0*	18	*20.5*	1	*1.1*	3	*3.4*	88	*100.0*
Total antenatal sites	**1,120**	***86.2***	**122**	***9.4***	**5**	***0.4***	**52**	***4.0***	**1,299**	**100.0**
Other sites										
Royal Brisbane Hospital:										
Primary Care Unit	25	*33.8*	42	*56.8*	2	*2.7*	5	*6.8*	74	*100.0*
Mater Adult Hospital:										
Emergency Department	79	*76.0*	23	*22.1*	-	-	2	*1.9*	104	*100.0*
Royal Women's Hospital:										
Gynaecology Outpatients	110	*82.9*	19	*14.4*	-	-	3	*2.3*	132	*100.0*
Total other sites	**214**	***69.0***	**84**	***27.1***	**2**	***0.6***	**10**	**12.6**	**310**	***100.0***
Total all sites	**1,334**	***82.9***	**206**	***12.8***	**7**	***0.4***	**62**	***3.9***	**1,609**	***100.0***

TABLE 2: EVALUATION OF THE DOMESTIC VIOLENCE INITIATIVE: EVALUATION OF CLIENT SATISFACTION

"IS IT A GOOD IDEA TO ASK QUESTIONS ABOUT DOMESTIC VIOLENCE?" BY PILOT SITE

	Yes		No		Total	
	No.	%	No.	%	No.	%
Antenatal clinic sites						
Royal Women's Hospital	420	*98.4*	7	*1.6*	427	*100.0*
Mater Mothers' Hospital	413	*98.6*	6	*1.4*	419	*100.0*
Cairns Base Hospital	186	*95.9*	8	*4.1*	194	*100.0*
Kirwan Hospital for Women	158	*96.9*	5	*3.1*	163	*100.0*
Mount Isa Base Hospital	85	*95.5*	4	*4.5*	89	*100.0*
Total antenatal sites	**1,262**	***97.7***	**30**	***2.3***	**1,292**	***100.0***
Other sites						
Royal Brisbane Hospital:						
Primary Care Unit	61	*80.3*	15	*19.7*	76	*100.0*
Mater Adult Hospital:						
Emergency Department	102	*95.3*	5	*4.7*	107	*100.0*
Royal Women's Hospital:						
Gynaecology Outpatients	131	*96.3*	5	*3.7*	136	*100.0*
Total other sites	**294**	***92.2***	**25**	***7.8***	**319**	***100.0***
Total all sites	**1,556**	***96.6***	**55**	***3.4***	**1,611**	***100.0***

TABLE 3: EVALUATION OF THE DOMESTIC VIOLENCE INITIATIVE: EVALUATION OF CLIENT SATISFACTION "HOW DID YOU FEEL WHEN YOU WERE ASKED QUESTIONS ABOUT DOMESTIC VIOLENCE" BY PILOT SITE	"I felt OK"		"I felt relieved"		"I felt uncomfortable"		Total	
	No.	%	No.	%	No.	%	No.	%
Antenatal clinic sites								
Royal Women's Hospital	391	*97.3*	5	*1.2*	6	*1.5*	402	*100.0*
Mater Mothers' Hospital	399	*97.1*	4	*1.0*	8	*1.9*	411	*100.0*
Cairns Base Hospital	179	*94.2*	5	*2.6*	6	*3.2*	190	*100.0*
Kirwan Hospital for Women	152	*94.4*	3	*1.9*	6	*3.7*	161	*100.0*
Mount Isa Base Hospital	75	*93.8*	1	*1.3*	4	*5.0*	80	*100.0*
Total antenatal sites	**1,196**	***96.1***	**18**	***1.4***	**30**	***2.4***	**1,244**	**100.0**
Other sites								
Royal Brisbane Hospital:								
Primary Care Unit	40	*76.9*	9	*17.3*	3	*5.8*	52	*100.0*
Mater Adult Hospital:								
Emergency Department	85	*93.4*	4	*4.4*	2	*2.2*	91	*100.0*
Royal Women's Hospital:								
Gynaecology Outpatients	120	*94.5*	2	*1.6*	5	*3.9*	127	*100.0*
Total other sites	**245**	***90.7***	**15**	***5.6***	**10**	***3.7***	**270**	***100.0***
Total all sites	**1,441**	***95.2***	**33**	***2.2***	**40**	***2.6***	**1,514**	***100.0***

TABLE 4: EVALUATION OF THE DOMESTIC VIOLENCE INITIATIVE: EVALUATION OF CLIENT SATISFACTION "WHO SHOULD ASK THE QUESTIONS ABOUT DOMESTIC VIOLENCE?" BY PILOT SITE						
	General Practitioner	Hospital Doctor	Nurse or Midwife	Social Worker	No-one	Total
	No.	No.	No.	No.	No.	No.
Antenatal clinic sites						
Royal Women's Hospital	288	213	284	214	6	431
Mater Mothers' Hospital	281	182	295	214	5	425
Cairns Base Hospital	106	83	145	93	4	197
Kirwan Hospital for Women	102	66	101	74	7	167
Mount Isa Base Hospital	45	43	47	39	8	90
Total antenatal sites	**822**	**587**	**872**	**634**	**30**	**1,310**
Other sites						
Royal Brisbane Hospital:						
Primary Care Unit	50	47	28	35	6	81
Mater Adult Hospital:						
Emergency Department	80	60	65	58	3	107
Royal Women's Hospital:						
Gynaecology Outpatients	100	74	99	78	3	139
Total other sites	**230**	**181**	**192**	**171**	**12**	**327**
Total all sites	**1,052**	**768**	**1,064**	**805**	**42**	**1,637**
	%	**%**	**%**	**%**	**%**	**%**
Antenatal clinic sites						
Royal Women's Hospital	*66.8*	*49.4*	*65.9*	*49.7*	*1.4*	*100.0*
Mater Mothers' Hospital	*66.1*	*42.8*	*69.4*	*50.4*	*1.2*	*100.0*
Cairns Base Hospital	*53.8*	*42.1*	*73.6*	*47.2*	*2.0*	*100.0*
Kirwan Hospital for Women	*61.1*	*39.5*	*60.5*	*44.3*	*4.2*	*100.0*
Mount Isa Base Hospital	*50.0*	*47.8*	*52.2*	*43.3*	*8.9*	*100.0*
Total antenatal sites	***62.7***	***44.8***	***66.6***	***48.4***	***2.3***	***100.0***
Other sites						
Royal Brisbane Hospital:						
Primary Care Unit	*61.7*	*58.0*	*34.6*	*43.2*	*7.4*	*100.0*
Mater Adult Hospital:						
Emergency Department	*74.8*	*56.1*	*60.7*	*54.2*	*2.8*	*100.0*
Royal Women's Hospital:						
Gynaecology Outpatients	*71.9*	*53.2*	*71.2*	*56.1*	*2.2*	*100.0*
Total other sites	***70.3***	***55.4***	***58.7***	***52.3***	***3.7***	***100.0***
Total all sites	***64.3***	***46.9***	***65.0***	***49.2***	***2.6***	***100.0***