

# 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](http://www.health.nsw.gov.au)**

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# 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

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## 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).