

NORTHERN TERRITORY DOMESTIC VIOLENCE  
INTERVENTION AND RESPONSE IN HOSPITAL SETTINGS

# DOMESTIC/FAMILY VIOLENCE SCREENING PILOT EVALUATION REPORT



May 2003

Women's Health Strategy Unit  
Northern Territory Department of Health and Community Services



This evaluation report was researched and prepared by the Northern Territory Department of Health and Community Services, Women's Health Strategy Unit with the support of *Partnerships Against Domestic Violence*, a Commonwealth Government initiative.

This work is copyright. It may be reproduced in whole or in part for study training purposes subject to inclusion of an acknowledgment of the source and no commercial usage or sale.

May 2003

## Acknowledgments

The Evaluation Report Team wishes to acknowledge the following for their support during the Pilot Project Phase:

- Women's Health Strategy Unit, NT Department of Health and Community Services
- Katherine Hospital Antenatal Department
- Royal Darwin Hospital Emergency Department
- Pilot Steering Committee and Working Groups
- Community and Hospital Domestic Violence Intervention Support Agencies and Networks
- School of Humanities and Social Sciences, Northern Territory University

Jenny Young, Beverley Hayhurst and Louise Page  
Evaluation Report Team  
May 2003

## Foreword

Extensive review of literature over the past decade demonstrates the serious health consequences of domestic and family violence. Routine domestic violence screening of patients presenting to health professionals provides a valuable opportunity for early identification and intervention. The domestic violence screening raised public awareness that domestic abuse has health consequences. It also increased staff awareness that they can provide assistance.

A three-month pilot from September to November 2002 was conducted into routine screening of hospital patients at two Northern Territory Public Hospital sites. This was achieved with assistance from the National Women's Health Program through the *Public Health Outcome Funding Agreement* (PHOFA).

This screening tool was developed and trialed in conjunction with a training package and resource kit. Analysis of the screening pilot found that screening significantly increases the level of domestic and family violence identified and the level of help offered to those disclosing.

This evaluation report will inform the implementation of routine screening in all Public Hospitals in the Northern Territory. Recommendations will guide the incorporation of routine screening into core clinical practice.

# TABLE OF CONTENTS

TABLE OF CONTENTS.....	5
<a href="#">Tables</a> .....	7
<a href="#">Appendices</a> .....	7
<a href="#">List of Acronyms</a> .....	7
<a href="#">EXECUTIVE SUMMARY</a> .....	8
Evaluation Goals and Objectives.....	8
Screening Pilot Project's Original Objectives.....	8
Evaluation Methodology.....	9
Key findings.....	9
Future Directions/Recommendations.....	10
<a href="#">SECTION ONE</a> .....	12
1. <a href="#">Pilot Project Summary</a> .....	12
2. <a href="#">Rationale for Project</a> .....	14
3. <a href="#">Summary of Literature Review</a> .....	15
4. <a href="#">Aims and Objectives</a> .....	15
5. <a href="#">Project Management</a> .....	16
Steering Committee.....	16
Working Groups.....	16
Time Frame.....	16
Ethics Approval.....	16
6. <a href="#">Project Components</a> .....	17
Knowledge and Attitude Survey.....	17
DV Screening Tool.....	17
DV Screening Training Package.....	18
DV Screening Resource Kit - Hospitals & GP's.....	18
Mentoring.....	18
Inservices.....	18
Referral Card.....	19
Screening Training Video.....	19
Patient Survey.....	20
Focus Groups and Interviews with Staff and Community Support Services.....	20
7. <a href="#">Communication Strategies</a> .....	20
Newsletters.....	20
Posters.....	20
Expo - Launches.....	21
Media.....	21
Internet - Web.....	21
Statistical Reports to Pilot Sites/DV Network.....	21
<a href="#">SECTION TWO</a> .....	22
<a href="#">PROJECT EVALUATION</a> .....	22
1 <a href="#">Evaluation Purpose</a> .....	22
2 <a href="#">Evaluation Objectives</a> .....	22
3 <a href="#">Scope</a> .....	22

<a href="#">4</a>	<a href="#">Evaluation Methodology</a>	23
4.1	Project Management	23
	Evaluation Team	23
	Time Frame	23
4.2	Evaluation Tools	23
	Ethics Approval	23
	The Knowledge and Attitude Survey	23
	Staff Feedback from the Screening Training	23
	Survey of Patient Experiences of the Screening Tool	24
	Stakeholder Focus Groups and Individual Interviews	24
4.3	Evaluation Limitations	24
<a href="#">5</a>	<a href="#">Evaluation Findings</a>	25
	Knowledge and Attitude Survey	25
	Feedback from DV Training	26
	Analysis of Screening Data	27
	Feedback on the Appropriateness and Effectiveness of the Screening Tool	29
	Summary of Key findings	33
<a href="#">6</a>	<a href="#">Conclusions</a>	34
<a href="#">7</a>	<a href="#">Recommendations for Future Implementation of DV Screening in NT Public Hospitals</a>	38
	<a href="#">BIBLIOGRAPHY</a>	39
	<a href="#">APPENDICES</a>	45
	<a href="#">Appendix 1</a>	45
	<a href="#">Appendix 2</a>	46
	<a href="#">Appendix 3</a>	47
	<a href="#">Appendix 4</a>	51
	<a href="#">Appendix 5</a>	52
	<a href="#">Appendix 6</a>	54
	<a href="#">Appendix 7</a>	56
	<a href="#">Appendix 8</a>	59

## Tables

1.	Breakdown of Screening Data from RDH Emergency Department September - November 2002.....	27
2.	Comparison of Australian Screening Sites for Disclosure Rates.....	28
3.	Feedback from Focus Groups and Interviews conducted with Patient, Staff and Referral Agencies on Appropriateness and Effectiveness of the Screening Tool at RDH ED.....	29
4.	Feedback on Appropriateness and Effectiveness of the Screening Tool at KH Antenatal Department.....	31

## Appendices

1. Initial Teleconference Attendance List
2. Steering and Working Group Membership
3. Knowledge and Attitude Survey Instrument
4. Domestic Violence Screening Training Feedback Form
5. Domestic Violence Screening Tool used in Pilot at RDH and KH
6. Patient Survey - Antenatal and Emergency Department
7. Focus Group/Interview Questions
8. Revised Screening Tool

## List of Acronyms

RDH	Royal Darwin Hospital
KH	Katherine Hospital
GDH	Gove District Hospital
TCH	Tennant Creek Hospital
ASH	Alice Springs Hospital
ED	Emergency Department
DHCS	Department of Health and Community Services
WHSU	Women's Health Strategy Unit
DHCS	Department of Health & Community Services
SARC	Sexual Assault Referral Centre
NT	Northern Territory
WAC	Women's Advisory Council
FACS	Family & Childrens' Services
ATSIC	Aboriginal & Torres Strait Islander Commission
NSW	New South Wales
QLD	Queensland
DV	Domestic Violence
FV	Family Violence

DV & FV are used interchangeably

## EXECUTIVE SUMMARY

### Evaluation Goals and Objectives

The trial of routine domestic (DV) and family violence (FV) screening was conducted at two pilot NT Public Hospital Sites from September to November 2002. A Steering Committee and Working Groups guided and developed the pilot tools and screening process. Evaluation measures were incorporated into the project and an Evaluation Team used findings from the measures to evaluate the screening pilot. The evaluation objectives were:

- To determine the extent to which the original objectives for the pilot project were met.
- To determine whether domestic violence screening is an appropriate and effective means of identifying and responding to domestic violence cases presenting to emergency and antenatal departments of Public Hospitals in the NT.
- To determine whether domestic violence screening is recommended for future implementation in Public Hospitals throughout the NT and if so, what issues need to be addressed for this to occur.

### Screening Pilot Project's Original Objectives

1. To develop a standardised method, for use in the hospital setting, for identifying women subjected to domestic violence.
2. To support accurate diagnosis and appropriate responses for women who experience domestic violence, by introducing a method for identifying women who have experienced domestic violence in hospital accident and emergency department and antenatal care settings.
3. To raise awareness of domestic violence amongst health care providers.
4. To support staff to develop the competence and confidence to identify and respond to domestic violence.
5. To incorporate information related to domestic violence into medical records and hospital data collection.
6. To identify and introduce appropriate responses and referrals for victims once identified.
7. To evaluate and document the methodology and outcomes and make recommendations for the continuing response to victims in the hospital setting.
8. To establish the participation by DHCS hospitals in the NT DV data collection.



## Evaluation Methodology

The evaluation methodology included a:

- Literature Review
- Ethics Committee Approval
- Knowledge and Attitude Survey of all health care personnel at all NT Public Hospitals
- Staff Feedback from Screening Training
- Data analysis from completed patient screening forms
- Client Survey on the Screening Tool
- Focus group and individual consultations with a wide range of stakeholders at each pilot site.

## Key findings

1. There is broad support amongst the client group for DV Screening.
2. 78% of the 602 staff surveyed through a preliminary Knowledge and Attitude Survey had not received training in domestic violence.
3. The majority of staff were moderately confident to screen after receiving training.
4. One in four patients screened at the Emergency Department of Royal Darwin Hospital disclosed domestic and family violence. Males constituted 30.3% and females 63.1% of this total (Unrecorded gender was 6.6%).
5. Of patients who were screened and disclosed DV at RDH ED 72.2% of female patients and 23.6% of male patients asked for immediate help.
6. The two main crisis shelter referral agencies in Darwin reported that referrals had doubled during the screening period.
7. The Hospital Based Constable at RDH reported up to 10 requests a day for restraining orders during the pilot. This was an increase of more than 50% from before the pilot.
8. Focus group feedback from pilot site staff indicated lack of privacy in their work area was a barrier to screening.
9. Feedback from the Knowledge and Attitude Survey, community agencies, and health care staff revealed the importance of back-up support staff to handle immediate requests for help. It was also highlighted that this form of back-up was not currently available at pilot sites.
10. Feedback from health care staff revealed the need for further referral options for male victims and perpetrators in the community. Feedback requested a male referral card.
11. Feedback from community focus groups and interviews suggested that some patients referred to shelters in Darwin and Katherine were discharged inappropriately and still required significant medical attention.
12. Health care staff and community focus groups supported the use of the WAC card and resource kit.
13. Community agencies reported improved relationships with the hospital as a result of screening. A protocol has been set up between Catherine Booth House Women's Shelter and the RDH Emergency Department.

14. Although the screening indicated a high degree of DV presenting to hospitals, hospital data does not currently collect the same data across all hospitals and this data when collated is not included in the NT Domestic Violence Data Collection compiled by the Office of Women's Policy.
15. Katherine Antenatal Department elected to continue screening.
16. Katherine Community agencies would like screening extended to other services.
17. Feedback from referral agency focus groups revealed the need for a pamphlet in different languages outlining the different restraining order protection options.

### Future Directions/Recommendations

It is recommended:

1. That Emergency and Antenatal Departments at all NT Public Hospitals commence routine DV screening following:
  - completion of staff training for screening
  - assessment of adequate privacy to screen
  - assessment of crisis accommodation capacity
  - assessment of appropriate staff support for screening (Social Work, Aboriginal Liaison or on-call services)
2. That the Emergency Department of Royal Darwin Hospital commence routine screening after moving to their new location.
3. That the Women's Advisory Council (WAC) Domestic Violence information referral card continues to be made available at all screening sites.
4. That a referral card in similar format to the WAC card be compiled and available for men.
5. That Domestic Violence data from all NT Public Hospitals be incorporated into the Northern Territory Domestic Violence Data Collection Project.
6. That a pamphlet on restraining order protection options be compiled by the Top End Women's Legal Service in cooperation with the RDH Hospital-Based Constable and that this pamphlet be made available at all screening sites.
7. That the screening tool and resource kit be available for use by other community agencies.
8. That a further evaluation be conducted after screening has been in place in all NT Public Hospitals.

9. That a Working Group is formed to guide implementation of the above recommendations.

## SECTION ONE

### 1 Pilot Project Summary

The DV screening pilot project commenced in February 2000. An initial meeting was held at RDH and teleconferenced with staff from other hospitals (See Attendance list at Appendix 1). Feedback from this meeting indicated that screening for DV in Emergency and Antenatal clinics would be difficult, but necessary. The initial meeting was followed by a series of information sessions for hospital staff on DV and background to the project conducted by the Women's Health Strategy Unit.

An extensive literature review was conducted into DV screening, DV and pregnancy, staff training and attitudes of medical staff.

A Project Officer was recruited to pilot the screening in December 2001 and a Steering Committee established. This Committee had representation from hospital management, hospital health professionals, aboriginal workforce support, hospital services and nursing policy (see Committee Members at Appendix 2). Working groups with representatives from key stakeholder groups were formed to guide each stage of the project (See Working Group Membership at Appendix 2). A working group with representation from the Research Branch of the Department of Health and Community Services and the Social Work Department at Northern Territory University provided input into Ethics Committee applications.

Approval to conduct a staff Knowledge and Attitude Survey was obtained from the Director of each hospital and the Human Research Ethics Committee of the Department and Menzies School of Health Research. In May 2002 this survey was sent to all Doctors, Nurses, Aboriginal Health Workers and Aboriginal Liaison Officers at all five NT Public Hospitals.

Two pilot sites were chosen for the screening. These were the Emergency Department at Royal Darwin Hospital and the Antenatal Department at Katherine Hospital. Both these pilot sites had some data about DV. However they had no formal recording mechanism nor strategy for responding to DV.

Royal Darwin Hospital is a major teaching hospital for northern Australia and South East Asia with 268 beds, plus 25 mental health beds. The ED has had stable management and has shown an interest in the levels of patients presenting with DV.

In 1998 a three-month project at Royal Darwin Hospital found that of 10,125 patients presenting to the Emergency Department, 64 people had experienced domestic violence. Of these victims 75% were female and 65% were Aboriginal. A one month unpublished audit of patients at RDH Emergency Department presenting with Domestic Violence in 2002, prior to the launch of the DV Screening Pilot confirmed similar findings. At Royal Darwin Hospital all men (due to high

percentage of male victims indicated at Audit) and women over 16 years of age presenting to the Emergency Department were targeted for screening over the pilot period. This screening ceased following the trial period.

Katherine Hospital is a 60-bed facility servicing the Katherine Region which extends approximately 34,000km<sup>2</sup> between the Western Australian and Queensland borders and has a population of approximately 19,000 people. The services in the community for patients affected by DV reflect the relative size of Katherine. The Antenatal Department conducts clinics for both local residents and patients who have come in to Katherine to have their baby from the outlying areas, therefore often not seeing pregnant women until near the end of their pregnancy. Management of the Antenatal Department has been stable for some time and has demonstrated an interest in the area of DV.

At Katherine Hospital Antenatal Department screening of women occurred at the initial booking appointment and again at 34 weeks of pregnancy. The screening has continued at the Antenatal Department since the completion of the pilot.

In line with current change management practices it was deemed important to keep the healthcare staff and community DV support services informed and encourage their participation in the process. A newsletter was developed and distributed with regular updates.

A three-hour training package and workbook was developed following interstate and overseas benchmarking. Training at the two pilot sites commenced in July 2002. This was provided by the Project Officer with help from a Ruby Gaea Sexual Assault Counsellor. Staff attendance was scheduled in work time and coordinated by the pilot site working groups. Training session times were flexible and open to other healthcare staff if places were available. Approximately 150 staff in Katherine and Darwin attended training. In-services by local domestic/family violence referral agencies were held at both pilot sites.

The Honourable Jane Aagaard, Minister for Health and Community Services launched the pilot at both screening sites in August 2002. Screening started at midnight on the 1<sup>st</sup> September 2002 at each site and was completed on 30<sup>th</sup> November 2002. Both pilot sites were asked by the Steering Committee if they would consider continuing screening until the evaluation reports recommendations were known. The RDH ED declined to continue but stated they would await the findings and consider re screening after their move to new premises. The Antenatal Department at KDH decided to continue screening Antenatal Clinic patients.

## 2. Rationale for Project

Research over the last decade shows that DV is associated with a range of physical and mental health problems and risk factors.

The rate of hospital admission for assault in the NT is the highest in the country<sup>1</sup> and violence, particularly domestic and family violence, is the single greatest cause of hospital admissions for injury among Aboriginal women in the Northern Territory. In the five years to 1997, 47% of all admissions to hospital for intentional injuries inflicted by another person were Aboriginal women, two-thirds of whom were aged between 25-49 years.

The Royal Darwin Hospital Emergency Department conducted a one-month domestic violence audit in 2002 (unpublished). This indicated that in one month 62 patients were treated in the Emergency Department for DV related injuries and of those 73% were female and 23% male. (4% unrecorded gender).

The DV Data Collection Project is a Territory-wide approach to the collection to DV data and is managed by the Office of Women's Policy. It collects information gathered from government and non-government organisations throughout the NT. The 1999-2000 DV Data Collection<sup>2</sup> reported a total of 8611 incidents of domestic violence from 19 agencies (government and non-government). Of these:

- 92% of victims were female
- 90% of offenders were male.
- 89% of victims reported experiencing violence previously from the same offender
- 87% of offenders were affected by alcohol or other drugs at the time of the incident.
- 76% of victims experienced emotional or psychological abuse; while 63% experienced physical abuse.
- 76% of both victims and offenders were Indigenous Territorians
- 72% of victims and 79% of offenders had living in the Territory for more than 10 years.
- 42% of reported incidents involved children who witnessed the violence or were nearby when the violence occurred.
- 7% or 143 victims were pregnant at the time of the domestic violence incident
- Only 7% of referrals had the hospital as a source of the referral.

The 1994 - 1999 NT DV Strategy highlighted the need to:

- Combat DV in clinical settings
- Assist children who are victims or witnesses of violence
- Train staff

---

<sup>1</sup> Willaims, G., Chaboyer W., and Schulter P., 2002. Assault-related admissions to hospital in Central Australia. Medical Journal of Australia; 177 (6): 300-304

<sup>2</sup> Northern Territory Government, 2000. Occasional Paper No 40 DV Strategy Data Collection Project Report 1999-2000, p2.

Routine screening has been introduced into New South Wales and Queensland Public Hospitals and evaluation of these initiatives has indicated screening increases domestic violence disclosure<sup>3 4 5</sup>.

### 3. Summary of Literature Review

An extensive literature review was conducted during 2001<sup>6</sup>. The review demonstrated that routine screening for DV provides a method for accurate diagnosis and appropriate response for women presenting with DV. Interstate benchmarking through the literature review indicated that awareness of domestic violence amongst health care providers could be raised through DV screening training. This screening enables staff to develop competence and confidence to identify and respond appropriately to DV.

### 4. Aims and Objectives

The broad aims of the project were:

- To reduce the morbidity and mortality from domestic/family violence<sup>7</sup> among Northern Territory women.
- To provide an appropriate service response to victims of domestic violence identified in the hospital setting.
- To raise the awareness and competence of hospital based practitioners in relation to domestic violence.

The objectives of the project were:

1. To develop a standardised method, for use in the hospital setting, for identifying women subjected to domestic violence.
2. To support accurate diagnosis and appropriate responses for women who experience domestic violence, by introducing a method for identifying women who have experienced domestic violence in hospital accident and emergency department and antenatal care settings.
3. To raise awareness of domestic violence amongst health care providers.
4. To support staff to develop the competence and confidence to identify and respond to domestic violence.
5. To incorporate information related to domestic violence into medical records and hospital data collection.

---

<sup>3</sup> Queensland Health (Internal Working Document), 2000, Initiative To Combat The Health Impact of Domestic Violence Against Women Stage 1 Evaluation.

<sup>4</sup> New South Wales Health Department, 2001, 'Unless They're Asked' Routine Screening for Domestic Violence in NSW Health, An Evaluation of the Pilot Project.

<sup>5</sup> Queensland Health (Internal Working Document), 2001, Initiative To Combat The Health Impact of Domestic Violence Against Women Stage 2 Evaluation

<sup>6</sup> Northern Territory Department of Health and Community Services (Internal Working Document), 2002, Screening Literature Review.

<sup>7</sup> The term "domestic violence" will be used in this document to include both domestic and family violence.

6. To identify and introduce appropriate responses and referrals for victims once identified.
7. To evaluate and document the methodology and outcomes and make recommendations for the continuing response to victims in the hospital setting.
8. To establish the participation by DHCS hospitals in the NT DV data collection.

## 5. Project Management

### Steering Committee

A Steering Committee was set up to guide the project, with representation from hospital management, hospital health professionals, Aboriginal Workforce Support, hospital services, policy and nursing policy. (See Members at Appendix 2).

### Working Groups

Working groups were established to provide input to the project, with representation from a range of government and non-government service providers. (See Members at Appendix 2). These included:

- Training Working Group
- Referral Working Group
- Screening Tool Working Group
- Initial Evaluation Working Group
- Evaluation Report Team

### Time Frame

The project commenced in February 2002 with a literature review and an interstate and overseas benchmarking exercise. The actual screening tool pilot was conducted over a three-month period between September and November 2002.

### Ethics Approval

Ethics approval was obtained from the NT DHCS Human Research Ethics Committee and the Menzies School of Health Research to conduct a Knowledge and Attitude Survey of staff, a patient survey on responses to the DV Screening and to conduct focus groups with staff and community referral agencies.



## 6. Project Components

### Knowledge and Attitude Survey

A Knowledge and Attitude Survey was conducted to assess the knowledge and attitudes of healthcare staff in NT Public Hospitals towards the identification and management of abused patients. The process involved interstate and overseas benchmarking to develop a valid and reliable measuring tool. The final tool was based on a survey instrument from Seattle USA<sup>8</sup>. (See Appendix 3). This instrument is a proven method for assessing provider characteristics and training needs and can be used to evaluate training and policy interventions in DV. Approval was sought from Public Hospital Managers and the Ethics Committees. The survey was mailed in May 2002 to all Doctors, Nurses, Aboriginal Health Workers and Aboriginal Liaison Officers at all five NT Public Hospitals.

### DV Screening Tool

Interstate and overseas review of DV screening in hospitals provided a number of examples of instruments that had been used and evaluated. Queensland and NSW had already piloted screening tools in hospitals as part of their DV initiatives. Of specific interest was the tool being trialed in the Top End of Queensland as part of the Queensland Domestic Violence Initiative<sup>3, 5</sup> for use in hospitals with a majority of Aboriginal patients.

An NT draft screening tool was developed and reviewed by a range of NT Aboriginal Organisations and individuals working in healthcare during July and August 2002. These included:

- Domestic Violence Community Development and Training Officer
- NT Correctional Services Prisoner Rehabilitation Team
- Policy and Advocacy Unit, ATSIC
- Aboriginal Interpreter Service, RDH
- DHCS Aboriginal Cultural Awareness Program
- Aboriginal Liaison Officer, RDH

Medical Records Management reviewed the design so that it could be incorporated into Patient Medical Records. Staff education for use of the screening tool included strategies for achieving privacy for the patient to answer the questions, methods for assessment of the situation and how to make appropriate referrals.

The screening tool used in the pilot is at Appendix 5.

---

<sup>8</sup> Sugg NK, Thompson RS, Thompson DC, Maiuro R, Rivara FP. 1999. Domestic Violence and Primary Care. Arch Fam Med 8:301-306.

## DV Screening Training Package

The Training Working Group guided production of a training package for screening and associated resource material. The training package was developed after a benchmarking exercise using material obtained from:

- Queensland Domestic Violence Initiative<sup>3,5</sup>
- NT Sexual Assault and DV Package<sup>9</sup>
- NSW Hitting Home Video<sup>10</sup>

The package consisted of a PowerPoint presentation convertible to overheads and a 25 minute NSW training video entitled 'Hitting Home'. The final training package can be delivered in 2 to 3 hours with a 20 minute break.

## DV Screening Resource Kit - Hospitals & GP's

A Resource Kit was developed and placed on the DHCS website to inform healthcare personnel how to ask clients about DV and what to do if they received a disclosure. The kit includes a flow diagram showing the various steps in identifying and responding to DV. This flow diagram was also displayed at screening sites.

Resources used to develop the kit were the Domestic Violence and Incest Resource Centre GP Booklet and the Office of Women's Policy DV Contact Card. The Resource Kit was laminated and placed in clinic areas at pilot sites for staff usage and also handed out and referred to during Screening Training.

## Mentoring

During training sessions staff who felt confident with the screening process were able to self nominate as mentors and provided with a mentor kit. A list of nominees was provided to management and staff at each pilot site.

## Inservices

In order to build better relationships between referral agencies and hospitals and to increase healthcare provider knowledge of available services the following agencies presented thirty minute in-service training sessions to staff at pilot sites. This initiative was well supported by staff at both hospitals and the community agencies.

---

<sup>9</sup> NT DHCS, 1996, Sexual Assault and Domestic Violence Training Package, Women's Health Strategy Unit

<sup>10</sup> NSW Health, 1994, 'Hitting Home - Hospital Responses to Domestic Violence', Women's Health & Sexual Assault Education Unit.

Agencies providing in-services to Emergency Department staff included:

- Dawn House Women's Shelter/Domestic Violence Counselling Service
- NT Police
- Family and Children's Services
- Catherine Booth House, Women's Shelter
- Crisis Line
- Employee Assistance Service - Healthcare Providers Service
- Sexual Assault Referral Centre
- Ruby Gaea House, Darwin Centre Against Rape
- Danila Dilba Counselling/Healing Service
- Victims of Crime Assistance League
- 

Agencies providing in-services to Katherine Hospital staff included:

- NT Police
- Family and Children's Services
- Employee Assistance Service - Healthcare Providers Service
- Centacare NT Katherine Family Link
- Katherine Aboriginal Family Support Unit
- Katherine Women's Information and Legal Service
- Katherine Women's Crisis Centre

## Referral Card

The Referral Working Group reviewed current referral/hand held cards and agreed that the Women's Advisory Council card was the most informative whilst being the least likely to place a person carrying it in danger from its discovery. The Women's Advisory Council were happy to provide their card template to the WHSU to print and make available at each pilot site.

## Screening Training Video

A screening training video was developed to complement the existing method of training staff to screen. It consists of 3 segments of 20 minutes each with input from the following agencies:

- Police Domestic Violence Unit
- Family and Children's Services, PECAN
- Palmerston Domestic Violence Shelter
- Top End Women's Legal Service
- Crisis Line Counselling Service
- Aboriginal Interpreter Service
- Aboriginal Liaison Service
- Midwives
- DV Trainer/Community Development Officer
- Sexual Assault Referral Centre

## Patient Survey

The purpose of the client survey was to gain feedback from patients on their experiences of the DV screening tool. Katherine Antenatal clients were surveyed on their second clinic visit. (See Appendix 6). A similar survey (See Appendix 7) was conducted with male and female patients after being admitted through the ED. Those patients who were physically able were approached by the Project Officer to complete the survey. Patients were given a choice of either completing the survey on site or returning the completed survey by mail.

## Focus Groups and Interviews with Staff and Community Support Services

Focus groups and interviews were held with key stakeholders at each pilot site towards the end of the pilot project. The purpose of these was to obtain feedback on the appropriateness and effectiveness of the screening tool.

Focus groups were held with the following:

- Social Work Department at the RDH
- Emergency Department Staff at the RDH
- Community Domestic Violence Network, Darwin
- Antenatal Department Staff at KDH
- Community Support Network (CHAIN), Katherine

Individual interviews were held with the Aboriginal Liaison Officer at Royal Darwin Hospital and Community Domestic Violence Support Services in Katherine.

The list of focus group questions used in the pilot is at Appendix 8.

# 7. Communication Strategies

## Newsletters

Because this pilot involved a change management process a total of five Project Newsletters were produced and distributed to staff at all five Public Hospitals and other interested community DV Agencies. These Newsletters were also used as a vehicle for recruiting to working groups.

## Posters

Flyers were used to advertise the screening, pilot launches and the regular in-services by referral agencies.

**Expo - Launches**

An expo launch was held at each pilot hospital during August 2002 with a wide range of services participating.

**Media**

Media releases for the Knowledge and Attitude Survey, Pilot Site Launches and Pilot Project Data were compiled for general press. Additional articles on the pilot also featured in The Bulletin Hospital Newsletter, Wednesday's Word, the Division of General Practitioner's Newsletter and ARCHI Net, the Hospital Innovations Internet Site and Magazine.

**Internet - Web**

The Resource Kit has been published on the DHCS Internet/Intranet to allow greater access to this resource.

**Statistical Reports to Pilot Sites/DV Network**

Weekly reports were provided to each pilot site providing a breakdown of the data obtained from screening forms. A summary of this data was also provided to the Darwin Domestic Violence Network bi-monthly meetings.

## SECTION TWO

### PROJECT EVALUATION

#### 1 Evaluation Purpose

To inform key stakeholders of the outcome of the pilot Domestic Violence screening at two Public Hospital sites in the Northern Territory and to make recommendations in relation to implementation of routine screening in all NT Public Hospitals.

#### 2 Evaluation Objectives

- To determine the extent to which the original objectives for the pilot project were met.
- To determine whether domestic violence screening is an appropriate and effective means of identifying and responding to domestic violence cases presenting to emergency and antenatal departments of Public Hospitals in the NT.
- To determine whether domestic violence screening is recommended for future implementation in Public Hospitals throughout the NT and if so, what issues need to be addressed for this to occur.

#### 3 Scope

The two pilot sites were RDH Emergency Department and Katherine Hospital Antenatal Department. The DV screening tool was trialed for a three-month period from September to November 2002. Those targeted were all males and females over the age of 16 years presenting to the RDH ED during the trial period in Darwin and all females over the age of 16 presenting to the Antenatal Department in Katherine. This evaluation does not measure the long-term impacts of the screening tool on DV incidence in the NT nor follow individual cases from screening to referral.

## 4 Evaluation Methodology

### 4.1 Project Management

#### Evaluation Team

The Evaluation Report Team included :

- Louise Page, Project Officer, Domestic Violence Screening Pilot, WHSU
- Jenny Young, Evaluation Adviser, WHSU
- Beverley Hayhurst, Health Promotion Officer, DHCS

#### Time Frame

The Evaluation commenced in January 2003 and was completed in April 2003.

### 4.2 Evaluation Tools

#### Ethics Approval

Ethics approval was obtained from the Human Research Ethics Committee, DHCS and the Menzies School of Health Research to conduct the staff Knowledge and Attitude survey, the patient feedback survey and the focus groups with key stakeholders.

#### The Knowledge and Attitude Survey

This survey measured staff knowledge and attitudes in relation to DV and the results were used to inform the development of training for staff at the pilot sites. Survey questions were grouped into key domains to ensure reliability and validity. The survey also included a general comments section.

Assistance in data entry and analysis was provided by Chris Bradbury, Lecturer Statistics Northern Territory University (NTU) and Wendy Afleck, Social Work Student, NTU.

#### Staff Feedback from the Screening Training

Data from training feedback forms (See Appendix 4) was entered into an Excel spreadsheet by the Project Officer.

## **Survey of Patient Experiences of the Screening Tool**

A total of forty-four patients completed the survey at RDH ED and 13 at Katherine Antenatal Clinic. (See copies of Patient Survey questions at Appendix 6).

## **Stakeholder Focus Groups and Individual Interviews**

In Darwin, two focus groups were held with staff at the ED, one with Social Work Department staff and another with personnel from DV Agencies. In Katherine one focus group was conducted with staff from the Antenatal Department and one with community DV agencies. Individual interviews were held with the Aboriginal Liaison Officer at RDH ED and personnel from Katherine Family Link and Katherine DV Shelter. (See Focus Group Questions at Appendix 7).

## **4.3 Evaluation Limitations**

### **Impact of the Bali Bombing on Staff at the RDH Emergency Department**

The Bali Bombing incident of 12 October 2002 occurred during the pilot screening. This took a serious mental and physical toll on RDH ED staff when the Australian victims were brought to the RDH ED for treatment. After this incident, screening rates dropped dramatically from 20% of all patients being screened during September 2002 to 4-5% of all patients being screened during November/December 2002.

### **High Staff Turnover at RDH Emergency Department**

There was a high staff turnover at RDH ED during the screening trial period. External relief Nursing Agency staff who had not received DV training, were recruited to cover shortages.

### **Knowledge and Attitude Survey**

The staff who completed the initial Knowledge and Attitude Survey may not be the same staff surveyed if a repeat survey is conducted for any future evaluation.



## 5 Evaluation Findings

### Knowledge and Attitude Survey

A total of 1450 surveys were sent to all Nursing, Medical, Aboriginal Health Worker and Aboriginal Liaison Officer classification streams in public hospital in the NT. A total of 602 responses were received (47% response rate) with 161 returned due to staff on leave and 12 withdrawn after respondents indicated they no longer worked in any hospital. The survey domains included:

- Blame the victim: - "People are only victims if they choose to be".
- Professional role resistance/fear of offending patient: - "I am afraid of offending the patient if I ask about DV".
- Perceived self-efficacy: - "I feel confident that I can make appropriate referrals for abused patients".
- Victim/provider safety: - "I am reluctant to ask patients about DV out of concern for my personal safety".
- System support: - "We have ready access to medical Social Workers to assist in the management of DV".
- Frequency of DV: - "In the past three months, when seeing someone with injuries, how often have you asked the patient about the possibility of domestic violence?"

Key findings from the domains measured were:

- The majority of staff agreed that the victim is not to blame.
- The majority of staff agreed that asking a patient about violence will not necessarily offend.
- The majority of staff felt safe asking about DV.
- The majority of staff indicated they felt supported in their work areas to provide assistance to patients affected by DV.

Key findings from individual survey questions are outlined below.

- Of the 577 who responded to this question 86% stated that they did not know or were unsure of any guidelines for the detection/management of DV in their work area.
- Of the 586 who responded to this question 78.7% stated that they had not attended any DV Training.
- Of the 511 who responded to this question 72% stated that DV in NT Hospitals was very common.
- Of the 583 who responded to this question 71% stated that they had identified a patient who was a victim of DV.
- Of the 587 who responded to this question 53% stated feeling extremely confident asking about frequency of smoking and alcohol use compared to only 11% of 585 and 15% of 586 who felt confident asking about emotional and physical abuse.

- Of the 546 who responded to this question 51% indicated the strategies they knew would either not at all or only slightly help victims of DV change their situation.
- Of the 590 who responded to this question 50% agreed that the role of the health care provider is limited in being able to help victims of DV.
- Of the 593 who responded to this question 46% were neutral or stated that they did not know how to ask about the possibility of DV.
- Of the 508 who responded to this question 46% stated they were not at all or only slightly confident they could make appropriate referrals for abused patients.
- Of the 566 respondents to this question 37% stated they had no access to information detailing management of DV.

The following is a summary of key responses from the Comments Section.

- 58 respondents stated that they saw DV cases every day at work.
- 44 respondents desired training on health issues associated with DV.
- 38 respondents perceived that DV in the NT was culturally accepted and/or condoned
- 27 respondents stated that DV strategies were needed.
- 12 respondents expressed frustration with DV victims when they returned to violent relationships or did not accept help.
- 11 respondents welcomed the survey hoping there would be outcomes for Territorians particularly Aboriginal patients.
- 10 respondents sought more support from Social Workers/Aboriginal Liaison Officers or on call services for the weekends and after-hours.
- 8 respondents expressed feelings of hopelessness at the levels of violence.

### **Feedback from DV Training**

A total of 121 training feedback forms were received and analysed. (See copy of Screening Training Feedback Form at Appendix 4).

The results indicated:

- The training was viewed as helpful by the majority of participants.
- Staff felt moderately confident to screen after the training.
- Staff felt moderately confident to screen after training.
- Staff requested more opportunities for DV training and more time to practice DV screening.

## Analysis of Screening Data

Table 1 Breakdown of Screening Data from RDH ED September - November 2002

Description	September	October	November	Total	Female	Male	Un-recorded gender
Adult Patients (16yrs & over) presenting to ED during pilot period	2589	2744	2540	7873			
Patients screened during pilot period	526 or 20.3%	128 or 4.7%	111 or 4.4%	765 or 9.7% of patients presenting to RDH were screened	386 or 50.4% of patients presenting to RDH	348 or 45.5% of patients presenting to RDH	31 or 4%
Patients screened and disclosing DV	128 or 24.3%	44 or 34%	26 or 23%	198 or 26% of patients screened disclosed DV	125 or 63.1% of patients screened	60 or 30.3% of patients screened	13 or 6.6%
Patients screened, disclosing DV and asking for immediate help	45 or 35.2%	17 or 39%	10 or 38.5%	72 or 36.3% of patients screened and disclosing DV asked for immediate help	52 or 72.2% of patients screened and disclosing	17 or 23.6% of patients screened and disclosing	3 or 4.1%

This table illustrates the dramatic decline in adult patients (ie those patients over the age of 16 years) screened after the Bali Bombing incident in October 2002. The fall in screening rates during October and November 2002 can also be attributable to the high staff turnover during these months with new staff not having received DV training. Staff focus groups also revealed other factors influencing patients not being screened. These included the presence of a partner in 30 (24%) instances, the presence of other family members in 23 (18%) instances and a medical condition in another 13 (10%) instances. 24 (19%) patients refused and 9 (7%) were too intoxicated. Other factors influencing patients not being screened included lack of privacy to screen and staff busy with other duties.

A total of 34 women completed the DV screening during the trial screening period at Katherine Antenatal Department. Of these 34 there were 4 disclosures (11.8%) with 1 person requesting immediate help. A number of patients presented to the Antenatal Department on more than one occasion therefore it is not possible to provide data on the total number of individuals presenting.

Table 2 Comparison of Australian Screening Sites for Disclosure Rates

State Figures for Emergency Departments	RDH Emergency Dept	NSW <sup>11</sup>	QLD Stage 1 <sup>12</sup>	QLD Stage 2 <sup>13</sup>
Percentage of total females screened who disclosed DV	32.3%	12.9-14.69%	0	8.5%
Percentage of all adult patients screened for DV during pilot period	9.7%	10-12%	7.7%	23.2%

This table demonstrates the high percentage of females at RDH ED disclosing domestic violence during screening in comparison to the QLD and NSW studies. The table also demonstrates the proportion of adults screened for DV during the pilot period in the NT compared to those screened in the QLD and NSW studies. The NT was the only jurisdiction that screened males as well as females.

---

<sup>11</sup> NSW DVI

<sup>12</sup> QLD DVI Stage 1

<sup>13</sup> QLD DVI Stage 2

## Feedback on the Appropriateness and Effectiveness of the Screening Tool

**Table 3 Feedback from Focus Groups and Interviews conducted with Patients, Staff and Referral Agencies on Appropriateness and Effectiveness of the Screening Tool at RDH ED.**

APPROPRIATENESS	Feedback From Pilot Site Staff	Feedback From Patients	Feedback From Internal and External Referral Agencies
	<ul style="list-style-type: none"> <li>Initial discomfort with screening which improved after practice.</li> <li>Support to continue screening in the new department "should be routine in new department".</li> <li>Some wondering why the screening had stopped.</li> <li>Limited clinic rooms at current ED, therefore some patients not afforded any privacy to complete screening.</li> <li>Need for 24 hour ALO/Social Work support</li> <li>Staff turnover was high.</li> <li>New staff not always introduced to screening or offered DV training.</li> <li>Heavy reliance on relief staff who are not free to attend DV training.</li> <li>Both doctors and nurses queried who was ultimately responsible for screening.</li> <li>Screening tool helpful, straightforward and easy to understand.</li> <li>The DV screening process reduced the need to counsel patients.</li> <li>Screening was easy format to follow.</li> <li>Some referral situations were difficult with remote areas poorly supported by shelters and safe houses.</li> </ul>	<ul style="list-style-type: none"> <li>The majority of patients completing a patient survey supported the screening process.</li> <li>Some patients felt relieved after being asked about DV.</li> </ul>	<ul style="list-style-type: none"> <li>Tool would benefit from fuller description of what is meant by DV/FV in the preamble. Take out the wording of "at home" as DV does not always occur at home.</li> <li>RDH ED staff inadequately supported.</li> <li>ED requires 24 hour support.</li> <li>Agency support for continued in-services to support screening.</li> <li>The Social Work department reported good feedback from staff and noted a raised awareness of DV throughout the hospital.</li> <li>Some inappropriate referrals.</li> <li>Two DV shelters reported a 50% increase in referrals as a result of the screening, one of which has applied for additional housing. Another shelter reported a 3-5% rise in referrals from the hospital.</li> <li>The Hospital Based Constable reported a dramatic start to the pilot with up to 10 restraining order requests a day.</li> </ul>

APPROPRIATENESS	Feedback From Pilot Site Staff	Feedback From Patients	Feedback From Internal and External Referral Agencies
	<ul style="list-style-type: none"> <li>Aboriginal staff enthusiastically adopted the screening but were not always sure of their role.</li> <li>Aboriginal staff are still using the DV screening tool.</li> <li>WAC card seen as handy resource, however need expressed for a men's referral card as WAC card clearly targets women.</li> <li>The resource kit was well received</li> <li>The majority of staff felt that the DV screening was of value. It let people know they were not alone, gave people the opportunity to talk about issues with someone where before it would have gone unnoticed.</li> <li>Training seen as effective.</li> <li>Staff perceived a difficulty with screening without training.</li> <li>The screening helped Aboriginal staff explain to patients about DV and the screening process.</li> <li>It was beneficial. Without the tool there was no reason to ask patients.</li> <li>Concern at the lack of privacy in the department and consequently the validity of some of the screening responses.</li> <li>It was suggested that pictorial diagrams may assist Aboriginal Patients to understand more about DV.</li> </ul>		<ul style="list-style-type: none"> <li>Information about restraining orders needs to be placed in the screening areas for patients and staff.</li> <li>Increase in demand for Hospital Based Constable services from Social Work Department, NESB and Asian patients.</li> <li>ED need a support person to address concerns about patients younger than 16 years of age ie pregnant 14 year olds, bashed 12 year olds.</li> <li>Referral process seen as satisfactory.</li> <li>A Social Worker working in the ED could provide support for staff in the form of debriefing.</li> <li>DV pamphlets could be available in other languages for patients from NESB.</li> <li>Some patients appear to still require medical attention after discharge to shelters and return to ED.</li> </ul>

Table 4 Feedback on Appropriateness and Effectiveness of the Screening Tool at KH Antenatal Department.

APPROPRIATENESS	Feedback From Pilot Site Staff	Feedback From Patients	Feedback From Internal and External Referral Agencies
	<ul style="list-style-type: none"> <li>• The Midwives saw value in the screening despite time constraints due to large groups of Aboriginal women arriving together.</li> <li>• Staff felt that with practice the screening tool became easier.</li> <li>• Staff felt adequately trained, their role was clear and they found the tools easy to use.</li> <li>• There was support for staff mentoring in relation to the screening process.</li> <li>• The midwives expressed concern for the high levels of DV in their patient population and supported screening, wishing to continue the screening as part of normal clinical practice. They felt that screening was not judgemental, discriminatory, selective nor subjective, with a practical flow on for the patient and staff.</li> <li>• Staff felt the resource kit made their job clear and information was handy.</li> <li>• The WAC card was described as useful and innocuous.</li> </ul>	<ul style="list-style-type: none"> <li>• All patients who were screened felt it was a good idea and felt okay about the process and questions asked.</li> <li>• Patients commented that screening offers help and shows that someone cares, it fights the problem of violence, provides an opportunity to talk truthfully and disclose about DV if questioned.</li> <li>• Although the screening tool was to be used in the hospital there was support for GP's to screen.</li> <li>• Patients were happy to be asked about DV by staff.</li> </ul>	<ul style="list-style-type: none"> <li>• Training reduces "unhelpful attitudes" in healthcare workers.</li> <li>• The questions were appropriate and direct.</li> <li>• There is enough community capacity to handle referrals.</li> </ul>

EFFECTIVENESS	Feedback From Pilot Site Staff	Feedback From Patients	Feedback From Internal and External Referral Agencies
	<ul style="list-style-type: none"> <li>Patients did not mind being screened. The only problem came with getting patients away from partners who had accompanied them.</li> <li>Include a video for patients to be shown in the waiting room to help with their education.</li> </ul>		<ul style="list-style-type: none"> <li>Raised awareness of DV services in the hospital and whole community. There is a feeling the community are fighting the issues together - good networking opportunity.</li> <li>Nurse Educators are now including a DV component in training. Student nurses tour the shelter now as part of orientation.</li> <li>Relationships between the hospital and the DV agencies have been greatly enhanced.</li> <li>In-services were effective in allowing agencies to address staff concerns and knowledge deficits.</li> <li>Need definition of violence in preamble to reduce confusion in tool.</li> <li>There is now an educational folder from the Shelter held at the Emergency Department at Katherine.</li> <li>Would like screening extended to other agencies in Katherine.</li> <li>Some patients appear to still require medical attention but are discharged to shelters, some to be returned as too ill to be discharged.</li> <li>Staff would benefit from more support such as Social Work or Aboriginal Liaison Officer or Administration to follow up referrals and organise the in-services to the hospital site.</li> <li>DV is not a cultural practice.</li> <li>A lot of DV occurs at night (Katherine offer 11pm crisis hour to address this).</li> <li>Some dual diagnosis eg mental health problems as well as DV.</li> </ul>



## Summary of Key findings

1. There is broad support amongst the client group for DV Screening.
2. 78% of the 602 staff surveyed through a preliminary Knowledge and Attitude Survey had not received training in domestic violence.
3. The majority of staff were moderately confident to screen after receiving training.
4. One in four patients screened at the Emergency Department of Royal Darwin Hospital disclosed domestic and family violence. Males constituted 30.3% and females 63.1% of this total. (Unrecorded gender was 6.6%).
5. Of patients who were screened and disclosed DV at RDH ED 72.2% of female patients and 23.6% of male patients asked for immediate help.
6. The two main crisis shelter referral agencies in Darwin reported that referrals had doubled during the screening period.
7. The Hospital Based Constable at RDH reported up to 10 requests a day for restraining orders during the pilot. This was an increase of more than 50% from before the pilot.
8. Focus group feedback from pilot site staff indicated lack of privacy in their work area was a barrier to screening.
9. Feedback from the Knowledge and Attitude Survey, community agencies, and health care staff revealed the importance of back-up support staff to handle immediate requests for help. It was also highlighted that this form of backup was not currently available at pilot sites.
10. Feedback from health care staff revealed the need for further referral options for male victims and perpetrators in the community. Feedback requested a male referral card.
11. Feedback from community focus groups and interviews suggested that some patients referred to shelters in Darwin and Katherine were discharged inappropriately and still required significant medical attention.
12. Health care staff and community focus groups supported the use of the WAC card and resource kit.
13. Community agencies reported improved relationships with the hospital as a result of screening. A protocol has been set up between Catherine Booth House Women's Shelter and the RDH Emergency Department.
14. Although the screening indicated a high degree of DV presenting to hospitals, hospital data does not currently collect the same data across all hospitals and this data when collated is not included in the NT Domestic Violence Data Collection compiled by the Office of Women's Policy.
15. Katherine Antenatal Department elected to continue screening.
16. Katherine Community agencies would like screening extended to other services.
17. Feedback from referral agency focus groups revealed the need for a pamphlet in different languages outlining the different restraining order protection options.

## 6 Conclusions

This section will be addressed through answering each of the evaluation objectives.

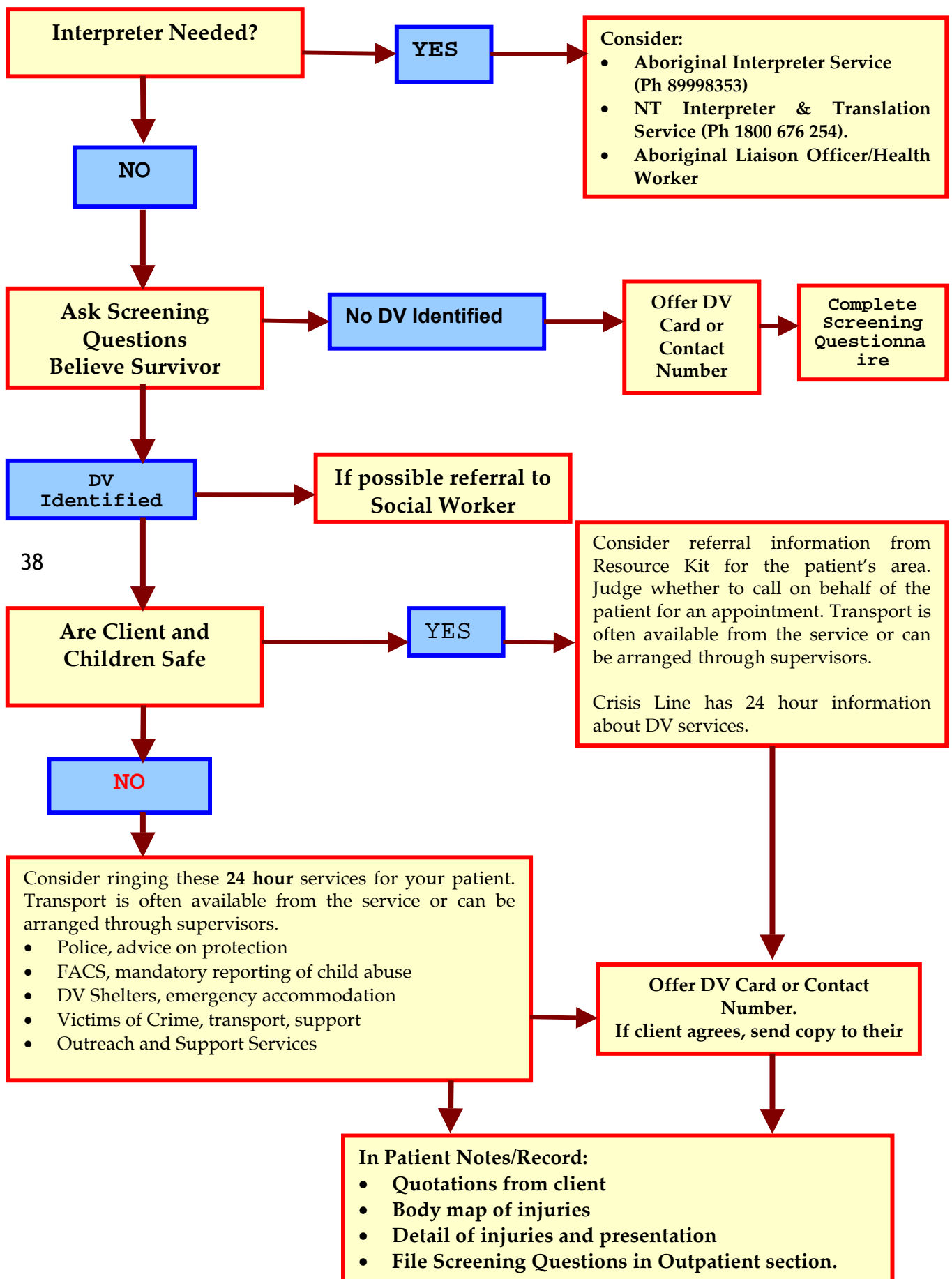
**Extent to which the original objectives for the pilot project were met**

**Objective 1 To develop a standardised method, for use in the hospital setting, for identifying women subjected to domestic violence.**

A standardised screening tool has been developed, trialed and amended. (See Appendix 9) and is now available to be incorporated as a standard procedure for future screening sites.

The standardised method for identifying DV patients presenting at NT hospitals is illustrated in the following flow chart:

## GET THE CLIENT ON THEIR OWN – EXPLAIN THE SCREEN



**Objective 2 To support accurate diagnosis and appropriate responses for women who experience domestic violence, by introducing a method for identifying women who have experienced domestic violence in hospital accident and emergency department and antenatal care settings.**

See discussion for Objective 1.

**Objective 3 To raise awareness of domestic violence amongst health care providers.**

Feedback from the Knowledge and Attitude survey and the focus groups indicates that the screening training, resource kit, screening tool and in service training raised awareness of domestic violence amongst healthcare providers.

**Objective 4 To support staff to develop the competence and confidence to identify and respond to domestic violence.**

Feedback from training sessions and focus groups indicated that the training, resource kit and screening tool increased staff competence and confidence in responding to DV.

**Objective 5 To incorporate information related to domestic violence into medical records and hospital data collection.**

The screening tool when completed is filed in a patient's personal medical record. At this stage the information placed on the patient's medical record is not collated into any hospital data collection.

**Objective 6 To identify and introduce appropriate responses and referrals for victims once identified.**

Although some shelters reported inability to cope with the increase in referrals the majority of referral agencies felt that referrals to their service from the hospital were appropriate. The Hospital Based Constable at RDH reported an increase in appropriate referrals. Some external referral agencies in both Katherine and Darwin reported patients being discharged and referred but still requiring medical attention.

**Objective 7 To evaluate and document the methodology and outcomes and make recommendations for the continuing response to victims in the hospital setting.**

This evaluation report documents the methodology and reports on the outcomes of the pilot screening project with recommendations for continuation of DV screening in all NT Public Hospitals.

**Objective 8 To establish the participation by DHCS hospitals in the NT DV data collection.**

This is still to be established. The collection of antenatal data is currently coordinated by the NTPIMG Perinatal Data Collection Committee. This Committee

is currently reviewing the inclusion of a collection field related to domestic and family violence screening at antenatal presentations.

**Appropriateness and effectiveness of the screening tool in identifying and responding to domestic violence cases presenting to emergency and antenatal departments of public hospital in the NT.**

Feedback from staff and community focus groups and interviews and patient survey feedback indicates that the strategy was an appropriate and effective tool for identifying and responding to patients experiencing DV.

**Recommendations for Future Implementation of Domestic and Family Violence Screening in NT Public Hospitals.**

Feedback from hospital staff prior to the implementation of the DV screening indicated staff support for screening training. Feedback from staff focus groups and individual staff interviews indicates that screening is supported by hospital staff. However the process of identifying domestic and family violence requires time to be available for disclosures and subsequent referrals.

Feedback from staff and referral agency focus groups indicates a need for adequate staff support in the form of Aboriginal Liaison or Social Work support. Disclosure at the Katherine Hospital Antenatal area, though high, was felt to be adequately supported by current workplace support. Disclosure in the RDH ED was felt to be inadequately supported by Aboriginal Liaison and Social Work staff due to DV often presenting after-hours when no support is available for staff to help with referral options. Adequate provision for privacy was also an important prerequisite for effective DV screening. A list of recommendations for future implementation is on the following page.

## 7 Recommendations for Future Implementation of DV Screening in NT Public Hospitals

It is recommended:

1. That Emergency and Antenatal Departments at all NT Public Hospitals commence routine DV screening following:
  - completion of staff training for screening
  - assessment of adequate privacy to screen
  - assessment of crisis accommodation capacity
  - assessment of appropriate staff support for screening (Social Work, Aboriginal Liaison or on-call services)
2. That the Emergency Department of Royal Darwin Hospital commence routine screening after moving to their new location.
3. That the Women's Advisory Council (WAC) Domestic Violence information referral card continues to be made available at all screening sites.
4. That a referral card in similar format to the WAC card be compiled and available for men.
5. That Domestic Violence data from all NT Public Hospitals be incorporated into the Northern Territory Domestic Violence Data Collection Project.
6. That a pamphlet on restraining order protection options be compiled by the Top End Women's Legal Service in cooperation with the RDH Hospital-Based Constable and that this pamphlet be made available at all screening sites.
7. That the screening tool and resource kit be available for use by other community agencies.
8. That a further evaluation be conducted after screening has been in place in all NT Public Hospitals.
9. That a Working Group is formed to guide implementation of the above recommendations.

## BIBLIOGRAPHY

American Medical Association, 1992. *Diagnostic and Treatment Guidelines on Domestic Violence*, Chicago.

Astbury J., Atkinson J., Duke J. E., Easteal P.L., Kurrle S.E., Tait P.R., and Turner J., 2000. The Impact of Domestic Violence on Individuals. *Medical Journal of Australia*, Vol 173 2 October :427-431.

Australian Bureau of Statistics 1996. *Women's Safety Australia 1996*. ABS Catalogue No. 4128.0.

Bagshaw D., and Chung D., 2000. *Women Men and Domestic Violence*. Partnerships Against Domestic Violence, Commonwealth of Australia

Bates L., Redman S., Brown W., Hancock L., 1995. Domestic Violence Experienced by Women Attending an Accident and Emergency Department. *Australian Journal of Public Health*, 19: 293-9

Baum F., 1998. *The New Public Health An Australian Perspective*. Oxford University Press., Melbourne: 294

Berenson A.B., Wiemann C.M., Wilkinson G.S., Jones W.A., and Anderson G.D., 1994. Perinatal Morbidity Associated with Violence Experienced by Pregnant Women. *American Journal of Obstetrics and Gynecology*, 170:1760-1769.

Bohn, D.K., 1990. Domestic Violence and Pregnancy: Implications for Practice . *Journal of Nursing Midwifery*, 35:86-98.

Bolger A., 1991. *Aboriginal Women and Violence*. Australian National University North Australia Research Unit, Darwin.

Braveman P.A. and Tarimo E. 1994. *Screening in Primary Health Care*. World Health Organization, Geneva.

Carcach C. and James M.. 1998. Homicide Between Intimate Partners in Australia, *Trends and Issues in Crime and Criminal Justice No. 90* , Australian Institute of Criminology, Canberra.

Clearinghouse. 2001. *From Policy to Practice: Routine Screening for Domestic Violence in NSW Health*, Issue No 6 March.

*Consultations With Women of Non English Speaking Background in Darwin Regarding Their Experiences and Attitudes Relevant to the Northern Territory Woman's Strategy* January 1993. Unpublished paper. Northern Territory Office of Women's Affairs and the Women's Advisory Council. Darwin: 7

Covington D.L., Dalton V.K., Diehl S.J., Wright B.D., and Piner M.H., 1997. Improving Detection of Violence Among Pregnant Adolescents. *Society for Adolescent Medicine*, 21: 18-24.

Crime Prevention Branch Attorney-General's Department. 2000. *Crime in Australia a State by State Comparison*. Canberra.

Cunneen C. and Stubbs J. 1996. *Violence Against Women. A Report for the Race Discrimination Commissioner and the Institute of Criminology*. The University of Sydney. Sydney.

Datner E.M., and Ferroggiaro A.A., 1999. Violence During Pregnancy. *Emergency Medicine Clinics of North America* 17(3): 645-655.

Davies M., (Ed) 1994. *Women and Violence*. Zed Books, London.

*Declaration on the Elimination of Violence Against Women*. 1993. UN Document No. A/RES/48/104. 20 December 1993.

Dienemann J., Trautman D., Shahan J.B., Pinnella K., Priya K., Whyne D., Bekemeier B. and Campbell J. 1999. Developing a Domestic Violence Program in an Inner-City Academic Health Center Emergency Department: the First Three Years. *Journal of Emergency Nursing* 25 (2): 110-115.

Dietz P.M. Gazmararian J.A., and Goodwin M.M, 1997. Delayed entry into Prenatal Care: Effect of Physical violence. *Obstetrics & Gynecology*. 90(2): 221-224

Easteal P.W., 1993. *Killing the Beloved: Homicide Between Adult Sexual Intimates*. Australian Institute of Criminology, Canberra.

Eastwell C and Cheyne K, 1997. *Making Waves. Violence Against Women With Learning Disabilities: a Resource Manual for Workers*, The Making Waves Project, Caxton Legal Centre, New Farm Neighbourhood Centre and Anglican Women's Hostel. New Farm QLD.

Family Violence Prevention Unit, Health Canada. 1999. *A Handbook for Health and Social Service Professionals Responding to Abuse During Pregnancy*. Prepared by Jamieson Beals, Lalonde and Associates, Inc. Health Canada, Ottawa.

Feldhaus K.M., Koziol-McLain J., Amsbury H.L., Norton I.M., Lowenstein S.R. and Abbott J.T. 1997. Accuracy of 3 Brief Screening Questions for Detecting Partner Violence in the Emergency Department. *JAMA*,. 277 (17):1357-1361

Fishwick .J., 1998, Assessment of Women for Partner Abuse. *JOGNN*. 27(6): 661-670.

Furbee P.M., Sikora R., Williams J.M., and Derk S.J., 1998. Comparison of Domestic Violence Screening Methods: A Pilot Study. *Annals of Emergency Medicine*, 31(4): 495-501.

Gazmararian J.A., Lazorick S, Spitz A. Ballard T.J., Saltzman L.E., and Marks J.S. 1996. Prevalence of Violence Against Pregnant Women. *JAMA*, 276: 1915-20.

Gelles RT.J., 1993. Through a Sociological Lens Social Structure and Family Violence in Gelles R.J. and Loseke D.R., (Ed) 1993. *Current Controversies on Family Violence*. Sage Newbury Park:31-33.

Gerlock A.A. 1999. Health Impact of Domestic Violence. *Issues in Mental Health Nursing*, 20: 373-385.

Gielen A.C., O'Campo P.J., Faden R.R., Kass N.E. and Xue X. 1994. Interpersonal Conflict and Physical Violence During the Childbearing Years. *Social Science and Medicine*, 39: 781-787.

Gondolf E.W., 1995. Alcohol Abuse, Wife Assault and Power Needs, *Social Service Review*, 69(2): 274-284.

Gremillion D.H. and Kanof E.P. 1996. Overcoming Barriers to Physician Involvement in Identifying and Referring Victims of Domestic Violence. *Annals of Emergency Medicine*, 27(6):769-773

Haile-Mariam T., and Smith J., 1999. Domestic Violence Against Women in the International Community. *Emergency Medicine Clinics of North America*, 17(3): 617-630.

Haywood Y.C. and Haile-Mariam T., 1999. Violence Against Women, *Domestic Violence in the Emergency Department*,17(3): 603-615

Hegarty K., Hindmarsh E.D., and Gilles M.T., 2000. Domestic Violence in Australia: Definition, Prevalence and Nature of Presentation in Clinical Practice. *Medical Journal of Australia*, Vol 173 2 October: 363-364.



- Helton A.S., Anderson E. and McFarlane J., 1987, Battered and Pregnant: a Prevalence Study with Intervention Measures. *American Journal of Public Health*, 77:1337-1339
- Hilliard P.J.A., 1985 Physical Abuse in Pregnancy. *Obstet Gynecol*, 66: 185-190
- Hoff L.A., and Rosenbaum L., 1994. A Victimization Assessment Tool: Instrument Development and Clinical Implications. *Journal of Advanced Nursing*, 20:627-634.
- Indermaur D. 2001. *Young Australians and Domestic Violence*. Australian Institute of Criminology Trends and Issues. Canberra.
- Janssen P.A., Basso M.C. and Costanzo R.M. 1998. The Prevalence of Domestic Violence Among Obstetric Nurses. *Women's Health Issues*, 8(5): 317-323.
- Larkin G.L., Hyman K.B., Mathias S.R., D'Amico F. and MacLeod B.A. 1999. Universal Screening for Intimate Partner Violence in the Emergency Department: Importance of Patient and Provider Factors. *Annals of Emergency Medicine*, 33(6): 669-675.
- Lo Vecchio A Bhatia and D Sciallo, 1998. Screening for Domestic Violence in the Emergency Department. *European Journal of Emergency Medicine*, 5: 441-444.
- Loughlin S., Spinola C., Stewart L, Fanslow J. and Norton R. 2000. Emergency Department Staff Responses to a Protocol of Care for Abused Women. *Health Education and Behaviour*. 27(5):572-590
- Markey G. 1998. *The Health Status of Women in the Northern Territory*. Women's Health strategy Unit, Territory Health Services, Darwin.
- Matar Curnow S.A., 1997. The Open Window Phase: Helpseeking and Reality Behaviours by Battered Women. *Applied Nursing Research*. 10(3): 128-135
- Mazza D., Dennerstein L and Ryan V., 1996. Physical, Sexual and Emotional Violence Against Women: a General Practice Based Prevalence Study. *Medical Journal of Australia* Vol. 164 January:14-17
- Mazza D., Lawrence J.M., Roberts G.L. and Knowlden S.M. 2000. What Can We Do About Domestic Violence. *Medical Journal of Australia*, Vol 173 2 October: 532-535.
- McCallum S., 2000. *Northern Territory Government Domestic Violence Strategy Data Collection Project Report Occasional Paper No 35*. Office of Women's Policy Department of the Chief Minister, Darwin.:2
- McFarlane J., Christoffel K., Bateman L., Miller V., and Bullock L., 1991. Assessing Abuse: Self-report Versus Nurse Interview. *Public Health Nursing*. 8:245-250.
- McFarlane J., Greenberg L., Weltge A., and Watson M., 1995. Identification of Abuse in Emergency Departments: Effectiveness of a Two-question Screening Tool. *Journal of Emergency Nursing* 21 (5):391-394
- McFarlane J., Parker B., Soeken K., 1996. Abuse During Pregnancy: Associations with Maternal Health and Infant Birth Weight. *Nursing Research*,. 45: 37.
- McFarlane J., Parker B., Soeken K., and Bullock L. 1992. Assessing for Abuse During Pregnancy: Severity and Frequency of Injuries and Associated Entry into Prenatal Care. *JAMA*, 267 (23): 3176-3178
- McFarlane J., Willson P., Malecha A. and Lemmey D., 2000. Intimate Partner Violence: A Gender Comparison. *Journal of Interpersonal Violence*, 15(2): 158-169.

- McLeer S.V., Anwar R., 1989. A Study of Battered Women Presenting in an Emergency Department. *American Journal Public Health*; 79: 65-66.
- McNutt L. Carlson B., Gagen D., and Winterbauer N., 1999. Reproductive Violence Screening in Primary Care: Perspectives and Experiences of Patients and Battered Women, *JAMWA*, 54(2):85-90.
- Memmott P., Stacey R., Chambers C. and Keys C., 2001. *Violence in Indigenous Communities*. Report to the Crime Prevention Branch of the Attorney-General's Department. Commonwealth of Australia, Canberra.
- Mezey G.C. and Bewley S. 1997. Domestic Violence and Pregnancy. *British Journal of Obstetrics and Gynecology*. 104: 528-531.
- Morgan Disney & Associates with Leigh Cupitt and Associates and Council on the Ageing, 2000, *Two Lives - Two Worlds Older People and Domestic Violence*, Vol 1, :63.
- Mouzos J., 1999. Femicide: an Overview of Major Findings *Trends and Issues in Crime and Criminal Justice*. Australian Institute of Criminology, No.124.Canberra.
- Naumann P., Langford D., Campbell T.S., and Glass N., 1999. Woman Battering in Primary Care Practice. *Family Practice* 16(4): 343-352.
- New South Wales Health Department, 2001, 'Unless They're Asked' Routine Screening for Domestic Violence in NSW Health, An Evaluation of the Pilot Project.
- Northern Territory Government, 2000. Occasional Paper No 40 DV Strategy Data Collection Project Report 1999-2000, p2.
- Northern Territory Department of Health and Community Services (Internal Working Document), 2002, Screening Literature Review.
- Office of Women's Policy. 1994. *Northern Territory Domestic Violence Strategy*. Office of Women's Policy Department of the Chief Minister, Darwin.
- Partnerships Against Domestic Violence and The University of New South Wales. 2001. From Policy to Practice: Routine Screening for Domestic Violence in NSW Health. *Clearinghouse* No.6.
- Partnerships Against Domestic Violence, 2000. *Two Lives - Two Worlds Older People and Domestic Violence*, prepared by Morgan Disney & Associates with Leigh Cupitt and Associates and Council on the Ageing. Commonwealth of Australia.
- Partnerships Against Domestic Violence. 1999. *Current Perspectives on Domestic Violence*. A Review of *National and International Literature*, prepared by Strategic Partners Pty. Ltd. in collaboration with the research Centre for Gender Studies University of South Australia.
- Peterson R., Gazmararian J.A., Spitz A.M., Rowley D.L., Goodwin M.M., Salzman L.E., and Marks J.S., 1997. Violence and Adverse Pregnancy Outcomes: A Review of the Literature and Directions for Future Research. *American Journal of Preventive Medicine*, 13 (5): 366-373.
- Plant A.J., Condon J.R., and Durling G. 1995. *Northern Territory Health Outcomes, Morbidity and Mortality 1979-1991*. NTH & CS, Darwin.
- Putt J., and Higgins K. 1997. *Violence Against Women in Australia: Key Research and Data Issues*, Australian Institute of Criminology, Canberra.
- Queensland Health (Internal Working Document), 2000, Initiative To Combat The Health Impact of Domestic Violence Against Women Stage 1 Evaluation.

Queensland Health (Internal Working Document), 2001, Initiative To Combat The Health Impact of Domestic Violence Against Women Stage 2 Evaluation

Robbe M. de Vries, Vinen J., Horner D., and Roberts G. 1996, Prevalence of Domestic Violence Among Patients Attending a Hospital Emergency Department. *Australian and New Zealand Journal of Public Health*, 20(4): 364-368.

Roberts G., O'Toole B., Raphael B., 1993. Domestic Violence Victims in a Hospital Emergency Department. *Medical Journal of Australia* 159: 307-10.

Roberts G.L., Lawrence J.M., Williams G.M., and Raphael B. 1998. The Impact of Domestic Violence on Women's Mental Health. *Australian and New Zealand Journal of Public Health*, 22(7):796-801.

Romans S.E., Poore M.R., and Martin J.L. 2000. The Perpetrators of Domestic Violence. *Medical Journal of Australia*, Vol 173 2 October: 484-488.

Rosenburg M.L., and Fenley M.A., 1991. *Violence in America: A Public Health Approach*. Oxford University Press, New York.

Sarre R., 1996. Family Violence and Surfacing Realities: a Victimological Perspective . in Pulla V.R., (ed) 1996. *The Family: Asia Pacific Perspectives: Compendium of Conference Papers*. Northern Territory University Darwin.

Stark E. and Flitcraft A., 1996. *Women at Risk* Sage Publications, Thousand Oaks Ca.: 11

Stark E. and Flitcraft A., 1996. *Women at Risk*. Sage Publications, Thousand Oaks Ca:13.

Stark E. and Flitcraft A., 1996. *Women at Risk*. Sage Publications, Thousand Oaks Ca: 22.

Stratigos S. 2000. *Queensland Health's Domestic Violence Initiative*, Australian Domestic & Family Violence Clearinghouse Newsletter 2 and Clearinghouse Newsletter No 5 December.

Stratigos S., 2000. Domestic Violence Screening and Pregnancy in *The Way Forward Children Young People and Domestic Violence*. Proceedings of a National Forum of Partnerships Against Domestic Violence. Commonwealth of Australia. Canberra : 45-50.

Stratigos S., 2000. *Queensland Health's Domestic Violence Initiative* Australian Domestic & Family Violence Clearinghouse Newsletter 2 and Clearinghouse Newsletter No 5 December.

Sugg NK, and Inui T., 1992. Primary Care Physician's Response to Domestic Violence: Opening Pandora's Box. *JAMA*, 267: 1357-1360.

Sugg NK, Thompson RS, Thompson DC, Maiuro R, Rivara FP. 1999. Domestic Violence and Primary Care. *Arch Fam Med* 8:301-306.

Sutton P., 2001. *The Politics of Suffering: Indigenous Policy in Australia Since the Seventies*, revised version of the Berndt Foundation Biennial Lecture, University of Western Australia, 23 September 2000.

Thompson R.S., Meyer B.A., Smith Di Julio K., Caplow M., Maiuro R.D., Thompson D.C., Sugg N.K., and Rivara F.R., 1998. A Training Program to Improve Domestic Violence Identification and Management in Primary Care: Preliminary Results. *Violence and Victims*, 13(4): 395-410.

Thurston W.E Cory J., and Scott C.M., 1998. Building a Feminist Theoretical Framework for Screening of Wife-Battering: Key Issues to be Addressed, *Patient Education and Counselling*, 33: 299-304

- Tilden V.P., Schmidt T. A., Limandri B.J., Chiodo G.T., Garland M.J., and Loveless P.A., 1994. Factors that Influence Clinicians' Assessment and Management of Family Violence. *American Journal of Public Health*, 84 (4): 628-633.
- Vinen J., Horner D. and Roberts G., 1996. Prevalence of Domestic Violence Among Patients Attending a Hospital Emergency Department. *Australian and New Zealand Journal of Public Health* 20(4): 364-368
- Waller A.E., Hohenhaus S.M., Shah P.J., and Stern E.A., 1996. Development and Validation of an Emergency Department Screening and Referral Protocol for Victims of Domestic Violence. *Annals of Emergency Medicine*, 27(6): 754-760.
- Warshaw C., 1997. Intimate Partner Abuse: Developing a Framework for Change in Medical Education. *Academic Medicine* 72 (1 supplement) :s26-s37.
- Webster J., 1994 Letter to Editor *Nursing Research*, 43(3):190-1.
- Webster J., Sweett S., and Stolz T.A., 1994. Domestic Violence in Pregnancy a Prevalence Study. *The Medical Journal of Australia* 161 17 October:466-470.
- Wiist W.H. and McFarlane J., 1999, The Effectiveness of an Abuse Assessment Protocol in Public Health Prenatal Clinics, *American Journal of Public Health*, 89(8): 1217-1221.
- Willaims, G., Chaboyer W., and Schulter P., 2002. Assault-related admissions to hospital in Central Australia. *Medical Journal of Australia*; 177 (6): 300-304
- Willinck L. and Schubert R., 2000. Antenatal Psychosocial Risk Assessment Project. *Australian College of Midwives Incorporated Journal*, September :7-12.
- Wilson J. and Jungner G. 1969. *Principles and Practices of Screening for Disease*, WHO Public Health Paper, No 34, World Health Organisation, Geneva.
- Woelz-Stirling N., Kelaher M. and Manderson L., 1998. Power and Politics of Abuse: Rethinking Violence in Filipina-Australian Marriages. *Health Care for Women International*, 19: 289-301.
- Women's Health Strategy Unit, 2001. *Domestic and Family Violence Services Mapping Project*, Territory Health Services Darwin.

## APPENDICES

### Appendix 1

**Attendees at the initial teleconference meeting for Screening for Domestic Violence in Hospital Settings 10 am, Wednesday, 20 September 2000**

**Attendees:**

*Darwin:*

Jenne Roberts - Women's Health Advisor, Women's Health Strategy Unit

Cate Kildea - Project Officer, WHSU

Margaret Stewart - Remote Area Birthing Project Officer, WHSU

Gabrielle Hickey - Director, Patient Care and Nursing Services, RDH

Martha Finn - Obstetrician, RDH

Frances Abbott - Cultural Consultant, RDH

Rose Cox - Acting Clinical Nurse Consultant, OPD, RDH

Penny Hill - Aboriginal Sexual Assault Counsellor, SARC

*Katherine:*

Sharon Weymouth - Women's Health Educator

*Gove:*

Jane Blake - Midwife, Gove Hospital

*Tennant Creek:*

John Heslop - Director of Nursing, TCH

## Appendix 2

### Steering Committee Membership

Ged Williams, Principal Nursing Consultant, RDH  
Kerrie Jones, Specialist, RDH Emergency Department  
Barbara Bauert, Clinical Superintendent, RDH  
Peter Pangquee, Director, Aboriginal Workforce Development, DHCS  
Louise Page, Project Officer, WHSU  
Women's Health Advisor, WHSU

### Working Group Membership

#### Training Working Group

Robyn Thompson, Project Officer, FACS, Health House, Darwin  
Susan Crane, DV Community and District Training Officer, Darwin  
Helen Van Roekel, DV Community and District Training Officer, Alice Springs  
(Helen left during pilot and was replaced by)  
Kaz Philips, DV Community and District Training Officer, Alice Springs  
Sharon Weymouth, Women's Health Educator, Katherine  
Margaret Stewart, Remote Area Birthing Project Officer, Health House, Darwin

#### Referral Working Group

Marg St Leone, Clinical Nurse Specialist, RDH Emergency Department  
Alison Edwards, Co-ordinator, Dawn House, Darwin  
Chris Lovett, Centrecare, Darwin

#### Initial Evaluation Working Group

Anthea Duquemin, Research Officer, Department of Health and Community Services  
Michelle Jones, Social Work Lecturer, Northern Territory University

#### Evaluation Report Team

Louise Page, Project Officer, Domestic Violence Screening Pilot, WHSU  
Jenny Young, Evaluation Adviser, WHSU  
Beverley Hayhurst, Health Promotion Officer, DHCS

## Appendix 3

# HEALTHCARE PROVIDER SURVEY ON DOMESTIC VIOLENCE

### PURPOSE

This is a Domestic Violence Survey that is a critical part of the NT Domestic Violence Intervention and Response in Hospital Settings Pilot Project. The data from this survey will provide valuable information to guide training provided to Hospital staff on Domestic Violence. Following a further survey at the completion of the project, it will also provide an important evaluation component of the Pilot Project. The general results of this anonymous survey will be made available via the Project Newsletter at the completion of the analysis of the survey. Doctors, Nurses, Aboriginal Liaison Officers and Aboriginal Health Workers currently working in NT Public Hospitals are being surveyed because of the important role you play in the delivery of healthcare. Because violence is such an important health concern, we hope that you will take 5-10 minutes to complete this survey.

### CONFIDENTIALITY

There is no identification upon the questionnaire and so your response is anonymous. Please fill out the survey that is sent to you, if you misplace your survey please contact us and we would be glad to send you an additional copy. Your participation in this survey is voluntary and your employment with NT DHCS will not be affected in any way by whether or not you participated.

There are likely to be staff members who have experienced DV at some point in their own lives. Answering these questions might bring back unwelcome memories or cause anxiety about a situation with which you are presently involved. There are resources both within and outside of NT DHCS if you would like any help with any of these feelings/issues. Resources include the Employee Assistance Service 1800 193 123 and Crisis Line 1800 019 116 which is a service that can provide you with referrals to most DV Services in the NT. You are free to omit answering any survey questions.

### INSTRUCTIONS

1. Please read the participant statement at the bottom of the page and review the enclosed questionnaire. If you are willing to assist with this study, complete the questionnaire. If you decline to participate, please indicate this on the survey
2. Return the questionnaire in the enclosed internal envelope by 28<sup>th</sup> May, 2002.
3. Enjoy your Women's Health Strategy Pen with our THANKS!!

**Participant Statement:** I have read the description and questionnaire and, by returning the questionnaire, indicate my willingness to contribute to this study. I understand that my employment with NT DHCS will not be affected by whether or not I participate. I may refuse to answer any questions. All information will be kept confidential. I understand that I may ask further questions at any time.

For more information or you have any additional questions, call the project co-ordinator Louise Page on 89992938 at the Women's Health Strategy Unit, Health House, Darwin. This project has been approved by the management of each NT Hospital and has ethics approval from the Human Research Ethics Committee. Complaints can be directed to the Secretary of the Human Research Ethics Committee (ph: 08 8922 8196).



For this survey, DOMESTIC VIOLENCE (DV) is defined as behaviour that is adopted by a person to control their victim that results in physical, sexual, emotional and/or psychological abuse, forced social isolation or economic deprivation, or behaviour that leaves a person living in fear. These behaviours are perpetrated by someone who is known to the victim. Some of the items in this questionnaire refer to DV in general while other items refer specifically to those who are abused (victims). *Please complete all items of the questionnaire.*

Please circle the Hospital you are currently working within: RDH ASH TCH KDH GDH <sup>3</sup>

Please circle your gender and age group: Male Female <sup>4</sup>

15-19 20-24 25-29 30-34 35-39 40-44 45-49 50-54 55-59 60+ <sup>5</sup>

Please circle if you are working in either of the following areas: Antenatal Outpatients Emergency Department <sup>6</sup>

Please circle the number of the response that best reflects your own level of agreement or disagreement with each of the following statements:

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	
1. DV tends to become more frequent and severe over time	1	2	3	4	5	<sup>7</sup>
2. The role of the health care provider is limited in being able to help victims of DV.	1	2	3	4	5	<sup>8</sup>
3. A victim must be getting something out of the abusive relationship, or else he/she would leave.	1	2	3	4	5	<sup>9</sup>
4. It is not my place to interfere with how a couple chooses to resolve conflicts.	1	2	3	4	5	<sup>10</sup>
5. I don't have the time to ask about DV in my work	1	2	3	4	5	<sup>11</sup>
6. I am afraid of offending the patient if I ask about DV.	1	2	3	4	5	<sup>12</sup>
7. If I find a patient who is a victim I don't know what to do.	1	2	3	4	5	<sup>13</sup>
8. There is nothing I can do to help the victim because he/she is unlikely to leave the relationship.	1	2	3	4	5	<sup>14</sup>
9. Asking patients about DV is an invasion of their privacy.	1	2	3	4	5	<sup>15</sup>
10. I think that investigating the underlying cause of a patient's injury is not part of medical care.	1	2	3	4	5	<sup>16</sup>
11. If patients do not reveal abuse to me, then they feel it is none of my business.	1	2	3	4	5	<sup>17</sup>
12. It is demeaning to patients to question them about abuse.	1	2	3	4	5	<sup>18</sup>
13. If I ask non-abused patients about DV, they will get very angry.	1	2	3	4	5	<sup>19</sup>
14. People are only victims if they choose to be.	1	2	3	4	5	<sup>20</sup>
15. When it comes to domestic violence, both people are usually responsible.	1	2	3	4	5	<sup>21</sup>
16. I have patients whose personalities cause them to be abused.	1	2	3	4	5	<sup>22</sup>
17. Women who chose to step out of traditional roles are a major cause of DV.	1	2	3	4	5	<sup>23</sup>
18. I don't know how to ask about the possibility of DV.	1	2	3	4	5	<sup>24</sup>
19. The victim's passive-dependent personality often leads to abuse.	1	2	3	4	5	<sup>25</sup>
20. The victim has often done something to bring about violence in the relationship.	1	2	3	4	5	<sup>26</sup>
21. I am reluctant to ask patients about DV out of concern for my personal safety.	1	2	3	4	5	<sup>27</sup>
22. There is not enough security at my work place to safely permit discussion of DV with patients.	1	2	3	4	5	<sup>28</sup>
23. There is no way to ask patients about DV without putting victims of DV in more danger.	1	2	3	4	5	<sup>29</sup>



	Very Rare 1/1000	Rare 10/1000	Somewhat Common 50/1000	Common 100/1000	Very Common 150/1000	
24. DV prevalence in my work is..	1	2	3	4	5	30
25. DV prevalence in NT Hospitals on the whole is..	1	2	3	4	5	31

Please circle the number that best represents your opinions about these issues:

26. In the past 3 months, when seeing someone with the following conditions, how often have you asked the patient about the possibility of DV? (Please circle NA if this is not part of your role responsibilities or you haven't seen the condition listed below in the last 3 months.)

	Never	Seldom	Sometimes	Nearly Always	Always	N/A	
a. injuries (bruises, lacerations, etc.)	1	2	3	4	5	6	32
b. chronic pelvic pain	1	2	3	4	5	6	33
c. irritable bowel syndrome	1	2	3	4	5	6	34
d. headaches	1	2	3	4	5	6	35
e. depression/anxiety	1	2	3	4	5	6	36
f. hypertension/coronary artery disease	1	2	3	4	5	6	37

	Yes	No	Unsure	
27. Have you ever identified a patient who was a victim of DV?	1	2	3	38
28. To your knowledge does your work area have any written guidelines for detection/management of DV?	1	2	3	39

	0	1-5	6-10	11-20	>20	
29. How many victims of domestic violence have you identified in the past year?	1	2	3	4	5	40

	Not At All	Only Slightly	Moderately	Quite A Bit	Extremely	
30. There are strategies I can use to help victims of DV change their situation.	1	2	3	4	5	41

31. How confident do you feel asking about the following topics as part of the medical history. If you do not take medical histories, mark "Not at All".

a. smoking?	1	2	3	4	5	42
b. alcohol use and frequency?	1	2	3	4	5	43
c. sexual orientation?	1	2	3	4	5	44
d. emotional abuse?	1	2	3	4	5	45
e. physical abuse?	1	2	3	4	5	46

32. I have ready access to information detailing management of DV.	1	2	3	4	5	47
33. I feel confident that I can make appropriate referrals for abused patients.	1	2	3	4	5	48
34. I have ready access to medical social workers to assist in the management of DV cases.	1	2	3	4	5	49
35. I feel that medical social work personnel can help manage DV patients.	1	2	3	4	5	50
36. I feel that community domestic violence services can meet the needs of DV victims.	1	2	3	4	5	51
37. I have ready access to community domestic violence services should my patients need referrals.	1	2	3	4	5	52
38. I feel that my level of training adequately enables me to identify and respond to victims of DV.	1	2	3	4	5	53

**39. Please circle when you last attended DV training?**In the last year  
1In the last three years  
2More than 3 years ago  
3I haven't attended DV training  
4

General Comments and Reactions:

---

---

---

---

---

---

---

---

---

---

Thank you for taking time to complete this survey!

This survey was adapted from a questionnaire developed by the Group Health Cooperative and Harborview Injury Prevention and Research Centre in Seattle, Washington.

## Appendix 4

### DOMESTIC/FAMILY VIOLENCE SCREENING TRAINING FEEDBACK

Training Date: \_\_\_\_\_ Your Dept: \_\_\_\_\_

Your comments are appreciated, please consider:

- How helpful did you find the screening training?

<b>not at all</b>	<b>only slightly</b>	<b>moderately</b>	<b>quite a bit</b>	<b>extremely</b>
<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>

---

- How could the training be improved?

---



---

- Do you feel confident to screen?

<b>not at all</b>	<b>only slightly</b>	<b>moderately</b>	<b>quite a bit</b>	<b>extremely</b>
<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>

---

- What do you believe is good/bad about the screening instrument and why?

---



---

- What do you believe is good/bad about the workbook and why?

---



---

- Any other comments you may have about screening/training?


---



---

If further comments, please use over page

## Appendix 5

 <p><b>Northern Territory Government</b> Department of Health and Community Services ROYAL DARWIN HOSPITAL</p>	<p>Surname _____ HRN _____          Given Name _____          Address _____          DOB ____/____/____  <small>(Affix patient label here and on second sheet if GP to be notified))</small></p>
<p><b>OUTPATIENT FORM DOMESTIC/FAMILY VIOLENCE SCREEN</b></p>	
<p><i>Healthcare provider to explain the following in own words:</i></p> <ul style="list-style-type: none"> <li>At emergency department we care about you, so we are asking <u>all</u> women and men over 16 years the same questions about violence at home.</li> <li>This is because violence is happening a lot and it is everywhere, and we want to help families experiencing violence.</li> </ul>	
<p><i>Healthcare provider to ask the following questions of ALL women and men on their own (consider using interpreter).</i></p>	
<p>Client is: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE</p>	
<p>1. Are you ever afraid of someone in your family?</p>	<p><input type="checkbox"/> YES <input type="checkbox"/> NO Sometimes</p>
<p>2. In the last year, has anyone in your family hit, kicked, punched or otherwise hurt you?</p>	<p><input type="checkbox"/> YES <input type="checkbox"/> NO Sometimes</p>
<p>3. In the last year, has anyone in your family put you down, made you feel ashamed or tried to control what you can do?</p>	<p><input type="checkbox"/> YES <input type="checkbox"/> NO Sometimes</p>
<p>4. In the last year, has anyone in your family threatened to hurt you in any way?</p>	<p><input type="checkbox"/> YES <input type="checkbox"/> NO Sometimes</p>
<p>5. In the last year, has anyone in your family forced you to have sex when you didn't want too?</p>	<p><input type="checkbox"/> YES <input type="checkbox"/> NO Sometimes</p>
<p><i>If family/domestic violence has been identified in any of the above questions, continue to question 6.</i></p>	
<p>6. Would you like help with any of this now? <input type="checkbox"/> YES <input type="checkbox"/> NO</p>	
<p>7. This could be important information for your health care.          Would you like us to send a copy of this form to your doctor? _____</p>	
<p>Name of Doctor: _____</p>	<p>Signature of Client _____</p>
<p>Address: _____</p>	<p>Date _____</p>
<p><b>This information is confidential and remains in your hospital records.</b></p>	
<p><b>FV/DV Risk Status:</b></p> <p>Family/Domestic Violence not identified <input type="checkbox"/></p> <p>Family/Domestic Violence identified, help refused <input type="checkbox"/></p> <p>Family/Domestic Violence Identified, help provided <input type="checkbox"/></p> <p><b>Provided with:</b></p> <p>Contact phone numbers <input type="checkbox"/></p> <p>Written information on Family/Domestic Violence <input type="checkbox"/></p> <p>Referral to hospital-based service <input type="checkbox"/></p> <p>Referral to community Dom/Fam Violence service <input type="checkbox"/></p> <p>Referral to GP/Community Doctor <input type="checkbox"/></p> <p>Other _____</p>	<p><b>Screening Not Completed due to:</b></p> <p>Presence of partner <input type="checkbox"/></p> <p>Presence of family members / friends <input type="checkbox"/></p> <p><b>Absence of interpreter</b> <input type="checkbox"/></p> <p>Client refused to answer the questions <input type="checkbox"/></p> <p><b>Additional Comments:</b></p> <p>Signature of Healthcare Provider _____</p> <p>Print Name _____</p> <p>Date _____</p>
<p><b>IF THIS FORM WAS NOT COMPLETED PLEASE SCREEN ON NEXT VISIT</b></p>	





# Northern Territory Government

Department of Health and Community Services

KATHERINE DISTRICT HOSPITAL

Surname \_\_\_\_\_ HRN \_\_\_\_\_

Given Name \_\_\_\_\_

Address \_\_\_\_\_

DOB \_\_\_\_/\_\_\_\_/\_\_\_\_

(Affix patient label here and on second sheet if GP to be notified))

OUTPATIENT FORM DOMESTIC/FAMILY VIOLENCE SCREEN

## Healthcare provider to explain the following in own words:

- At Katherine Hospital we care about you, so we are asking all women over 16 years the same questions about violence at home.
- This is because violence is happening a lot and it is everywhere, and we want to help families experiencing violence.

## Healthcare provider to ask the following questions of ALL women and men on their own (consider using interpreter).

Client is:

☐ MALE ☐ FEMALE

- Are you ever afraid of someone in your family? ☐ YES ☐ NO Sometimes
- In the last year, has anyone in your family hit, kicked, punched or otherwise hurt you? ☐ YES ☐ NO Sometimes
- In the last year, has anyone in your family put you down, made you feel ashamed or tried to control what you can do? ☐ YES ☐ NO Sometimes
- In the last year, has anyone in your family threatened to hurt you in any way? ☐ YES ☐ NO Sometimes
- In the last year, has anyone in your family forced you to have sex when you didn't want too? ☐ YES ☐ NO Sometimes

## If family/domestic violence has been identified in any of the above questions, continue to question 6.

- Would you like help with any of this now? ☐ YES ☐ NO

- This could be important information for your health care.

Would you like us to send a copy of this form to your doctor? \_\_\_\_\_

Name of Doctor: \_\_\_\_\_

Address: \_\_\_\_\_

Signature of Client \_\_\_\_\_

Date \_\_\_\_\_

**This information is confidential and remains in your hospital records.**

<b>FV/DV Risk Status:</b> Family/Domestic Violence not identified <input type="checkbox"/> Family/Domestic Violence identified, help refused <input type="checkbox"/> Family/Domestic Violence Identified, help provided <input type="checkbox"/>  <b>Provided with:</b> Contact phone numbers <input type="checkbox"/> Written information on Family/Domestic Violence <input type="checkbox"/> Referral to hospital-based service <input type="checkbox"/> Referral to community Dom/Fam Violence service <input type="checkbox"/> Referral to GP/Community Doctor <input type="checkbox"/> Other _____	<b>Screening Not Completed due to:</b> Presence of partner <input type="checkbox"/> Presence of family members / friends <input type="checkbox"/> <b>Absence of interpreter</b> <input type="checkbox"/> Client refused to answer the questions <input type="checkbox"/> <b>Additional Comments:</b>  Signature of Healthcare Provider _____ Print Name _____ Date _____
--	---

**IF THIS FORM WAS NOT COMPLETED PLEASE SCREEN ON NEXT VISIT**

## Appendix 6

Client Questionnaire Survey Form - Antenatal

### DOMESTIC VIOLENCE ANTENATAL SURVEY

#### Reason for this survey

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

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

(Please tick box)

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

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

Other feelings (please comment).....

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

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

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

Yes ☐ No ☐

Why:.....

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

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

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

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

.....

.....

.....

#### 6. Is there anything else we should ask about?

.....

.....

#### 7. Did anyone help you complete this form?

Yes ☐ No ☐

#### 8. If 'yes' who helped? .....

#### 9. When did you complete this questionnaire?

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

*Thank you for answering these questions.*

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

*Your name is not required; your answers are anonymous.*



Client Questionnaire Survey Form - Emergency

## DOMESTIC VIOLENCE EMERGENCY DEPARTMENT SURVEY

## Reason for this survey

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

It would help us and other men and women coming to the Emergency Department, if you would answer the following questions

(Please tick box)

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

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

Other feelings (please comment).....

## 2. Do you remember being asked questions about domestic violence at the Emergency Department?

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

## 3. Do you think it is a good idea to ask men and women about domestic violence?

Yes ☐ No ☐

Why:.....

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

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

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

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

## 6. Is there anything else we should ask about?

## 7. Did anyone help you complete this form?

Yes ☐ No ☐

## 8. If 'yes' who helped? .....

## 9. Please tick your sex/gender

Male ☐ Female ☐

Thank you for answering these questions.

Please place the form in the envelope and ask the nursing staff to place it in the internal mail.

Your name is not required; your answers are anonymous.

## Appendix 7

### **ROYAL DARWIN HOSPITAL EMERGENCY DEPARTMENT DOMESTIC/FAMILY VIOLENCE SCREENING PILOT FEEDBACK**

The Women's Health Strategy Unit on behalf of the Department of Health and Community Services has conducting a Pilot Domestic Violence Screening Program at Royal Darwin Hospital (RDH) Emergency Department (ED). Piloted is a design for an appropriate service response to victims of domestic and/or family violence identified in the hospital setting. The pilot at the RDH ED commenced on the 1<sup>st</sup> September and ended on Saturday 30<sup>th</sup> November, 2002. As part of the evaluation of the program referral agencies will be asked to participate in one focus group interview on the 23<sup>rd</sup> January or complete and return a feedback form. 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.

Your participation will be of help in evaluating the benefits or drawbacks in asking about the existence of domestic/family violence. Your contribution will enable us to improve our services to our clients with regard to domestic/family violence. Any persons with concerns or complaints about the conduct of a research study can contact the Secretary of the Human Research Ethics Committee (phone: 08 89228196). Please feel free to attach further comments on other paper.

**Voluntary:** *Name of Organisation and Contact Person/No:*

.....

(Your details will not be used in the evaluation report but it could be helpful to contact you to clarify any points that you may raise).

*Please consider each section of the feedback form:*

#### **SCREENING:**

- 1. What was your agency and client's experience of the screening pilot for domestic/family violence?**

---



---

- 2. Do you think that screening for domestic/family violence is of value? Why?**

---



---

- 3. Was your agency able to support the hospital staff to screen patients? How?**

---



---

- 4. Do you think there is enough support in the community to screen patients? Why**

---



---

- 5. What issues did the screening raise for your agency?**

---



---



6. What do you think could be done to improve screening?

---

7. What do you think could be done instead of screening?

---

8. What do you think your role was in the screening of patients at RDH Emergency Department?

---

9. Do you think that hospital staff safety was an issue at any point? Why?

---

10. Do you think hospital patient safety was an issue at any stage? Why?

---

11. Did you feel staff were adequately trained to screen? Why?

---

#### SCREENING TOOL/QUESTIONNAIRE

12. What did you like/dislike about the screening tool? Why?

---

13. Could the screening tool be improved? How?

---

#### RESOURCE KIT/REFERRAL AND INFORMATION BOOKLET

14. What did you like/dislike about the resource/referral booklet? Why?

---

15. Could the resource book be improved? How?

---

#### WOMEN'S ADVISORY COUNCIL HANDOUT CARD

16. What did you like/dislike about the screening using the WAC Card as a handout resource? Why?

---

---

17. Do you have any suggestions for providing a written resource to patients?

---

---

**MAKING REFERRALS**

18. What was your experience of obtaining referrals from the hospital staff?

---

---

19. Could the referral process be improved? How?

---

---

**Other Comments:**

---

---

---

Thank you for your input. Please email your reply to [louise.page@nt.gov.au](mailto:louise.page@nt.gov.au) or mail to Louise Page, Women's Health Strategy Unit, PO Box 40596, Casuarina NT 0811. By returning your comments you are consenting to their use in the evaluation of the pilot screening at RDH ED.

## Appendix 8



Northern Territory Government

Department of Health and Community Services

**HealthCare Provider to explain the following in own words:**

Surname \_\_\_\_\_

Given Name \_\_\_\_\_ HRT \_\_\_\_\_

Address \_\_\_\_\_

DOB \_\_\_\_\_

(Affix patient label here and on second sheet if GP to be notified)

In this department we care about you, so we are asking all people over 16 years the same questions about domestic and family violence. Whatever you reply will remain strictly confidential and remains in your hospital records.

This violence can take many forms such as being hit, continually put down or made to feel ashamed by someone you know. It could also be when money or freedom is used to control what you do. The person who does this violence could be your partner, or one of your family. This type of violence is happening a lot and has long term health effects.

**Ask the following questions of ALL women and men on their own.**
☐ Emergency ☐ 1<sup>ST</sup> Antenatal ☐ 2<sup>ND</sup> Antenatal

☐ MALE ☐ FEMALE

1. Are you ever afraid of your partner or someone in your family? ☐ YES ☐ NO ☐ Sometimes
2. In the last year, has your partner or anyone in your family hit, kicked, punched or otherwise hurt you? ☐ YES ☐ NO ☐ Sometimes
3. In the last year, has your partner or your family often put you down, made you feel ashamed or tried to control what you do? ☐ YES ☐ NO ☐ Sometimes
4. In the last year, has your partner or anyone in your family threatened to hurt you in any way? ☐ YES ☐ NO ☐ Sometimes
5. In the last year, has your partner or anyone in your family made you have sex when you didn't want to? ☐ YES ☐ NO ☐ Sometimes

**Continue to Question 6 ONLY If DV/FV has been identified in any of the above questions.**

6. Would you like help with any of this now? ☐ YES ☐ NO
7. This could be important information for your health care. May we send a copy of this form to your doctor?

Name of Doctor: \_\_\_\_\_

Signature of Client \_\_\_\_\_

Address: \_\_\_\_\_

Date \_\_\_\_\_

**HealthCare Provider to complete****DV/FV Risk Status:**

- Domestic/Family Violence not identified ☐
- Domestic/Family Violence identified, help refused ☐
- Domestic/Family Violence Identified, help provided ☐

**Provided with:**

- Contact phone numbers ☐
- Written information on Domestic/Family Violence ☐
- Referral to hospital-based service ☐
- Referral to community Dom/Fam Violence service ☐
- Referral to GP/Community Doctor ☐
- Referral to Police ☐
- Other \_\_\_\_\_ ☐

*If indicated, note DV/FV in patient history, consider diagrams and quotes if presenting due to DV/FV injury.*

**Screening Not Completed due to:**

- Presence of partner ☐
- Presence of family members / friends ☐
- Absence of interpreter ☐
- Client's injury/illness/level of intoxication ☐
- Client refused to answer the questions ☐

**Additional Comments:**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Name of Healthcare Provider : \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**IF THIS FORM WAS NOT COMPLETED PLEASE SCREEN ON NEXT VISIT**

OUTPATIENT FORM DOMESTIC/FAMILY VIOLENCE SCREEN