

**‘I HAVE LEARNT HOW
TO ASK QUESTIONS’:
IMPLEMENTING
SCREENING FOR
DOMESTIC VIOLENCE**

**Michelle Bonner, Lydia Campillo &
Gwen Cosier**



18 – 22 February 2002, University of Sydney, Australia

‘I HAVE LEARNT HOW TO ASK QUESTIONS’:
IMPLEMENTING SCREENING
FOR DOMESTIC VIOLENCE

Michelle Bonner

Domestic Violence Project Officer

South Eastern Sydney Area Women’s Health Service

Lydia Campillo

Policy Analyst

Violence Prevention Team, NSW Health Department

Gwen Cosier

Violence, Abuse and Neglect Co-ordinator

South Eastern Sydney Area Women’s Health Service

Introduction

In the NSW Health Domestic Violence Policy Discussion Paper (1999), the Department proposed the introduction of routine screening for domestic violence. This followed extensive study of both local and international research which highlighted the low identification of domestic violence in health services; the high incidence of domestic violence in female clients/patients; positive responses by victims to direct questioning about violence; and the high value of early intervention to protect adults and children who are victims of domestic violence. The short and long-term health effects of violence against women including mental health issues and drug and alcohol abuse were clear. The physical effects of violence, the most extreme being homicide or suicide, are also clearly documented. Webster (1995) states, “domestic violence is the leading cause of injury among women of reproductive age, the single most common trigger for female suicide and at the most extreme end of violence continuum, up to 60% of women who are murdered, die as a result of a domestic dispute.”

The proposal to introduce routine screening received strong support from health services and other agencies.

In 2000 the Department of Health received funding from the Commonwealth Partnerships Against Domestic Violence to pilot routine screening in two Area Health services: South Eastern Sydney and Macquarie Area Health Services, followed by state-wide implementation.

The initial project involved piloting a series of questions about domestic violence in health services. Prior to screening, health staff undertook a training program developed by the Education Centre Against Violence. The pilot project was researched and evaluated by Associate Professor Jude Irwin and Dr Fran Waugh in University of Sydney, commissioned by the Violence Prevention Team in NSW Health.

Outcomes of pilot

A total of 4,170 women aged sixteen and over presented to the eight health services including antenatal, mental health and alcohol and other drugs services and emergency departments that participated in the pilot. Of these, 999 women (24%) were screened for domestic violence. Screening forms were also completed for an additional 212 women (5%), specifying why they had not been screened. The main reasons for not screening the women were the presence of a partner or other family members.

Eleven percent (106) of the women screened responded positively to questions of being hit, slapped or hurt in other ways by their partner in the last 12 months, with 12 of these women not feeling safe to go home and 32 women agreeing to some form of assistance.

The overwhelming majority of women (97% of the 586 who completed the survey questionnaires) indicated they felt either "OK" or "relieved" about being asked questions about abuse they might have received from their partner or ex-partner.

The majority of women (92% or 447) screened identified that the written information given to them about domestic violence included useful information about resources and support for women experiencing domestic violence.

Other things that we have learned during the pilot is that routine screening increases the identification of domestic violence and tells a woman that:

- she is believed;
- she is respected;
- she is not alone;
- she can get help;
- that the health worker is willing to listen;
- the issue is being taken seriously; and,
- the abuse happens to a lot of women and she can get help.

Most importantly, routine screening gives all women the clear message that domestic violence is wrong, domestic violence hurts the health of women, and health workers care and are able to help. Research indicates that even in the absence of further interventions or referrals, asking the questions improve outcomes for women (Parker et al., 1999).

The introduction of routine screening for domestic violence has involved staff training, staff and management briefings, skills development and the integration of screening questions into intake/history schedules. Strong links have been established with antenatal, drug and alcohol and mental health services in relation to current practices in these services and how to respond more effectively to domestic violence cases.

Implementation

The Department of Health recommends that Area Health Services adopt the modelled routine screening questions for all women aged sixteen years and over attending drug and alcohol, mental health, antenatal and early childhood services. Many health services, recognising the impact of domestic violence on the health of their clients/patients, have previously signalled improved identification of domestic violence as a priority, and see this tool as a means to bring this about.

There are two projects within NSW Health where the screening questions will be included: Mental Health Outcomes and Assessment Training Project (MH-OAT); and the Integrated Perinatal and Infant Care (IPC).

An Implementation Package has also been developed by the Education Centre Against Violence. This package includes:

- an implementation guide for managers which contains information about how to implement screening in their service;
- the evaluation report of the pilot project, titled 'Unless They're Asked';
- the Protocol;
- the screening form used to conduct screening and document the results;
- a learning program – Asking the questions: the program contains eleven modules that will help health workers to understand the rationale for screening and be able to carry it out;
- a domestic violence flow-chart; and,
- a 'Domestic violence is wrong' information card – a copy of this resource is to be given to all women who are screened, regardless of whether domestic violence is identified.

The Department of Health has extended the funding to continue the provision of training and support to health services. Fifteen Area Health Services across NSW are now preparing for the introduction of screening.

It is anticipated that the NSW Health Domestic Violence Policy will be finalised this year and it is likely that routine screening will be mandatory in the identified health services. Implementation of screening is expected to be completed over a three-year period.

A Local Example

There are still some challenges that Area Health Services are dealing with at the local level which and an example of this will now be discussed.

Sutherland Hospital Antenatal and Outreach Clinic participated in the screening pilot for 3 months in 2000 and decided to continue screening women for domestic violence even after the pilot had finished. The following is an outline of their experience in implementing domestic violence screening, including the workplace outcomes and the factors needed for screening implementation to be successful.

Workplace Outcomes

- Staff became aware that to undertake the screening they would need to separate the women from their partners. This was a complete change to

the Antenatal process where partners and family members have been encouraged to be involved and present during the visits. The screening however, made staff aware that often women will not disclose other medical histories eg terminations, STDs due to the presence of partners and family members. Previously, disclosures of this kind were occurring, if at all, when the midwife and woman were on their own often happening when women were giving their urine sample. It was decided that the midwives would now ask the more personal questions at the beginning of the interview without anyone present to allow for privacy and confidentiality. As a result, women are asked questions regarding their obstetric and gynaecological history, drug and alcohol use and the domestic violence screening questions first. Support people are then invited into the interview for the basic medical history taking and education session

- The Antenatal clinic card has been changed to incorporate the preamble and screening questions. An addition to this has been a question asking women if they would like their GP notified if domestic violence is disclosed. The midwife must obtain consent from the woman before this information will be referred on to her GP.
- A domestic violence protocol for the Maternity Service at Sutherland Hospital has been developed in consultation with the midwives, maternity social worker, Nurse Unit Manager, Midwifery Educator, Employee Assistance Program, Sutherland Division of GP's, Domestic Violence Liaison Officers at the local police stations and the Department of Community Services. As part of this protocol, a site-specific flowchart for domestic violence was also developed.
- Links were made with the psychosocial screening currently being undertaken in maternity services. Both screenings were seen to be interrelated with the aim being of incorporating the two, as is now to happen with the IPC as referred to earlier.
- Other training opportunities have developed out of the screening including an interviewing skills workshop developed with Employee Assistance Program counsellor for the Antenatal Clinic staff. This workshop aims to enhance the midwives current interviewing skills and confidence in asking questions not only about domestic violence but also drug and alcohol and perinatal mental health issues.

- Ongoing liaison and consultation has occurred with the Sutherland GP Division both during and following the pilot. The aim of this has been to keep the GPs informed about the screening and also to continue to improve the continuity of care between the hospital and GPs of pregnant women in violent relationships. The result of this liaison has been an inclusion of the screening and domestic violence services and referral sources in the GP Shared Care protocols. Two articles about the screening have been written for the Division newsletter with an insert provided for GPs on domestic violence services.

Factors for Success

Management Support

The screening pilot was actively supported and encouraged by the Director of Child, Family and Youth Services, Divisional Nurse Manager of Maternity Services, Nursing Unit Manager in the Maternity Services, Midwifery Educator and the Maternity Social Worker. This gave clear and positive messages to the midwives that the screening was considered as an important identification and intervention tool, that it was part of the role and responsibility of the midwife's care and that it was supported at the senior level. As a result, although the midwives had initial reservations about the screening, which were recognised and discussed, the overwhelming message they received was that domestic violence was considered a health issue that needed to be addressed in the antenatal period.

Key Players

Involvement of key players encouraged a team approach to the screening. Services such as EAP, social worker, community liaison midwife were involved right from the beginning looking at the possible impact on their services and their support and involvement. It also ensured that the screening wasn't reliant on the project officer but there was support after the project officer had left.

Feedback from Women

Responses from the women screened throughout the pilot project that were supportive and pleased about the screening were essential in encouraging the midwives to continue screening. Midwives also spoke anecdotally of women pleased that the clinics were interested enough in their wellbeing beyond the pregnancy to ask the questions. As a result, some midwives felt the screening enhanced their relationships with women.

Ownership

Encouraging ownership of the screening by the midwives was essential to it being taken on as part of their work. This was achieved by giving feedback on the statistics and women's responses to the screening, writing articles with key staff, offering opportunities to staff to comment on domestic violence protocols and offering opportunities to present at conferences.

Resources and support

Offering a variety of training and resources to back the screening is crucial to the midwives feeling supported. Laminated flow-charts, resource lists and information cards were placed at the sites. Protocols were developed. Training was continually provided on domestic violence awareness raising, screening and then when requested interviewing skills. Support was also provided around the development of new clinic cards and psycho-social screening.

Social Work Support

The Antenatal services have only one social worker who staff felt was already overloaded with referrals. However from the social worker's perspective, the screening made it easier for her to work the woman as disclosure had already occurred. The screening resulted in early identification, which meant for the social worker intervention could occur early in the antenatal period rather than post-natally when the woman is about to leave hospital. The social worker also felt they could communicate to the staff on domestic violence, as they knew the midwives now had the background and training on it. They found the screening very productive in this way.

Child Protection

During the pilot, the new Children and Young Persons (Care and Protection) Act 1998 began. This reinforced the importance of midwives being clear about their role and responsibilities in reporting children at risk. As screening for domestic violence could potentially raise child at risk concerns, child protection had to be covered in the training particularly covering the link between domestic violence and child abuse.

Global Issue

The training highlighted the issue that domestic violence is a global concern and therefore the midwives or other health staff could be either current or past victims of domestic violence. This can have an influence on how or whether health staff undertakes screening. It also raised the need for managers to be aware of the issues that their staff may have and how to support their staff. To address this, the Employee Assistance Program presented to the Sutherland Hospital Nursing Unit Managers meeting on “How Best to Support Staff who are in a Domestic Violence Situation”, to try to prepare managers for possible disclosures.

Training

Logistically organising training for all the midwives was difficult due to time and cost restraints. Originally the manager recommended those midwives who they felt were more likely to come into contact with women to be trained, but then felt all midwives need to be trained. Midwives felt lucky to have had the 4-hour training.

The Antenatal Clinics have undergone a number of important changes as a result of their participation in the Domestic Violence Screening Pilot. For the midwives, these changes have involved some anxiety and concern but have also allowed them to acknowledge a health issue and enhance both their and their services' capability to respond. Screening for domestic violence encourages a holistic approach to the well being of women and their children, and because of this, midwives feel it complements their midwifery philosophy of care.

References

NSW Health Department (1999). *Review of NSW Health domestic violence policy*. Discussion Paper.

Parker, B.; McFarlane, J.; Soeken, K.; Silva, C.; & Reel, S. (1999). 'Testing and intervention to prevent further abuse to pregnant women'. *Research in Nursing & Health*, 22: 59-66.

Webster, J. (1995). 'The silence of violence: Let's not talk about abuse during pregnancy'. *Irish Medical Journal*, 88: 3.