

Routine screening for domestic violence program

Snapshot report 1



NSW DEPARTMENT OF HEALTH

73 Miller Street
NORTH SYDNEY NSW 2060
Tel. (02) 9391 9000
Fax. (02) 9391 9101
TTY. (02) 391 9900

www.health.nsw.gov.au

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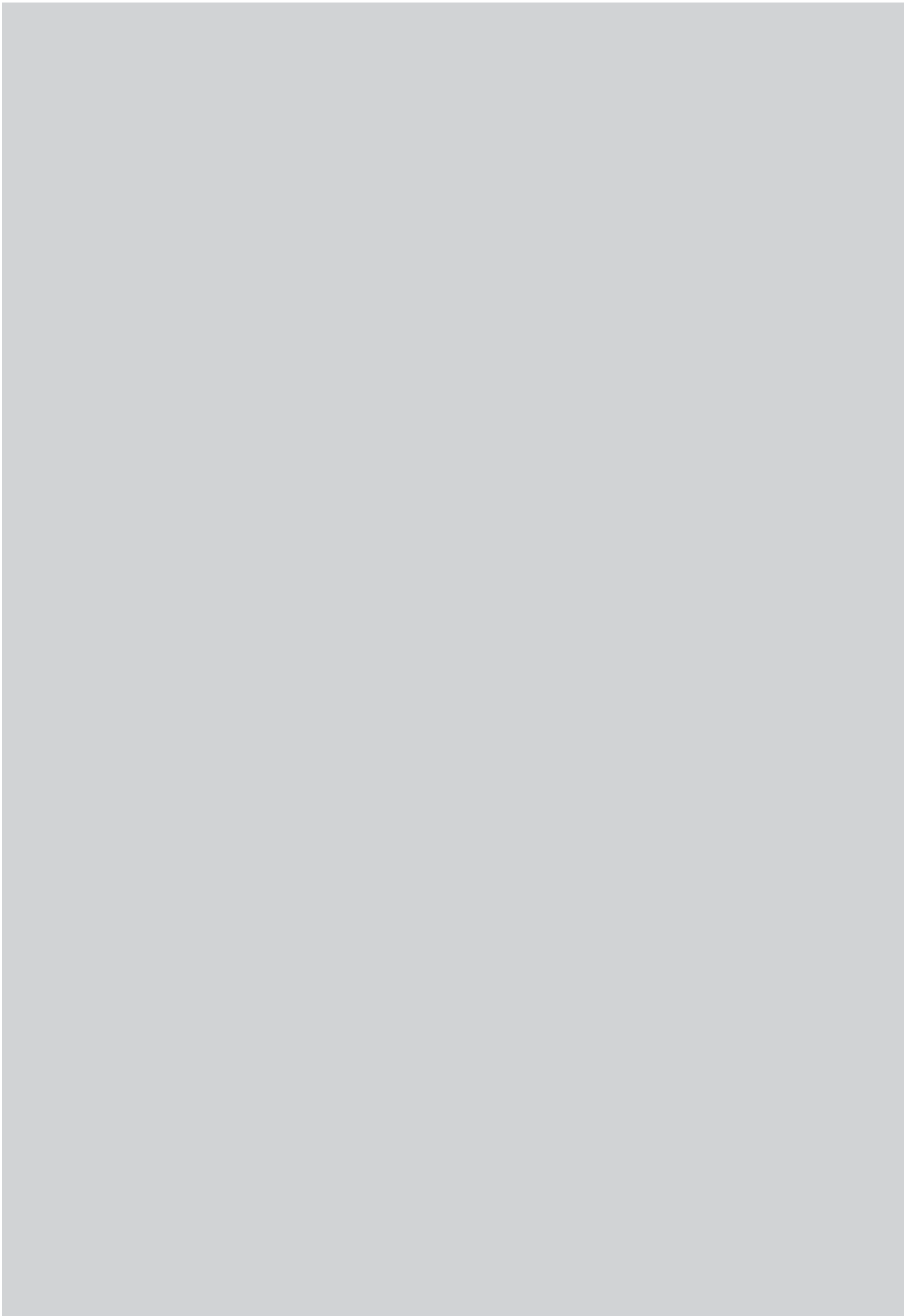
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Contents

Summary	1	7. Discussion of findings	17
1. Purpose of the report	2	7.1 Screening rates	17
2. Outline of the Routine screening for domestic violence program	3	7.2 Identification of domestic violence	17
2.1 Health issues	3	7.2.1 Identification rates.....	17
2.2 Rationale	3	7.2.2 Non-disclosure of domestic violence.....	18
2.3 NSW Health policy context.....	4	7.3 Acceptance of assistance and action taken.....	18
2.4 The NSW Health pilot.....	4	7.3.1 Assessment.....	18
2.5 The screening process	5	7.3.2 Action taken	18
2.6 Data	5	7.3.3 Notifications to police	19
3. Snapshot methodology	7	7.3.4 Reports to the Department of Community Services.....	19
4. Overall results	8	7.3.5 Intervention.....	19
4.1 Extent of screening in programs	8	8. Conclusion.....	21
4.2 Screening rate	9	9. Key issues.....	22
4.3 Reasons screening not completed	9	9.1 Key issues for NSW Department of Health.....	22
4.4 Domestic violence identified	10	9.2 Key issues for the Education Centre Against Violence	22
4.5 Assistance accepted and action taken	11	9.3 Key issues for Area Health Services	22
5. Results in each of the targeted programs.....	12	10. References.....	23
5.1 Antenatal.....	12	Appendix 1	25
5.2 Early childhood health	13	Appendix 2	26
5.3 Alcohol and other drugs	14	Appendix 3	27
5.4 Mental health.....	15		
6. Results in additional programs	16		
6.1 Women's health nursing	16		
6.2 Sexual health.....	16		
6.3 Sexual assault	16		



Summary

Domestic violence is an important public health issue. NSW Health is responding to this issue through the implementation of the *Policy and Procedures for Identifying and Responding to Domestic Violence* (2003). A key element of this initiative is routine screening for domestic violence, which is aimed at preventing domestic violence by providing information to at-risk populations as well as providing a strategy for early intervention.

Area Health Services began introducing routine screening for domestic violence in 2001. The primary target groups were all women attending antenatal and early childhood health services and women aged 16 years and over who presented to alcohol and other drugs and mental health services. Some Area Health Services also introduced screening into other programs. Implementation is supported by the *Routine Screening for Domestic Violence: An Implementation Package* (2001), which includes a manager's guide, protocol, and learning program. Staff training and the development of referral pathways are required before screening commences.

A one-month snapshot to determine the level and outcomes of screening was conducted in November 2003. Key findings of the one-month snapshot are:

- 13 Area Health Services had commenced screening in all or some of the targeted programs
- 4,036 (70%) of the 5,800 women who attended the participating services were screened

- 283 (7%) of all women screened identified domestic violence
- 115 (41%) of women identified with domestic violence accepted assistance offered by the health worker
- five notifications to the police, 23 reports to DoCS and 99 other referrals were made as a result of identification
- referrals were made to other health services, predominantly social worker services, and to services outside Health including referrals to accommodation, court assistance, legal aid, and counselling or family support services.

The findings of the snapshot indicate that a significant proportion of female clients of these health services are living with domestic violence. The implementation of routine screening to identify women provides the opportunity for more appropriate interventions by health services that address the risk and trauma issues associated with living with domestic violence.

The snapshot has yielded valuable information for the NSW Health Department, Area Health Services, and for individual services. This information will be an important benchmark for monitoring the implementation of routine screening by Area Health Services and provides baseline data regarding the prevalence of current domestic violence for clients and patients accessing particular services.

1 Purpose of the report

The purpose of this report is to present the findings of a one-month snapshot of routine screening for domestic violence in NSW Health services which occurred in November 2003. The report will provide feedback for Area Health Service programs that participated in the snapshot, and useful information for other programs and services yet to implement this strategy.

Outline of the Routine screening for domestic violence program

2

2.1 Health issues

The World Health Organisation recognises domestic violence as a significant international public health issue (Krug et al 2002). A considerable body of evidence demonstrates that living with domestic violence has a serious impact on short-term and long-term psychological, emotional and physical health.

Victims of domestic violence are at increased risk of mental health conditions such as depression, anxiety, post-traumatic stress disorder, and suicide attempts; chronic conditions such as psychosomatic disorders, irritable bowel syndrome, genitourinary infections, as well as physical injury such as bruising, ocular damage, stab wounds and fractures. Women who experience domestic violence are also at elevated risk of suicide and homicide (Chamberlain 2004, Humphreys & Thiara 2003, Krug et al 2002, Mouzos 2003, Taft 2003, VicHealth 2004).

Violence during pregnancy has been associated with poor weight gain, anaemia, infections, preterm labour, post-natal depression and reduced head circumference in infants; teenage mothers are at increased risk (Campbell 2002, Quinlivan & Evans 2001, Taft 2002).

In addition, domestic violence is associated with health risk factors such as increased drug and alcohol use, smoking, poor physical activity, unhealthy eating habits, and exposure to sexually transmissible infections including a higher rate of Pap smear abnormalities (Champion et al 1998, Sherrard et al 1998, VicHealth 2004).

The social, emotional and cognitive development of children who live in families where there is domestic violence, whether it is directly witnessed or not, are also impacted (Laing 2000). Exposure to domestic violence constitutes a form of child abuse. Where children are at risk of serious harm due to domestic violence, health workers are mandated reporters to the NSW Department of Community Services (NSW Health 2000).

As well as adversely affecting the health of many women and children, domestic violence results in other

high personal and community costs (Campbell 2002, Laing 2000, Waters et al 2004). Domestic violence contributes nine per cent to the total disease burden in women in Victoria aged 15-44 (VicHealth 2004).

2.2 Rationale

Research indicates that although high numbers of women present to health services with health problems related to their experience of domestic violence, their identification as victims is low (Laing 2001a, Taft 2003). There is also evidence that women are unlikely to disclose domestic violence unless specifically asked (Hegarty & Taft 2001, Laing 2001b, Lawler 1998, Mazza et al 1996). This limits the capacity of health services to intervene and provide appropriate and effective health care.

As domestic violence is under-identified by health workers and under-documented in medical records, the practice of routinely asking questions regarding women's experience of violence by a partner or ex-partner is increasingly being promoted and used (Family Violence Prevention Fund 1999, Laing 2001b, Kramer 2002.) Direct questioning about domestic violence has been introduced in clinical settings in the United Kingdom and the United States as well as Queensland and the Northern Territory and emerging evidence from these interventions is that screening can reduce violence and the threat of violence (McFarlane 2003, McFarlane et al 1998). Screening reduces the isolation experienced by women who experience domestic violence, breaks the secrecy of the abuse and increases the person's sense of support (Chang et al 2003).

NSW Health piloted routine screening in 2000 and the evaluation (Irwin & Waugh 2000) found 97% of women who were screened supported the intervention. This finding is reflected in other screening research (Bagshaw et al 1999, Ramsay et al 2002). Furthermore, the literature indicates that even if women in domestic violence situations do not disclose at the time, they do receive information about domestic violence and about the support available upon which they may act at a later time (Standing Together, 2003).

2.3 NSW Health policy context

More than 10 years have passed since the release of the first NSW Health Domestic Violence Policy (1993). This period has also seen the development of policies in Area Health Services, the introduction of the NSW Domestic Violence Core Training Program (1990) and other training on this issue through the Education Centre Against Violence (ECAV). However, identification of and responsiveness to domestic violence has been variable and dependent on the existence of local service protocols or the particular interest of individual workers.

Routine screening for domestic violence in antenatal, early childhood health, alcohol and other drugs services and mental health services is one of the key elements of the NSW Health *Policy and Procedures for Identifying and Responding to Domestic Violence* (2003). This strategy aims to fulfil a dual role of prevention, by providing information to at-risk populations, and early intervention, by providing an opportunity for identification and appropriate action (NSW Health 2003).

The NSW Health policy defines domestic violence as: *'Violent, abusive or intimidating behaviour carried out by an adult against a partner or former partner to control and dominate that person. Domestic violence causes fear, physical and/or psychological harm. It is most often violent, abusive or intimidating behaviour by a man against a woman. Living with domestic violence has a profound effect upon children and young people and may constitute a form of child abuse.'* (NSW Health 2003) The screening intervention is based on this definition. Concrete questions are asked of women about violent or abusive behaviour by a partner or former partner, and whether they are fearful of that person.

The definition recognises that women are the overwhelming majority of victims of domestic violence. Research from a range of sources indicates that between 88% and 92% of victims of domestic violence are women and the level of injury and trauma they experience is greater than that of men (Bagshaw & Chung 2000, Taft et al 2001). Men may also be victims of domestic violence but they are more likely to be at risk from male strangers or acquaintances in public places than from female partners in the home (Flood 1999, Krug et al 2002).

2.4 The NSW Health pilot

The NSW Health Domestic Violence Policy Review Committee was formed in 1999 to guide the development of the revised domestic violence policy. This resulted in a *Discussion Paper* (NSW Health 1999), which flagged the introduction of routine standardised assessment for domestic violence. The proposed new strategy received widespread support from Area Health Services. Funding obtained through the Commonwealth Government's Partnerships Against Domestic Violence, enabled a screening to be conducted in South Eastern Sydney and Macquarie Area Health Services. The aim of the pilot was to develop and test the screening tool in specific program areas: antenatal, alcohol and other drugs services, mental health services and emergency departments. An independent evaluation by the University of Sydney (Irwin & Waugh 2001) found that identification of domestic violence by health staff was improved by screening and that 97% of the women screened supported health workers asking these questions. The training program improved the staff understanding of the issues, and their skills in asking questions and responding appropriately were also improved (see also Hunter Area Health Service 2003).

Subsequently the shorter term 'screening' was adopted rather than 'standardised routine assessment'. This was seen as a more accurate reflection of the questions, which identify the existence of violence but do not represent a thorough assessment of the woman's situation. However, it appears that the term 'screening' may not be the most appropriate description as the program does not satisfy all of the tests for the introduction of a screening tool as identified in public health literature (see for example, Ramsey et al 2002, Wathen & McMillan 2003). Using the term 'routine enquiry for domestic violence' may have been more useful to avoid the debates around the use of health screens. This illustrates the difficulty of applying a medical model to an issue that has many health-related manifestations but no easily definable 'cause' or 'treatment', and is, at the same time, a social and legal issue.

The NSW Minister for Health approved the implementation of the Routine Screening for Domestic Violence Program in Area Health Services in antenatal, early childhood health, mental health and alcohol and

other drugs programs in 2000. Emergency departments were not recommended for the screening intervention as the nature of the work, the priorities and the lack of private space and time to interview were not conducive to routine screening. Early childhood health was included to ensure a flow-on from antenatal services, and because of the importance of child protection issues. The NSW Health *Policy and Procedures for Identifying and Responding to Domestic Violence* (2003) directs that screening be implemented in all these targeted programs by the end of December 2004. The Policy notes that screening may also be introduced in other service streams such as dental clinics, child and family, women's health nurse services, community health centres, gynaecology clinics and sexual health services.

Routine Screening for Domestic Violence: An Implementation Package, provided through ECAV, supports the Routine Screening for Domestic Violence Program. This includes a guide for managers, the pilot evaluation report, screening protocol, flow chart and the learning program. ECAV provides train-the-trainer implementation education and ongoing support for screening services. In preparation for screening, frontline staff are trained in asking the questions and providing appropriate responses, and services must identify local referral pathways.

2.5 The screening process

Screening questions are to be asked of all women attending antenatal and early childhood health services and women aged 16 and over who attend mental health and alcohol and other drugs services. These are termed 'eligible women'. It need not be used for women for whom domestic violence has been identified in other ways, for example, on presentation or in a referral.

The NSW Health screening model addresses safety, privacy, confidentiality and choice. The screening protocol directs that questions be asked in person by a trained health worker in a private, safe setting with no others present, apart from a health care interpreter if needed or child under three years of age. Screening is not carried out if the woman is physically or mentally unwell.

A screening form is available for recording the intervention and guiding the process (see Appendix 1).

It includes a preamble explaining the service's interest in helping address domestic violence, the universality of the screening tool and the limitations to confidentiality, and it offers the choice to participate in the screening.

There are two direct questions to identify domestic violence. If a woman answers 'yes' to either of the questions, a further two questions are asked, one addressing safety and the second offering assistance. There is a section to record actions taken, and the reasons if screening is not completed. The form becomes part of the woman's medical record. The screening protocol, staff training and domestic violence policy provide guidance in further assessment and intervention for the health worker for cases where domestic violence is identified. Action regarding referrals, notification to police or reports to the NSW Department of Community Services is noted on the form. These actions are also outlined in detail in the NSW Health *Policy and Procedures for Identifying and Responding to Domestic Violence* (2003). More detailed information can be recorded elsewhere in the medical record.

The screening protocol directs that regardless of whether domestic violence is identified according to the questions, all women should be offered an information card. This gives basic information about domestic violence in simple language and illustrations. Statewide 24-hour phone numbers for assistance are included. Information is also provided in eight major community languages. Provision of this information is part of the prevention strategy. The aim is also to provide useful information to those who may be experiencing violence but choose not to disclose it at the time of screening. The information often goes to a wider audience as many women pass on the card to family or friends who are experiencing abuse (Irwin & Waugh 2000).

2.6 Data

The Domestic Violence Policy requires Area Health Services to participate in data collection processes, which document the level and some outcomes of screening.

Relevant, comparable domestic violence data in the NSW public health system is useful to inform service planning and facilitate targeted service delivery. There is limited data currently available from statewide data collections from hospital and community health services.

Outline of the Routine screening for domestic violence program

Information generated by the screening process is valuable in its potential to provide Area Health Services and the NSW Department of Health with data regarding prevalence of domestic violence in the particular client groups. This information is also useful for partnership work with other government agencies.

Data recording and collection methods vary across all service streams and within Area Health Services. In order to provide some consistency, the screening tool has now been integrated into the revised Mental Health Outcomes Assessment Tool (MH-OAT), the Integrated Perinatal and Infant Care (IPC) psychosocial assessment,

and the OBSTET database. The form and protocol will be available through the Community Health Information Management platform (CHIME) in 2004. These steps will assist in integrating domestic violence screening into the regular clinical work of antenatal, mental health, alcohol and other drugs services, and early childhood health and other community health services. These systems have the potential to provide data locally and statewide as a secondary outcome of routine record-keeping. The longer-term aim is to render unnecessary short data collection exercises such as this snapshot.

Snapshot methodology

3

Area Health Services were requested to provide a one-month snapshot of data for each service or facility that had commenced screening. The snapshot period was from 1 to 30 November 2003. The time frame was selected to provide baseline information for comparison with a further snapshot proposed for November 2004, ahead of the planned full implementation by the end of December 2004.

Information was collected for each program from the data forms used in each facility over the one-month period. This data includes numbers of eligible women attending the service, numbers screened, the responses to the questions, and key actions taken, specifically reports to the Department of Community Services, police notifications and other referrals. In addition, where screening was not completed, the data forms provided for the key reasons to be noted and included two other categories that had been previously identified as possible issues: 'lack of privacy' and 'woman too unwell to screen' (see format at Appendix 2).

Consultation also occurred with Women's Health Coordinators who have involvement or carriage of the roll-out of screening in their Area Health Services. Explanatory notes were given to assist the services in filling out the form and enhance consistency of responses.

Only numerical information from the screening forms was requested. Provision was made for services to note 'any local events or conditions that may result in this period being atypical' to assist in data analysis. The form was also made available electronically in Word and Excel formats. Area Health Services were requested to forward copies of the forms with collated information from each facility to the NSW Department of Health. The methods used locally to collect the data were determined by the Area Health Services, program areas or facilities, according to current practice and feasibility.

South Eastern Sydney, Hunter, Central Sydney, Mid Western and Northern Sydney Area Health Services also provided further information regarding the nature of other referrals made when domestic violence was identified. Some individual facilities volunteered information on the data collection form. This gives some indication of the range of referrals that health services are making for women.

Area Health Services were also asked to provide an estimate of the extent of implementation in each program at the time of screening.

4 Overall results

This section presents an overview of the findings, with the combined results by program from all Area Health Services.

4.1 Extent of screening in programs

At the time of the snapshot, 13 of the 17 Area Health Services had commenced screening in all or some of the targeted program areas (see Figure 1). Three Areas had

commenced planning and staff training for the introduction of routine screening and two of these Areas indicated intention of participating in the next snapshot. Data was received from all facilities screening.¹

The uptake of screening has been greatest in antenatal services with all or some services in 12 Area Health Services participating. This is followed by seven Area Health Services screening in alcohol and other drugs services, four screening in early childhood health

Figure1: Percentage of targeted and additional programs screening in Area Health Services, November 2003

Area Health Service	Targeted programs				Additional programs		
	Antenatal	Alcohol and other drugs	Early childhood health	Mental health	Women's health nurse	Sexual health	Sexual assault
Central Coast*	100	85	100	0	100		
Central Sydney	50	0	100	0			
Far West	0	0	0	0			
Greater Murray	0	100	0	0	100		
Hunter	13***	100	0	0			
Illawarra	100	0	100	0	100		
Macquarie	90**	0	0	0			
Mid North Coast	100	100	100	100	100		
Mid West	100	0	0	0			
New England	0	0	0	0			
Northern Rivers	27	0	0	0			
Northern Sydney	40	38	0	0			100
Southern	65	100	40	0	100		
South Eastern Sydney	66	75	0	50	66	50	
South Western Sydney	0	0	0	0			
Wentworth	0	0	0	0			
Western Sydney	100	70	0	25			

* 50% antenatal and 50% women's health services in Central Coast participated in the snapshot.

** Macquarie antenatal includes some clients from Upper Sector Far West.

*** Singleton (Lower Hunter) also includes some surgical patients. Numbers not separated.

¹Except from Central Coast, which decided not to formally participate in this snapshot. Two facilities elected to provide data.

services, and three in mental health services. In six Areas, women's health nursing services are screening and in one Area, a sexual health service has also commenced screening, and in another Area, one sexual assault service has chosen to screen clients (see also Figure 1).

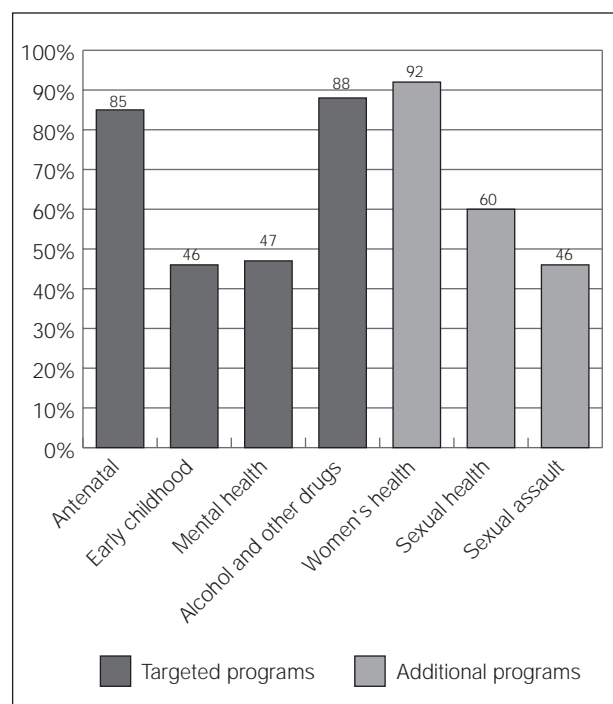
A small number of services, including women's health in Greater Murray, mental health in Sutherland (South Eastern Sydney) and an alcohol and other drugs service in South Eastern Sydney noted that November 2003 experienced lighter client activity than usual. One women's health service in Albury (Greater Murray) saw a higher number of Aboriginal women as they were conducting a targeted women's health program.

4.2 Screening rate

During November 2003, a total of 5,800 eligible women were seen by all services participating in the domestic violence screening snapshot. Antenatal services saw the highest number of women with 2,459 attendees. The number of women attending in other programs was as follows: early childhood (1,956), women's health (595), mental health (333), alcohol and other drugs (258), sexual health (175), and sexual assault (24). Some women may have been counted more than once if they presented to multiple services in this period.

Screening for domestic violence occurred for 4,036 women, 70% of the total of eligible women presenting to all services, a high screening rate. The screening rate ranged from 46% for early childhood health and sexual assault, to 92% for women's health nurses (see Figure 2).

Figure 2: Screening rate as a percentage of total eligible women participating in screening (November 2003)



4.3 Reasons screening not completed

The reasons screening did not occur is illustrated in Figure 3. The most frequently given reason for not screening was the presence of partners (54%), followed by the presence of others (38%). A small proportion of women (5%) were too unwell to screen, 2% of women refused to answer the questions and the lack of privacy accounted for 1% of women not screened.

In 52 cases (29%) the reasons for not screening were not stated. Some services noted that there were other reasons for not screening, such as that a previous service had already screened or domestic violence had already been disclosed, or no health care interpreter was available.²

²Any cases not specifically stated within the categories nominated were classified as 'not stated'.

Overall results

Figure 3: Reasons provided for not screening as a percentage of eligible women not screened

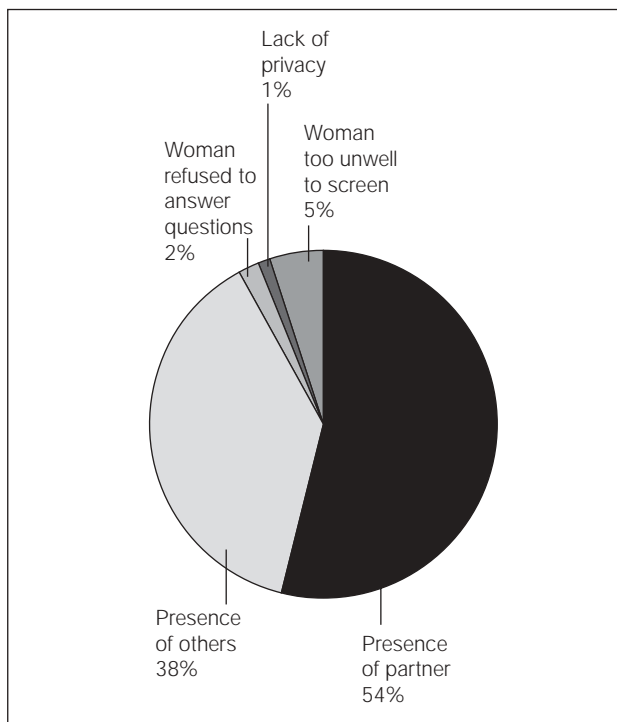
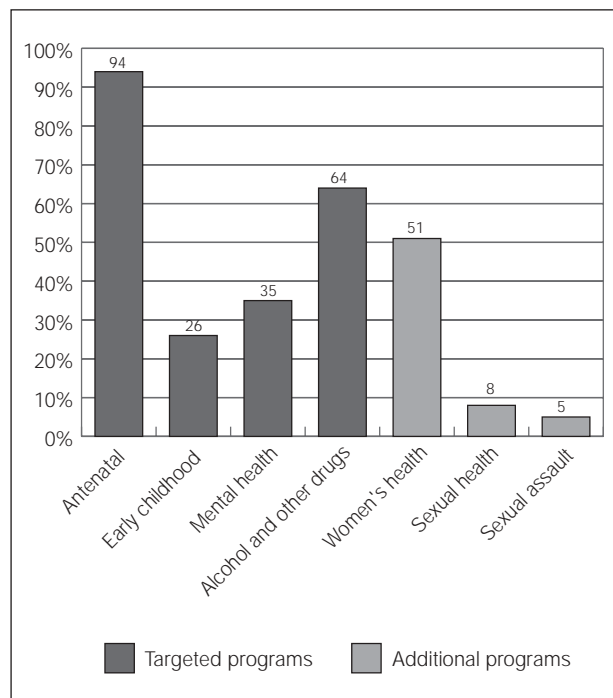


Figure 4: The number of women identifying domestic violence in response to screening questions in participating programs

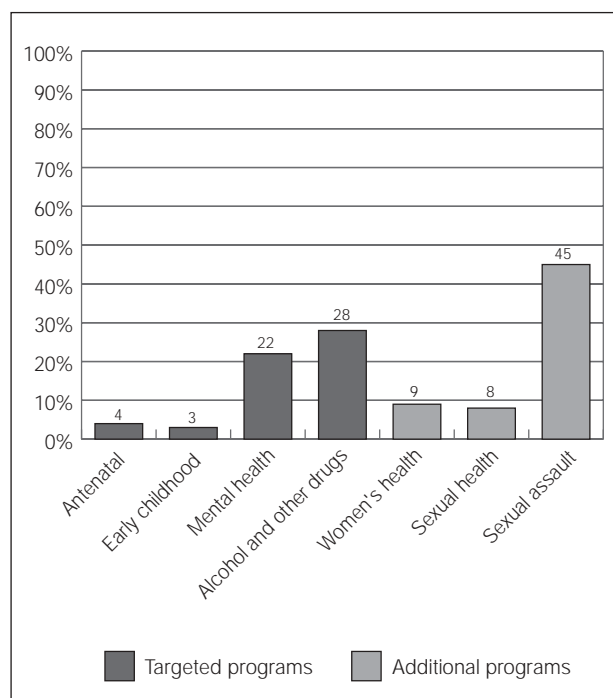


4.4 Domestic violence identified

A woman was identified as a victim of domestic violence if she answered 'yes' to either or both of the following questions: 'Within the last year have you been hit, slapped or hurt in other ways by your partner or ex-partner?' and 'Are you frightened of your partner or ex-partner?'

A total of 283 women (7%) answered 'yes'. The number identified in each program is given in Figure 4 and ranged from a total of 94 in antenatal to five in sexual assault. This reflects, in part, the number of facilities screening in each program and the numbers of women attending these services. The overall rate of identification of domestic violence by the screening questions was 7%, with a range from 3% to 45% (see Figure 5).

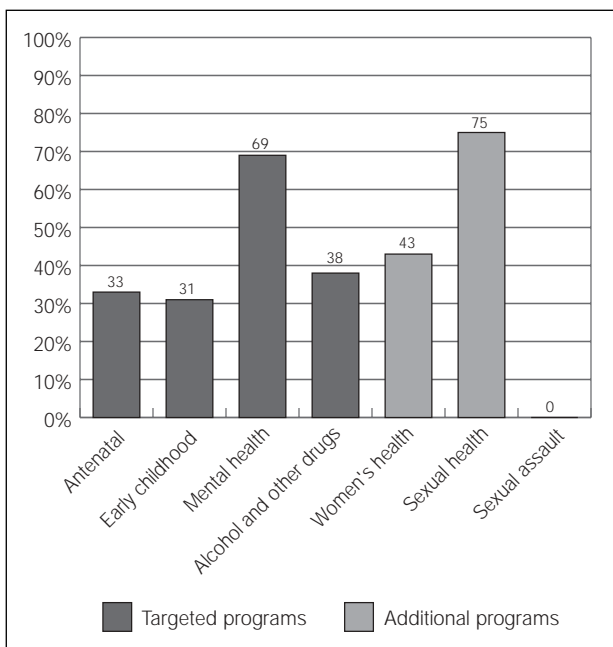
Figure 5: The percentage of women identifying domestic violence in response to screening questions in participating programs



4.5 Assistance accepted and action taken

Of the 283 women who identified domestic violence, a total of 115 (41%) accepted an offer of assistance. The numbers ranged from 31 in antenatal, 24 each in alcohol and other drugs and mental health, 22 in women's health and six in sexual health. These are expressed in Figure 6 as percentages of women positively identified as experiencing domestic violence.

Figure 6: Accepted offer of assistance as a percentage of women identified with domestic violence



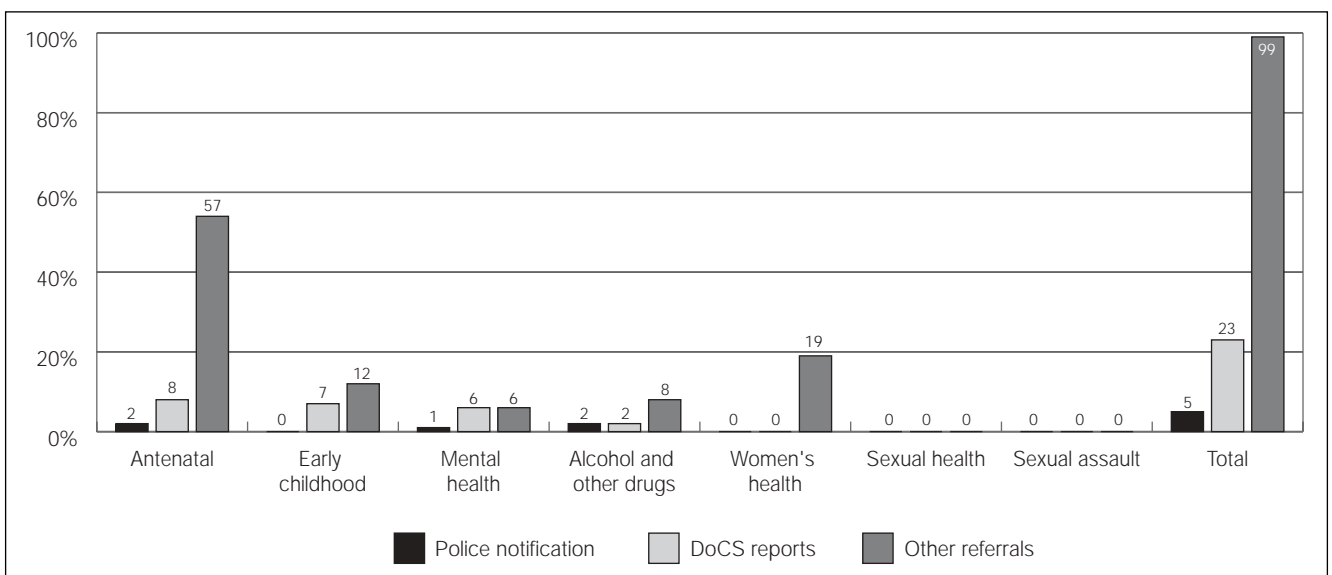
In terms of action taken, there were five notifications to the police, 23 reports to the NSW Department of Community Services and 99 other referrals.

An analysis of the data indicated some services may have included in the Other Referrals section, referrals made for reasons other than domestic violence.

There may be more than one referral for an individual woman (see Figure 7).

Other referrals were made both within the hospital and community health systems and to other external services. Intra-health referrals were mainly to hospital or community health social workers, including antenatal social workers. Some referrals were made to mental health and alcohol and other drugs services. External services included community-based services such as women's refuges or other crisis accommodation, legal aid services, the Women's Domestic Violence Court Assistance Scheme, Family Support, and Relationships Australia.

Figure 7: Action taken



5 Results in each of the targeted programs

This section presents detailed findings by targeted program and Area Health Service. Targeted programs are antenatal, early childhood health, alcohol and other drugs and mental health.

5.1 Antenatal

Antenatal services in 12 Area Health Services screened patients.³ Of the 2,459 women attending these services in November 2003, 2,090 (85%) were screened. The screening rates ranged from 99% in Western Sydney to 62% in Mid Western. The number of women attending antenatal services ranged from 63 in Central Coast to 626 in Western Sydney (see Figure 8).

The presence of a partner or others accounted for 95% of the recorded reasons for not screening. A reason was not stated in 26% of cases.

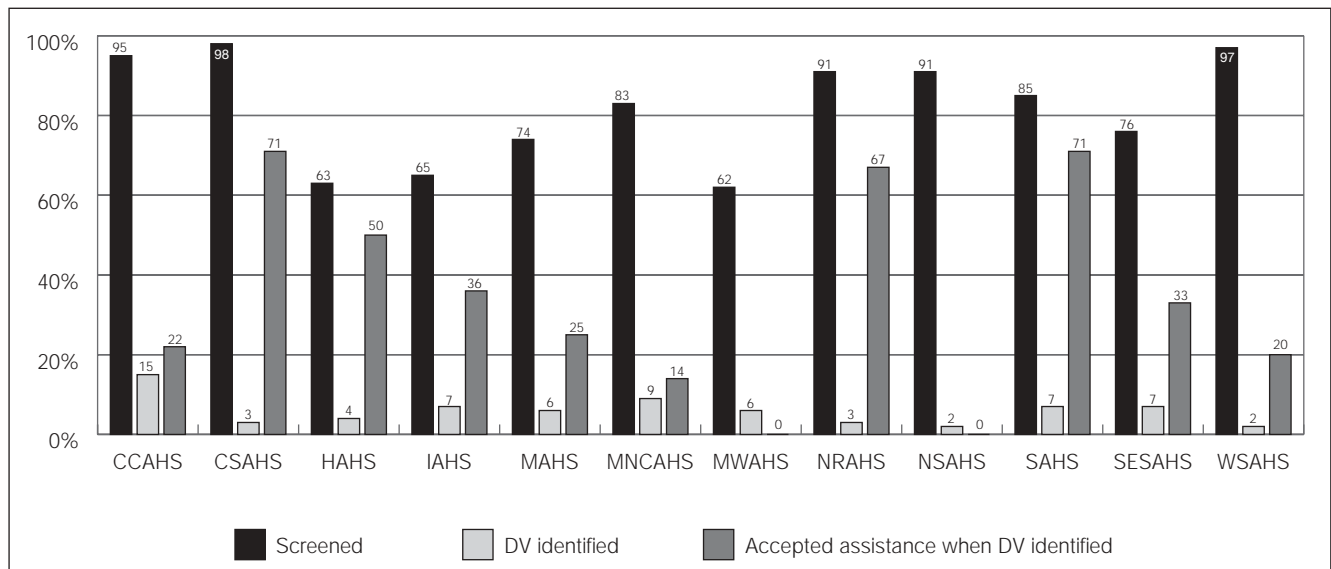
Ninety-four women (4%) were identified as having experienced domestic violence. Rates of identification of

domestic violence ranged from 2% in Western Sydney and Northern Sydney to 15% in Central Coast. Western Sydney, with the lowest identification rate, screened the largest number of clients – 29% of the total number.

Of those women identified, the proportion of women accepting assistance ranged from 71% in Central Sydney and Southern to nil in Mid West. However, in all cases the actual number of women was small, 31 in total, with five being the most in any one Area Health Service. This information is presented in percentages in Figure 8.

Two police notifications, eight reports to the Department of Community Services and 54 other referrals occurred in antenatal services. Data was not specifically collected on the nature of the other referrals; however, some Area Health Services noted referrals were made to a social worker, and some specifically stated this was a maternity services social worker.

Figure 8: Antenatal services screening rates, domestic violence identified, and assistance accepted



Note: Column 3 is a percentage of column 2.

³Maternity clients (unknown number) from the Upper Sector of Far West are included in Macquarie's figures.

5.2 Early childhood health

Five Area Health Services implemented screening in early childhood health services.^{4, 5} In Central Sydney, Illawarra and Mid North Coast, all of the early childhood health services are screening.

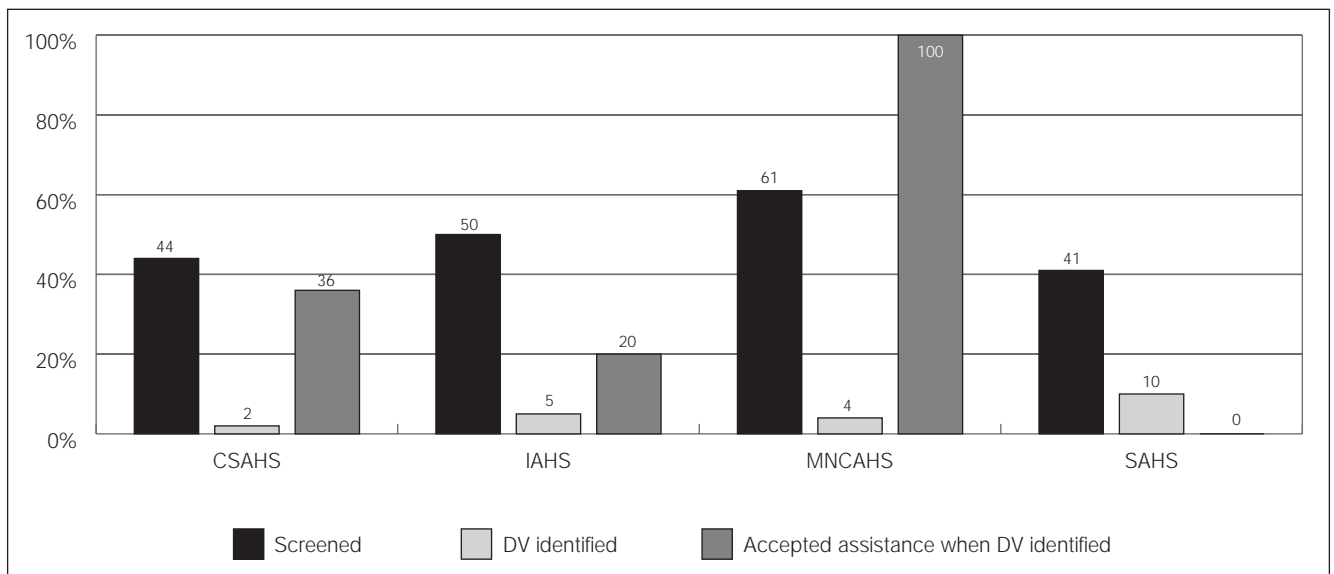
Of 1,956 women attending these services in November 2003, 902 (46%) were screened. Screening rates were relatively low, ranging from 41% in Southern to 61% in Mid North Coast (see Figure 9).

'Presence of a partner' and 'presence of others' accounted for 55% and 42% respectively of recorded reasons for not screening. Illawarra stated that in some services, more than one reason was given for not

screening, but this has not had any significant effect on the percentages.

Of the 902 women screened, 26 (3%) identified domestic violence according to the screening questions. The rates of identification ranged from 2% in Central Sydney to 10% in Southern. Of those women identified, acceptance of assistance ranged from 100% in Mid North Coast to nil in Southern. In all cases the actual number of women identified was small, eight in total, with four being the highest number in one Area Health Service, Central Sydney. There were no police notifications, seven reports to the Department of Community Services, and 12 other referrals.

Figure 9: Early childhood health screening rates, domestic violence identified, assistance accepted



Note: Column 3 is a percentage of column 2.

⁴Central Coast services are all screening but were unable to participate in the snapshot.

⁵The Tresillian Family Care Centres based in Central Sydney, with two centres in Northern Sydney and one in Wentworth also participated and are represented in the Central Sydney data

5.3 Alcohol and other drugs

Women clients of alcohol and other drugs services in eight Area Health Services were screened. Seven Areas participated in the snapshot. In four Area Health Services, all of the alcohol and other drugs facilities were screening.

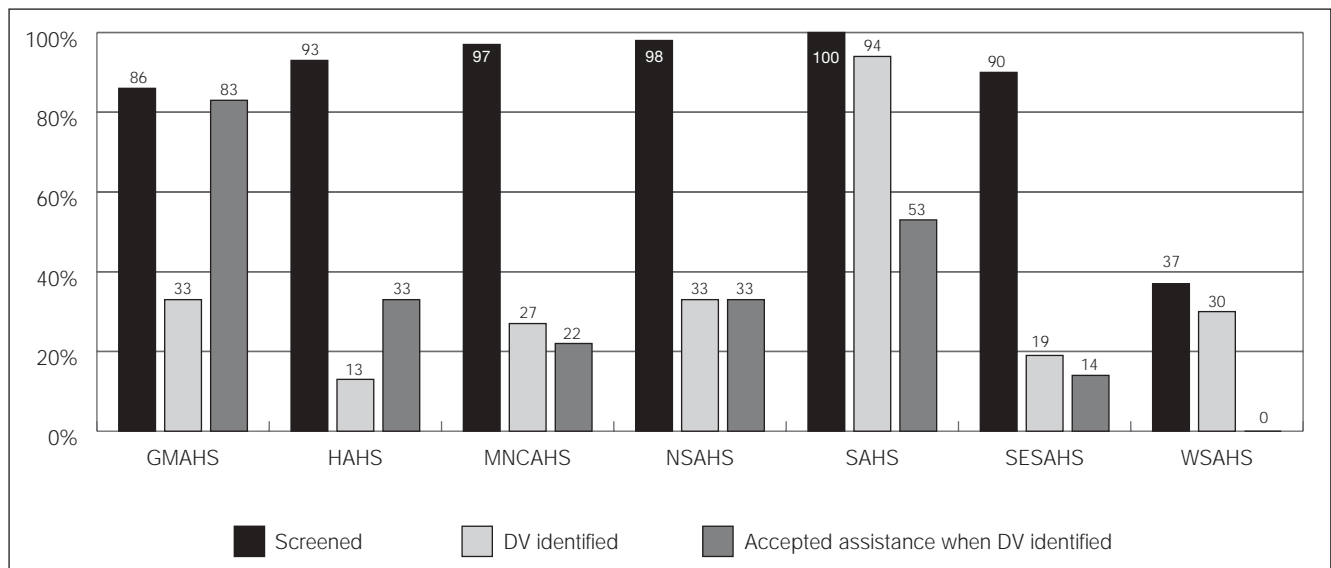
Of 258 women attending these services, 227 (88%) were screened, giving a very high screening rate. The rates varied from 100% in Southern to 37% in Western Sydney (see Figure 10).

In only six cases were reasons stated for not screening. The presence of a partner accounted for three cases,

in two cases women refused to answer the questions and in one case lack of privacy was the reason for not screening. In 25 cases the reason for not screening was not stated.

Of the 227 women screened, 64 (28%) identified domestic violence. The rates of identification ranged from 13% in Hunter to 94% in Southern. A total of 24 women or 38% accepted the offer of assistance. There were two notifications to police, two reports to the Department of Community Services, and eight other referrals.

Figure 10: Alcohol and other drugs services screening rates, domestic violence identified, assistance accepted



Note: Column 3 is a percentage of column 2.

5.4 Mental health

Mental health services in four Area Health Services had commenced screening and three participated in the snapshot. In Mid North Coast, all of the services were screening.

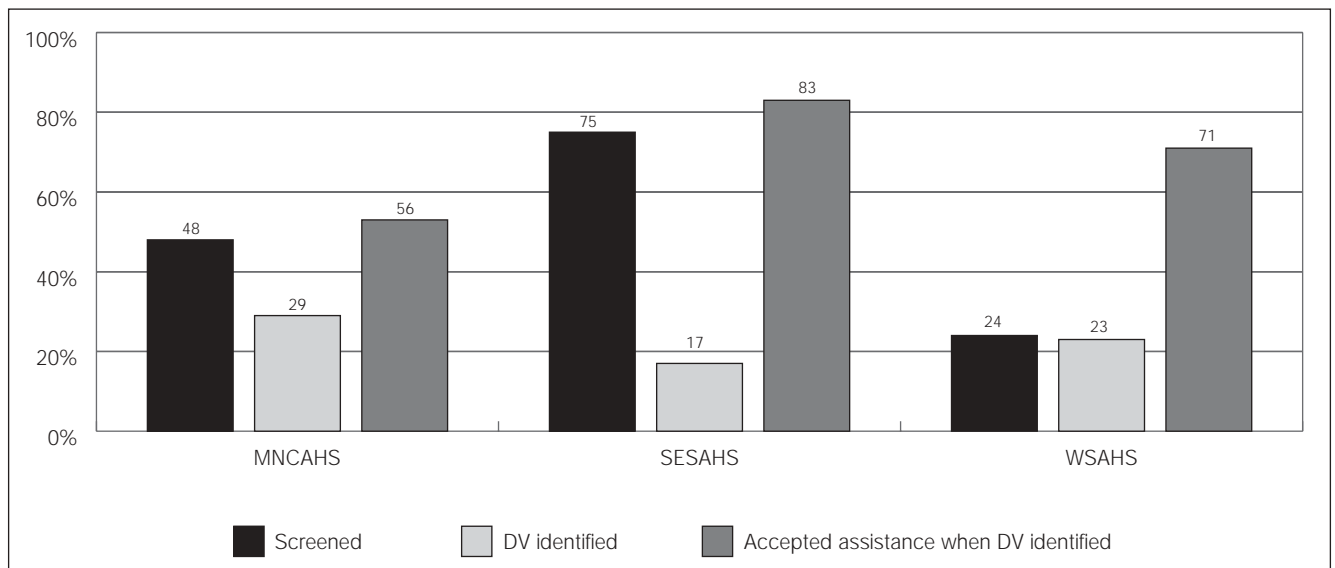
Of 333 eligible women who attended mental health services in November, 156 (47%) were screened. The screening rates ranged from 24% in Western Sydney to 75% in South Eastern Sydney (see Figure 11).

Where a reason was stated for not screening, in 48% of cases this was because the women were too unwell to screen. The presence of a partner accounted for 15%

and presence of others for 14% of those not asked the questions. In addition, 18% of women refused to answer the questions. In over half of the cases where screening was not completed, the reason was not stated (see Appendix 4).

Of the 156 women screened, 35 (22%) identified domestic violence according to the screening questions. The rates of identification ranged from 17% in South Eastern Sydney to 29% in Mid North Coast; 24 women, 69%, accepted the offer of assistance. There was one notification to police, six reports to the Department of Community Services, and six other referrals.

Figure 11: Mental health services screening rates, domestic violence identified, assistance accepted



Note: Column 3 is a percentage of column 2.

6 Results in additional programs

This section presents detailed findings by additional program and Area Health Service. Additional programs that participated in the snapshot are: women's health nursing, sexual health and sexual assault.

6.1 Women's health nursing

In six Area Health Services, women's health nursing services were screening their clients and participated in the snapshot. In five of these Area Health Services, all of the services were screening. Fifty percent of the services in Central Coast participated in the snapshot.

Of 595 women attending these services in November 2003, 454 (92%) were screened, which is an excellent screening rate overall. Rates varied from 76% in South Eastern Sydney to 100% in Central Coast and Illawarra (see Figure 12).

A reason was given for not screening in nine instances. In five cases the reason was that the women were too unwell to screen, in one case a partner was present, and in three cases others were present. In 41 instances, 82%, the reason was not stated.

Of the 545 women who were screened, 51 (9%) identified domestic violence according to the questions. A total of 22 women, 43%, accepted the offer of

assistance. Nineteen women were given referrals; there were no notifications to police and no reports to the Department of Community Services.

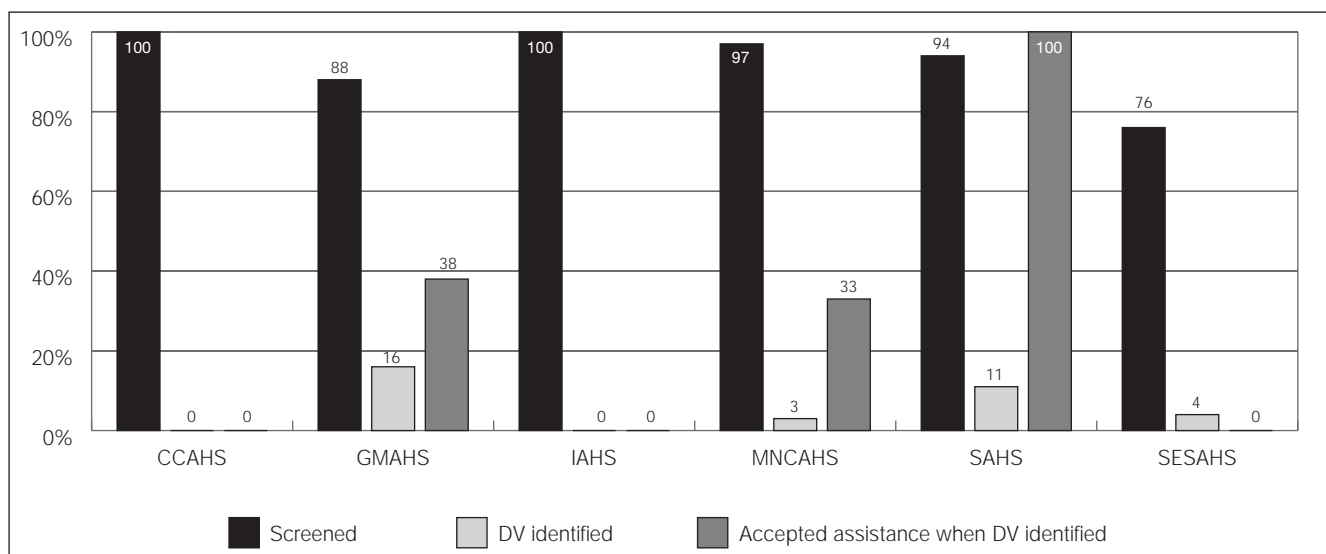
6.2 Sexual health

One sexual health service in South Eastern Sydney is screening female clients aged 16 and over. Of 175 eligible women presenting to the service, 105 (60%) were screened. Screening was not completed in 70 cases, and no reasons were given. Eight women (8%) identified domestic violence. Six (75%) accepted the offer of assistance. There was no information given regarding referrals.

6.3 Sexual assault

The sexual assault service in Northern Sydney has chosen to screen female clients aged 16 and over. Of the 24 women attending the service, 11 (46%) were screened. In one instance, screening was not completed due to 'presence of others' and in 12 cases the reasons for not completing screening were not given. Five women (45%) identified domestic violence according to the questions. No offers of assistance were accepted and no other referrals, reports or notifications were noted.

Figure 12: Women's health nursing services screening rates, domestic violence identified, assistance accepted



Note: Column 3 is a percentage of column 2.

Discussion of findings

7

Area Health Services vary in the number and size of participating services, the number and characteristics of client groups, service usage patterns, and when the screening questions are asked. While it is not possible to directly compare individual services, there is sufficient data to provide an overview of programs in some aspects. It is also methodologically difficult to compare the snapshot with the pilot or other research; however, it may be useful to make some observations.

7.1 Screening rates

Seventy percent of the eligible women attending the services were screened. This is a significant improvement since the pilot when the average screening rate was 56%. The difference is greatest in alcohol and other drugs services, from an average of 13% to 88%, then mental health service from an average of 21% to 47%, and a smaller increase in antenatal services from 72% to 85%. However, the mental health services taking part were not the same services, and there were additional alcohol and other drugs and antenatal services in the snapshot.

The reasons given for not screening varied between programs and this most likely reflects the nature of the clinical setting as well as current clinical practices in those programs or facilities. The screening rate varies greatly between individual facilities within some service streams in the same as well as in different Area Health Services. For example, some maternity services have been able to provide a setting where part of history taking happens in private. In others, the practice of taking the history of a woman with a partner and/or others present and with no routine way to interview the woman on her own leaves the questions unasked, at this stage at least.

In early childhood health services, significant numbers of women were not screened due to the woman's partner or others being present during the first visit. Although in these cases it is difficult to interview the woman alone, there may be future opportunities to conduct the screening if the woman presents to an early childhood health service on her own. Under the new policy of universal home visiting being implemented under

Families First, the opportunity to screen women for domestic violence may be missed if interviewing a woman alone for even part of the visit does not occur.

In 29% of cases where screening was not completed, reasons were not stated. In some services, this accounted for the majority of clients not screened.

7.2 Identification of domestic violence

7.2.1 Identification rates

The total number of 283 women identified in the one-month period by the services in the program areas currently screening would equate to approximately 4,000 if it were possible to extrapolate this to 12 months, presuming no seasonal variations in patient presentations and no fluctuations in identification rates. Many of these women would not be identified by health services in any other way, particularly in services where issues of domestic violence have not traditionally been addressed.

Lawler (1998) cites research identifying prevalence rates of domestic violence in women attending antenatal services from 3.9% to 17%. The three antenatal services in the South Eastern Sydney pilot, reported a range from 5% to 11% (South East Health 2004). The overall snapshot finding of 4% average with a range from 2% to 15% is therefore consistent with these findings.

For the overall finding of 3% in early childhood health, there is no pilot with which to compare. However, given that it is the population of women in the postnatal period, there may be similarities with the antenatal population and accordingly the range of identification from the four Area Health Services screening; 2-10% is also consistent, though relatively low.

The comparatively higher rate in alcohol and other drugs and mental health services than in the other services is consistent with research findings in these smaller clinical populations (see for example Quinlivan & Evans 2001, Raphael 2000).

Discussion of findings

The rate of 46% in the sexual assault service is also consistent with research findings on the high prevalence of sexual assault perpetrated by a partner or ex-partner, and the presence of sexual abuse as part of domestic violence (Campbell 2002, Heenan, 2004). It is not known if the sexual assault perpetrator is the same person as the domestic violence perpetrator.

7.2.2 Non-disclosure of domestic violence

Although routine screening does increase identification, domestic violence may still be under-disclosed.

The reasons may relate to the woman, the service and/or the health worker.

The screening preamble makes it clear that a woman does not have to answer the questions. There may be many reasons for choosing not to disclose violence. These may include feelings of embarrassment or shame, not being 'ready' to disclose or discuss, lack of comfort with the questions, questioner or clinical setting, thinking that the violence isn't important or unlikely to recur or concern about the consequences such as reports to the NSW Department of Community Services, involvement of police, or fear of what may happen if the partner finds out.

Further information would be needed to clarify why services varied so widely in identification rates of domestic violence and why some services seem to be more 'successful' in this respect. Factors such as the workers' attitudes, the manner and timing of screening, or the service environment may be responsible.

Presenting information through the screening process and offering the information card can provide an opportunity for women to seek assistance at a later time through the health service or somewhere else (eg Standing together against domestic violence 2003). It is not known if action does happen later and if so whether and how the interaction with the health service may contribute to this decision, as this information is beyond the scope of the snapshot. Anecdotal information suggests however, that a number of women re-present to the service provider at a later period and refer to the previous questions and disclose the violence then.

7.3 Acceptance of assistance and action taken

Information on the nature of the assistance accepted was not requested from Area Health Services. The three categories mentioned, police notifications, reports to the Department of Community Services, and a generic 'Other Referrals' were the only specific actions on which information was requested. If the assistance provided was not included in these categories, it would not have been recorded on the data form, unless volunteered. It may therefore relate to other assistance such as information given or simply a notation that the issue was open for discussion as to the woman's needs and options available. It could also include the above reports, notifications or referrals.

7.3.1 Assessment

The screening protocol requires that once domestic violence is identified and help is accepted, further assessment is necessary. This is particularly in relation to the safety of the woman and her children, as well as for other needs. Further assessment is to be undertaken whether the woman accepts an offer of assistance or not if there are serious safety concerns. However, it is clearly more straightforward if assistance is accepted. Depending on the service protocols, the interviewing worker may make this assessment or a referral may be made to, for example, a social worker to complete the assessment process then take whatever action is appropriate. It was beyond the scope of this exercise to gather information on when or whether referrals were taken up or what the outcomes of such interventions were.

7.3.2 Action taken

The types of action taken when domestic violence was identified varied between Area Health Services and within programs. This could reflect a range of issues including the local availability of other domestic violence related services, the relationship between the client and worker or service, the nature and relative priority of the presenting health issues being addressed, and the services needed or requested by the client.

Clients of alcohol and other drugs services, where the acceptance of assistance was 38%, are often engaged in ongoing contact rather than one-off sessions, with the opportunity for the worker to provide counselling or other assistance in future contacts. This may be the case in mental health services also, however, the highest rate of clients accepting assistance occurred in mental health services (69%). This may be a reflection of the services' focus on the presenting mental health issue with referrals being made for the domestic violence issue. In sexual assault services, where no referrals were noted, there may also be opportunity for addressing these issues in the context of counselling. Where domestic violence is identified in an antenatal service, there are also further opportunities to monitor the situation through future antenatal contact, and in labour and postnatally, including by early childhood services.

Having noted the identification of domestic violence in the medical record of a client, and, perhaps more importantly, having raised it as an issue directly with her, gives the health worker the opportunity to provide more holistic and increased quality of care.

7.3.3 Notifications to police

There were five reports to police from a total of 283 women who were identified. Reports were made from antenatal (2), mental health (1) and alcohol and other drugs (2) services. This compares similarly with two out of 106 in the pilot. The rate of police reporting may be due to the timing; that is, screening is not necessarily performed when there is a crisis situation, as women are presenting for other reasons. Other possibilities are that police may already be involved (as in one case noted in Northern Sydney), or the situation is not regarded as one where more immediate police protection is needed. The decision would need to be made by the screening services about contacting police according to the *NSW Health Policy and procedures for identifying and responding to domestic violence* (2003). This may include the need for the service to contact the police independently of the woman's decision.

7.3.4 Reports to the Department of Community Services

Twenty-three reports were made to the NSW Department of Community Services. This is significantly higher than the rate during the pilot. This may indicate increasing awareness of where a report should be made according to the NSW Health *Frontline Procedures for the Protection and Care of Children and Young People* (2000), following the introduction of new child protection legislation and extensive training on this issue since the pilot.

Given the high correlation between the coexistence of domestic violence, mental health and/or drug and alcohol issues in child at-risk situations and, as reported by the NSW Child Death Review Team (2002), addressing safety issues for women and children is an extremely important part of health workers' responsibilities.

It is possible that for a particular client, the decision to make a report may be made at a later stage in this assessment, at another occasion of service or by a service to which the client has been referred when further information may become available. The report may then not be noted on the screening form.

7.3.5 Intervention

It is usual for health care providers to take responsibility for intervening to treat a health problem once it is identified. In relation to domestic violence, however, it is not the sole responsibility of the health service to address all issues, and intervention may not be needed or wanted at the time the problem is identified. Dealing with domestic violence is very complex and it is subject to factors outside the control of health services or patient.

A woman who is experiencing domestic violence may need a range of services outside the health system, depending on her current circumstances, preferences and safety needs. For example, she may need police or legal protection, crisis, medium-term or longer-term accommodation, financial or other practical support.

A person experiencing domestic violence is likely to require a number of interventions before she takes steps to change her situation or before something happens to

Discussion of findings

precipitate change. It is important that any intervention from the health service is a positive one, as a 'poor or negative response may deter or delay a woman from accessing help' (Office of the Status of Women 1998). Health services can be key providers of information on domestic violence and services available at this point. Further, identification of domestic violence is important in assisting to manage future risk – for example, at the time a woman becomes an inpatient or to assist in more accurate diagnosis.

As this intervention is with women who are not presenting because of domestic violence but rather to receive a different health service, and who are not necessarily in a crisis situation, direct referrals may not be salient for her at this stage, although appropriate information may be given for the woman to use at a later stage.

Delivery of the screening questions by a trained worker and provision of basic information is in itself an intervention: it breaks the silence, reduces the isolation and sends a message that this abuse is wrong, that it can adversely affect her health, and that something can be done. It may be but one of the interventions and interactions around this issue that a woman may experience. It may be the first intervention that leads to others in the near or later future (Laing 2001, Lawler 1998, Office of the Status of Women 1998).

Conclusion

8

It is clear that a significant proportion of female clients of alcohol and other drugs and mental health services are in current domestic violence situations. This is also particularly the case for significant numbers of women accessing antenatal services. The existence of domestic violence in the lives of these women is an important consideration in their care. Routine screening to identify domestic violence is important to enable more appropriate intervention with women: intervention that takes into account the risk and trauma issues associated with experiencing domestic violence.

The number of women requesting assistance at the time of the screening do not present a significant additional pressure on the capacity of health services overall. This issue was of concern to health services prior to the introduction of screening. The police, local courts and

non-government organisations also play an important role in providing protection and support to women. Continued liaison with all of these services and the establishment of local referral pathways is essential.

This first data collection snapshot for the routine screening for domestic violence program has yielded valuable information for the NSW Department of Health, the targeted and additional programs at a statewide and Area level, Area Health Services, and for individual services. It has provided the opportunity to monitor the introduction of this strategy by Area Health Services, and to monitor programs and quality of medical records. It has provided baseline data regarding the prevalence of domestic violence for clients and patients accessing particular services and some information regarding the response of the health services to these clients.

9 Key issues

9.1 Key issues for NSW Department of Health

- 9.1.1 The repetition of the snapshot in November 2004, and no later than November 2005, will provide trend data and monitor implementation. The integration of the screening tool into CHIME, MH-OAT and OBSTETS data collection systems will assist some Area Health Services with provision of data.
- 9.1.2 In the second snapshot, more information should be sought on outcomes of screening, specifically referrals and type of assistance accepted. Provision should be made for 'any comments' to allow staff to present issues to Area Health Services and the NSW Department of Health.
- 9.1.3 Further evaluation of this strategy is needed to provide valuable information on the outcomes for women. This should provide information such as the effects of the screening process on women and on their future safety.

9.2 Key issues for the Education Centre Against Violence

- 9.2.1 The revision of the implementation package is necessary to include updated information such as new policies, and to develop the assessment processes further. This has been scheduled to occur in 2004/05.
- 9.2.2 Assured ongoing provision of the printed resources as a necessary part of the screening process is needed.

9.3 Key issues for Area Health Services

- 9.3.1 Strategies and service protocols need to be developed and implemented, particularly in early childhood health and antenatal services, to increase opportunities to interview women on their own.
- 9.3.2 Where women cannot be screened at the usual time, the opportunity should be taken to complete the screening questions at subsequent visits.
- 9.3.3 Medical records, including the routine screening for domestic violence form, need to be filled in fully. Area Health Services which have not already identified their intention to conduct file audits, could consider this activity to monitor recording.
- 9.3.4 The ongoing training and support for staff including opportunities for debriefing are relevant for all staff and are particularly important in programs where prevalence of domestic violence in clients is higher.
- 9.3.5 Consideration of access to social work staff as an early intervention measure.

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10

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Appendix

1

NSW HEALTH SCREENING FOR DOMESTIC VIOLENCE

Health Worker to complete this form.

Medical Record Number Date / /

Explain:

- In this Health Service we ask all women the same questions about violence at home.
- This is because violence in the home is very common and can be serious and we want to improve our response to women experiencing domestic violence.
- You don't have to answer the questions if you don't want to.
- What you say will remain confidential to the Health Service except where you give us information that indicates there are serious safety concerns for you or your children.

Ask:

Q1. Within the last year have you been hit, slapped or hurt in other ways by your partner or ex-partner? YES NO

Q2. Are you frightened of your partner or ex-partner? YES NO

If the woman answers NO to both questions, give the information card to her and say:
Here is some information that we are giving to all women about domestic violence.

If the woman answers YES to either or both of the above questions continue to question 3 and 4.

Q3. Are you safe to go home when you leave here? YES NO

Q4. Would you like some assistance with this? YES NO

Consider safety concerns raised in answers to questions.

Complete:

<p>Action taken</p> <p><input type="checkbox"/> Domestic violence identified, information given</p> <p><input type="checkbox"/> Domestic violence identified, information declined</p> <p><input type="checkbox"/> Domestic violence not identified, information given</p> <p><input type="checkbox"/> Domestic violence not identified, information declined</p> <p><input type="checkbox"/> Support given and options discussed</p> <p><input type="checkbox"/> Reported to DoCS</p> <p><input type="checkbox"/> Police notified</p> <p><input type="checkbox"/> Referral made to _____</p> <p><input type="checkbox"/> Other action taken _____</p> <p><input type="checkbox"/> Other violence/abuse disclosed _____</p>	<p>Screening was not completed due to</p> <p><input type="checkbox"/> Presence of partner</p> <p><input type="checkbox"/> Presence of other family members</p> <p><input type="checkbox"/> Woman declined to answer the questions</p> <p><input type="checkbox"/> Other reason (specify) _____</p> <p>_____</p> <p>_____</p> <p>Signature of Staff <input type="text"/></p> <p>Name <input type="text"/></p> <p>Designation <input type="text"/></p>
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Routine screening for domestic violence

Data collection snapshot 2003

To: All services and facilities which have commenced screening for domestic violence

The NSW Health Policy and Procedures for Identifying and Responding to Domestic Violence (2003) requires the introduction of routine screening of eligible women for domestic violence in maternity, early childhood, mental health, and alcohol and other drugs services by the end of 2004.

The Domestic Violence Policy identifies the need for Area Health Services to participate in data collection processes, which document the level and outcomes of screening. To make this process as straightforward as possible, the data collection will take the form of an annual snapshot over a one-month period in each service facility that has commenced screening. The 2003 snapshot will occur **1-30 November 2003** inclusive.

Each facility, which has commenced screening, is asked to complete the attached proforma and submit to the Area Health Service for forwarding to the Department by **10 December 2003**.

For further information or an electronic format (Excel), the officer to contact is Gwen Cosier, A/Senior Policy Analyst, on 9391 9905 or gcosi@doh.health.nsw.gov.au.

Explanatory notes for completing data snapshot form:

1. Whole numbers or percentages only are required.
2. 'Service' refers to the broad program area eg early childhood, alcohol and other drug service.
3. 'Facility' refers to the specific service, unit or site eg X Antenatal Clinic, Y Community Mental Health Centre.
4. Please note a contact person for the screening facility, with contact details.
5. Column 1 asks for total numbers of eligible women presenting during 1-30 November inclusive. This means all women attending antenatal and early childhood services, and women aged 16 and over attending mental health, alcohol and other drugs, or other services.
6. Column 2 asks for total numbers of all eligible women who were screened.
7. Column 3 is the percentage of eligible women attending the service who were screened.
8. Column 4 is the total number of women who answered, 'yes' to either or both of questions 1 and 2 on the screening form, thereby identifying positive for domestic violence.
9. Column 5 is the number of women who identified positive to domestic violence and accepted some form of assistance.
10. The 'Action taken: referral' section asks for total numbers of Police notifications, Department of Community Services reports, and other referrals. Count all such referrals. Individual women may be in more than one category.
11. The 'Screening not completed due to:' section asks for facilities to note the reasons why screening may not have been completed.

Appendix

3

Routine Screening for Domestic Violence: Snapshot 1 November - 30 November 2003

Area: Service: Facility: Date screening commenced: Service contact person:													
Phone:					Email:								
Action taken: referral					Screening not completed due to:								
Numbers of eligible women who presented to the service	Numbers Screened	% women screened	Numbers Domestic violence identified	Numbers Assistance accepted when domestic violence identified	Numbers Police notifications	Numbers DoCS reports	Numbers Other referrals	Numbers Presence of partner	Numbers Presence of others	Numbers Woman refused to answer questions	Numbers Lack of privacy	Numbers Women too unwell to screen	Numbers Not stated

Does November seem a generally typical month, or is it noticeably different in any way? Please comment.

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