Unless they're asked

Routine screening for domestic violence in NSW Health

An evaluation report of the pilot project

NSW HEALTH
Better Health *Good Health Care*

Health
Working as a Team
The Way Forward

NSW Health Department

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Foreword

NSW Health has a strong commitment to the safety, welfare and well being of families. Over the last decade, domestic violence has been increasingly recognised as a health issue. A substantial body of research has established a strong link between domestic violence and other health problems. Research has established a strong correlation between the presence of domestic violence and child abuse. The use of this screening tool for identification of domestic violence promotes early intervention for families living with domestic violence.

In 1999, the NSW Health Domestic Violence Policy Review Advisory Committee was formed to guide the development of a new domestic violence policy which took into account the many legislative and agency changes that have been instituted. One of the recommendations by the committee was the introduction of routine screening for domestic violence in Health Services. Routine screening provides a critical opportunity for early identification and intervention. The screening process itself gives a clear message that domestic violence is wrong, that it has adverse health outcomes for women and that health professionals can offer information.

With the assistance of Federal funding from the Partnerships Against Domestic Violence Strategy, routine screening has been piloted in NSW Health Services.

During the pilot project, the screening tool was developed and tested in Health Services. This evaluation report indicates that identification of domestic violence has been improved by screening. The results of the pilot also show that this initiative received strong support from the women who participated.

This evaluation will inform the implementation of screening in Health services.

Services will be able to incorporate the recommended screening tool within initial assessment and intake protocols, as a component of core clinical practice.

It is with great pleasure that I present the evaluation Unless They're Asked for NSW Health Domestic Violence Screening Project. I encourage active participation from all levels of the health system and collaboration with other key agencies to promote the safety of women and their families in NSW.

Michael Reid
Director-General

Abbreviations

DB Obs	Dubbo Base Hospital Obstetrics
DoCS	NSW Department of Community Services
MAHS	Macquarie Area Health Service
MAHS AOD	Macquarie Area Health Service Alcohol and Other Drugs Service
MAHS MHS	Macquarie Area Health Service Mental Health Service
Mudgee ED	Mudgee Hospital Emergency Department
SESAHS	South Eastern Sydney Area Health Service
St G. ANC	St. George Antenatal Clinic
STOMP	St. George Outreach Maternity Project
TSH ANC	The Sutherland Hospital Antenatal Clinic
TSH AOD	The Sutherland Hospital Alcohol and Other Drugs Service
TSH ED	The Sutherland Hospital Emergency Department
WHN	Women's Health Nurses, SESAHS

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1 Summary of outcomes of evaluation

1.1 A total of 4170 women over the age of 16 years presented to the eight health services participating in the pilot domestic violence screening project in South Eastern Sydney and Macquarie Area Health Services. Of these, 999 women (24%) were screened and screening forms were completed for an additional 212 (5%) women, specifying why they had not been screened. The main reasons specified for not screening the women were the presence of a partner or other family members.

1.2 Screening forms were not completed for 2957 (71%) women presenting to the services. Explanations for not screening which were drawn from focus group interviews and post-training questionnaires included the lack of privacy to ask questions; limited time as a consequence of heavy workplace demands; discomfort with asking such personal questions and uncertainty about what to do if a woman disclosed.

1.3 Eleven percent (106) of the women who were screened identified either being hit, slapped or hurt within the last year and/or being frightened of their partner or ex-partner, with 12 of these women not feeling safe to go home and 32 women agreeing to some form of assistance. In comparison with data collected on domestic violence disclosures for a period of time prior to the pilot, it appears that the number of disclosures increased during the pilot.

1.4 Overall health practitioners who undertook the training for the project had a sound knowledge of the indicators and effects of domestic violence. However, many were less confident about how to respond to domestic violence.

1.5 Training was identified by health practitioners as critical to the success of the implementation of routine screening for domestic violence.

1.6 The importance of the provision of adequate staffing and suitable facilities was seen as essential by health practitioners for such a project to be effective.

1.7 The policies and protocols that were developed for the routine screening of domestic violence were considered by health practitioners as being critical for the successful implementation of the project. The implementation of these may result in changes to workplace practices and processes.

1.8 Information and resources for women need to be developed to ensure the needs of diverse populations of women are addressed (for example, pamphlets and information to be available in community languages).

1.9 Both health practitioners and the women participating in the screening identified that general practitioners are in a key position to identify women who have experienced domestic violence. Sixty-seven percent (395) of the women who were screened considered that it would be appropriate for general practitioners to screen for domestic violence. Social workers, clinic doctors and nursing staff were also identified as professionals who could routinely screen for domestic violence.

1.10 The overwhelming majority of women (95% of the 586 who completed the survey questionnaires) indicated they felt either 'OK' or 'relieved' about being being asked questions about abuse they may have received from a partner or ex partner. The majority of women who participated in telephone interviews (96% or 48) expressed satisfaction with the explanation given for routine questioning, the questions and the information about domestic violence which was provided to them.

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

1.12 There were some specific issues identified that related to particular communities or populations. For example, in small rural communities the fear that disclosure of domestic violence could result in this becoming public knowledge may act as a deterrent for women disclosing. The lack of local services and resources can also be a deterrent.

2

Outline of the domestic violence screening pilot project

2.1 Background and development of screening

Over the last 25 years, there has been widespread acknowledgment that domestic violence is an issue of major social concern. Over this period of time, there has been a substantial amount of research that has established a strong link between domestic violence and physical and emotional health problems and risk factors (Bates et al 1995; Chamberlain 2000: Hayden et al 1997; Roberts et al 1993). Health practitioners in NSW have for many years recognised that domestic violence was a cause of negative health outcomes for women and children, but until 1993 when NSW Health announced its first domestic violence policy there was minimal recognition that domestic violence was the business of the public health system. With the announcement of this policy, training of health practitioners, specifically those working in Accident and Emergency, was instituted. The training focused on how to recognise and respond to domestic violence.

The development of domestic violence policy and practice at an Area level often rested with Women's Health Co-ordinators whose responsibilities included the development of domestic violence protocols and the initiation of training for health practitioners. Across the NSW health system, responses to domestic violence differed from Area to Area as domestic violence competed with other major health concerns to be given some priority. As a consequence, there has been a variable response to domestic violence across the state. Some Area Health Services have high levels of awareness and sound protocols that are well utilised whereas in other Area Health Services, domestic violence has not been regarded as a priority but rather the responsibility of community agencies, thus resulting in limited policy and practice responses from the health system.

In 1999, the NSW Health Domestic Violence Policy Review Advisory Committee was formed to guide the development of a new domestic violence policy, which took into account the many legislative, service and agency changes that have been instituted since 1993, when the initial domestic violence policy was announced. The committee included representatives from a broad range of state health services, including Women's Health, Nursing, Alcohol and Other Drugs, Mental Health, Aboriginal Health and Multicultural Health. One of the early issues considered by the committee was the introduction of routine screening for domestic violence. A proposal to introduce routine screening for domestic violence was introduced, following a review of the findings of both local and international research which highlighted the low identification of domestic violence in health services; the high incidence of domestic violence; 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 (Tuxford 2000). This proposal was included in the NSW Health Domestic Violence Discussion Paper. Feedback from the consultation process on this Discussion Paper indicated strong support for the initiative both from health services and other agencies.

2.2 Overview of the research

A large body of literature and research over the last decade has explored a number of issues relating to domestic violence as a health concern and the introduction of routine screening. Some of this research has been focused on the extent of domestic violence in patients attending health care services and has indicated that there may be a higher incidence of domestic violence in particular clinical populations. Some literature has also explored the barriers to identification of violence in health care settings. Other areas to be examined are the role of training and education in the early identification and prevention of violence and the importance of routinely screening women for abuse.

2.2.1 The extent of violence in particular clinical populations

There have been a number of research studies undertaken exploring the extent of domestic violence in particular clinical populations. The areas that much research has explored have included mental health, alcohol and other drugs, antenatal and emergency.

Mental health

Judith Lewis Herman (1986) reviewed the files of 190 consecutive psychiatric outpatients and found that although they were not routinely interviewed about assault histories, 22% of the patients reported victimisation; 16% reported perpetration of violence; 81% of the identified offenders were male; 81% of identified victims were female; 33% of female patients were victimised; 29% of male patients were abusive to others; 23% of married women had been beaten by their husbands and 20% of men had assaulted their wives. She argued that while the figures are higher than would be expected in a general population sample, the figures could be even higher as the results are from reviewing the patient's files and the information was volunteered rather than routinely sought. She goes on argue that the reality of sexual and domestic violence has not yet been integrated into ordinary clinical teaching or practice and that basic information about sexual and domestic violence should be included in the core curriculum for mental health professionals. She also argues that protocols for routine evaluation of all patients should include questions about experiences of domestic and sexual violence (Herman, 1986,140).

Carlile (1991) assessed 152 married women who had been diagnosed with a psychiatric disorder and who were consecutively seen at, or admitted to, a psychiatric unit. Overall, he found that 49% of the patients had been assaulted by their husbands. Forty-two percent of the assaulted clients stated that they had been assaulted more than twenty times. More than one-half of the sample had been hit at least monthly, and even when they were badly hurt they were prevented (by their husbands or their shame) from going for medical attention. Carlile argued that a sense of hopelessness and helplessness was often felt by these women and is reflected in their passive responses

to the violent episodes. Fifty-three percent of the attacked women did nothing or just walked away. Less than one out of four patients told their current psychiatrists about it. Carlile reasoned that this figure indicated that doctors did not ask patients about spouse abuse as part of their routine psychiatric assessment (Carlile, 1991, 268).

More recently in Australia, Roberts et al (1998) explored the nature of symptoms and patterns of mental illness associated with domestic violence. The study was undertaken over a period of a year and included women who attended an emergency department in a hospital. The study showed that a history of victimisation was a strong risk factor for development of lifetime mental health problems. Women who reported domestic violence had significantly higher rates of depression, somatisation, anxiety, phobias, dissociation, alcohol abuse and drug dependence. Women who were abused both as a child and as an adult were at greatest risk of mental illness. The researchers argued that training on domestic violence be included in undergraduate and postgraduate courses for health professionals with particular focus on the effects of domestic violence on women's mental health. They also argued that histories of violence go undetected among psychiatric patients and that education programs are not enough to increase detection and management of victims of domestic violence, but that the development and use of protocols requiring the routine assessment of women do increase the identification of women who have experienced domestic violence.

Alcohol and other drugs

Anecdotal and practice evidence indicates that women who abuse alcohol and other drugs are much more at risk of experiencing violence, and women who are abused are far more likely to abuse alcohol and other drugs (Quinlivan and Evans 1999). This has been confirmed by some research studies. For example Miller and Downs (1993) compared women in Alcohol Treatment Programs with a household survey and found that 70% of the women in the treatment program had experienced domestic violence as compared with 35% of the women in the household survey.

Emergency departments

There have been a number of studies undertaken in Australia examining the extent of domestic violence in patients attending Emergency Departments in hospitals. In 1992, a study was undertaken in Newcastle involving 401 women who attended an Accident and Emergency Department (Bates et al 1995). The researchers found that one-quarter of these women had experienced domestic violence at some point in their lives and that those women who were at greatest risk of experiencing domestic violence were women who were divorced or separated or who had no medical cover.

In a study conducted in Brisbane, Roberts et al (1993) measured the number of domestic violence victims who presented in an Accident and Emergency Department in a large hospital and found that in a sample of 1214 presentations, 14% had some history of domestic violence with 40% of these experiencing violence over the last 12 months.

Antenatal services

Research and literature in relation to domestic violence and pregnancy has shown that domestic violence is likely to begin or escalate during pregnancy, prevalence rates increase markedly during pregnancy, there is a higher risk of abuse for pregnant adolescents and domestic violence increases the likelihood of substance abuse, smoking and a poor diet. This can have an impact on birth outcomes including low birth weight, increased risk of miscarriage, post-natal depression and increased levels of abuse after the birth (Tuxford 2000). Quinlivan and Evans (1999) argue that domestic violence in teenage pregnancy is considerably higher than rates reported in the general community. They explored antenatal associations of domestic violence in young adolescent pregnancy and the impact of this abuse on the mother and infant outcomes. Their study showed that nearly 30% of pregnant teenagers aged 12-17 years who participated in their research were victims of domestic violence. These young women were less likely to plan the pregnancy, presented later for antenatal care and had significantly higher levels of postpartum morbidity and extended periods of hospitalisation, which considerably increased the costs of antenatal care. The researchers argued that it was critical to identify these young women early and to provide services and support to increase their opportunity to 'break the cycle of violence'.

2.2.2 Barriers to identification of domestic violence

Some recent literature has explored the barriers amongst health care professionals to identifying violence . Ellis (1999) explored the barriers to screening for domestic violence in emergency departments. Nurses were asked to identify the main barriers in screening for domestic violence. They identified the lack of privacy for screening; the lack of time to ask about domestic violence and the lack of knowledge about how to ask. It was argued that these barriers need to be addressed by the provision of private areas conducive to screening for domestic violence and that ongoing training to develop skills and knowledge for asking about and identifying domestic violence was important. The authors argued that the issue of time constraints could be addressed by early identification and management of domestic violence, which could effectively reduce the workload in Emergency Departments by decreasing the number of patients who repeatedly present as a consequence of abuse. Another possible barrier was personal experience of domestic violence. Ellis (1999) found that 57.5% of respondents had a personal experience of domestic violence.

A study by Farslow et al (1999) also identified a number of barriers to maintaining positive changes in early identification of domestic violence in an Emergency Department. This study explored whether the benefits of an initially successful Emergency Department protocol for abused women was maintained a year after its introduction. The introduction of the protocol had resulted in positive changes in the identification and management of women who had experienced abuse. However an evaluation showed that this change was not maintained. The authors posited that one-off training programs and other support activities were insufficient to support ongoing

change. They also identified a number of other factors particularly applicable to Emergency Departments which mitigate against ongoing change. Farslow et al argued that the barriers which are likely to interfere with change need to be identified and addressed. The barriers they identified concerned issues about privacy perceptions, lack of time, training and resources. Another major impediment identified amongst practitioners was the belief that domestic violence was not a real health issue. They considered that institutionalising procedures for abuse assessment could enhance consistency of response by staff and that policy at departmental, hospital, Area Health and national levels was likely to promote responsive action to victims and show organisational commitment to the issue.

2.2.3 Education and training

Education and training about domestic violence has been identified as critical in the identification of domestic violence in health care settings. Training can be aimed at increasing awareness of domestic violence; developing skills and knowledge to respond to disclosure; and establishing domestic violence as a health issue.

A four year project undertaken by the American College of Nurse-Midwives' was designed to both influence professional awareness of domestic violence and to establish domestic violence as a health issue. It aimed to encourage universal screening for domestic violence (Paluzzi 2000). The authors argued that adopting a policy of universal screening would have the preventative function of discussing domestic violence with patients who have not experienced violence. They commented that for sustained change in identification of domestic violence, there needs to be a change in core competencies that specifically address the need to assess for abuse. They stressed that to successfully affect professional behaviour through training and education there needs to be a consistent message, an interactive and participatory approach to the transfer of information, policy orientation, senior staff support of the change process, a combined bottom up/ top down approach and pre-service orientation.

There are numerous researchers who argue that the inclusion of domestic violence in undergraduate and postgraduate courses for health practitioners is important to increase the likelihood of early identification (Farslow et al 1999; Herman 1986; Roberts et al 1998).

There have also been studies exploring screening behaviour amongst particular health professionals. In a study aimed at identifying screening behaviours and barriers to screening for abuse by obstetricians and gynaecologists, Parsons et al (1995) identified that obstetricians and gynaecologists do not routinely screen for abuse in their patients. After the professional medical associations provided guidelines to educate for the identification of abuse there was some improvement in screening behaviours. However, it was argued that a more comprehensive approach beyond the provision of information is needed to convince obstetricians and gynaecologists of the relevance to their practice of screening for abuse and to help them incorporate the management of abuse.

This is consistent with research that has shown that while training in recognising the indicators of domestic violence may improve identification, it alone may be insufficient to increase identification of women who are survivors of domestic violence (Roberts et al. 1998). However training combined with the introduction of routine questioning has been shown to increase the detection and early identification of women living with domestic violence (Roberts et al 1993).

2.2.4 Routine screening for domestic violence

Several authors argue that the implementation of routine screening in health settings is essential to both early identification and the prevention of violence. Eisenstat and Bancroft (1999) argue that routine screening by all medical practitioners is important in order to identify women who are abused. They argue that routine medical, gynaecology, obstetric and paediatric visits all provide opportunities for screening. They comment that medical practitioners are in an important position to identify women who experience abuse as these women may be more likely to visit a medical practitioner without the perpetrator questioning this. They also comment that women are more likely to discuss their abuse if they are asked about it directly and in a caring manner.

Research has consistently indicated that women are comfortable about being asked questions about domestic violence. A recent study explored how women felt about discussing domestic violence in an Emergency Department of a hospital (Hayden et al 1997). The study showed that while most women would feel comfortable disclosing domestic violence to Emergency Department professionals, many of these women (36%) would not volunteer this information and would disclose domestic violence only if asked directly. The women were comfortable in discussing domestic violence with a range of professions. For them the critical issue was not who asks the questions, but that the questions are asked of all women presenting to Emergency Departments. The researchers went on to argue for routine assessment of domestic violence as part of a routine social history.

Tuxford (2000), in an overview of literature about the use of screening to improve detection of domestic violence in women in health systems, found that over 98% of women screened for domestic violence support it as an intervention; most women see health workers as appropriate people to be asking about domestic violence; a health facility is a safe place to be asked these questions; direct questioning is most effective; repeating the questions every three months improves the positive response rate and screening by itself produces improved outcomes. She cited a study which found that domestic violence was reduced after screening and the authors summised that women's awareness of domestic violence as a health issue had been raised because health practitioners had screened for domestic violence (Parker et al 1999).

Much literature comments that validation by the health care providers gave relief and comfort, and also increased women's awareness of their situation (Chamberlain 2000; Gerbert et al 2000). Chamberlain (2000) argues that routine screening is critical as it can plant the seed to raise awareness and to educate about domestic violence in communities. In areas where there are

few services available for women, health professionals are often the only service provider the victims come into contact with who have the opportunity to talk to the victim in a safe environment. Chamberlain also argues that there are three criteria to assess whether screening is justified; effectiveness, human costs and sustainability and comments that routine screening for domestic violence meets all these criteria. She comments that screening is a prevention strategy. In relation to tertiary prevention, every time a health care provider talks to a victim about abuse they are ending the victim's isolation and providing the opportunity for disclosure in a safe environment. The aim of secondary prevention is to detect a health risk early. Early identification of domestic violence can help victims escape before the violence traps them. In relation to primary prevention, asking questions about abuse can increase awareness of abuse and its effects and educate women and the community about violence.

2.3 The pilot project

After reviewing and discussing the research the NSW Health Domestic Violence Policy Review Advisory Committee decided to embark on a pilot domestic violence screening project in two Area Health Services in NSW, South Eastern Sydney and Macquarie. Federal funding from the Partnerships Against Domestic Violence Strategy was obtained for the project which began in July 2000. The grant included funds for an external evaluation of the pilot project. An interagency steering committee was set up to guide the project, with representatives from NSW Police Service; Domestic Violence Line (DoCS); Domestic Violence Advocacy Service; the Women's Refuge Resource & Referral Centre; Violence Against Women Specialist Unit, NSW Attorney General's Department; Drug Program Bureau, Centre for Mental Health, Nursing Branch and Health Services Policy from NSW Health. In addition, a working party from the NSW Department of Health was established in December 1999 and included two representatives from the Violence Prevention Team in Health Services Policy Branch, the project officer from the Education Centre Against Violence as well as the Women's Health Co-ordinators and the project officers from the participating Area Health Services. The role of the working party was to establish and monitor the operation of the project. The external evaluators although not members of the working party reported directly to the working party.

The project was developed by the Violence Prevention Team in Health Services Policy Branch in NSW Health in consultation with the domestic violence working party. For the purposes of this initiative, screening was defined as;

> *The systemic application of a test or enquiry, to identify individuals at sufficient risk of a specific disorder to benefit from further investigation or direct preventative action, amongst persons who have not sought medical attention on account of symptoms of that disorder. (Peckham & Dezateaux, 1998)*

The overall aims of the pilot project were to:

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

The objectives of the project were to:

- conduct a six month pilot of procedures to routinely screen whether female patients of accident and emergency, antenatal, drug and alcohol and mental health services experience domestic violence
- develop and conduct training and information strategies tailored to staff of each of the participating services in the pilot and implementation stage
- develop model routine screening procedures, forms and data collection methods within the pilot services to:
    - i) refine and ensure appropriate use of the screening tool
    - ii) provide participating staff with clear guidance about their role in routinely screening for domestic violence
    - iii) develop model localised inter-agency protocols between the Area Health Service, the NSW Police Local Area Command and the local Department of Community Services Community Service Centre (DoCS), in accordance with NSW Health policy on domestic violence and child protection where serious injury of adults and certain child protection matters must be referred to NSW Police and Department of Community Services respectively
    - iv) ensure referrals to appropriate health services and to DoCS, Police and other community agencies
    - v) ensure appropriate documentation of the patients/clients experiences of domestic violence and action taken on disclosure

- promote and assist state-wide implementation of the routine screening models in Early Childhood Services, Accident and Emergency, Antenatal, Drug and Alcohol, Community Health and Mental Health
- promote the results of the pilot in each of the 17 Area Health Services.

In developing the questions for the pilot, a number of similar projects in Australia and overseas were considered. This included the Queensland Health Domestic Violence Initiative (Queensland Health 1999). The working party decided to focus on physical abuse in the pilot but recognised the prevalence of emotional abuse against women and the harm it can cause. This decision to focus on physical abuse was made for a number of reasons. There are clearly identifiable links between physical violence and mortality and morbidity. Physical abuse can be more readily identified as a health issue by both consumers of health services and health practitioners, which is important when health practitioners are asking direct questions of patients/clients who have not previously identified that they are experiencing violence. It was also decided to avoid using the term 'domestic violence' in the questions. Domestic violence can be defined in many different ways, and not all those who experience violence understand this term to relate to their experience.

The screening questions were developed to be as straightforward as possible to administer. It was thought that focusing on specific behaviours such as hitting and slapping would mitigate against minimisation by women and allow for clarity by both the health practitioner and woman as to what is meant. In order to capture non physical violence, 'hurt in other ways' was included. A common element to domestic violence, no matter what the form of the abuse, is fear of the abuser which is reflected in most definitions of domestic violence. For this reason it was decided to include a specific question about fear of the abuser. Questions three and four on safety and assistance were included, as it was considered that if a woman disclosed domestic violence, health practitioners had a responsibility to check any immediate safety concerns and offer appropriate assistance.

The questions were to be asked over a 12 week period to all women over the age of 16 who attended the participating services and who were considered well enough to answer the questions. Although it is acknowledged that males are also assaulted, and that violence occurs in a range of relationships, there is evidence that assaults on women by partners and ex-partners comprises the most significant proportion of domestic violence and has the highest mortality and morbidity rate. This is also consistent with the definition of domestic violence outlined in the NSW Health Domestic Violence Discussion Paper (NSW Health 1999) and current Domestic Violence Policy (NSW Health 1993).

The questions were preceded by a preamble explaining the rationale for the pilot in everyday language and explaining the limits to confidentiality (see Appendix 1). There was a specification that the questions were to be asked in privacy by staff who had completed training. In addition the health practitioners were asked to specify any action they had taken (for example, referral or information given).

Screening questions

1. Within the last year have you been hit, slapped or hurt in other ways by your partner or ex-partner?
2. Are you frightened of your partner or ex-partner?
3. Are you safe to go home when you leave here?

If domestic violence has been identified in any of the above questions, continue to question 4.

4. Would you like some assistance with this?

2.4 Training and resources

The Education Centre Against Violence, NSW Health specialist training and resource unit in domestic violence, sexual assault and child protection, was responsible for the development of training and resource material for the project. It was originally intended that all health practitioners who participated in the domestic violence screening pilot were to undertake a four-hour training session. However this proved to be logistically impossible for some of the services and the training sessions were re-organised to ensure maximum participation of health practitioners from the participating services. In some situations, this meant a reduction of the time available for the training to either one or two hours. The training in each participating Area Health Service was carried out by the statewide Domestic Violence Educator from the Education Centre Against Violence and/or the Project Officers appointed to co-ordinate the pilot in each Area. In MAHS the Women's Health Coordinator also assisted with the training. In SESAHS the Domestic Violence Project Officer was also involved in co-ordinating the training. The content of the training varied depending on the time allowed for the training sessions. The two and four hour training sessions included basic information about the extent and effects of domestic violence and the legal requirements of health practitioners in relation to domestic violence, information about the screening project and its implementation and referral sources. The four-hour sessions included case scenarios, a video and the opportunity for role play in order to develop skills in asking questions and responding to disclosures of domestic violence. The training sessions of less than two hours provided basic information about the identification of domestic violence and information on the implementation of the pilot project. The Project Officers employed in the two Area Health Services were responsible for co-ordinating the project and for the training, support and evaluation of the project in each of the participating services. They were supported by the Women's Health Co-ordinators and the statewide Domestic Violence Educator from the Education Centre Against Violence.

A resource manual was also provided to each participating service. A resource card identifying services that women could utilise was developed for the project by the Education Centre Against Violence. This was to be available to all women who participated in the screening project (see

Appendix 2). The Working Party recognised that women who were experiencing domestic violence may not disclose this when asked the screening questions. For this reason it was decided that all women would be given a copy of the information card. In this way women who were experiencing violence but were unable to disclose this information would still have access to information in a non-stigmatising way.

2.5 Participating services

The two participating Areas, South Eastern Sydney and Macquarie Area Health Services were chosen so as to include an urban and rural area and also because there was a willingness of management and staff to be involved. Antenatal, Emergency, Alcohol and other Drugs and Mental Health Services were chosen because of the research evidence indicating a high level of violence amongst these clinical populations (see for example Carlile 1991; Herman 1986).

i) Macquarie Area Health Service

Macquarie Health Area Service covers a large geographical area. Health services are predominantly located at Dubbo with local health services located in rural townships. Whereas the turnover of health service staff in Dubbo is quite high, it is much more stable in smaller rural townships. The population in this area is predominantly Anglo Australian with a higher than average percentage of Indigenous Australians. The rural nature of the area and the large distances often make it difficult to access health and community services. Training for health personnel participating in the program was conducted in both Dubbo and Mudgee. There were two four-hour training sessions, and one 45 minute information session conducted in Dubbo with health personnel from participating services attending. One two-hour session and two one-hour sessions were held in Mudgee for those health personnel in Emergency at Mudgee Hospital.

a) Dubbo Base Hospital Obstetric Service(DB Obs)

Description of service, staff and clientele

This service provides booking in services for pregnant women in MAHS. All the screening was undertaken by the triage midwife who was on leave for three weeks during the screening period, so screening was undertaken over a nine-week period.

Screening time

September to November 2000

Training

The triage nurse who undertook all the screening completed a four hour training session.

b) Macquarie Area Drug and Alcohol Services (MAHS AOD)

Description of service, staff and clientele

Five staff provide services for drug and alcohol users and their families for the large Macquarie Health Area. Services include a range of treatment programs including replacement therapy and withdrawal programs (for example, methadone).

Screening time

September to November 2000

Training

Staff all completed a four-hour training session.

c) Macquarie Area Mental Health Services (MAHS MHS)

Description of service, staff and clientele

There are a number of mental health services in Macquarie region. In Dubbo, 17 staff are employed to provide treatment, rehabilitation and education services for children, adolescents and adults. In addition there are a number of specialist services throughout the Area. There are seven regional nurses employed in local communities (Mudgee, Coonabarabran, Trangie and Gilgandra). There is a satellite residential rehabilitation, respite and community outreach service (Nioka) employing four allied health practitioners; a living skills program employing three allied health practitioners; and a satellite residential anxiety and depression program (Lyndarra) employing five health practitioners.

Screening time

September to November 2000

Training

Sixteen staff completed a four-hour training session and three staff completed a 45 minute information session.

d) Mudgee Hospital Emergency Department (Mudgee ED)

Description of service, staff and clientele

This service provides 24 hour emergency medical care for people from the local area. It is staffed by Visiting Medical Officers. There are 26 nursing staff who rotate through the Emergency Department with only one full time staff member on each shift.

Screening time

September to November 2000

Training

Two one-hour training/ information sessions with a total of 13 participants; and one two-hour session with seven participants.

ii) South Eastern Sydney Area Health Service

South Eastern Sydney has a population of approximately 715 530 which represents 12% of the NSW population. It covers the local government areas of Botany, Randwick, Waverley and Woollahra in the east, Rockdale, Kogarah and Hurstville in St. George, Sutherland in the south and nearly 60% of South Sydney and the inner city of Sydney. The Area is characterised by regions of substantial wealth and pockets of great poverty. South Eastern Sydney Area features a population in which 25% of residents were born in non-English speaking countries (compared to 16% in NSW) and 0.7% of the residents were Indigenous Australians. Training for health personnel participating in the pilot was conducted in the different services. There were a total of 28 training sessions conducted across the participating services in SESAHS. The training sessions varied in length from 20 minutes to four hours depending upon the amount of time staff could be released from their normal duties.

a) The Sutherland Hospital Antenatal Service (TSH ANC)

Description of service, staff and clientele

Antenatal and maternity services are provided at Sutherland Hospital and Menai Community Health Centre. The service sees approximately 70 first visit interviews each month. There are 27 staff employed at this service including a Divisional Nurse Manager; Director of Child, Youth and Family; the Nursing Unit Manager; a Maternity Educator; five Clinical Nurse Specialists, 11 certified midwives, six student midwives and a social worker.

Screening time

September to November 2000

Training

Three four-hour training sessions were provided with 22 staff attending (midwives, maternity social worker and community midwife).

b) The Sutherland Hospital Emergency Department (TSH ED)

Description of service, staff and clientele

This is a 24 hour medical emergency service with around 600 patients each week. Clients are mainly Anglo Australian from a range of socio-economic backgrounds. The greatest number of patients are over 65 years old. Around 20% of clients are children. The unit employs 42 female and eight male nurses in the equivalent of 36 full time positions. The workload is extremely heavy at times and the lack of privacy posed issues for the screening.

Screening time

October to December 2000

Training

Given the large number of staff, heavy workload demands and shiftwork, several different forms of information and training sessions were conducted. Initially, three information sessions were held with staff over morning tea to explain the pilot and respond to questions. Seventeen staff attended these sessions. Subsequent to this, nine short information/training sessions (20-45 minutes) were conducted. A total of 34 staff (mainly nursing staff, some students and some medical staff) attended these sessions. An additional

three short information/training sessions (20-45 minutes) were conducted which were attended by 11 medical staff (students, registrars and residents). These were followed by two three-hour training sessions which were attended by a total of eight nursing staff.

c) Sutherland Alcohol and Other Drugs Service (TSH AOD)

Description of service, staff and clientele

There are seven staff (a manager, four psychologists and two nurses) in Sutherland Alcohol and Other Drugs Service located at Sutherland Hospital, Sylvania Community Health Centre and Engadine Community Health Centre. Those using the service are local people who are mainly middle class professionals from predominantly Anglo Australian or second generation Eastern European backgrounds.

Screening time

September to November

Training

One four-hour training session with five participants.

d) St. George Hospital Antenatal Service (St G. ANC)

Description of service, staff and clientele

There were three participating services from the St. George Hospital Antenatal Service — the Birth Centre, the Antenatal Clinic and the St George Outreach Maternity Project (STOMP). In addition, for the purposes of this report the South Eastern Sydney Area Women's Health Nurses which is an Area based service was included with the St. George Antenatal Service.

Birth Centre

The Birth Centre at St George Hospital contains two clinic rooms and two birthing rooms. Women who wish to receive care in the Birth Centre are accepted if they have been assessed to be at low obstetric risk. Midwives in the Birth Centre provide antenatal, intrapartum and postpartum care unless medical or obstetric complications necessitate review by an obstetrician and subsequent transfer to the antenatal clinic or the delivery suite. There are 5.6 full time positions (nine female midwives, several of whom are employed part-time). The Birth Centre books 35 women per month. In general, women in the Birth Centre are most likely to be from English speaking backgrounds.

St George Outreach Maternity Project (STOMP) Teams

Continuity of midwifery care is also a focus of the STOMP model. A team of six fulltime midwives provide care for 360 women per year. Antenatal care is provided through two antenatal clinics situated in community centres. One clinic is based in an early childhood centre and the other in a family planning clinic. One midwife from each STOMP team is always 'on call' for women in labour and to provide advice and information. The 'on call' STOMP team midwife provides care during the labour and birth in the delivery suite at the hospital. For women who have an elective or an emergency caesarean section, the STOMP midwife continues to provide midwifery care in the operating theatre. After the birth, women can either choose to remain in hospital for postnatal care with STOMP midwives or be

discharged early and receive domiciliary care by the STOMP midwives. The midwives in the STOMP team are all women. The women booked with STOMP come from a diverse range of ethnic and socio-economic backgrounds. These women are representative of the population of childbearing women in the Area.

St George Antenatal Clinic

The Antenatal Clinic is located at St George Hospital. It is part of Maternity and Women's Health within the Division of Women and Children's Health. It provides antenatal care for women from the local area. The age range of the clients is from 18-45 years. Women present from a variety of ethnic and socio-economic backgrounds; a large proportion of women attend from non-English speaking backgrounds with the main ethnic groups including Arabic (Egyptian, Lebanese, Iraqui), Chinese, Turkish, Japanese, Serbian, Croatian, Macedonian and Korean.

Staffing

There are a total of 13 staff including one Nurse Unit Manager, nine midwives, one enrolled nurse, two administration assistants and three medical staff. Except for the medical staff all the staff are female.

Screening time

September to November 2000.

Training

Several training sessions were conducted in order to maximise the number of staff attending. Two four-hour training sessions were held with a total of nine staff attending (including midwives, maternity social worker, community midwife, and ethnic liaison officer). Three two-hour sessions were also conducted with 10 midwives attending. A one-hour training session was also held for student midwives with six staff attending.

e) South Eastern Sydney Area Women's Health Nurses

Description of service, staff and clientele

The Well Women's Clinics – Outreach Services are located at St George Hospital, Engadine and Rockdale Community Health Centres, Caringbah Women's Information Centre and GP practices. They provide antenatal care and other women's health services for women from the local area. Between three to 40 clients are seen weekly by each Health Nurse. Both young and older women attend the clinics from a range of socio-economic backgrounds. The clients' ethnic backgrounds include Anglo Australian, Greek, Macedonian and Croatian.

Screening time

September to November 2000.

Staffing

Two Clinical Nurse Consultants who have five to eight years of experience work in the service

Training

Both Clinical Nurse Consultants attended a two-hour training session held with staff from participating services.

3 Evaluation of the project

3.1 Description of evaluation process

The evaluation incorporated a number of components including the systematic collection of feedback on the screening process from both health practitioners and the women patients/clients who participated in the pilot.

3.1.1 Pre-pilot – establishment of a baseline to estimate the number of clients/patients where domestic violence is identified in each of the participating services before the screening pilot

In the Macquarie Area Health Service, an audit of files was undertaken at each of the participating services to identify the number of domestic violence presentations and referrals for a period of one month prior to the commencement of the pilot screening project. Given the volume of clients and the complexity of the services, a similar audit of files was not possible in South Eastern Sydney Area Health Service. As patients/clients who are identified as experiencing domestic violence in Antenatal and Emergency Departments are routinely referred to social workers in the health service, it was decided to audit referrals to social workers for the three months prior to the commencement of the pilot screening project. This method of collecting baseline data was irrelevant for Sutherland Alcohol and Other Drugs Service, as they do not routinely refer patients who disclose domestic violence. It was considered that this data would provide an estimate of the number of patients/clients where domestic violence was identified. The problems in establishing the number of women patients/clients where domestic violence has been identified in each of the participating services needs to be acknowledged.

3.1.2 An analysis of the responses to the screening questions

The Project Officers located in the two Area Health services obtained data from each of the participating services relating to the number of women patients/clients who met the screening criteria. In addition, data from the completed screening questionnaires was analysed to establish the reach of the pilot and to establish the percentage of women where domestic violence was identified. This data was compared to baseline data to establish whether there was an increase in identification of domestic violence as a consequence of routine screening.

3.1.3 Survey questionnaires assessing health practitioners knowledge about domestic violence

All health staff who participated in the pilot program were expected to undertake training prior to the commencement of the pilot program. These staff were given written information about the project (see Appendix 3) and asked to complete a survey questionnaire twice during the pilot; prior to undertaking the training and towards the completion of the pilot program. This survey questionnaire was aimed at assessing health practitioners knowledge of, and attitudes towards, domestic violence as well as to obtain practitioners views about the training and their skills at identifying domestic violence (see Appendix 4).

3.1.4 Feedback from health practitioners

Focus group interviews with participating health practitioners were conducted towards the end of the pilot project. Practitioners were asked to sign a consent form prior to participating in the focus groups (see Appendix 5).The purpose of this was to identify issues arising in the course of the pilot and to seek views of health practitioners on the effectiveness of the pilot (see Appendix 6). Feedback was also sought from the Area Women's Health Co-ordinators and the project officers employed to co-ordinate the project in each area.

3.1.5 Feedback from women patients/clients

Women who participated in the pilot were asked to complete a short self-administered questionnaire which gave them the opportunity to comment on the usefulness (or not) of the screening process (see Appendix 7). This was accompanied by written information about the project (see Appendix 8) and a consent form to participate in a telephone interview if they wished to do so (see Appendix 9). Women completed this questionnaire anonymously.

3.1.6 Telephone interviews with women patients/clients

Women were also invited to participate in a short telephone interview giving them the opportunity to elaborate on their experience of participating in the pilot (see Appendix 10). Women who participated in a telephone interview completed a consent form separately from their self-administered questionnaire so that their anonymity in relation to their questionnaire was assured. Women who consented to participate in the short telephone interview were given the option of either telephoning the researchers directly or having a researcher telephone them at a day and time they specified.

3.2 Analysis of data

The data collected from health personnel involved in the implementation of the screening pilot and the women patients/clients participating in the pilot was both quantitative and qualitative. Quantitative data from the screening questions and the questionnaires completed by the women participants was analysed with the assistance of the software package, SPSS (Statistical Package for Social Sciences). A content analysis was undertaken of the qualitative data (from the pre and post health personnel training questionnaires, the individual and focus group interviews with health personnel and the telephone interviews with the women) identifying particular themes and issues. This provided a more nuanced understanding of the data, complementing the quantitative data.

3.3 Ethical approval

Ethical approval for the evaluation of the pilot project was obtained from three Human Ethics Committees (University of Sydney and both participating Areas Health Services). These committees were provided with details of the project including all data collection tools (questionnaires, focus group interview questions, individual interview guides). Copies of the project information to be given to participants and consent forms were also provided.

4 Evaluation outcomes

4.1 Estimation of women who are identified as victims/survivors of domestic violence by the participating services in the pre-pilot period

In an attempt to estimate the number of women for whom domestic violence was identified by the health service personnel prior to the pilot project, different methods were used in each Area Health Service. In Macquarie Area Health Service, an audit of files was undertaken at each of the participating services for a period of one month prior to the commencement of the pilot screening project. In South Eastern Sydney Area Health Service, it was decided to audit referrals from the Antenatal and Emergency Departments to social workers for the three months prior to the commencement of the pilot screening project.

4.1.1 Macquarie Area Health Service

a) Mudgee Accident and Emergency

All file notes were audited for a one month period prior to the commencement of the pilot project. During this period of time there was one identification (from 191 presentations) of domestic violence when a patient was brought in by the police. There were a number of injuries (bruised ribs, knife wound to the thigh, crushed toe) in another patient's file which may have involved domestic violence but was not identified as such in the patient's file.

b) Alcohol and Other Drugs Service

In the month prior to the commencement of the project, 58 women presented who were 16 years or over. Three of these women were identified as currently experiencing domestic violence and five women had previously experienced domestic violence. Three of the caseworkers at the service had previously completed domestic violence core training.

c) Mental Health

In the month prior to the commencement of the screening project, 139 women presented who were 16 years or over. Seven women were identified as currently experiencing domestic violence with a further four women having a previous history of domestic violence.

d) Dubbo Hospital Obstetrics

In the month prior to the commencement of the screening project, 90 women presented who were 16 years or over. None were identified as experiencing domestic violence.

4.1.2 South Eastern Area Health Service

a) Sutherland Alcohol and Other Drugs Service

For the three months prior to the commencement of the screening project, 39 women presented. No pre pilot baseline data on the extent of domestic violence was available from this service.

b) The Sutherland Hospital Antenatal Service

For the three months prior to the commencement of the screening project, 242 women presented to the antenatal services for first visit interviews

(Sutherland and Menai) with one patient referred to the maternity social worker as a consequence of domestic violence.

c) Sutherland Hospital Emergency Department

For the three months prior to the commencement of the screening project, 2608 women 16 years old and over presented to the service and eight patients were referred to a social worker as a consequence of domestic violence.

d) St George Antenatal Service

For the three months prior to the commencement of the screening project, 627 women attended the services (St. George, STOMP, Birth Centre and Women's Health) with between 12 to 18 patients being referred to a social worker as a consequence of domestic violence.

4.2 Analysis of the screening questionnaires

4.2.1 Number of women screened

In total, 4170 women over the age of 16 presented to the health services that were undertaking the domestic violence screening during the three months of the pilot. Of these, 24% (999) of the women were screened. Of the 3171 women who were not screened, an explanation was provided as to why 212 (5%) women were not screened. No explanation was provided as to why the remaining 2959 (71%) women were not screened (see Tables 1 and 2). The antenatal services screened the highest percentage of women, ranging from 82% (161 women) at Dubbo Base Obstetrics to 80% (159 women) at Sutherland Hospital Antenatal Clinic[1] and 65% (306 women) at St George Antenatal Clinic[2]. Screening by Alcohol and other Drug Services workers were lower, namely 22% (10) at Sutherland and 8% (7) at Macquarie. The Emergency Departments screening numbers were also lower, 10% (245) for Sutherland and 12% (62) for Mudgee. Twenty-one percent (49) of the women who attended the Macquarie Mental Health Service were screened.

Table 1

Total number of women who presented to the health services during the three month pilot period compared with the number of women who were screened

Service	Numbers of women who presented to the services during the pilot	Numbers	%
		Screened	
TSH ANC	199	159	80%
TSH ED	2446	245	10%
TSH AOD	46	10	22%
St.G ANC	469	306	65%
MAHS AOD	83	7	8%
MAHS MHS	236	49	21%
DB Obs	198	161	82%
Mudgee ED	493	62	12%
Total	**4170**	**999**	**24%**

Service	Numbers of women who presented to the services during the pilot	Not screened, explanation provided		Not screened, no explanation provided		Not screened
		Numbers	%	Numbers	%	TOTAL
TSH ANC	199	21	11%	19	9%	40 (20%)
TSH ED	2446	80	3%	2121	87%	2201 (90%)
TSH AOD	46	6	13%	30	65%	36 (78%)
St.G ANC	469	60	13%	102	22%	162 (35%)
MAHS AOD	83	4	5%	72	87%	76 (92%)
MAHS MHS	236	1	0.5%	186	79%	187 (79%)
DB Obs	198	1	0.5%	35	18%	36 (18%)
Mudgee ED	493	39	8%	392	79%	431 (87%)
Total	**4170**	**212**	**5%**	**2957**	**71%**	**3169 (76%)**

Table 2

Total number of women who presented at the health services during the three month pilot period compared with the number of women who were not screened

4.2.2 Reasons provided for deciding not to screen

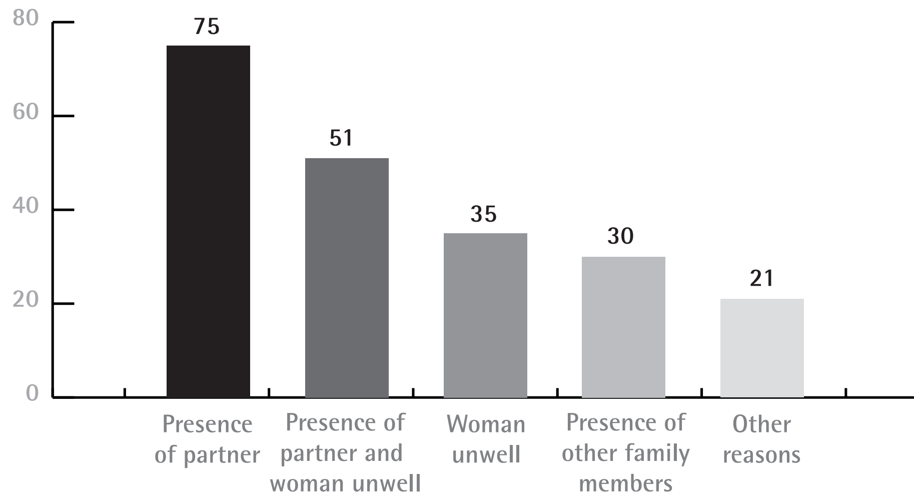
A range of reasons were provided by the health practitioners for deciding not to screen 212 of the women. These included the presence of a partner in 75 (35%) instances, presence of other family members in 30 (14%) instances, the women being unwell in another 35 (17%) instances or a combination of the presence of a partner and the woman being unwell in 51 (24%) instances (see Graph 1). Questions remain about the reasons as to why 2957 (71%) of the women were not screened. Possible explanations were provided by workers in the focus groups relating to organisational difficulties, lack of facilities to ensure the women's privacy, high work demands, lack of training of staff at some health services and the fact that some workers already included questions about domestic violence in their work practices. It appears from information obtained in the focus groups that some health practitioners considered the screening for domestic violence to be optional as they were not provided with a directive to routinely screen.

1. Data from Menai Outreach Service is included with the Sutherland Hospital Antenatal Clinic

2. Data for St George Antenatal Clinic also includes the Birth Centre, The Outreach Services and the Women's Health Nurses. During the pilot the Women's Health Nurses had 58 women attend their services of whom 36 were screened and one woman disclosed being hit, slapped or hurt within the last year.

Graph 1

Reasons provided for not screening



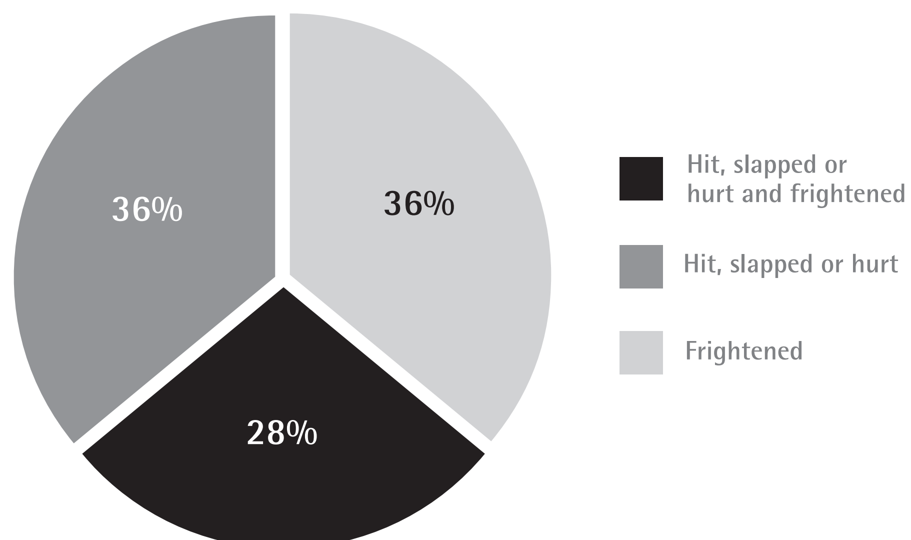
4.2.3 Disclosures of domestic violence

4.2.3.1 Identification of domestic violence

In the screening period, 11% (106) of the women disclosed being either hit, slapped or hurt by and/or frightened of, their partner or ex-partner within the last year. Seventy-two percent (76) of these women disclosed having been either hit, slapped or hurt in other ways by their partner or ex-partner within the last year. Of these, 38 women also indicated they were frightened of their partner or ex partner. An additional 30 women stated they were frightened of their partner or ex-partner but did not identify being hit, slapped or hurt (see Graph 2). This seems to indicate that it is important to continue to separate the questions concerning abuse and fear.

Graph 2

Number of women who disclosed being either hit, slapped or hurt by and/or frightened of, their partner or ex-partner

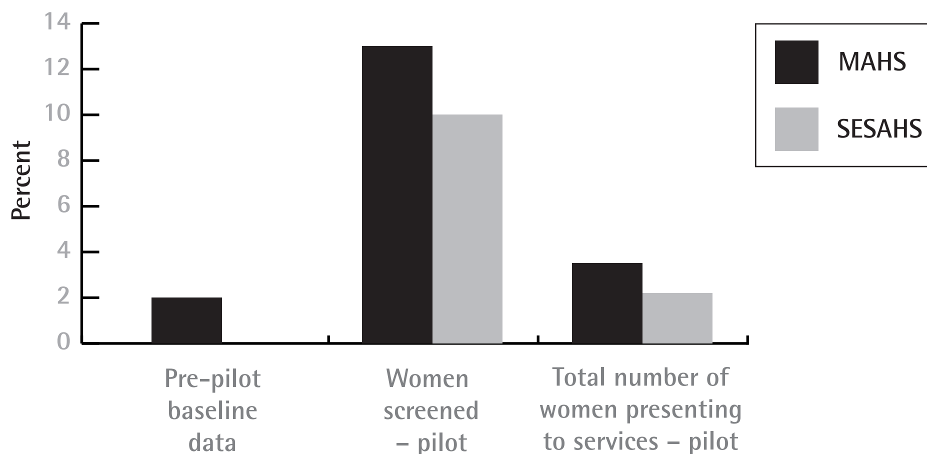


Despite the women disclosing they had been either hit, slapped or hurt in other ways and/or frightened by their partner or ex-partner within the last year, health staff completing the screening form did not identify this as

domestic violence in 20% of the women (15). Twenty-eight percent (30) of women disclosed they were frightened of their partner but did not disclose being hit, slapped or hurt in other ways. Of the 72% of women (76) who disclosed either being hit, slapped or hurt or hit, slapped, hurt and frightened, 14% (11) disclosed that they did not feel safe to go home when they left the health service. One of the 30 women who disclosed being frightened by their partner or ex-partner in the last year did not feel safe to go home.

In response to question three it was noted that an additional 72 women were not safe to go home but had not disclosed being hit, slapped or hurt in other ways and/or frightened by their partner or ex-partner (in questions one and two).

While it is methodologically problematic to compare identification of domestic violence pre pilot data and pilot data as they were obtained in different ways, we do so to obtain an indication of whether the pilot routine screening has resulted in an increase in the identification of domestic violence. Combining the four services in Macquarie, domestic violence was identified in 11 (2%) instances during the one month baseline data collection, whereas in South Eastern Sydney there were between 21 to 27 domestic violence referrals to social workers (from the services participating in the pilot), representing .006 % of the total number (3516) of women who presented to the participating services in the three month baseline data period. In comparison, during the three month screening pilot period 36 instances of domestic violence were identified in Macquarie, representing 13% of the women who were screened (279) or 3.5% of the total number (1010) of women presenting to the services (see Appendix 12). Whereas in South Eastern Sydney, 70 instances of domestic violence were identified during the screening pilot period, representing 10% of the women who were screened (720) or 2.2 % of the total number (3160) of women presenting to the services (see Appendix 11). From the data obtained, it appears that there has been an increase in the rate of identification of domestic violence (see Graph 3).



Graph 3

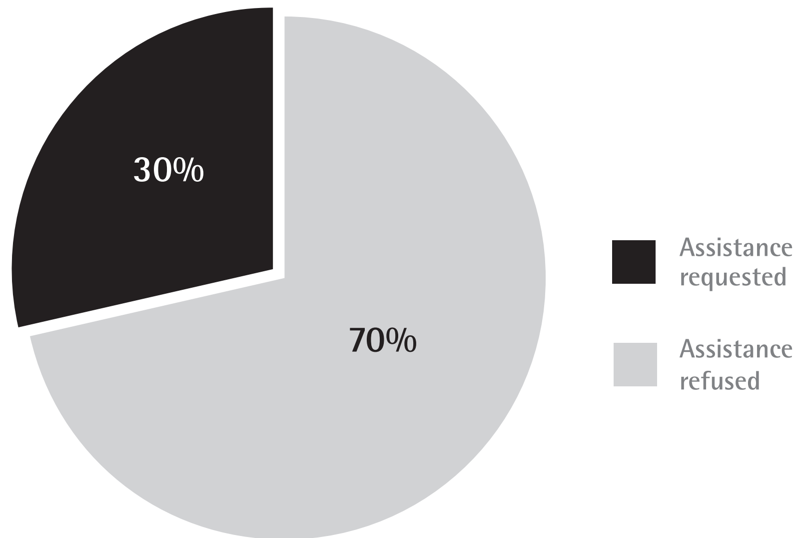
Identification of domestic violence pre pilot and during the screening pilot project

4.2.4 Requests for assistance and action taken by health practitioners

Eleven percent (106) of the women who screened identified either being hit, slapped or hurt within the last year and/or being frightened of their partner or ex-partner. Only thirty percent (32) of these women requested some form of assistance (see graph 4).

Graph 4

Requests for assistance among women who idenitifed being hit, slapped or hurt and/or frightened by their partner or ex-partner in the last year



All the women (32) who requested assistance received information about domestic violence. In addition, 19 women were referred to health and other services (for example, social worker, refuge, support services), two women were notified to the police and two reports were made to the Department of Community Services.

4.2.5. Providing information on domestic violence

Information on domestic violence was offered to more than 88% (883) of the women who were screened. Of these, all but 12% (107) accepted this information. Ten of the women who refused written information had disclosed domestic violence. Two of these women indicated that they were not safe to go home.

4.3 Pre and post training questionnaires assessing health practitioners knowledge about domestic violence

All staff involved in the screening project were asked to complete a questionnaire before taking part in the training and towards the end of the screening period (see Appendix 4). The aim of the questionnaire was to obtain an overall assessment of health practitioners knowledge of, and

attitudes towards domestic violence prior to the commencement of the project and towards the end of the project. There were, however, particular issues that made this aim difficult to achieve.

i) There was a reasonable return rate of the pre-training questionnaires (80 responses – 53%) but a poor rate of return from the post-training questionnaires (22 responses – 14%).

ii) Pre-training questionnaires were completed by health workers at all sites of the pilot screening but less than half the sites were represented in the completed post-training questionnaires.

iii) Staffing demands at various sites made it difficult for health practitioners participating in the project to attend the training. In many situations, the training was substantially reduced from the planned four-hour session (in some situations training was replaced by an information session of half an hour).

4.3.1 Health practitioners knowledge of domestic violence

It was evident from the questionnaires that health practitioners overall had a sound knowledge of domestic violence, its indicators and effects. In response to the question about the important aspects of domestic violence more than three-quarters (61) of those who completed the pre-training questionnaire commented on the importance of ensuring safety for the woman (and her children). Other issues commented on by many were the importance of believing and supporting the woman and her children; being aware of indicators of domestic violence so that it is identified early; knowledge of resources in order to refer women to appropriate services and an awareness of the pervasive effects of domestic violence. There were similar responses in the post training questionnaire although the issue of safety was identified by a much lower percentage of health practitioners and the importance of education about domestic violence (both to health personnel and to the community) was commented on more frequently.

4.3.2 Indicators of domestic violence

Numerous indicators of domestic violence were identified. Almost all health practitioners identified various aspects of physical violence (bruising, unexplained injuries, broken bones). Over two-thirds identified indicators related to the behavioural and emotional responses of the women, including depression, social withdrawal, sadness, anxiety, low self-esteem and sleeping and eating difficulties.

Some behaviours of women in the presence of their partner were also identified as possible indicators of domestic violence, including fear, anxiety, passivity or submissiveness.

Behavioural indicators in relation to abusive partners were also identified.

These included not allowing the woman to speak for herself, over protectiveness and possessiveness.

Some participants considered that women from lower socioeconomic backgrounds and those in de facto relationships were more at risk of experiencing domestic violence.

The indicators identified by health practitioners often related to the area in which they worked. For example, the vast majority of health practitioners working in Emergency Departments identified the physical indicators of domestic violence such as broken bones, extensive bruising. Similarly, antenatal staff identified the emotional effects on women, which can influence her health and her ability to care for her children and drug and alcohol counsellors identified issues relating to alcohol and substance abuse.

The indicators in both the pre and post training questionnaires were similar, however a higher percentage of post training questionnaires focused on non-physical indicators of domestic violence.

4.3.3 Effects of domestic violence

Practitioners identified a broad range of effects of domestic violence in both pre and post training questionnaires. These included physical injuries, stress related illness, mental health and drug and alcohol issues. Numerous effects on women's social and emotional life were also identified. These included social withdrawal, with a consequent loss of friendships and social supports; depression; reduced self esteem; loss of dignity; loss of confidence; a sense of responsibility and shame for the violence. Many practitioners also identified family life as being negatively influenced by the existence of domestic violence particularly as it related to the children. Particular concerns identified were possible separation or divorce; increased likelihood of miscarriage, the risk of developmental delays or effects on children; behavioural effects in children (for example, acting out or withdrawing).

4.3.4 Responses to women remaining in the violent situations

Again, practitioners identified a wide range of responses to women remaining in the violent situations. Responses in the pre-training questionnaire tended to focus on the health workers own reactions to women remaining in the violent situation. Some health practitioners commented that they could not understand why women tolerated the violence.

> *This puts them and their children at greater risk.*
>
> *I find it hard to understand the mind set of a person who returns to such a relationship.*
>
> *I often think this is a disaster waiting to happen.*
>
> *This is asking for trouble.*

My reaction is 'silly woman!'

We have failed!

Others commented on their struggle to understand and respect women's decisions to remain in the violent situation.

I feel concern and sadness but respect the woman's decision.

I often feel understanding and helplessness.

I find it common that women won't leave but totally disheartening.

I find it difficult to understand but try to respond with empathy but feel they should leave the relationship.

I try to understand and be aware of the negative factors in leaving.

Yet others commented on their attempts to be non-judgmental and respect the women's decision to remain in the violent situation.

I try to remain non judgmental.

I am supportive of women's decisions.

I try to be accepting and understanding.

Many of those in the latter two groups also stressed the importance of taking into account safety issues and ensuring the woman has support and information if she decides to stay.

Safety planning becomes very important.

It is important to provide information.

We need to provide continuing support.

Responses from the post-training questionnaire tended to focus on the importance of safety planning and referring women to support services and less on workers own reactions.

4.3.5 The role of health practitioners in identifying and responding to domestic violence

Similar responses were identified in both pre and post training questionnaires. A large number of health practitioners (30) considered that health workers did have an important role but did not elaborate what this role should be. Others identified a range of activities they considered important in responding to women who disclosed domestic violence. These included:

The identification of indicators of domestic violence

Listen and support.

Information giving.

Treatment of injuries.

Identifying and referring to appropriate resources.

Validation.

Ensuring the safety of the woman and her children.

Empowering women –focussing on their strengths.

Advocating for women.

Notify authorities if appropriate.

4.3.6 Comments on the effectiveness of training

The majority of participants were positive about the training. Comments included:

It improved my knowledge and practice.

It increased my skills in the assessment of domestic violence.

Assisted with early identification and referral.

It changed some of my attitudes towards domestic violence.

I have a better understanding of the legal situation of domestic violence.

It helped me to identify children at risk.

I know how to deal with a disclosure.

I have learnt how to ask questions.

It increased my awareness of the complexities of domestic violence.

The few negative comments about the value of the training appeared to come from people who had completed previous training and who considered they were not presented with any new information or material.

4.3.7 Overall comment

From the data obtained from the pre and post training questionnaires, most health practitioners responded to the questions related to indicators and effects of domestic in a fairly detailed way, indicating they had a sound knowledge of domestic violence. Responses to the questions relating to roles of health service personnel were far less detailed, indicating that while knowledge is important in identifying domestic violence, it may not be sufficient to respond to domestic violence.

4.4 Feedback by health practitioners from individual and focus group interviews with health personnel

Feedback on all aspects of the pilot project was sought from the health practitioners who participated in the project. Six individual interviews were undertaken with staff involved in the organisation of the project in the Area Health Services. In addition, practitioners who participated in the implementation of the routine screening questionnaire were invited to participate in focus group interviews held in South Eastern Sydney and Macquarie Area Health Services. Overall, seven focus group interviews were held, four in South Eastern Sydney and three in Macquarie.

i) South Eastern Sydney Area Health Service

One focus group interview was held in each of the participating services and all health workers who had been involved in the implementation of the pilot project were invited. As only one focus group interview was held at each site, attendance at the group was limited. This particularly applied where health practitioners work on rotating shifts. In some situations, the excessive work demands on the day of the focus group limited attendance.

a) Sutherland Drug and Alcohol Service

Seven staff were involved in the implementation of the project and all attended the focus group interview.

b) Sutherland Hospital Emergency Department

Over 50 staff were involved in the implementation of the project and 11 of these attended the focus group interview.

c) Sutherland Antenatal Service

Approximately 22 staff were involved in the implementation of the project and nine attended the focus group interview.

d) St George Antenatal Service

Approximately 21 staff were involved in the implementation of the project and five attended the focus group interview.

ii) Macquarie Area Health Service

Three focus group interviews were held in Macquarie Area Health Service. One was held in Mudgee specifically for those workers who were involved in the implementation of the project in the Emergency Department at Mudgee Base Hospital. Twenty-six staff were involved in the implementation of the project at this site and six of these attended the focus group interview. Two focus group interviews were held in Dubbo and all participating health practitioners were invited to attend. There were two participants in one focus group interview (one from the mental health service and one from the drug and alcohol service) and three participants in the other (one from the

mental health service, one from the drug and alcohol service and the triage nurse from Obstetrics at Dubbo Base Hospital). Given that in all services in Macquarie Area Health Services there were approximately 68 health practitioners carrying out the screening, the attendance rate at these focus groups was very low.

4.4.1 Overview of comments from health practitioners

There was a wide range of views on the implementation of the project ranging from being very positive to quite negative. Overall, antenatal services were generally positive about both the process of the routine screening and the outcomes. Emergency Department staff varied in their views about the requirement to screen routinely for domestic violence, with some considering it was important and others considering it was 'a waste of time'. Drug and alcohol and mental health services were the least positive about the process, arguing that participating in this pilot project involved duplication as they already identified domestic violence in their routine intake assessments.

4.4.2 The questions

Overall, there was positive feedback about the questions asked in the routine screening.

> *I think the questions asked were fine.*
>
> *These were good –you have to be direct.*
>
> *This was a nice soft approach to asking.*
>
> *Being straight forward and direct helps.*
>
> *There is no easy way to ask these questions, the person asking can only ask in the most gentle way possible and hope they will be responded to positively.*
>
> *The questions were well worded, easy to ask and easy to adapt to own interview.*

There were a few negative comments about the questions with one person stating that asking the questions was 'a waste of time'. Another stated that the questions 'were too abrupt'.

4.4.3 Asking the questions

Many practitioners commented that they initially had some difficulty asking the routine questions because of the sensitive nature of the issue. Many also commented that as they became more familiar with the questions they became more comfortable and that their patients/clients became more

comfortable in responding. Many made similar comments about the preamble saying that once they became more familiar with it and were able to use their own words it felt more comfortable. For one practitioner however being uncomfortable about asking the questions did not decrease with time as she remained 'overwhelmed by asking the questions as it is a private issue.'

Many practitioners commented that they found it more effective to ask questions at the end of the interview when they had been able to establish some rapport with the women. In some situations, this was not possible especially when women had to be separated from their partners or family for the routine screening.

4.4.4 The importance of the routine screening

Some practitioners commented that asking the questions was really important for a number of reasons even if women did not disclose violence.

> *It planted the seed.*
>
> *Talking about violence is normalised and women may feel more comfortable to talk about it at a later visit.*
>
> *Older women disclosed emotional abuse.*
>
> *It challenged younger women's views.*

Practitioners in one antenatal service commented on the number of young women who had experienced physical violence from their partner and who considered this was a 'normal' part of a relationship.

> *Some of the young women answered yes that they had been hit but they didn't see that it was a problem 'doesn't everybody hit?'*

Some of the workers in this situation commented that this enabled them to challenge the young women's normalisation of violence in their relationships.

There were several comments that routine screening for domestic violence should be permanently implemented.

> *The screening should be implemented on a permanent basis as it assists in the identification, raises women's awareness and says that violence is not acceptable.*

4.4.5 Patient/clients response to routine questioning

Health practitioners thought that generally women responded well to being asked the questions.

> *No-one was affronted by the questions*
>
> *Women responded well.*

Some women felt that if they were supporting the screening they would be assisting other women.

A few health practitioners commented that some women responded negatively to being screened. One health practitioner commented that some patients were too ill to be screened. He went on to say that 'Patients were disgruntled with the screening questions'. Some staff from Emergency Departments commented that some patients could not understand why they were asked the screening questions when they came in for medical treatment.

Some health practitioners commented that asking the routine screening questions had enhanced their relationships with their patients. This is reflected in a comment made in one of the focus groups.

The screening positively affected my relationships with my patients. It conveyed that we were generally interested in who they are and where they had been and provided an opportunity for women to talk about other areas.

However this was not a view shared by all the participating health practitioners. Practitioners in drug and alcohol services identified some particular difficulties in the implementation of routine screening. Many commented that asking the screening questions disrupted their relationships with their clients who had come to discuss specific concerns around drug or alcohol use. Many of these practitioners argued that they already had a comprehensive knowledge of domestic violence from previous training and would identify it in the assessment stage of the contact without having to participate in a routine screening. As one said 'The screening duplicates something we are already doing' While they commented that the screening questions were relevant they considered that asking women to complete the evaluation questionnaire was 'pushing it'. A similar comment was made by a mental health worker.

4.4.6 Gender

Some male health practitioners considered gender was an important issue. Two male staff thought some women would find it difficult to be asked the screening questions by male staff and were reticent to ask the screening questions. Other male staff considered that how and when the questions were asked was more critical than gender. They considered that wherever possible it was preferable to ask the questions after some rapport was established with the patient. However, this was not always possible especially when the patient was accompanied by her partner or relatives and it was only possible to interview her alone briefly. Female health practitioners did not mention gender as an issue. All nine male staff at Sutherland Emergency Department were reluctant to screen.

4.4.7 Barriers to screening

Many of the difficulties identified by the health practitioners related to the workplace conditions (for example, lack of space), workplace culture and environment and excessive workplace demands.

4.4.7.1 Privacy

There were two issues identified related to privacy – finding suitable space to ask the questions and separating women from their partner or family to ask the routine questions.

In some services there was limited space and it was often difficult to find a place to ask the questions privately. This was of particular concern in Emergency Departments where treatment areas were divided only by curtains making it almost impossible to have a private conversation.

Separating the woman from her partner or family in order to ask the routine screening questions was another major difficulty identified by health practitioners. This applied more frequently to Antenatal and Emergency Services. Many health practitioners identified particular strategies they developed to separate the woman from her partner or family thus enabling them to ask the routine questions. In some services, workplace practices were changed to facilitate separating women from their partners. Despite this, there were many instances where women could not be screened because they could not be seen alone.

4.4.7.2 Heavy workloads

For some practitioners, high workload demands or crises meant that undertaking the routine screening became problematic. Several identified the requirement to screen as an additional time commitment that increased their already high workload.

There is a time and staff resource issue in terms of the training and completing the forms.

For some, this meant that in many situations they decided it was too difficult and time consuming to screen women for domestic violence. This was most particularly an issue in Emergency Departments where the workload demands are high and medical crises are frequent.

4.4.7.3 Lack of resources and facilities

There were many comments about the lack of overall resources and facilities (staff, physical space, time) available to enable the screening project to be undertaken successfully.

> *Staffing levels were down which posed difficulties.*
>
> *Lack of continuity of staff has made this difficult.*
>
> *There needs to be resources to allow staff to be released for training.*

4.4.7.4 Who asks the routine screening questions?

Some practitioners in Emergency Departments commented that the screening was often seen as the responsibility of nursing staff and considered that in many situations it would have been appropriate for medical staff to ask the screening questions.

4.4.7.5. General lack of resources to support women

Several practitioners commented on the lack of resources available to women who disclosed violence. Some commented that accommodation resources were often difficult to locate thus limiting women's options to leave the relationship. This applied particularly in some rural areas where services available to support women were very limited.

4.4.7.6 Limited access to interpreter services

The unavailability of interpreters for patients from non-English speaking backgrounds was identified as a concern by some services. Some health practitioners assisted women from non-English speaking backgrounds, who had difficulty reading English, to complete the evaluation.

4.4.8 Changes to workplace practices

In some services, changes in workplace practices were introduced to accommodate asking the routine questioning. There were several comments in the focus group interviews that once the decision was made to change workplace practices, and there was an acceptance that the screening would take additional time, it became a routine aspect of everyone's workload.

> *The clinic had to change the interview times from one hour to one and a half hours to allow for problems to arise. This worked out OK.*
>
> *Staff separated partners from the women so we could ask the screening questions. This was a good change as it meant staff could get an accurate medical history from the woman when she was alone.*

4.4.9 Training

In some services, ensuring staff undertook the training was extremely difficult especially where staff worked on shifts.

> *The biggest issue was getting the training done for all the staff and logistically this was a nightmare.*
>
> *Funding was available to replace staff to attend training, but there were no staff available to be the replacements.*

One of the limitations of the project was the difficulty of ensuring that staff attend training. Both Area Health Services organised the training to facili-

tate health practitioners attendance. In South Eastern Sydney, resources were provided to release staff to undertake training in two of the participating services. SESAHS also provided training at the beginning and end of shifts, that is, at 7am. At Macquarie, training was provided at the end and beginning of shifts (for example one training session was at 11pm) to facilitate staff attending. Different forms of training were also organised to accommodate the work demands of practitioners. Both the two and four hour sessions included general information about domestic violence whereas the shorter sessions mainly focused on the implementation of the pilot project. There were several comments on the critical importance of training. This is reflected in a comment by a practitioner:

> *Training is essential and staff need to be released from their normal duties to attend.*

Health practitioners who attended the training expressed a range of views about its adequacy.

> *The training was good but I knew most of it.*
>
> *Training was good . It gave us a chance to practise our skills.*
>
> *It was good and a useful way of connecting with other staff.*
>
> *The training could have been better tailored to our skills and experience.*
>
> *The training gave me good ideas of how to ask the questions but you are never quite sure what the response will be to the questions.*

Despite the provision of training to all the participating services one staff member commented:

> *There was a lack of education before the screening commenced because of a lack of time and staff resources.*

Some practitioners commented on the particular skills and confidence they gained from attending the four hour training sessions.

> *Training was good especially role plays to practise asking questions and gain confidence.*
>
> *Training was helpful – it helped to reflect on attitudes and experiences.*
>
> *I was more confident on how to cope if a woman disclosed.*
>
> *Training conducted in the large group – enhanced team work and we became aware of each other's attitudes.*
>
> *Training was confronting but essential.*

4.4.10 Provision of ongoing support

Some health practitioners stressed the importance of having support to implement a project such as this, commenting that the assistance of the project officer was invaluable in providing general support that complemented the formal training.

4.4.11 Information and referral

Health practitioners considered that giving information to the women was important and commented positively on both the resource manual that was provided and the information card that was developed for the project. Many commented that the women who were routinely screened were keen to take the information provided even when they had not disclosed domestic violence. Two practitioners (in different focus groups) commented that women they gave the information cards to knew of women who were living with domestic violence (in one situation it was a neighbour and in another the woman's sister) and planned to give the cards to them. Some practitioners commented that they felt awkward giving the cards to women who did not disclose and as a consequence often did not provide the cards to the women.

Health practitioners commented that when violence was disclosed or suspected they asked the woman if she wanted assistance and if so referred her to the social worker. In situations where the woman did not want assistance, some practitioners indicated as a consequence of the training they had a better knowledge of strategies and resources and could make some suggestions to the woman. There were some situations where practitioners considered that there were safety concerns for the women and her children and it was necessary to notify relevant authorities (for example, the police or DoCS). In some services health practitioners commented on the limited resources available and also on the additional workload demands that referrals put on the social worker.

4.4.12 Issues for rural communities

There were some specific issues raised that related especially to small rural communities. Privacy and confidentiality are of particular concern for small rural communities and health practitioners identified that patients were often fearful that aspects of their lives may become public knowledge and this may act as a deterrent to women patients disclosing domestic violence. Comments were also made that women in small rural communities may find routine questioning intrusive especially if they are asked the questions by someone they will come into contact with in the community. Another concern identified was the lack of services and resources available in rural communities to which women who disclose domestic violence can be referred.

4.4.13 Suggested changes

Practitioners identified a number of changes they considered would improve the screening process.

4.4.13.1 Appropriate allocation of resources

Health practitioners suggested changes that were mainly related to the allocation of resources which would facilitate routine screening. These included:

a) space to enable the routine questioning to be implemented in a safe and private environment

b) recognition that routine screening will take additional time which should be taken into account in staffing levels

c) resources to enable staff to be replaced so that they can participate in relevant training

d) the provision of ongoing training

e) professional support for the project so staff can consult about particular concerns related to the routine screening.

> *Need to allocate more time and resources.*
>
> *Need to have resources to backup the implementation of the screening – time for staff to undertake training.*
>
> *We need to have ongoing support. Support from the Project Officer was invaluable – stepped in and answered any questions which were raised.*
>
> *In addition to the training, need to have ongoing workshops on a regular basis and a contact person in Area Health who could assist with any queries which may arise and update resources and legislation.*

4.4.13.2 Wording of questions

There were some comments from health practitioners on the inclusion of the words 'hurt in other ways' in the first question in the screening project. Some practitioners considered that the women found this wording confusing and were unsure what it meant.

> *Some women would say 'I was hurt verbally' e.g. it was a bad argument but it wasn't violent.*
>
> *Some women were not sure how to answer that, as they couldn't differentiate between domestic violence and generally being hurt.*
>
> *Maybe use another word for ' hurt' in the screening question.*

These words were included to capture non physical forms of violence that women may experience. While acknowledging that the word 'hurt' may for some people be confusing it nevertheless allows women to identify different forms of violence.

4.4.13.3 Development of clear protocols and policy

Some practitioners identified the importance of establishing new systems and clear protocols to enable routine screening to 'run smoothly'. Some commented that with the introduction of new protocols it would be necessary to change some work practices to accommodate the routine screening.

4.4.13.4 Extension of screening to other forms of family violence

There were various comments that the screening should be included to include elder abuse, abuse against men, and abuse against children. There were also comments that if this happened, resources would be stretched to the limit.

4.4.13.5 Interpreter services and information in languages other than English.

Practitioners identified the importance of screening women who do not speak English. They stressed that interpreter services should be available as well as information about the screening required in a range of different languages. Information given to women should be available in community languages.

4.4.13.6 Inclusion of general practitioners and medical centres

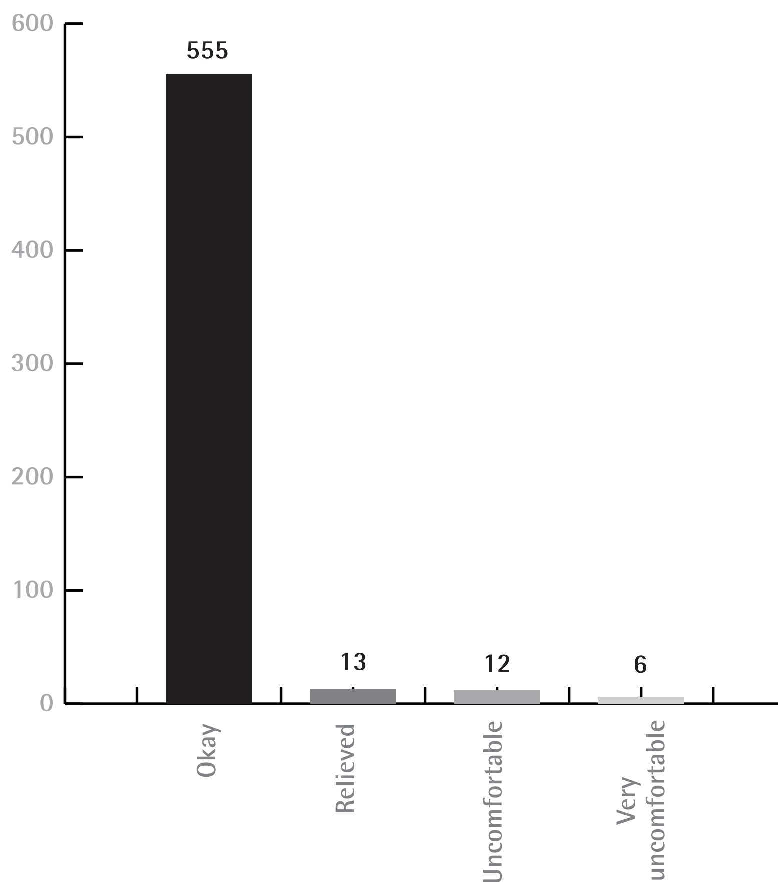
In all but three services, health practitioners considered that general practitioners should participate in routine screening for domestic violence. This was particularly stressed by antenatal services where for many women antenatal care is shared by a general practitioner and a hospital antenatal service.

4.5 Women's views

Nearly 59% (586) of the women who were screened completed a short self-administered questionnaire which gave them the opportunity to comment on the usefulness (or not) of the screening project. Most of the questions were closed ended, however the final two questions were open ended and gave the women the opportunity to make some comments on how the questions were asked and whether there were other issues they considered should be included in the routine questioning.

4.5.1 Women's responses to being routinely screened

The overwhelming majority of women indicated they felt either 'OK' (555, i.e. 95%) or 'relieved' (13, i.e. 2%) about being being asked questions about abuse they may have received from a partner or ex-partner, with only 12 women (2%) identifying that they felt 'uncomfortable' and six women (1%) identifying being 'very uncomfortable' (see Graph 5).

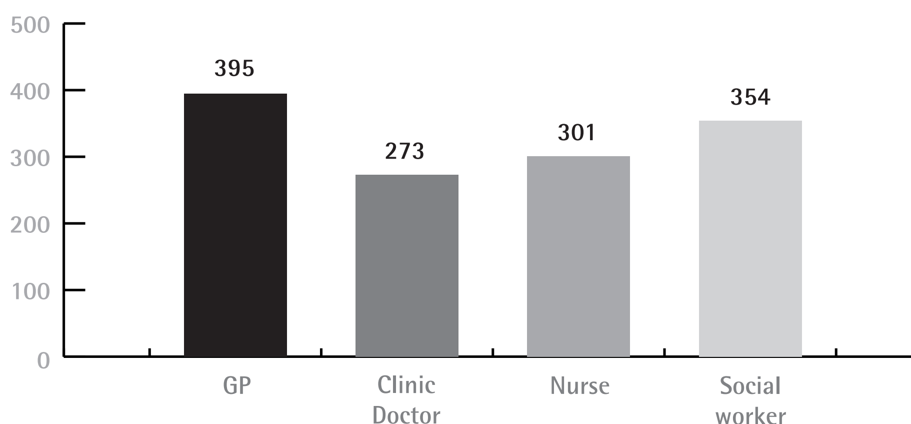


Graph 5

Women's responses to how they felt about being asked the questions

4.5.2 Who should be asking the routine screening questions

Women considered it was appropriate for a range of health professionals to routinely screen them for domestic violence. This included general practitioners (67% -395 women), social workers (60% -354 women), nursing personnel (51% -301 women) and a clinic doctor (47% -273 women). In addition, three women considered a close friend or relative should ask questions about domestic violence (see Graph 6).



Graph 6

Health personnel who should ask women questions about domestic violence

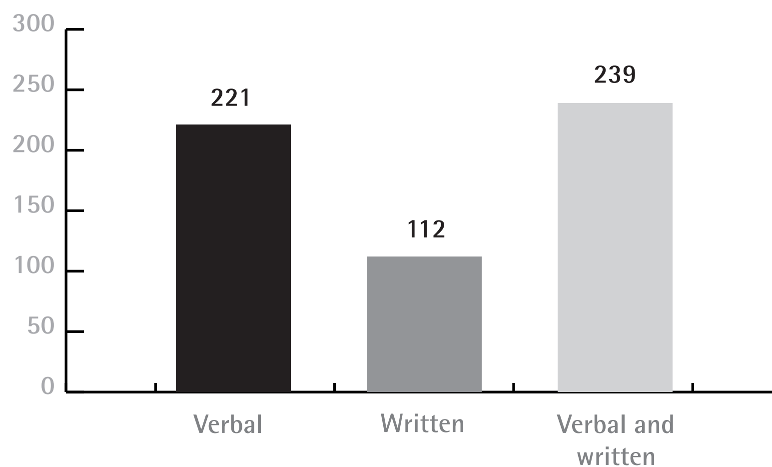
When asked about the health service they were currently attending, 94% (548) thought that women should be asked questions about domestic violence when they visited their particular health service. Only 10 women (< 2%) considered that women should not be routinely screened for domestic violence by their current health service, whereas another seven women stated that the questions asked should be extended, for example, previous history of violence, childhood abuse.

4.5.3 Information given to women

Almost 98% (572) indicated they had received written and or verbal information when they were routinely screened for domestic violence (see Graph 7).

Graph 7

Type of information given to the women



Specific feedback was sought on the information card that was provided to women who were routinely screened. Almost all the women who responded to this question (485) considered the card to include the most important information about domestic violence resources and considered the size and design of the card to be useful. Twenty women considered the card did not include important information while 18 women did not consider the design and size of the card to be useful.

4.5.4 Women's responses to the open ended questions

In response to the question 'Is there a better way to ask these questions?, the overwhelming majority of women who responded were satisfied with the way the questions were asked.

> *Direct questions are best.*
>
> *There is no nice way to ask.*
>
> *It seemed very professional.*

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

Coax or invite the person to speak about it.

This was a nice, soft approach to asking

No, just straight out.

No, I think the questions asked were fine.

Some commented that while asking questions about domestic violence is appropriate other issues needed to be taken into account.

The questions were OK, but it should be continually monitored. Pregnancy is a stressful time for both partners throughout.

Depends on individual person, best to gauge each person's emotional well being.

Just ask a general question overall re stress in the home.

Offer the information and let the person come to you if they want to. Asking them questions may not necessarily mean they'll answer truthfully.

In response to the question 'Is there anything else we should ask about?' many of the women who responded considered that all the issues were covered by the questions they were asked. However, a few women considered that the routine questioning should be extended to include other family violence.

Child abuse?

Abuse of children - verbal or physical.

Threats against themselves/children/ old women.

If there has been or if they have experienced history of domestic violence.

What about male abuse, child abuse.

Some women thought there should be more questions about non physical violence.

Make it clear that verbal abuse is also a form of violence.

Intimidation is also important and some women may not include this as domestic violence.

Emotional abuse, not just physical.

Emotional violence and violence within the family.

Others had some suggestions on seeking more detail about the violence.

More on what caused the problem.

If there is really family violence maybe some in depth questions should be asked. Otherwise it is O.K.

Some women had suggestions on how practitioners should respond to the disclosure of domestic violence.

Just be reassuring that the woman will remain safe.

Refer to counsellors or police for advice and where to get help.

4.6 Women's comments – telephone interviews

Fifty telephone interviews were conducted with women including forty-two from South Eastern Sydney Area and eight from Macquarie Area. Another 12 calls were made unsuccessfully (either there was no answer, the phone had been disconnected or the woman no longer lived there).

4.6.1 Women's views on the explanation of routine screening for domestic violence

Most women were positive about the explanation given about the routine screening with only two women expressing some concern about the adequacy of the explanation. One woman stated 'I was just handed the questionnaire and asked to fill it out' and the other woman commented that 'the clinic was very busy and impersonal and I was just handed that form and asked to fill it out. I thought, 'do I look like I've been abused?"

4.6.2 Women's reactions to being routinely screened

The majority of women interviewed (48) indicated that they felt positive about being routinely screened for domestic violence and the actual questions.

I felt all right about them.

I didn't mind answering them.

I didn't feel uncomfortable.

Happy to help people to try to stop domestic violence.

I didn't mind as I knew they were asking everyone so it didn't bother me.

They were straightforward and easy to understand, direct, clear, don't beat around the bush.

One woman, although she considered it important to screen, thought that the questions may be too confronting.

Maybe more gentle not so confronting.

Two women commented they had been initially uncomfortable until an explanation was given. Another commented

I was uncomfortable because I didn't know why they were asking me these questions.

Fifteen women commented that although they felt OK about the questioning they may have felt differently if they had experienced domestic violence.

I felt alright about them but I don't know how I'd feel if I was in that sort of relationship myself.

Fine with me but I thought the questions may have been too confronting for some people.

Some women, although they thought routine screening for domestic violence was important, commented about the timing of the questions.

At first I thought it was strange when I had gone to book in to have a baby.

Yes but maybe at a different time to when you're booking in to have your baby.

Several women made comments that they felt safe when they were asked the questions.

I felt it was a safe environment in which to talk.

One woman commented on who should ask the questions.

Only that I think it is important to be asked these questions by a woman. There are lots of male nurses now and I don't think they should be involved. They might put you off saying anything if you were a victim.

4.6.3 Women's views on the questions

The majority of women considered the questions were appropriate, however many considered there could be additional questions. Almost two-thirds of the women interviewed (31) thought there should be questions asked about children's exposure to the violence and the safety of women and children.

Yes questions about children at home.

Do children see the bashings and violence and are they safe.

Several thought that questions should be extended to ask about other family members and violence.

Yes about other people in close relationships.

Not just about the partner for example, son, son-in-law.

Some women considered that there could be further questions about forms of abuse other than physical.

Yes should ask questions about other types of abuse.

Not just physical as a lot of violence starts with verbal and emotional abuse.

Others considered that if domestic violence was identified this should be further explored.

There should be more questions about domestic violence as it is too basic especially if a woman is in a violent relationship.

4.6.4 The importance of screening all women for domestic violence

All but two women commented that it was important to routinely screen all women for domestic violence. One of these women considered that women would seek help if they needed it and the other was uncertain about asking the questions.

No I think if women need help they will ask for it.

Not sure because it's a personal thing. It's up to the person in the situation to find help.

Most of the women who considered the routine questioning important elaborated on their reasons. Some thought it was important to acknowledge the existence of domestic violence to give women who experience domestic violence an opportunity to disclose. Others commented on their own or their family's experience of domestic violence and how routine screening may have assisted.

Yes because it is common and women need to know how to stop it and where to get help. Some women have just learnt to accept it.

Yes because of being in the situation myself.

Yes my mother was in this situation and didn't know where to get help from any of the services.

I have a sister who was in that situation and didn't know what to do or who to talk to about it.

Yes because of experience of past violent relationships.

I was in a violent relationship when I was younger and I think if someone would have asked me the questions like that maybe I would have told someone instead of putting up with it.

I was in a violent relationship a few years ago and I found it very difficult to leave. Maybe if someone had taken an interest in my life and asked me then I could have got help sooner.

Because a lot of women don't say anything unless they're asked.

4.6.5 Women's views on written material

The majority of women were positive about the written information that was given to them.

> *Information card was good with phone numbers of where to get help.*
>
> *The card was really good. I gave it to my sister and she left the man who was belting her.*
>
> *It was good to have basic information, phone numbers of help lines.*

Some women, although they thought the information on the card was important, considered there may have been better ways of providing this.

> *There was too much on the little card. You only need one or two phone numbers of where to get help.*
>
> *Pamphlets are better.*

There were some comments about the importance of this information being available in different languages.

> *Card should have been translated into other languages.*
>
> *I think it's important to think about how to reach women who can't speak English.*

Some women identified concerns about the card and considered it may compromise the safety of some women.

> *The card was too obvious. It was small but it should be disguised somehow. If a woman was living with a violent man and he found this card in their home, it could make him worse.*
>
> *The card was inappropriate. The way it was drawn with a comic-strip style took away from how serious domestic violence is. I don't think that was a good idea.*

4.6.6 Overall comments on women's views

While women had some suggestions for changes to aspects of the project, overall they were very positive about routine screening. Many commented that this project was very important and should continue.

> *I think it's really important to ask women these questions especially when they're pregnant.*
>
> *A really good project and it's important to reach women who may not know how to reach help.*
>
> *I think it's a really good idea to continue this kind of thing. I think women should be asked if they need help because sometimes it's really hard to speak up.*

5 Discussion of evaluation findings

5.1 Who was screened

A total of 4170 women over the age of sixteen presented to the eight health services participating in a pilot domestic violence screening project in South Eastern Sydney and Macquarie Area Health Services. Of these, 999 women (24%) were screened. Of those who were not screened (3169 or 76%), explanations were provided as to why 212 women (5%) were not screened. The reasons specified for not screening in these instances were the presence of a partner or other family member (73% or156) and/or the women were unwell (40% or 86). In the pre and post training questionnaires and in the focus groups health practitioners identified a number of barriers to screening. It appears some health practitioners do not perceive domestic violence as a primary health concern. This may be an influencing factor in their decision about whether to routinely screen. A number of other barriers were also identified:

- workload demands
- lack of privacy
- disruption of work practices
- disruption of relationship with patient/client
- presence of partner or other family member
- patient/client too ill
- discomfort of health care practitioner
- lack of information about the screening project.

Antenatal Clinics were most likely to screen for domestic violence, screening between 65% (306 women- St G. ANC) and 82% (161 women-DB Obs) of patients/clients. This was followed by Mental Health Services where 21% (49 women MAHS MHS) were screened. Alcohol and Other Drug Services screened up to 22% (10 women – TSH AOD) and Emergency Departments screened between 10% (307 – TSH ED) and 12% (62 women – Mudgee ED).

The overall reach of the routine screening during the pilot period was low and this is of major concern. The barriers related to screening need to be addressed. The provision of adequate workplace resources may contribute to increasing the percentage of women who are screened. This includes:

- the provision of a space where interviews could be conducted confidentially
- recognition that domestic violence screening is a task which takes additional time
- release of staff for training and the provision of resources to employ relief staff.

However the overarching issue that needs to be addressed is positioning of domestic violence as a health priority.

5.2 Identification of domestic violence

Eleven percent (106) of the women who were screened identified either being hit, slapped or hurt by and/or frightened of, their partner or ex-partner in the past 12 months, with twelve of these women not feeling safe to go home and 32 women accepting some form of assistance. Comparing this with the baseline data collected from services prior to the screening there appears to have been an increase in identification of domestic violence in participating services over the pilot period.

Alcohol and Other Drug Services and Mental Health Services identified the highest percentage of domestic violence (Alcohol and Other Drug Services 52% or 9; Mental Health Services 39% or 19). Eighteen percent (66) of the women presenting were screened but lower numbers of women presented to these services in comparison to Antenatal and Emergency. Despite the low numbers screened, evidence from research in both of these clinical areas (see Section 2.2) and the high percentage of identification in this project provide a strong argument for the continuation of screening in these services.

Large numbers of women (2939) presented to Emergency Departments of whom 307(10%) were screened with domestic violence being identified as an issue in 14% (44) of these patients. In comparison, 866 women presented to the Antenatal Services with 626 (72%) being screened and domestic violence was identified in 5% (34) of these patients.

5.3 Views about the screening tool

The overall comments from both the women and the practitioners about the screening preamble and the questions were positive. Although there were some comments about the use of the word 'hurt' in question one, we would argue that it is important for women to be given the opportunity to identify non-physical forms of violence and that there be no change to the wording of this question.

There were also some comments about broadening the screening to include other forms of family violence. We would argue that the focus on domestic violence should remain.

There were inconsistencies in the responses to questions three and four with 72 women identified as being unsafe to go home (question three) and 10 women agreeing to assistance despite the fact that no forms of violence had been identified (questions one and two). The way the responses to questions three and four are structured needs to be reviewed to minimise possible recording error.

5.4 Views about the introduction of routine screening

Women patients/clients were overwhelmingly positive about the introduction of routine screening whereas health practitioners although overall positive identified a number of issues they considered would need to be addressed if routine screening were to be implemented.

5.4.1 Women's views

Women patients/clients were positive about their experiences of being screened for domestic violence with 95 % (555) of the women who completed the survey reporting that they felt okay about being asked the questions about domestic violence. They were also positive about the information about domestic violence that was given to them. Many women who completed the survey and were interviewed expressed the view that routine screening could provide women who experienced domestic violence an opportunity to seek assistance and convey the message that violence was not acceptable. Some women also identified the preventative role that routine screening for domestic violence can provide.

5.4.2 Health practitioners views

Health practitioners expressed a range of views about routine screening. Many health practitioners in antenatal services were generally positive about both the process and the outcomes of the routine screening and saw domestic violence as an important health concern. Some staff in other services appeared to have reservations in identifying domestic violence as a priority issue in their work and identified particular problems in implementing routine screening. Many of these problems related to workplace culture and resource issues, which would need to be addressed if routine screening was to be introduced. These include:

- limited space
- additional time required to undertake screening
- resources to enable staff to undergo training

5.5 Training

Training was a key factor which influenced the extent to which the screening protocol was implemented during the three month pilot. Overall the training provided for the pilot was regarded positively. However, it was evident that specific health services have differing training requirements often as a consequence of previous training and the differing knowledge that practitioners have of domestic violence. Originally it was planned that all practitioners involved in the project would participate in a four-hour

training session. However, for some services this proved to be logistically impossible. Alternative training sessions which were shorter, not as comprehensive and which accommodated workplace demands of services were organised in order to involve as many health practitioners as possible in the training. There was also a number of health practitioners who did not attend any training and therefore did not participate in the screening. We consider that it is likely that the limited training may have played an instrumental role in restricting the reach of the screening. Regular and ongoing training for all heath practitioners is essential for the successful implementation of routine screening ensuring that new staff are trained and that all staff are informed of new developments, policy and practice as they relate to domestic violence.

5.6 Professional support

Professional support for health practitioners was critical in the pilot period of the project with the two project officers playing a key role providing information, training and offering support to staff. Continuation of professional support is essential if routine screening is to be implemented. This support could include:

- negotiating with services about their specific training requirements
- the organisation and/or provision of regular training
- provision of particular forms of support services that are considered necessary to successfully implement routine screening (for example, updating resource manuals)
- the development of service specific protocols and procedures
- ongoing evaluation of routine screening processes in each service.

5.7 Development of relevant policies and protocols

If domestic violence screening is to become a routine part of a health assessment, state wide policies and protocols specifically related to screening for domestic violence are essential. The practices and processes associated with the implementation of these need to be negotiated with each participating service. Clear guidelines need to be established in each service specifying who is (or is not) to be screened, when screening will be undertaken and by whom.

5.8 Information and resources for women patients/clients

The successful implementation of routine screening for domestic violence is dependent on adequate information being available for all women. It is important to ensure that the needs of diverse client populations are considered, especially for example women from non English speaking backgrounds. Information on domestic violence should be available in community languages and interpreters need to be available to assist with the screening when women are unable to communicate in English.

6 Recommend-ations

1. Routine screening for domestic violence be introduced in all Drug and Alcohol, Mental Health, Emergency and Antenatal Services in NSW Health. Consideration should also be given to the introduction of routine screening in other services in NSW Health (for example, early childhood services; women's health; community health). Resources similar to those provided in the pilot project should be provided to all participating services (that is a resource manual, information cards, provision of training and professional support).
2. NSW Health clearly articulates in policy that domestic violence is a health issue and that the development of protocols reflect this to ensure that this policy is translated into service delivery.
3. The identified barriers to screening need to be addressed for routine screening to be effective. A major barrier is ensuring that domestic violence is perceived as a health issue. This needs to be addressed on a statewide basis. Other barriers, such as workplace practices, time and privacy, need to be negotiated with Area Health Services and the relevant health service.
4. Policies and protocols specifically related to screening for domestic violence are essential and need to be developed on a statewide basis if universal routine screening for domestic violence is adopted. The implementation of these should be negotiated with each particular service and should take into account particular workplace issues. This would include who is (or is not) to be screened, when screening will be undertaken and by whom; how the screening is incorporated into workplace practices and changes to workplace practices which could facilitate routine screening.
5. Ongoing training and education should be a part of any implementation of routine screening. For the success of routine screening, all participating health practitioners would need to complete a comprehensive training program. The logistics of this would need to be negotiated with participating agencies and take into account workplace demands.
6. Area Health Services should provide professional support for the services implementing routine screening for domestic violence. This would include negotiating with services about their specific training requirements; the organisation and/or provision of regular training; provision of particular forms of support services that are considered necessary to successfully implement routine screening (for example, updating resource manuals), the development of service specific protocols and procedures and ongoing evaluation of routine screening processes in each service.
7. NSW Health to negotiate with the College of General Practitioners about the possibility of introducing a domestic violence screening protocol. This is particularly applicable in Area Health Services where there are shared care arrangements, for example, in antenatal.
8. There needs to be provision for interpreters for routine screening for patients/clients whose first language is not English. Written material should be translated into community languages and be culturally appropriate.
9. If universal domestic violence screening is to be adopted the preamble and the content of the questions should remain the same. To minimise possible recording error, the way the responses to questions three and four are structured should be reviewed.

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8 Appendices

Appendix 1: NSW Health – Screening for Domestic Violence Pilot project

Health worker to explain the following:

- In this Health Service we have begun a new project to routinely ask all women the same questions about violence at home
- This is because violence in the home is very common and can be serious and we want to improve our response to women experiencing domestic violence
- You don't have to ask the questions if you don't want to
- All answers to the questions will remain confidential to the Health Service, except where you give us information that indicates that you or your children are at immediate risk of serious harm. We would discuss this with you.
- Also, we are interested to know how women feel about being asked these questions, so afterwards we give you a brief survey to fill out and leave in a box at the front desk. Your answers to this will be completely anonymous.

Health Worker to ask the following questions

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

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

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

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

4. Would you like some assistance with this?...

Health Worker to complete the following information

Action taken:..

....

Domestic violence not identified, information given: .... ☐

Domestic violence not identified, information refused: .... ☐

Domestic violence identified, information given:.. ☐

Domestic violence identified, information refused:.. ☐

Support given and options discussed: .... yes/no

Reported to DoCS: .... yes/no

Police notified:... yes/no

Referral made to: ....

Other action taken: ....

....

Other current violence disclosed: ....

....

Screening was not completed due to

Presence of partner: .... ☐

Presence of other family members: .... ☐

Inability to book an interpreter:... ☐

Woman was not well enough to continue with questions: .... ☐

Woman refused to answer the questions: .... ☐

Other reason (specify):..

....

....

Appendix 2: Resource card (Z card)

The exact formatting of the z card could not be inserted. The information contained in the z card included:

Domestic violence is wrong

Domestic violence is when someone you are in a past or present relationship with:

- assaults you physically or
- abuses you verbally, emotionally or psychologically or
- controls all the money or
- stops you from seeing your family or friends.

Domestic violence is when one person in a relationship uses violence or abuse to instill fear and get control over the other person.

Domestic violence is wrong.

1. Domestic violence is wrong

- Punching you or hurting your body is wrong.
- Threatening you or making you feel scared is wrong.
- Forcing you to do sexual things when you don't want to is wrong.
- Controlling your money is wrong.
- Stopping you from seeing your friends or family is wrong.

2. Domestic violence hurts your life

- Domestic violence can hurt your health.
- Domestic violence can make you feel scared and alone.
- Domestic violence hurts children too.

3.You don't have to live with domestic violence.

- Domestic violence can happen to anyone.
- You do not have to live with domestic violence

4.You can get help.

There are lots of things you can do. You can:

- Call the police if you are in danger or scared.
- Tell someone, a friend or someone you trust.
- Call a domestic violence service to find out more about what you can do

or to talk with someone about the violence.

- Go to a safe place, like a refuge for women and children.
- Use the law to protect you and your children.
- Make a safety plan in case you and your children have to leave home quickly.

Domestic violence can happen to anyone

You can get help.

You have the right to be safe.

List of services that can help:

Domestic Violence line 1800 65 64 63

Domestic Violence Advocacy Service 1800 810 784

Women's Legal Resources Centre (Indigenous Women's program) 1800 639 784

Wirringa Baiya 1800 686 587

Immigrant Women's Speakout (02) 9635 8022

Women's Information and Referral Service 1800 817 227

Community health centres

Appendix 3: Staff evaluation information

University of Sydney letterhead

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NSW Health – Screening for Domestic Violence Pilot project

Staff evaluation information

The Department of Health is conducting a Pilot Domestic Violence Screening Program in this health service. Health care personnel who are participating will undertake a training course prior to the beginning of the program. The training course is aimed at equipping staff with the knowledge and skills to participate in the program. As part of the evaluation of the program health care personnel will be asked to complete short questionnaires both before and at the end of this training. During the pilot program health care participants will also be asked to participate in one focus group interview towards the end of the program. This will provide an opportunity for participants to give feedback on the program. As your participation in this study is voluntary you may withdraw your involvement at any time.

Any person with concerns or complaints about the conduct of a research study can contact the Manager of Ethics and Biosafety Administration, University of Sydney on (02) 9351 4811.

Associate Professor Jude Irwin and Dr Fran Waugh
Social Work, Social Policy and Sociology
School of Society, Culture and Performance
University of Sydney, NSW 2006

Appendix 4: Pre and post training questionnaire

NSW Health – Screening for Domestic Violence Pilot project

Health personnel training evaluation – pre and post training questionnaire

1. What do you think are the important aspects of domestic violence?
 ....
 ....
 ....

2. What might the indicators be that a patient may be experiencing domestic violence?
 ....
 ....
 ....

3. What do you consider are the effects of domestic violence on victims?
 ....
 ....
 ....

4. What is your response when a victim of domestic violence returns to a violent relationship?
 ....
 ....
 ....

5. What role do you see health workers have in identifying and responding to domestic violence?
 ....
 ....
 ....

6. How do you consider training will help you in participating in the Domestic Violence Screening Project?
 ....
 ....
 ....

7. Any other comments?
 ....
 ....
 ....

Health Service: ....
Name: ....

Appendix 5: Staff consent form - focus groups

University of Sydney letterhead

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NSW Health — Screening for Domestic Violence Pilot project

Staff consent form

1. I am willing to participate in a focus group.
2. I understand that I may change my mind and withdraw at any point before or during the focus group.
3. I understand that my name or other identifying information will not be used.
4. I agree to the focus group interview being electronically recorded and to this material being secured in a locked cabinet and destroyed after five years.
5. I understand that if I have any concerns or complaints about the conduct of the focus group I can contact the Manager of Ethics and Biosafety Administration, University of Sydney on (02) 9351 4811.

Signature and date: ....

Witness and date: ....

Appendix 6: Staff - focus group questions

NSW Health — Screening For Domestic Violence Pilot project

Focus group questions

1. How have you found implementing the screening on domestic violence? Did it become easier as you gained experience in asking the questions?

2. Have any difficulties arisen as a result of the screening?

3. Do you consider there are better ways of undertaking the screening?

4. How useful do you think the screening for domestic violence has been?

5. How did the screening affect your relationships with your patients and were there issues related to other work practices (for example, the time taken)?

6. Did you feel you had enough training to understand the reason for the screening and were you provided with adequate support throughout the pilot?

Appendix 7: Client survey

NSW Health – Screening for Domestic Violence Pilot project

We value your opinion

You have just been asked some questions about abuse you may have experienced from your husband or partner. We asked these questions because emotional or physical abuse may affect your health. What we would like to know is how women feel when talking about these issues with health care providers. It would help us and other women if you would answer the following questions.

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

1. How did you feel about being asked these questions?

   I felt OK about being asked .... ☐

   I felt relieved to be able to tell someone about my problems .... ☐

   I felt uncomfortable about being asked but it didn't bother me too much .... ☐

   I felt very uncomfortable about being asked personal questions........ ☐

2. Were you given

   Verbal information .... ☐

   Written information .... ☐

   Other........

3. Does the information card 'Domestic violence is wrong' appear to have the most important information a woman experiencing violence would need?

   Yes .... ☐

   No .... ☐

4. Is the size and design of the card 'Domestic violence is wrong' information card useful?

   Yes .... ☐

   No .... ☐

5. Do you think women should be asked questions about domestic violence when they visit this service?

   Yes ☐

   No ☐

   Other

6. Who do you think should ask questions about domestic violence?

   My own GP ☐

   The clinic doctor ☐

   Nurse ☐

   A social worker ☐

   No-one ☐

   Other (please list)

7. Is there a better way to ask these questions?

8. Is there anything else we should ask about?

Thank you for completing this questionnaire.
If you are interested in participating in a telephone interview to talk more about your opinion please complete the sheet attached to the back of this questionnaire. Remove it from the questionnaire and put it in the box provided with your questionnaire.

Appendix 8: Client evaluation information

University of Sydney letterhead

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NSW Health – Screening for Domestic Violence Pilot project

Client evaluation information

The Department of Health is conducting a Pilot Domestic Violence Screening Program in this health service. We are undertaking an evaluation of this project and are seeking the views of clients about this pilot project. Women who are clients at this service have been asked questions about abuse they may have experienced from a partner. If you participated in this, you will be asked to complete a questionnaire which will give you an opportunity to comment on these questions. You can complete the questionnaire anonymously. You will also be asked if you wish to participate in a short telephone interview. This is voluntary and you may stop the telephone interview at any time. If you agree to this could you please complete the form on the back of the questionnaire, separate it from the questionnaire and place it in the return box.

Any person with concerns or complaints about the conduct of a research study can contact the Manager of Ethics and Biosafety Administration, University of Sydney on (02) 9351 4811.

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Appendix 9: Client consent form – telephone interview

University of Sydney letterhead

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NSW Health – Screening for Domestic Violence Pilot project

Client consent form

1. I am willing to participate in a telephone interview to comment on my experience of the Screening Program.
2. I understand that as my participation in this study is voluntary I may change my mind and withdraw at any point before or during the telephone interview.
3. I understand that the interview will be confidential and my name or other identifying information will not be used.
4. I understand that if I have any concerns or complaints about the conduct of the telephone interview I can contact the Manager of the Ethics and Biosafety Administration, University of Sydney on (02) 9351 4811.
5. I understand that either I can phone Fran Waugh (researcher, University of Sydney) on (02) 9351 4207 during office hours between September and mid-December 2000 *or*
   I would prefer her to phone me and give the following information so she can do so:

   My telephone number is: ....

   The best day and time to telephone me is: ....

   When you phone, please ask for: ....

Signature: ....
Date: ....

Fran Waugh
(Screening Project Evaluation
University of Sydney)

(02) 9351 4207
Monday to Friday
9 am to 5 pm

Appendix 10: Questions for telephone interviews with clients

NSW Health – Screening for Domestic Violence Pilot project

Questions for telephone interviews with clients

Interview number: ....

Interview date: ....

Interview time: ....

Area: ....

1. Was the explanation as to why you were being asked the questions clear? .... yes/no
2. How did you feel about the questions that were asked about domestic violence? (probe responses).
   ....
3. Do you think it is important to ask all women these questions? (explore response)
   ....
   ....
   ....
4. Do you think there were additional questions that should have been asked? (What were they?)
   ....
   ....
   ....
5. Do you think there could have been other ways of asking the questions? (explore)
   ....
   ....
6. What written material do you think would be useful for women to receive (for example, information card)?
   ....
   ....
   ....
7. Are there any other issues you want to raise?
   ....
   ....

Appendix 11: Identification of domestic violence by service during the pilot in MAHS and SESAHS

Service	Numbers of women who presented to the services during the pilot	Screened	Hit, slapped, or hurt and frightened	Hit, slapped or hurt	Fright-ened
TSH ANC	199	159	4	6	6
TSH ED	2446	245	16	13	7
TSH AOD	46	10	2	1	1
St.G ANC	469	306	2	7	5
MAHS AOD	83	7	4	1	
MAHS MHS	236	49	5	6	8
DB Obs	198	161		4	
Mudgee ED	493	62	5		3
Total	**4170**	**999**	**38**	**38**	**30**

Appendix 12 — Acknowledgments

The Domestic Violence Screening Project was an initiative of NSW Health. Funding for this publication was provided by the Commonwealth Government as a result of agreements reached by all Heads of Government at the 1997 National Domestic Violence Summit to work cooperatively on the Partnerships Against Domestic Violence Strategy.

The evaluation report was researched and prepared for NSW Health by Associate Professor Jude Irwin and Dr Fran Waugh Department of Social Work, Social Policy and Sociology, University of Sydney.

Working party members for the pilot

- NSW Health Department - Health Services Policy Branch and Centre for Mental Health
- South Eastern Sydney Area Health Service and Macquarie Area Health Service
- Education Centre Against Violence

NSW Interagency Reference Group members for the pilot

- NSW Health Department - Health Services Policy Branch, Central for Mental Health, Drug Programs Bureau and Nursing Branch
- South Eastern Sydney Area Health Service and Macquarie Area Health Service
- Education Centre Against Violence
- NSW Attorney General's Department - Violence Against Women Specialist Unit
- NSW Department of Community Services - Domestic Violence Line
- NSW Police Service
- NSW Women's Refuge Referral and Resource Centre
- Domestic Violence Advocacy Service

Local Implementation Groups and Domestic Violence Committees in both pilot areas played a key role in establishing screening.

Jenny White and Wendy Farley developed the information resource for women and the flow chart for health workers.

Finally, this pilot would not have been possible without the cooperation and support of the women who agreed to be screened and the health workers who carried it out.