Australian Domestic & Family Violence CLEARINGHOUSE

Routine Screening for Domestic Violence in Health Services *

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Domestic violence and women's health

Domestic violence impacts adversely on women's physical and mental health. In comparison with non-abused women, abused women have a 50-70 per cent increase in gynaecological, central nervous system and stress-related problems (Campbell et al. 2002). Domestic violence is also associated with a range of adverse mental health impacts (Roberts et al. 1998) such as anxiety, depression, post-traumatic stress disorder, substance abuse problems (Clark & Foy 2000) and suicidality (Stark & Flitcraft 1995). Women in abusive relationships suffer from fear and stress which result in long-term health problems and can reduce women's immunity to illness overall (Coker et al. 2000a; 2000b; Sutherland Bybee & Sullivan 2002; Campbell et al. 2002). Research shows that domestic violence 'has long-term negative health consequences for survivors, even after the abuse has ended.' (Campbell et al. 2002, p.1157)

Domestic violence and the health system

Because of the physical and mental health manifestations of intimate partner abuse, the health system is an important component of a co-ordinated response to domestic violence:

> *Battered women often seek medical attention for abuse-related injuries as well as health problems that appear unrelated to any specific injury or predisposing health condition. In many cases a physician or nurse may be the only person women feel comfortable talking to about their partner's violence. This provides health care providers with a unique opportunity to identify and assist domestic violence survivors.* (Sullivan, Bybee & Sullivan 2002, p. 631)

Australian research confirms the key role which health care providers can play in assisting women experiencing domestic violence. For example, women who do not use specialist domestic violence services do seek help from a range of health services (Keys Young 1998). The Women's Safety Survey (ABS 1996) found that, after close family and friends, doctors were one group to whom women turned to disclose their experiences of domestic violence.

Findings from qualitative studies have identified the types of response which women find helpful from health services. Gerbert et al. (1999) found that validation from a health-care professional played an important role in empowering women experiencing violence. In this study, the common theme that emerged was the importance of a non-judgemental, sympathetic and caring health-care provider. Health-care providers who paid attention to possible risk factors, listened for hints, documented injuries and questioned clients in a sensitive manner, play an important role in assisting women:

> *The women...described how (with or without direct identification or disclosure) validation from a health care provider had "planted a seed", leading to turning points or epiphanies in their relationships with the abusers. Validation served to slightly shift their mental landscape, which in time helped them to see the relationship and themselves differently. (Gerbert et al., 1999, p. 130)*

In an Australian study, Bates (2001) explored the factors which enabled women to tell their story. In common with Gerbert et al. (1999) she found that women identified the attitude of the health care provider to be very important. An attitude

which conveyed trust, compassion, support and understanding, facilitated women talking about their abuse. Among environmental factors, women mentioned:

- the size and appearance of the waiting room
- privacy in the waiting room
- the triage situation and the consulting area
- length of wait for service

Barriers to women discussing their situation included negative service provider attitudes, lack of continuity of service providers and time constraints on service providers. Fear of having their children removed was another barrier to disclosure, particularly for Aboriginal women.

Over the last decade, the increasing recognition of the potential role which health services can play as part of a co-ordinated response to domestic violence has promoted a range of initiatives within health services, such as the development of policies, protocols (e.g. SESAHS 1997) and training programs. One initiative, routine screening, has been recommended, to increase rates of identification of women experiencing violence in their intimate relationships. Screening usually takes the form of three or four questions being asked of women presenting to the Emergency Department, antenatal clinic, or other health context, such as mental health services.

The case for routine screening

Although domestic violence is associated with a range of adverse health impacts, even after the abuse has ended (Campbell et al. 2002), it is not easily identified by health service providers, for several reasons. As Campbell et al. (2002, p. 1157) point out:

> *There is no agreement on the constellation of signs, symptoms, and illnesses that a primary care physician should recognize as associated with a current or prior history of DV.*

Further, although abused women use health services at a higher rate than non-abused women, they do not seek medical attention only for abuse-related injuries, but also for health problems which appear unrelated to the abuse (Sullivan, Bybee & Sullivan 2002; Rhodes & Levinson 2003). Because of the difficulties in identifying abused women within health services, and the importance of identification to early intervention, the practice of routinely enquiring of all women about domestic violence, has been widely advocated. For example, the Department of Health in England recommends that health professionals consider "routine enquiry" of some or all women patients for a history of domestic violence (Ramsay et al. 2002) and routine screening is recommended by a number of US medical organisations, such as the American Medical Association's Council on Scientific Affairs and the American Academy of Family Physicians (Rhodes & Levinson 2003). Sullivan, Bybee and Sullivan (2002, p. 631) present a typical argument in favour of universal screening in health services:

> *Early identification of abuse is essential to eliminating violence and subsequent health problems in women's lives. Universal screening procedures may be the most effective way to identify battered women. The signs of abuse are not always visible, and if physicians rely on the presence of suspicious injuries to ask women about violence, they may miss the chance to provide valuable assistance. Worse yet, they may misdiagnose the underlying cause of the health problems or provide treatment options that could further jeopardize women's physical and psychological well-being (e.g., prescribing tranquilizers).*

Campbell et al. (2002) argue, based on their findings that abused women have increased risk of gynaecological, central nervous system and stress-related health problems, even after the abuse has ended, that women be screened for domestic violence, including specific inquiry about sexual abuse. Thus, screening is not only useful in identifying women who require assistance for current abuse. It can also alert the health care provider to the need to thoroughly

assess women's physical and mental health and to provide treatment which can overcome the longer-term health impacts of domestic violence:

> *Physicians are becoming more aware of the immediate health problems associated with abuse and need to expand this awareness to those that persist or develop over time or that occur after the women has left the abusive relationship. Many women may not associate these problems with previous abuse and, therefore, may not disclose abuse. This information may be vital in creating an effective treatment plan. (Campbell et al. 2002, p. 1162)*

Those who advocate routine screening, essentially a way of integrating the identification of domestic violence into the everyday work practices of health care providers, are reflecting the approach advocated by the Duluth Abuse Intervention Project (DAIP), the internationally renowned leader in co-ordinated responses to domestic violence. Reflecting on over two decades of work aimed at centralising victim safety within the domestic violence interagency response, Pence (1999, p. 37) describes the focus of current efforts to bring about systemic change:

> *…somewhere down this long road to change we came to the realization that even if we could handpick every police officer and judge and prosecutor, we would still not eliminate the bad outcomes that continued to occur after we had changed almost every policy. We had attributed failure of the system to effectively address victim safety to individual attitudes and poor training. We began to see an institutional ideology that was embedded in the work practices that standardized practitioners' actions regardless of their personal idiosyncratic work habits or beliefs.*

This has led to a focus on the minutiae of the work practices of players in the system - the forms, rules, regulations, documentary practices and communication networks etc. Including routine inquiry within existing assessment processes can be seen as an example of operationalising this approach to systemic change within health services.

Arguments and cautions against routine screening

Support for routine screening, however, is not universal. For example, Taft argues that screening treats violence, a psycho-social problem, as a "disease": '…the use of a biomedical term such as "screening" is both misleading and undesirable, as the "treatment" is not within the medical profession's remit, but located more broadly in the entire community.' (Taft 2002, p. 10) While screening aims to increase the rate of identification of abused women, Taft argues that greater attention first needs to be paid to ensuring that the health system is able to respond appropriately to women's disclosures. This is important because poor responses can jeopardise women's safety and can lead to re-victimisation, stigmatisation or feelings of hopelessness (Taft 2002). Attention also needs to be paid to the risks to women from routine screening. These may include loss of custody of children because a woman receives a mental health diagnosis arising from her experience of domestic violence (Taft 2002). In raising concerns about policies of routine screening, however, Taft (2003) is not arguing against health professionals inquiring directly about domestic violence or acting on suspicion that a woman is experiencing abuse.

The Canadian Task Force on Preventative Health Care (2001, cited in Rhodes & Levinson 2003) has adopted the position that there is at present insufficient evidence to recommend either for or against routine screening. This reflects the findings of a recent, systematic review of published quantitative studies of screening for domestic violence in health care settings (Ramsay et al. 2002). This review tests what it identifies as the implicit assumptions underlying recommendations for universal screening, namely that:

- it will increase the identification of women experiencing violence
- it will result in appropriate intervention and support
- it will ultimately decrease exposure to domestic violence and its negative physical and psychological health impacts

- women and health professionals will not object to participating in screening (Ramsay et al. 2002)

The review identified few good quality studies. Key findings from the review were that:

- in primary care settings, between half and three quarters of women find screening acceptable, with the proportion finding screening acceptable higher for women who have experienced abuse

- among health professionals, a minority of doctors and half of nurses were in favour of screening

- screening programs increased rates of identification in antenatal, primary care clinics and Emergency Departments; however, the increase was modest and no evidence was found that it was sustained

- little evidence was found that health interventions following identification, are effective. (Ramsay et al. 2002)

Although concluding that, on the available evidence, it is premature to recommend routine screening programs, the reviewers emphasise that domestic violence is an important issue for the health system, and that health care providers should attempt to identify and support abused women. This is consistent with the recommendations of many medical organisations for case finding with referral when cases of domestic violence are identified. For example, the American Academy of Pediatrics 'advocates a high degree of clinical suspicion and outlines key physical and psychological presenting symptoms. While not directly encouraging routine screening, they provide a brief set of screening questions to be used as part of history-taking.' (Rhodes & Levinson 2003, p. 604)

Screening in Australian health services

In Australia, a number of projects were initiated in the 1990s to increase the level of identification of domestic violence in hospital emergency services and the sensitivity of medical and nursing staff to women experiencing violence (Roberts 1994). Extending this work, Queensland (Stratigos 1999) and New South Wales (NSW Health 2001) have implemented routine screening programs.

The Queensland Domestic Violence Initiative (DVI) commenced in 1998. Its aims are to:

- raise awareness about domestic violence with health care professionals and the wider community
- increase communication between stakeholders
- develop a standardised method for identifying women who have been subjected to domestic violence (Queensland Health 2001, p. 2)

It 'seeks to incorporate screening for domestic violence into routine history taking protocols, as a component of core clinical practice.' (Queensland Health 2001, p. 1) This entails health workers asking several additional questions about domestic violence, as part of routine history taking, an approach consistent with the recommendation of Pence, described earlier.

The initiative was introduced in two stages, the first involving a pilot of the screening tool at eight sites in rural and city hospitals in antenatal, outpatient gynaecology and Emergency Departments. Following positive evaluation of the pilot, including the finding that 97 per cent of surveyed women supported screening, stage two of the DVI was implemented. This involved expanding the DVI to include an additional 11 sites.

The screening tool comprises the following four questions. Two additional questions are asked only if domestic violence is identified:

1. Are you ever afraid of your partner?

2. In the last year, has your partner hit, kicked, punched or otherwise hurt you?

3. In the last year, has your partner put you down, humiliated you or tried to control what you can do?

4. In the last year, has your partner threatened to hurt you?

(If domestic violence has been identified in any of the above questions)

5. Would you like help with any of this now?

6. This could be important information for your health care. Would you like us to send a copy of this form to your doctor? (Queensland Health 2002)

Findings from the stage two evaluation include the following:

- 82 per cent of women were screened across all sites. Seven per cent of women screened positive for domestic violence (compared to 6.5% in stage 1)

- Screening rates were highest in antenatal clinics (89.2%, 6.8% positive); followed by gynaecology clinics (45% screened, 12.4% positive); and Emergency Departments (23% screened, 8.5% positive). In stage 1, only 7.6 per cent of women presenting to emergency department were screened, with 1.6 per cent screened positive.

- Across all sites, 13 per cent of women who disclosed violence accepted help at the time of screening. However, no women accepted help in gynaecology or emergency settings. (Queensland Health 2001, p. 4)

In New South Wales, the introduction of routine screening was recommended by the NSW Health Domestic Violence Policy Review Advisory Committee and piloted over a six-month period in a metropolitan and rural area health service in Emergency, mental health, alcohol and other drugs and antenatal services. The rationale for introducing screening was the low rates of identification of domestic

violence in health services; the high incidence of domestic violence in the community; and the importance of early intervention (NSW Health 2001). The screening tool comprises two questions, with a third and fourth asked if domestic violence is identified:

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?

   If the woman answers NO to both questions, she is given an information card, with the explanation: 'Here is some information that we are giving to all women about domestic violence.' If the woman answers YES to either or both of the above, questions 3 and 4 are asked.

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

4. Would you like some help with this? (NSW Health 2003, p. 11)

The pilot was overseen by an interagency steering committee and was independently evaluated. The objectives of the project included, in addition to piloting and refining the screening tool:

- the development of training and information strategies tailored to the needs of staff in the various participating health services;

- development of model screening procedures, forms, localised inter-agency protocols and data collection methods, including documentation of domestic violence identified and action taken;

- ensuring appropriate referrals to the statutory child protection agency, Police and community based services.

Training was provided to staff and a resource manual provided to each participating health service. A resource card with information about domestic violence and about services was developed and was distributed to every woman

who was screened, whether or not domestic violence was disclosed. This reflects recognition that women may not choose to disclose and provides information in a non-identifying and non-stigmatising way (NSW Health 2001).

The evaluation of the pilot found that 24 per cent of eligible women were screened. Eleven per cent of these women (106) were identified as experiencing domestic violence in the last 12 months. Of these women, 12 did not feel safe to go home and 32 accepted some form of assistance.

The presence of a partner or other family members, was the most common reason for the health worker not implementing the screening protocol. Although the protocol required health workers to complete information about the reasons for not screening women, these forms were not completed for 71 per cent of women. In focus groups with health workers, the following reasons were given for not screening: lack of privacy to ask questions; limited time due to workloads; discomfort at asking personal questions; and uncertainty about how to respond to disclosures of abuse (NSW Health 2001, p. 1).

The majority of women (95%) who completed the evaluation survey, indicated that they felt either 'OK' or 'relieved' about being asked about domestic violence. Their comments in support of screening often referred to their own or others' experience of domestic violence and the role that screening could have played. For example:

> *Yes my mother was in this situation and didn't know where to get help from any of the services*
>
> *I was in a violent relationship when I was younger and I think if someone would have asked me questions like that maybe I would have told someone instead of putting up with it.*
>
> *Because a lot of women don't say anything unless they're asked.* (NSW Health 2001, p. 46)

As in Queensland, rates of screening in the NSW pilot were highest in antenatal services and lowest in Emergency Departments. At one of the Sydney antenatal screening sites, the pilot successfully raised domestic violence as an important issue for midwives and a decision was taken to continue the screening after the pilot period:

> *The screening questions provided the midwives with a tool to ask women about a sensitive issue that they knew was a concern to their patients but did not know how to ask about. Midwives commented that in some cases the screening enhanced their relationships with the women as it showed that the clinic was concerned and interested in the women's well-being and not just her pregnancy.* (Jones & Bonner 2002, p. 18)

In contrast, the pilot of routine screening at an Emergency Department in the same area health service, was less successful. During the pilot, only 10 per cent of eligible women were screened, with barriers to screening being similar to those reported elsewhere: lack of privacy; time constraints; and no after hours social work services for referrals (Ramsden & Bonner 2001). However, the pilot program, which identified 14.6 per cent of screened women as having been subjected to domestic violence, raised staff awareness of domestic violence as an issue for their service (Ramsden & Bonner 2002). Subsequently, an alternative case-finding model for identifying victims of domestic violence in an Emergency Department has been developed. This is: '[a]n early identification and intervention model… using clinical indicators… This model complements the assessment strategies already in place for any patient attending the ED…' (Ramsden & Bonner 2001, p. 370).

Following the pilot and its evaluation, NSW Health recommended that all Area Health Services implement routine screening for domestic violence for all women aged over 16 years attending drug and alcohol, mental health, antenatal and early childhood services. A comprehensive resource package has been developed to assist in the process of state-wide implementation of routine screening (Education Centre Against Violence 2001). Based on the findings of

the pilot, an alternative strategy for identifying and responding to domestic violence in Emergency Departments is being developed.

Conclusion

Over the past decade, domestic violence has increasingly been recognised as an important issue for the health system because it has adverse negative impacts on women's physical and psychological health in both the short- and long-term. Abused women use health services at rates higher than other women, with costs to the health system increased when domestic violence is not recognised as the underlying problem. Since most abused women do not present to primary health care settings with injury-related complaints, their history of domestic violence is not commonly identified. While most women do not disclose their experience of violence to health care providers, they will do so when asked directly about violence and abuse in their lives (Rhodes & Levinson 2003).

The debate over routine screening is a debate about how best to improve rates of identification of abused women within health care settings: whether it is better to ask all women routinely, or whether the health care provider should have a high index of suspicion and ask when there are indicators that a woman may have a past or current history of domestic violence. With either approach, the response of the health provider is critical. Survivors report that a sympathetic and informed response is extremely valuable and can be a catalyst to change. Those urging caution in implementing routine screening point to the lack of evidence that it leads to better outcomes for women, in terms of reducing violence and improving their physical and mental health. However, the outcomes of health interventions such as these are not easy to evaluate:

> *…the process of changing any health behaviour takes time and may happen gradually or not at all. The primary care physician may help initiate thoughts of change by discussing the abuse, but patients may take weeks, months or years before they contact community resources or initiate changes in their lives; and they may never take such action. In the*

end, physicians may never know whether they were able to help the patient. (Rhodes & Levinson 2003, p. 602)

Whether domestic violence is identified by routine enquiry or by other approaches to case-finding, it is essential that health care providers are resourced through training, policies and protocols to respond in ways which have been identified by survivors as helpful and empowering.

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