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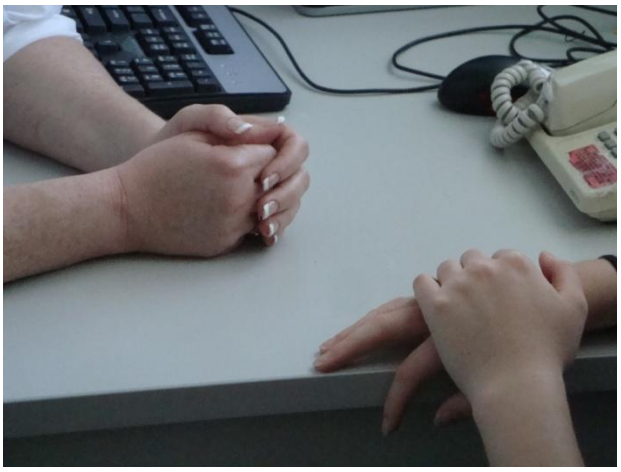
THE UNIVERSITY OF NEW SOUTH WALES

SCHOOL OF PUBLIC HEALTH
AND COMMUNITY MEDICINE

After the Questions: Impact of Routine Screening for Domestic Violence in NSW Health Services



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Spangaro, J, A Zwi, R Poulos & WYN Man, (2010) “Six months after routine screening for intimate partner violence: Attitude change, useful and adverse effects” Women and Health 50 (2) pp 125-132 (Taylor and Francis)

Spangaro, J, A Zwi, R Poulos & WYN Man (2010) "Who tells and what happens: Disclosure and health service responses to screening for intimate partner violence " Health and Social Care in the Community 18 (6) pp 671-680 (Wiley Blackwell)

Spangaro, J, A Zwi & R Poulos “Persist. Persist.”: A qualitative study of women’s decisions to disclose and their perceptions of the impact of routine screening for intimate partner violence (2011) Psychology of Violence 1 (2) pp 150-162 (Copyright © 2011 by the American Psychological Association. Reproduced with permission.)

Spangaro, J, R Poulos & A Zwi (2011)“Pandora doesn’t live here anymore: Normalization of screening for intimate partner violence in Australian antenatal, mental health and substance abuse services” Violence and Victims 26 (1) pp 130-144 (Springer Publishing Company)

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List of Abbreviations

AHS	Area Health Service
D&A	Drug and alcohol
CS	Community Services
DV	Domestic violence
ED	Emergency Department
IPV	Intimate Partner Violence[1]
NSW	New South Wales
Negative screen	An answer of "no" to both screening questions
Positive screen	An answer of "yes" to either screening question

[1] The term *intimate partner violence* is gaining increasing use internationally to denote abuse by a partner and is used interchangeably with the term *domestic violence* in this report.

Executive Summary

Background

The World Health Organization has documented the serious long term health effects of domestic violence (DV), [1] which affects one in four adult women and has an annual incidence of 8%.[2-3] Routine screening for domestic violence was introduced as part of state-wide policy for domestic violence in NSW Health services in 2003. The policy requires that standardised questions are asked of all women who attend public antenatal, early childhood, and women aged over 16 years who attend mental health and Drug and alcohol (D&A) services, at the first point of presentation. Annual data since 2003, finds that 5.6%-7% of all women screened, report abuse.

Evaluative study

An evaluative study undertaken by the School of Public Health and Community Medicine at the University of NSW has been conducted in four antenatal, five D&A services and one mental health service in South Eastern Sydney Illawarra and Central Coast Northern Sydney Area Health Services. The study was funded by the Primary Health and Community Partnerships Branch of the NSW Department of Health and the Australian Research Council. It comprised surveys with both women who screened positive for abuse, as well as a sample who screened negative. It also included in-depth interviews with women screened positive and focus groups with a sample of health workers who implement the screening questions in NSW Health services.

Overall

The study found that the NSW Health DV screening policy is strongly established, with a sustained screening rate that is higher than that found in many similar programs internationally. The program increases workers' responsiveness to and awareness of DV as a problem.

Screening operates as a complex intervention by assisting women who are screened in diverse ways, that include provision of opportunities for first disclosure, provision of information about abuse, and after six months, evidence of increased awareness about abuse and reduced abuse as well as reduced isolation and being prompted to evaluate the situation.

Other groups are potentially also assisted by screening, including women who have not experienced abuse, for whom there was evidence of attitude change, those who received the card from women who had participated in the screening program, and women who elect not to

disclose abuse at the point of screening but nonetheless receive information about DV through the screening process.

Key findings

Women screened positive for abuse (ie. said yes to either screening question):
23% (22/120) were disclosing the abuse to any person for the first time.

81% (55/68) of those who recalled being given written information at the point of screening read it and 16% (11/68) of those who received the written information talked about it with or gave it to another person.

43% (51/120) were referred to another service in response to disclosing abuse.

47% (53/114) of women who screened positive reported increased awareness /changed attitudes towards domestic violence after screening.

77% strongly agreed six months after screening that abuse affects a woman's health (from reported 51% at screening).

81% strongly agreed six months after screening that it is a good idea for health workers to ask about abuse (from reported 62% at the point of screening).

There was a statistically significant decline in the proportion of women reporting that they had experienced current abuse six months after screening (22/62) compared to recalled current levels of abuse at the time of screening (62/114).

Seven women (7/119) (6%) reported adverse consequences. One reported further abuse following the offender's discovery that she had disclosed, the remainder reported negative emotional reactions.

34% (41/120) reported that they derived specific useful effects from screening – most commonly being prompted to evaluate their situation and reduced isolation. Three women said the abuse had ended as a result of screening.

Women screened negative for abuse: **(ie. said no to both screening questions)**:
There was almost no difference in the proportion of negatively screened women who recalled receiving the information card, compared to the positive group (55% (133/241) and who reported reading the card (104/133), however they were significantly *less* likely to have discussed the card with, or given it to another person 5% (7/133).

14% (34/240) of the women who screened negative for abuse had given "intentional false negative" responses.

The main reasons given for not disclosing were that women considered the abuse to be insufficiently serious and fear of detection by the abuser. Similar proportions of the women who gave "intentional false negative" responses reported useful and adverse effects from screening as those who gave positive screening responses.

The negative screened group were less likely to report increased awareness /changed attitudes in relation to abuse (22%; 50/231) than the positive screened group.

Experience of screening and impact: Results from interviews with abused women
Women's situations were complex and not readily described as "in" or "out" of abuse.

Women disclosed their abuse after making active judgments about safety in three different domains: from the abuser, from shame and from losing control.

Women with previous experiences of police, courts or child protection services and particularly those women who had continued to experience ongoing harassment after relationships ended, were less likely to report benefits from screening.

For others, the experience of screening shaped their constructions of abuse, giving name to it, re-connecting with others through the care and back up offered by health workers and connecting to narratives of competence. These impacts tie to elements identified by psychiatrist Judith Herman as key to recovery from trauma.[4]

Health workers' views
Screening for DV is facilitated by brief scripted questions embedded into assessment schedules, training, and access to referral services.

Sustained practice has been reinforced, by familiarity and women's favourable reactions to being asked.

Remaining barriers to implementing screening include: lack of privacy' tensions about limited confidentiality, and frustration when women remain unsafe.

Screening adds to the complexity of work, but is well accepted by workers and increases responsiveness to DV through i) heightened alertness to DV, ii) enhanced understanding of the links between DV and specific health problems, iii)a greater sense of providing comprehensive care when DV is addressed and increased capacity to make appropriate referrals for women experiencing DV.

On-site social work services play an important role as referral services, providing back-up to workers particularly in areas where rates of DV are higher.

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Section 1: Introduction & Methodology

1.1 Background to Project

Domestic violence has been described as a health problem for women that is *"four times more common than breast cancer, [which] spills over to children and incurs health costs twice the norm"* [5] (p.447). A state-wide policy to routinely screen women for domestic violence and so address this problem, was introduced in NSW Health services in 2003, specifically public antenatal, mental health, drug & alcohol and infant health services.[6]

The policy was introduced to improve identification of and responsiveness to domestic violence, drawing on emerging Australian research that established the extent of this problem. This included a community study of over 6000 women which found that one in four women, who had been in relationships, had experienced DV as adults. [7] In a study of 3000 women attending general practitioners, the same proportion reported an experience of partner abuse within the previous year [8]. A second important rationale was growing evidence of the serious health effects caused by DV, exemplified by the World Health Organization report which found that being the target of violence puts women at increased risk of depression, suicide attempts, chronic pain syndromes, psychosomatic disorders, injury, gastro-intestinal disorders and reproductive health consequences. [9] A final reason was the knowledge that despite increased health needs and service use, abuse remained under-identified by health services with only 27% of women who had experienced abuse being found to have told their health provider. [8] This literature informed the policy discussion paper,[10] screening protocol[11] and state-wide policy for DV. [6]

Under the NSW Health definition, domestic violence comprises *"violent, abusive or intimidating behaviour carried out by an adult against a partner or former partner to control and dominate*

that person" [6] and is now widely accepted as affecting one on four adult women in their lifetime, with an incidence of 8%.[2-3] Domestic violence is also recognised as contributing significantly to health costs, calculated in 2004 to result in health costs of $314m annually in Australia[12] and to comprise the lead burden of disease in women aged 15-44 years.[13] Routine screening has been introduced in many health settings in the United States, Canada, New Zealand, and parts of the United Kingdom. [14-19] The lead was taken by health care organizations in the United States with the American Medical Association guidelines on partner violence, issued in 1992 stating:

> *"domestic violence and its medical and psychiatric sequelae are sufficiently prevalent to justify routine screening of all women patients in emergency, paediatric, pre natal and mental health settings."*[20]

Routine screening, defined here as asking all adult female patients standardized questions about DV at presentations to designated health services, has been adopted in many health settings.

This is the first evaluative study of the program to be undertaken and addressed the following questions:

1 What proportion of women use screening to disclose abuse for the first time or elect not to disclose abuse they are experiencing?
2 What changes to abuse-related attitudes did women who screened positive OR negative for abuse, report six months later?
3 Among women who screened positive for abuse, what were reported:
~changes to the level of abuse
~useful or adverse effects
~services used or other actions taken in relation to the abuse, six months later?
4 Among women who screened positive, what facilitated disclosure of abuse and what effects and meaning did they attribute to the experience, six months later?
5 What factors enabled or limited health workers capacity and willingness to undertake screening and does implementation of the policy influence their practice?

The NSW Health DV screening program

Screening by health services was initially introduced by NSW Health in 2001. Under the *NSW Health Policy and Procedures for Identifying and Responding to Domestic Violence* (2003), its use was directed with presenting female patients in public antenatal, early childhood, mental health and Drug and alcohol (D&A) services. A written protocol directs the process, which is undertaken face to face by the regular health care provider. The questions and explanatory pre-amble appear in Box 1.

Box 1 NSW Health Domestic violence screening preamble and questions

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

Q.2 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 give to all women about domestic violence.

If the woman answers YES to either or both questions continue to Questions 3 & 4

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

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

Under the protocol, services must follow up any cases where abuse is identified with two further questions about immediate risk and the patient's desire for referral. A wallet sized information card is provided regardless of whether abuse is disclosed, which contains information about what constitutes DV and its effects, as well as options for assistance and safety including a 24 hour free-call telephone DV service. [11] The policy requires each screening service to develop a referral pathway. Referral services include non government advocacy services, hospital social work teams and for some antenatal services, peri-natal case managers who provide antenatal case management and referral to mental health and other non-government services.[21] A pilot study conducted prior to introduction of the policy found that 95% of the pilot participants supported being asked about abuse from their partner. [22] Annual one month snapshots of the screening carried out since 2003, report that approximately 12,000 women are asked the questions each month and 5.6%-7 % of women asked, say yes to one or both questions.[21 23] The screening questions have been embedded into the antenatal booking in computerised assessment schedule, ObstetriX and the Mental Health Outcomes Assessment Tool (MH-OAT) used in mental health and some D&A services.

2003-2008 November data snapshots

Year	Eligible women Attending services	Number Screened	% Eligible women screened	Number Identified domestic violence	% Identified of those screened	Women unsafe to go home	Number Accepted offer of assistance
2003	5,800	4,036	70%	283	7%	Not asked	115
2004	10,343	7,774	75%	504	6.5%	94	358
2005	16,290	10.090	62%	736	7.3%	217	166
2006	17,456	11,581	66.3%	695	6%	229	180
2007	17332	11,701	67.5%	659	5.6%	367	202
2008	19,749	12,536	63.5%	737	5.9%	308	172

1.2 Literature on screening for domestic violence

To date, four systematic reviews conducted on the evidence for routine screening for DV, conducted since 2002 have concluded that although detection of violence is increased, there is a lack of evidence on the existence of effective interventions to reduce DV or for other beneficial outcomes. As a result the reviewers concluded that there is insufficient evidence to recommend routine screening for DV in health settings.[14 16 18 24] They also note the lack of evidence on possible adverse effects from screening.

Debate continues as to whether screening should continue while waiting for definitive evidence. [17 25-29] In part, the debate is fuelled by recognition that evaluating the impact of DV interventions generally, is hampered by many methodological barriers. [30-31] These principally arise from potential or perceived risks to participants. Studies with abuse victims often suffer from low levels of participation[2 32] as well as high loss to follow-up, [33-36] and those who drop out may have higher abuse scores.[36] A further challenge to studies on screening is the possibility of a "research effect" which may occur through repeated questioning about abuse during baseline and repeat survey or interview.[37] These challenges may have contributed to a situation where relatively few DV victim follow up studies have been undertaken[15 26 37-39] and fewer on the impact of screening.[14 17]

Over 33 different DV screening tools are in use [17] although one review of tools tested in healthcare settings concluded that none have well established psychometric properties. It

found that even the most common tools have been evaluated in only a small number of studies, and sensitivities and specificities were found to vary widely. [40]

Qualitative research has also illuminated women's experiences of disclosing abuse and of screening programs. Early literature showed that abused women exercise complex decision-making as to when and to whom DV is disclosed, and that receiving validation from a health provider can change the way they view their situation.[32 41] Findings from subsequent studies found that barriers to disclosure include fear, shame, and invalidation, by having injuries ignored. Benefits to disclosure included realizing that abuse is a problem, decreased isolation, and feeling that the provider cares.[42] A small number of studies have considered women's experiences of specified screening protocols. One found that disclosure in response to screening was influenced by time, privacy, continuity of care and availability of resources.[43] Another found that while screening stirred up painful memories for some, it also increased women's knowledge of DV and provided welcomed opportunities to receive support.[15]

Studies on women's views indicate that most abused women who have been screened for DV in health settings support it.[17 38-39 44-45]

Another area of research on screening has addressed implementation issues. Emergency Departments which widely implement screening in the United States have struggled to implement screening in a systematic way with screening rates being reported at the level of 13-29 %.[46-47] Two reviews of screening implementation found the main barriers to be: lack of training, time, and effective interventions, as well as fear of offending the patient and patient non-disclosure.[47-48] Lack of privacy, particularly in maternity services, when family or partners are often present, is a further impediment.[49 50] Training on its own has been found to be insufficient to increase and sustain screening rates.[47 51] Use of specific screening questions,[47] distribution of information cards, adapted medical charts, [52] and visual prompts such as posters [53] in combination with training, can elevate screening rates. It has also been suggested that system-wide strategies, such as institutional policies and support are needed to maintain strong practice, but these are not currently standard.[27]

The findings from some of this research informed the design of the NSW Health strategy which appears to have benefited from the experiences in other jurisdictions. Centralized monitoring of the rate of screening and identification in NSW Health services occurs through an annual state-wide one-month snapshot. This data indicates that since 2003, 62%-75% of eligible patients have been screened.[21 23]

Australian Responses

In Australia the lead on implementing DV screening was taken by Queensland Health which began to introduce screening in antenatal services across Queensland in 1999, when a pilot in pre-natal clinics and emergency departments in five hospitals took place.[54] The screening comprised six questions relating to fear, physical abuse, emotional abuse, threats, need for

assistance and consent to send a copy of the information to the patient's doctor. Evaluation of patient acceptability in the prenatal clinics indicated that 98% of the women screened supported screening.

In 2002 screening was piloted in antenatal services and emergency departments by the Northern Territory Department of Health and Community Services.[55] Patient support for screening was broad and the incidence of violence in the ED was high, at 25%. Screening is now being implemented across Territory maternity services.[56]

In 2003, the Australian Domestic & Family Violence Clearinghouse issued a discussion paper [57] canvassing the issue of routine screening in health services which reflected the growing debate about screening versus asking about violence only when the clinician has a high index of suspicion. The paper noted that women tend to disclose to health workers only when directly asked. It concluded that whether services implement routine screening or use a case finding approach, the important feature is supportive, respectful health professionals.

Prevalence of DV in different health settings

In NSW, DV screening has been implemented in antenatal, early childhood, mental health and D&A services. This reflects either high prevalence or risk in each of these specialty areas although research indicates that the rate of all physical health problems for women abused in the past year is approximately 60% higher than for never abused women.[58]

US research has found that 25-40 % of women who attend emergency departments have a history of domestic violence [33 44 59-62] and that 3-14% have presented as a direct result of it.[33 63]

Pregnancy is a time of high risk for domestic violence. For 20% of women who experience domestic violence, pregnancy is the time of onset [7] and having been pregnant is associated with a 230 % increase in partner violence. [64]The prevalence of violence amongst pregnant women ranges from 3-9% during the pregnancy, increasing to 16-25% when prior violence is included. [65-68] The importance of this period is underscored by the finding by Martin et al that absence of abuse before pregnancy has been found to be strongly protective against post-partum abuse.[69] A systematic review has found femicide to be a leading cause of maternal death,[70] with at least one study finding it to be the cause of death in half of pregnant victims. [71] The effects of violence in pregnancy are not isolated to mothers, with infants born to women experiencing domestic violence in pregnancy found to have smaller birth weight and head circumference.[72] Infant birth weight [73]and weight change [73-74] have also found to be directly linked to the mother's experience of ongoing violence.

Mental health services have begun to identify the very high levels of violence many of those patients have experienced. One Canadian study found that 49% of married female psychiatric patients had been assaulted by their husbands.[75] Dutton et al found that victims of intimate partner violence have 3-5 time greater likelihood of depression, suicidality, substance abuse

and post-traumatic stress disorder (PTSD) than non victims with psychological abuse and multiple separate victimization experiences most strongly associated with PTSD.[76] A meta-analysis by Golding similarly found that abused women had significantly higher prevalence rates for the same illnesses.[77]
Women who have substance abuse problems also experience elevated levels of abuse. One study reported that 72% had experienced sexual or physical assault as adults.[78] Among women who have experienced abuse, those with more severe post-trauma symptoms are more likely to drink heavily[79]. The risks in this population are exacerbated with pregnancy, which can also trigger increased alcohol and illicit substance use by women experiencing violence.[80-81]

1.3 Methods

The overall study comprised four elements: (see Figure 1)

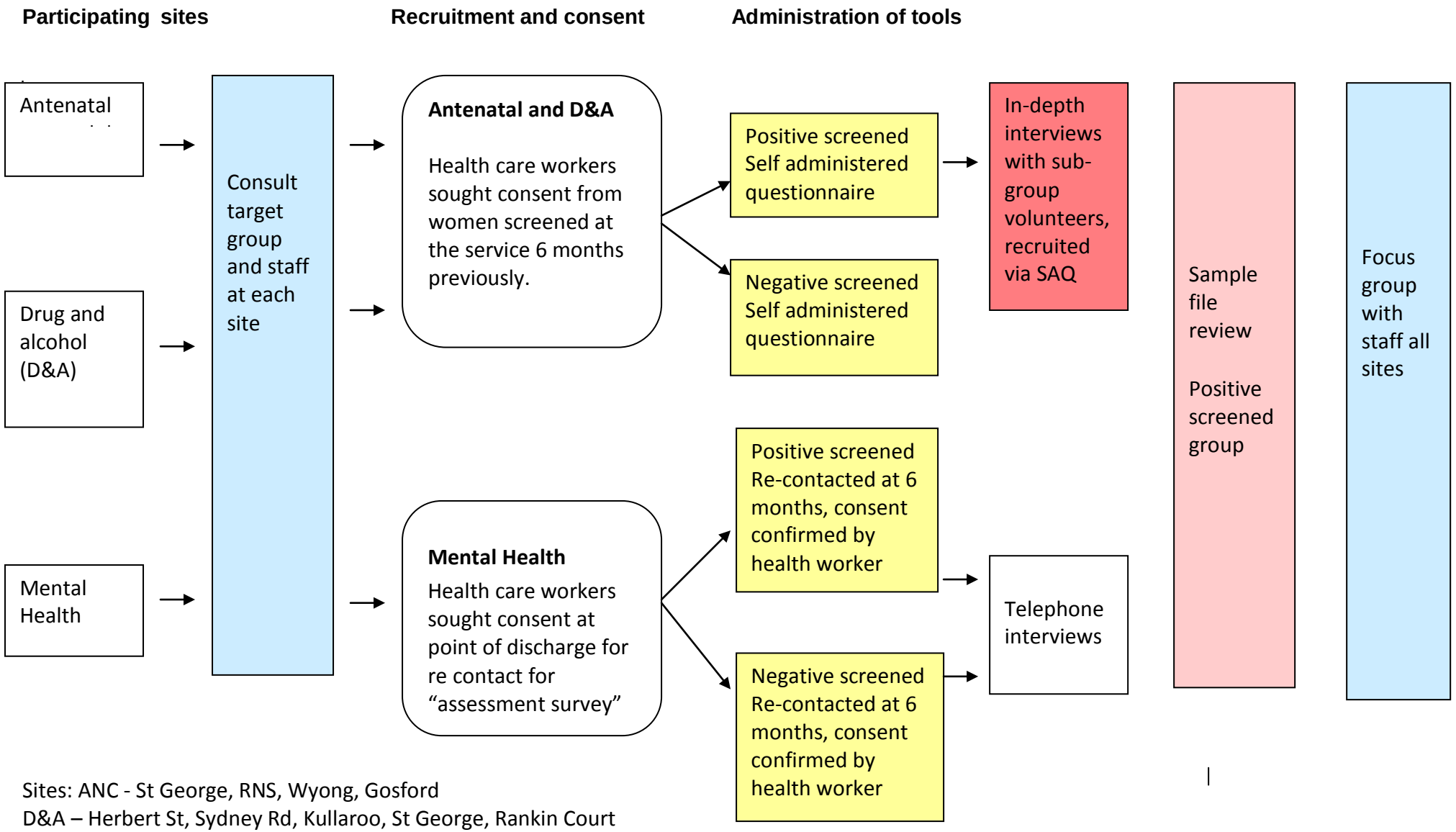
1. Surveys with 122 women identified as experiencing domestic violence through screening [b]
2. Surveys with 241 women where abuse was not identified at screening
3. In-depth Interviews with 20 volunteers from the positive screened survey group
4. Focus groups with staff from ten health services that participated in the study

The ten sites were located in Northern Sydney Central Coast Health and South Eastern Sydney Illawarra Area Health Service (AHS), two of the AHSs delivering public health services in NSW. These two AHSs were selected to reflect urban and regional populations with a diversity of socio-economic status and language groups. Individual sites were selected on the basis of having a sufficient number of clients, willingness of the service to participate, and treatment periods typically six months or longer. Four antenatal, five substance abuse and one mental health service participated. Early childhood health services were not included in the study due to the typical short term nature of their contact with services, leading to difficulties in contacting women at six months. Although this situation applied also to mental health patients and was overcome by use of telephone surveys, it was reasoned that there was a high degree of cross-over between early childhood service users and antenatal patients.

The D&A participants were predominantly opiate maintenance patients. Antenatal patients were recruited from midwifery outpatient clinics, and the mental health patients were recruited from services providing post-acute daily to weekly visits by mental health nurses for periods of 4-6 weeks.

[b] A note on terminology: For the purpose of this report "positive screened," refers to answering yes to either of the two screening questions. At times women disclose previous abuse or abuse by another person, or disclose abuse at a later visit to the same health service. For the purposes of the NSW Health policy and this study, this is not counted as a positive screening response . The same applies to "negative screened," which here is taken to mean, answering no to both screening questions.

Figure 1: Study components and sequencing



Sites: ANC - St George, RNS, Wyong, Gosford
D&A – Herbert St, Sydney Rd, Kullaroo, St George, Rankin Court
MH – Gosford Home-based Treatment Team

Survey Methods

Female patients aged 16 to 60 years who had been screened at the participating sites and who answered yes to either or both of the screening questions were eligible to participate in the study. Four further inclusion criteria were: remaining a patient of the service for 4-9 months, attendance at an appointment during this follow up window, attendance at the appointment alone or with opportunity for health workers to offer the survey privately, and sufficient literacy in one of the three languages the survey was provided in (Arabic, Chinese and English). At all sites, screening was conducted as per usual practice and no reference was made at the time to participation in the study. Participants were recruited from March 2007 to July 2008 from the participating health services. Attempts were made to recruit all eligible positive screened women and negative screened women were also recruited up to an agreed site target (predicted number of positive screened participants). Further description of the methods and analysis of the surveys is found in Appendix 1.

Interview Methods

The interviews were conducted with women who volunteered for a paid interview via a consent form attached to the survey. Semi-structured interviews lasting 40 min to 1.5 hours, were held in consulting rooms at the health service and audio-recorded. Participants were paid $45. Safe strategies employed for re-contacting volunteers and further description of the methods and analysis of the interviews are included at Appendix 1.

Focus Group Methods

Focus groups were conducted with health care workers from the ten participating health services at the close of the survey period. All health care professionals delivering screening at each site were invited to participate and times were selected to maximize participation, although only staff rostered to work and available attended. Participants gave verbal informed consent to participate and sessions lasting 70-110 minutes were audio-taped and transcribed. The focus group sessions concluded with a presentation of the results from the surveys and health workers provided input into explaining some of the results. The focus groups were also used to triangulate the findings from the interviews.

The findings from both the interviews and focus groups are illustrated with sample quotes of participants. These are representative of quotes from a wider group of respondents unless otherwise indicated.

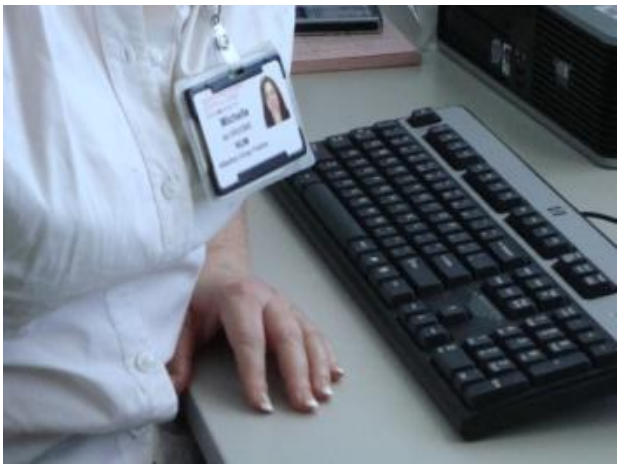
Ethics

The study was carried out in adherence to the World Health Organization ethical and safety recommendations for research on DV and the safety of respondents infused all project decisions.[82] Ethical approval for the study was provided by the Human Research Ethics Committee of The University of New South Wales and those of the St George Hospital, St Vincent's Hospital and the Northern Sydney Central Coast AHS.

Report structure

The rest of this report is divided into six sections. Section 2 provides the results from surveys with women screened positive for abuse. Section 3 reports on survey responses from women who screened negative. Section 4 provides the results of the in-depth interviews with a sub-sample of women who screened positive, Section 5 reports on findings from focus group discussion with health workers who undertake screening and Section 6 comprises Discussion and Recommendations.

In the following two sections reporting on survey results, the denominators vary slightly due to the fact that the level of missing data varied across items.



Section 2: Findings from surveys with women who screened positive for abuse

2.1 Positive screened sample

146 women who gave positive responses to the screening questions were approached to participate. 130 women agreed and completed the surveys (response rates of 88%). Data from eight women who had screened positive (2 substance abuse and 6 mental health participants), and data from 43 women who had screened negative (6 antenatal, 9 substance abuse and 27 mental health participants) were removed from the analysis, as their responses indicated they did not recall the screening. Table 1 shows the key attributes of the sample.

Table 1: Demographics of survey sample of women screened positive for abuse

	P O S I T I V E S C R E E N E D			
	Antenatal n (%)	**D&A** n (%)	**Mental Health** n (%)	**TOTAL** n (%)
Program	58 (48%)*	51 (42%)	13 (11%)	**122 (100%)****
Age(years)				
17-20	6 (10%)	0 (0%)	1 (8%)	**7 (6%)**
21-30	28 (48%)	19 (37%)	2 (15%)	**49 (40%)**
31-40	21 (36%)	23 (43%)	4 (31%)	**47 (39%)**
41-50	3 (5%)	10 (18%)	4 (31%)	**16 (13%)**
51 – 60	0 (0%)	1 (2%)	2 (15%)	**3 (3%)**
Language other than English	16 (28%)	3 (6%)	0 (0%)	**19 (16%)**
Indigenous	3 (5%)	12 (24%)	0 (0%)	**15 (12%)**

*Percentages are as a proportion of sample size for each program.

** Percentages in totals column are the proportion of that variable in the whole sample

Although across the state more antenatal patients are screened than women using D&A or mental health services, which reflects thi size of the different programs, the number of women who screen positive for abuse in each of the three programs is approximately equal. This occurs because a higher proportion of D&A (21%) and mental health (16%) service users give positive responses to the screening questions than antenatal patients (3.4%)[23] Annual snapshot data suggests that 170-180 women give positive screening responses from each program per month.[21] Mental health patients are therefore under-represented in this sample.

The largest age group were those 21-30 years. Antenatal participants tended to be younger and mental health participants older than the others. Women who spoke a language other than English at home comprised 15% of the sample compared to 26% of women in NSW.[83] Greek, Arabic and Tongan were the most common of the 14 languages spoken. The non-English speakers were predominantly users of the antenatal services. Twelve percent of the sample identified as having an indigenous heritage compared to the state population of 2.3%.[84]

Table 2 displays the demographic characteristics of all female patients in the three programs for the purposes of comparison with this study sample.

Table 2: Demographics and screening results for total female client populations

	Antenatal	D&A	Mental Health [2]
Number DV + screens per month[1]	177	182	172
% of total DV+ identified in NSW Health services	25.4%	26.18%	24.7%
Age groups *17-20* *21-30* *31-40* *41-50* *51+*	Data from antenatal and Drug and alcohol databases not available as at 23/3/09)		 6% 21% 24% 19% 30%
Indigenous			5.4%
Language other than English			12%

1 Source: 2006 NSW Department of Health Snapshot:
2 Source: HIE Datamart NSW Health, InforMH – Female clients 2007/08

2.2 Disclosure of abuse

Prior asking and disclosing

Fifty six percent (67/120) of the women who had screened positive reported that this was the first time they had been asked at a health service about being hurt by a partner. Perhaps more importantly, 23% (27/120) of the positive group reported that the screening was the first time they had *told anyone* about being hurt by their partner. The estimates from the multi-variable logistic model of variables predictive of first disclosure are shown in Table 2. There was no apparent association between program type or demographic characteristics, and first time of disclosure. The odds ratio for first time of being asked in a health service about abuse, may suggest that asking by health services promotes first time disclosure, however this result was not significant.

Table 3: Logistic regression predicting first disclosure of abuse at screening for DV

Variable	Odds Ratio	95% Confidence Interval	P values
Program			0.27*
Antenatal	1		
D&A	1.5	0.7 – 5.4	0.21
Mental health	0.6	0.1 – 3.5	0.57
Indigenous	0.7	0.2 – 3.1	0.66
Language other than English spoken at home	0.7	0.2 – 2.9	0.61
Age ≤ 30 years	0.9	0.3 – 2.2	0.74
First time asked about abuse in a health service	2.4	0.9 – 6.4	0.08

*Overall p value for program

Of the 85/120 women who *had* told others about the DV prior to the screening, 71% (57/85) had told a family member; 59% (50/85) had told friends or neighbours; 48% (41/85) police; 40% (34/85) a health professional. Seven percent (8/120) could not recall whether screening was the first time of disclosing.

2.3 Use of information and referrals

Access to and use of information

Fifty six percent (68/121) of the positive screened group recalled receiving the NSW Health routine screening information card (Table 4). At none of the sites did 100% of respondents report being given the card. The range of positive response to this question by sites was 25%-75%. The survey design does not differentiate between those who were not offered from those who were offered the card but declined to take it. Of the positive screen group who recalled receiving the information card, 81% (55/68) reported that they had read it. As well as reading the card, 16% (11/68) gave it to, or talked about it with, another person.

Table 4: Use of information card by women screened positive for abuse

Use of card	*Antenatal*	*D&A*	*Mental Health*	***Total***
Given card (n=122 missing=1))	*35 (61.4%)*	*28 (54.9%)*	*5 (38.5%)*	*68 (56.2%)*
Read card (n=68 missing =0)	*29 (82.8%)**	*23 (82.2%)*	*3 (60%)*	*55 (80.9%)*
Talked about/ gave card to other (n=68: missing = 0)	*4 (11.4%)**	*5 (17.9%)*	*2 (40%)*	*11 (16.2%)*

*As a percentage of those who recalled receiving the card

Referral and uptake of services

Forty three percent of the positive group (51/120) reported being referred to a service as a result of the screening (Table 5). Referral to a service was in addition to provision of the information card to women and usually occurred when women answered yes to the adjunctive screening question asked when a positive response to either of the first questions is given. As part of the implementation of the program, each service established appropriate internal or external services to which women could be referred, should further assistance be wanted or required. Additionally some incidents may require reports to police or Community Services.

A smaller proportion actually attended the services (35%; 43/120). The services most commonly attended were: social workers attached to the clinic (15%; 18/122); police (9%; 11/122); and domestic violence services (8%; 10/122). It appears that where internal services were available, these were used, , otherwise referrals were made to external agencies such as police. Of the 43 women who attended services, 24 attended only one and 19 attended two or more services. Six percent of the positive screen group were aware that their response resulted in a report to the Community Services.

Table 5: Referrals of women screened positive to services by program

Referral	Antenatal	D&A	Mental Health	**Total**
Women referred to service (n=118)	21 (36.8%)	26 (52%)	4 (30.8%)	51 (43%)*
Actually attended service	18 (31%)	21 (41%)	4 (31%)	43 (35%)
REFERRAL SERVICES(n=122)				
Hospital social worker	11	7	0	18 (14.8%)
Police	1	9	1	11 (9%)
Domestic violence service	4	4	2	10 (8.2%)
24 hour DV line	4	5	0	9 (7.4%)
Other health service	2	4	2	8 (6.6%)
Dept Community Services	4	3	0	7 (5.7%)
Court or legal service	0	7	0	7 (5.7%)
Refuge	1	3	0	4 (3.3%)
Other	2	4	0	6 (4.9%)
Total referrals	29	46	5	80

*All percentages are as a proportion of total sample

There is little indication that women who were experiencing current abuse accessed services more often than those who were not. Of the 63 experiencing current abuse at the time of screening, 25 (40%) accessed a service as a result of screening. Less than 100% referral may be due to a range of reasons that include, abuse not being current and assistance not being seen to be relevant, women not wanting to be referred, under-referral by health workers or issues with access to services.

2.4 Reported change to attitudes and level of abuse

Reported change to abuse-related attitudes

Attitude change towards five abuse-related beliefs was canvassed in the survey. Forty six percent (53/114) of positive screened participants reported increased awareness on one or more attitude. Respondents were asked to rate their level of agreement with statements at the current time and then to consider whether these had changed since the time of screening. The data below shows the reported change in the proportion of agreement/ disagreement with each statement. Figure 2 shows the change for each attitude for “then” (time of screening) and “now” (follow up survey six months later).

Attitude 1: Abuse by a partner or ex-partner happens to a lot of women

Forty nine percent of the sample (52/107) reported that at the time of screening they had agreed strongly that abuse is common and this increased to 61% (65/107) six months later.

Attitude 2: Being hurt by a partner affects a woman's health

Fifty five percent (60/110) reported that at the time of screening they had agreed strongly at that abuse affects women's health and this increased to 78% (86/110) six months later.

Attitude 3: If a woman gets hit by her partner she probably deserves it

For this negatively worded attitude statement increased disagreement is the relevant outcome. Sixty nine percent (77/112) of women reported that at the time of screening they had disagreed strongly with the statement that women deserve to be hit. This was reported by 80% (89/112) six months later. This was the attitude with least change and the highest baseline rate.

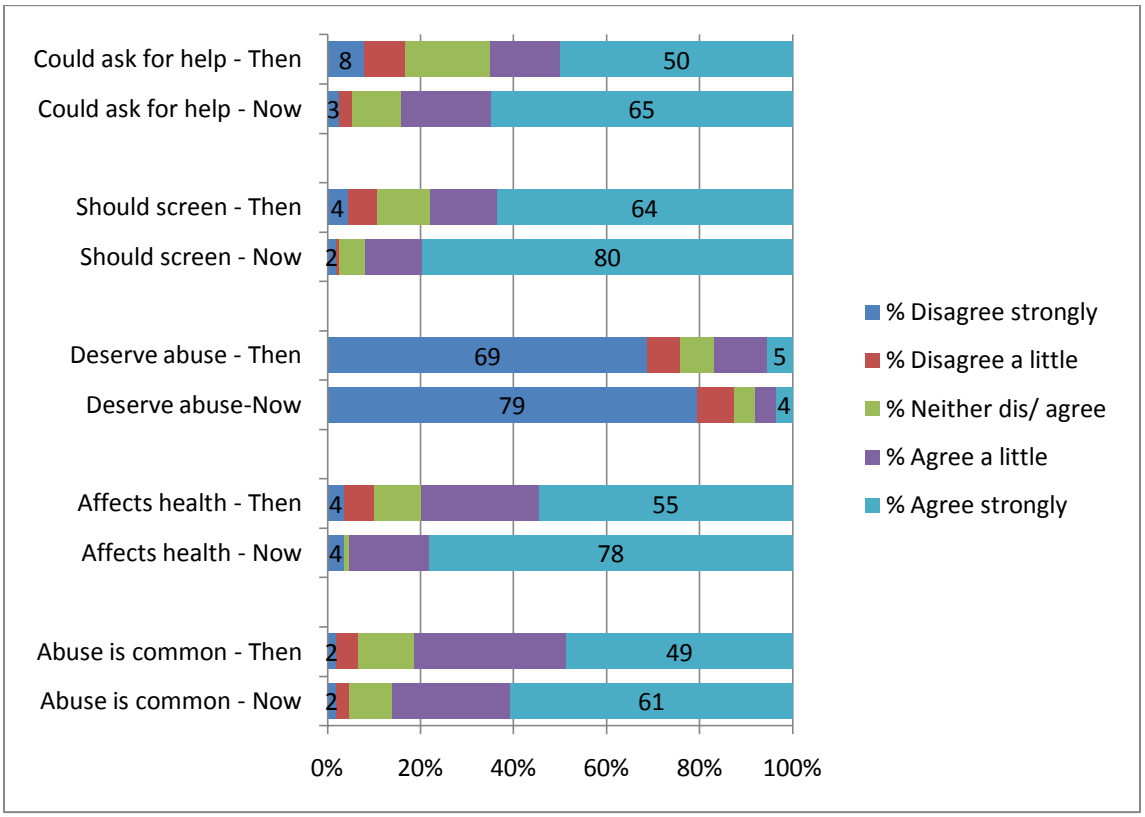
Attitude 4: It's a good idea for health services to ask women about abuse

64% (72/113) of women reported that they had initially agreed strongly that health services should ask about abuse and this increased to 80% (90/113) six months later. In total 92% of positive screened group agreed at six months that health services should ask about abuse.

Attitude 5: I could ask for help from health workers about abuse

Fifty percent (57/114) reported that at the time of screening they had agreed strongly they could ask for help from health workers and this increased to 65% (74/114) six months later.

Figure 2: Percentage agreement with each attitude for women screened positive for abuse



ALL ATTITUDES

The degree of agreement with the attitudes and changes to the degree of agreement post-screening, were broadly consistent across the three programs. The attitude towards which the largest number of women felt most strongly was that that services should ask about abuse, with which 80% strongly agreed post-screening. The attitude for which there was the greatest increase in the number of those agreeing was "*Being hurt by a partner affects a woman's health."* 28% reporting they had increased agreement with this statement. Forty six percent of the positive screened group increased their agreement with at one or more attitude.

Although the means of measuring attitude change can be considered weak methodologically, relying as it does on recall and completion of responses for two time points simultaneously, the comparison to the negative screened group reveals a distinctly different pattern with greater reported change on each attitude for the positive group than the negative group.

Change in status of abuse post-screening

The scope of the screening questions used by NSW Health potentially includes past abuse. This occurs because the questions cover abuse "in the past 12 months", as well as "fear of an ex-

partner". Although all the participants in the sample said yes to one or both of the screening questions, not all were experiencing current abuse. Perceived change in abuse since the time of screening was measured by the four item HITS tool, which has been validated against the Conflict Tactics Scale, and Index of Spouse Abuse, much more comprehensive tools which are considered the gold standard abuse measures[85-86] and is further described in Appendix 1 (A3). The scores derived from the HITS tool, indicate that 54% participants (62/114) were experiencing abuse which was current at the time of screening. When asked to complete the HITS tool for their present situation in relation to abuse from that same person, 35% (40/114) of the women had scores indicating abuse (Table 6). Because the HITS tool has previously only been used as a cut point measure to establish presence of DV or not,[85-86] reporting here is confined to abuse status determined by whether the scores were over or under the cut point of 10.5, rather than increases or decreases in the score.

Four women's HITS responses suggested that abuse was not current at the time of screening, but was six months later. The situation of the remaining women was unchanged. The reported change in abuse for those who screened positive at the time of screening, was statistically significant ($\chi^2$14.7, df 1, p <.005). Analysis by program indicated that the change was significant only for the antenatal participants (p <.005).

Table 6: Abuse status from HITS scores at screening and 6 months later

	Antenatal (n=55)	D&A (n= 47)	Mental Health (n=12)	**Total (n=114)**
Current abuse at screening	22 (40%)*	33 (72%)	7 (59%)	62 (54%)
Current abuse six months later	11 (20%)	25 (53%)	4 (33%)	40 (35%)

*Percentages are as a proportion of all women who screened positive on the NSW protocol by program

RELATIONSHIP OF REDUCED ABUSE TO KEY VARIABLES

Logistic regression analysis was undertaken to determine whether any demographic or policy related factors predicted change in abuse status. Age, ethnicity, indigeneity, and reading the information card appeared not to be predictive. Being an antenatal patient (OR 2.46, 95% CI 0.89-6.76, p=.08) receiving a service (OR 2.08, 95% CI 0.75-5.74, p=.16) and disclosing abuse for the first time (OR 1.18, 95% CI.0.36-3.83, p=.78) appeared to have some association with change to "not current abuse," however these were not significant and confidence intervals were wide. It was not possible to determine whether the lack of statistically significant results was due to a true lack of association or insufficient statistical power due to sample size. ?

2.5 Useful and adverse effects from screening

Adverse effects from screening

Seven women (6%; 7/119) reported adverse effects from screening in response to the survey question "*Did anything that was bad or negative happen to you from being asked the screening questions?*" Six women provided answers to the open-ended prompt "*if Yes, what?*" One woman reported that her partner found out and further abuse occurred. The remaining five reported negative emotional reactions. Because the issue of adverse effects has been highlighted as a gap in the literature, and there is a small number indicating adverse effects, the full text of responses is reported (Table 7).

Table7: Descriptions of adverse effects of screening by positive group

Did anything bad or negative happen to you from being asked ? If yes.. what ?	Program	Current abuse at screening	Current abuse at follow up
"Bashed again for dobbing and playing victim"	D&A	Yes	Yes
"Fell apart"	D&A	Yes	Yes
(No comment made)	D&A	Yes	Yes
"Depressed at recalling situation"	Mental health	Yes	No
"Felt sad and hurt"	Antenatal	Yes	Yes
"Made me feel worse"	Antenatal	No	No
"Went through a little depression from recalling experiences from years ago"	Antenatal	No	No

Of the seven women, five were experiencing current abuse at the time of the screening, based on their HITS scores. At the time of the survey, the HITS scores indicate that four were still experiencing current abuse.

Useful effects of screening

Thirty four percent (41/120) of the women who screened positive indicate they had received benefits from screening, in response to the question "*Did anything useful happen from being asked the screening questions?"* Of the seven women who reported adverse effects, one also reported useful effects and three were unsure. Thirty two respondents (76%) who reported a useful outcome provided further information. The most common type of useful outcome described was being prompted to think further about their situation, followed by diminished isolation (see Table 8). Three women indicated that they moved or the abuse ended as a result of screening.

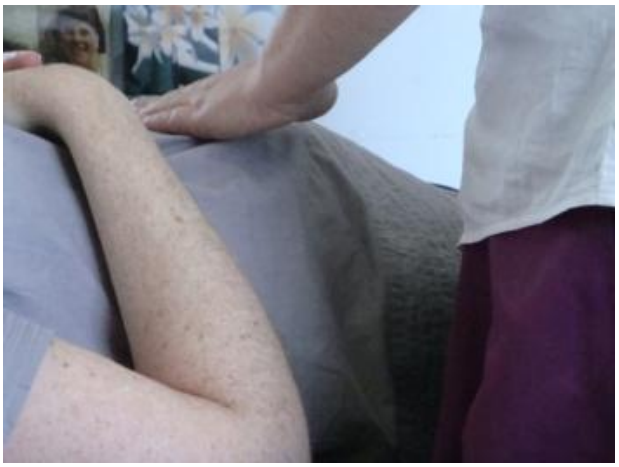
Table 8: Useful outcomes and sample narratives reported from screening

Further thinking about situation	10
"Made me think about it and that I have other options"	
"I accepted that I was a victim of dv when previously denying the situation"	
"Opened my eyes a lot. Realised some things are bad that I didn't think were before"	
"Made me evaluate more seriously the type of company I was prepared to keep"	
"Talking to a mental health worker about it helped me to see how bad it was"	
Diminished isolation	9
"I was able to bring it out in the open. Enabled me to find someone to talk to about it."	
"Knowing I have people to talk to if it comes to it"	
"Can talk openly about it"	
"I feel I am not alone with this"	
Access to services / support	4
"Ongoing support and info through pregnancy"	
"Went to counselling and a group. Now I feel I can tell people"	
Moved / abuse ended	3
"Living alone"	
"Empowered me, resourced me, relocated me"	
"The abuse stopped"	
Other	5
"Talked to partner and it changed his views"	
" I try to be calm and my husband supports me with that"	
"Am happy he is not in my life at all"	
Total	31

Cross tabulation was undertaken to look for any association between first disclosure and reported useful outcomes (Table 9). Those who disclosed abuse for the first time were more likely (than those who had previously disclosed) to report useful outcomes. Chi square analysis indicated this was just significant at the p<05 level ($\chi^2$4.03, df 1, p=0.045).

Table 9 2x2 table of first disclosure by useful outcomes

	Prior disclosures	First disclosure	Total
Useful outcomes	26	13	39
No useful outcomes/ unsure	64	13	77
Total	90	26	116



Section 3: Findings from surveys with women screened negative for abuse

3.1 Negative screened sample

Approximately 316 women who gave negative screening responses were approached to participate at a regular appointment by health workers, and of these 284 (90%) completed the surveys. Forty three records from the negative group (6 antenatal, 9 D&A and 27 mental health participants) were removed from the analysis, as their survey responses indicated lack of recall of screening. The final negative screen sample size was 241. Table 10 shows the key attributes of the sample. Compared to the positive screened survey sample, the negative screen sample had a higher proportion of antenatal patients, but otherwise age and other demographic attributes were similar.

Table 10: Demographics of survey sample of women screened negative for abuse

	N E G A T I V E S C R E E N E D			
	Antenatal n (%)	**D&A** n (%)	**Mental Health** n (%)	**TOTAL** n (%)
Program	161 (67%)*	64 (27%)	16 (7%)	**241 (100%)****
Age(years)				
17-20	5 (3%)	1 (2%)	0	**6 (3%)**
21-30	88 (55%)	20 (31%)	3 (19%)	**111 (46%)**
31-40	68 (42%)	18 (28%)	7 (44%)	**94 (39%)**
41-50	0	25 (34%)	4 (25%)	**22 (9%)**
51 – 60	0	6 (9%)	2 (13%)	**8 (3%)**
Language other than English	35 (22%)	3 (4%)	1 (6%)	**38 (16%)**
Indigenous	3 (2%)	5 (8%)	0	**8 (3%)**

*****Percentages are as a proportion of sample size for each program.
** Percentages in totals column are the proportion of that variable in the whole sample

Access to and use of information by negative screened group

Fifty five percent (133/241) of the negative screened group recalled receiving the NSW Health routine screening information card. This is very similar to the proportion of the positive screened group who recalled receiving the card (56%, 68/121), which is of interest as it may be expected that if the card is being under-distributed to the positive group, even fewer of the negative screened group would receive it.

The negative screen group who recalled receiving the information card, were also almost as likely to report that they read it 78% (104/133) as the positive group (81% (55/68)). The negative group were however significantly *less* likely to have discussed or given the card to another person 5% (7/133). This was significantly lower than the 16% in the positive group who did so (χ^2 =5.21, 1 (df), p = 0.01).

The survey for the negative group included a question about who the screening itself was discussed with. This question was not included in the positive survey due to the need for brevity. Fifty of the negative respondents (20.7%; 50/241) reported that they talked about the screening questions with another person. The proportion reporting this was similar across the three programs. The most frequently spoken to person was a partner 11.6% (28) followed by friend 8.7% (21/241) and a family member 5.8% (14).

3.2 Attitude change among the negative screened group

Reported change to abuse-related attitudes

The items about attitude change towards abuse-related beliefs were included in the negative survey. Respondents were asked to rate their level of agreement with statements at the current time and then to consider whether these had changed since the time of screening.

Twenty two percent of the negative group reported changing their attitude on one or more of the five items (50/231) which is less than the positive group (47%). The data below shows the reported change in the proportion of agreement/ disagreement with each statement.

Attitude 1: Abuse by a partner or ex-partner happens to a lot of women
Of the negative group 37.7% (77/204) reported that at the time of screening they had agreed strongly that abuse happens to a lot of women. This increased to 43.1% (88/204) six months later. Both at the time of screening and after, the negative screened group were not as likely as the positive group to believe that abuse happens to a lot of women.

Attitude 2: Being hurt by a partner affects a woman's health
Eighty percent (166/208 reported that at the time of screening they had agreed strongly at that abuse affects women's health and this increased to 87% (181/208) six months later.

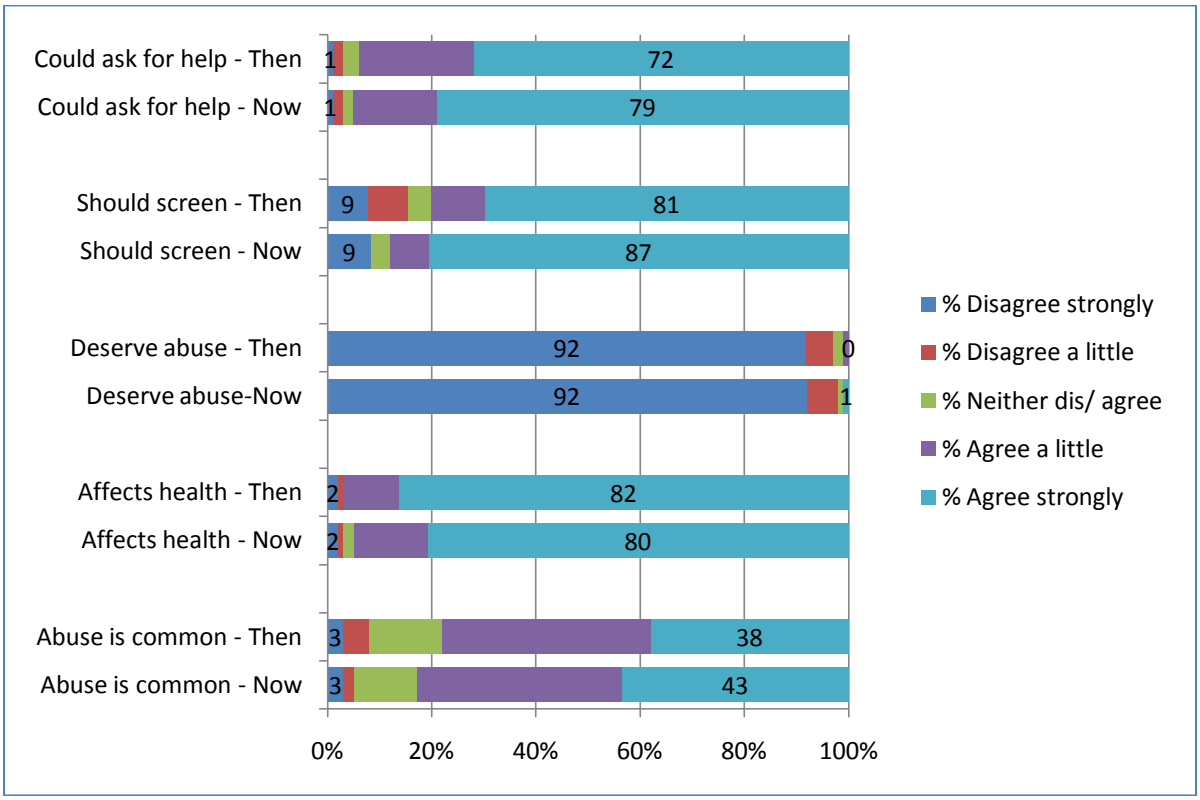
Attitude 3: If a woman gets hit by her partner she probably deserves it
For this negatively worded attitude statement increased disagreement is the relevant outcome. There was no change in the number of women reporting they had strong disagreement with this statement (91.7% (211/230)) at both time points. There was however an increase in the proportion of women disagreeing slightly after six months. The small increase in women agreeing strongly is most probably due to error as a result of reversing the direction of the attitude. Fewer women were neutral (ie. neither agreed nor disagreed after six months).

Attitude 4: It's a good idea for health services to ask women about abuse
Women who had not experienced abuse agreed more strongly with asking than the positive screened group, both before and after screening, with 79.5% (182/229) reporting they had strongly agreed initially that health services should ask about abuse. This increased to 86% (197/229) who strongly agreed after screening.

Attitude 5: I could ask for help from health workers about abuse

There was less agreement on this attitude by the negative screen group than with three previous attitudes with 71.6% (166/232) reporting they had agreed strongly at the time of screening that they could ask for help increasing to (78.9% 183/232) six months later.

Figure 3: Percentage agreement with each attitude for women screened negative for abuse



ALL ATTITUDES

Amongst the negative screened group, the attitude on which there was strongest agreement was that women do not deserve abuse, with which 92% of the negative group strongly disagreed post-screening (compared to 80% of the women who gave positive screening response.

The negative screen group was slightly more likely to agree strongly that services should ask about abuse, with which 86% strongly agreed post screening (80% positives).

The attitude on which the greatest increase in agreement was " *I could ask for help from health workers about abuse"*, on which 22/232 women increased their agreement. The negative screen group reported a greater degree of awareness on all attitudes both before and after screening, than the positive group, with the exception of awareness about the prevalence of DV, about which the positive group were more aware. In total only 22% of the negative group reported changed attitudes, compared to 46% of the positive group.

3.3 "Intentional false negative" responses to screening

Under-disclosure of abuse by women who gave negative screen responses

The survey given to women who screened negative for abuse included an item designed to measure the number of women who had experienced abuse as defined by the NSW Health screening questions, but who elected not disclose this when asked the questions. These responses are referred to here as "intentional false negative" responses. This term is used to reflect that not disclosing occurred through choice, rather than insensitivity in the screening tool. The item used to ascertain these responses is in Appendix 1 (A.4).

Fourteen percent (34/240) of the women who screened negative reported they had been experiencing abuse consistent with the screening questions, at the time of screening. Twenty one percent of these women reported that they had been *"hurt"* only by a partner in the last 12 months only (7/34). A further 44% (15/34) reported that they experienced "*fear"* only, and the remaining 35% (12/34) reported *hurting* and *fear*. Further analysis found that "intentional false negative" responses were more likely to be given by D&A (OR 8.8; 95% CI 3.4-23.3.) or mental health service participants (OR 12.2; 95% CI 3.3-46.1), compared with those from antenatal clinics.

The survey given to the negative screened group also asked respondents to indicate the *main reason* for not disclosing from a list of six possible reasons. Twenty-nine women provided responses. The results are shown in Table 11.

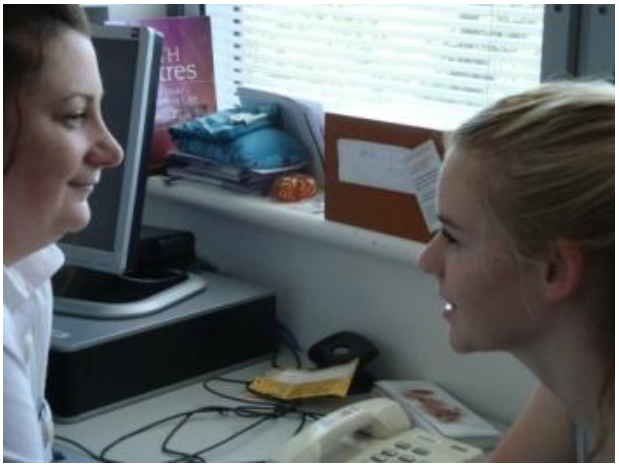
Table 11: Reasons for providing "intentional false negative" responses

Abuse not considered serious enough	8
Fear of offender finding out	4
Not comfortable with the health worker	2
Worry about who else would be told	1
Embarrassment or shame	1
Thought it was own fault	0
Multiple reasons selected	4
Other	9
eg	
Abuse is infrequent and manageable	
Wasn't a priority to talk about it then, just wanted to get better	
Not with that person anymore	
Current partner was present – didn't want to discuss in front of him	
I was a drug addict and didn't care about anything but drugs	
	Total 29

Adverse and useful effects reported by women who gave“intentional false negative” responses

Of the 33 women who gave “intentional false negative” responses to the screening questions, three (9%; 3/33)reported adverse effects from being asked the screening questions, in response to the survey item, *Did anything that was bad or negative happen to you from being asked the screening questions?* One woman reported that she felt distressed at recalling events, and another felt or reported feeling embarrassed and inadequate. The third woman did not provide details.

Ten women (30%; 10/33) provided responses indicating they experienced benefits from screening, with seven providing further information. One reported that she ended the relationship, three reported that they had been prompted to think further about the abuse (eg *“Reassessed my situation”, “Encouraged by availability of support”*), and three reported that they had been provided with information (eg *“The card gave me the information on where to call”*).



Section 4: In-depth interviews with women who screened positive

4.1 Interview sample and purpose of interviews

In-depth interviews with women who screened positive for abuse revealed findings in five key areas. These were:

i) the diversity of women's situations
ii) women's decisions to disclose abuse
iii) effects from the act of *asking* about abuse
iv) effects from *responses to disclosures*
v) factors which contributed to women experiencing useful effects from screening. Each of these is discussed in turn.

The 20 women who participated in interviews comprised 11 antenatal, 7 D&A and 2 mental health service users. Recruitment for volunteers took place at all study sites, and the participants were drawn from 9 of the 10 sites.[3] Ages ranged from 17-50 years. Thirteen of the participants were Anglo-Australian, two were indigenous and five were from other cultures (South America, the Indian sub-continent and the South Pacific). A comparison of the attributes of the interview sample with the larger sample of positive screened women who completed surveys is found in Table 14.

[3] At the remaining site, only one woman volunteered for interview but cancelled two planned appointments and a third was unable to be scheduled in the time available.

Table 12: Attributes of interview sample (n=20) compared to overall positive sample

Attribute		Interview sample	Interview sample %	Survey sample %
Program	Antenatal	11	55%	47.5%
	Drug & Alcohol	7	35%	41.8%
	Mental Health	2	10%	10.7%
Language other than English spoken		2	10%	15.6%
Aboriginal		2	10%	12.3%
Age	Aged 17-20	1	5%	5.7%
	Aged 21-30	10	50%	40.2%%
	Aged 31-40	5	25%	38.5%
	Aged 41-50	4	20%	13.1%
	Aged 51-60	0	0	2.5%
First disclosure		5	25%	22.5%
Access to information card	Recall receipt	11	55%	56.6%%
Of those who received card	Read	7	63.6%	64.7%
	Read and talked/ gave card to another	2	18.2%	16.2%
	Didn't read	2	18.2%	19.1%
Referral	Referred and saw service	7*	35%	35%
Attitude change	Any positive attitude change	10	47.6%	46.5%
HITS score	Decrease	14	70%	57.4%
	No change	4	20%	31.3%
	Increase	1	5%	11.3%
	Missing data	1	5%	
	HITS >10 at screening	8	40%	54.3%
	HITS >10 at 6 months	5	25%	35%
Abuse status	No current abuse both points	13	65%	39.3%
	Abuse current-> No abuse	2	10%	21.3%
	Abuse current both points	4	20%	29.5%
	No abuse -> Abuse current	0	0	3.2%
	Missing	1	5%	6.5%
Adverse effects	Adverse effect	0	0	5.7%
	No adverse effect	17	85%	84.4%
	Not sure	1	5%	6.6%
	Missing	2	10%	3.3%
Useful effects	Yes	8	40%	33.6%

4.2 Nature of abuse and women's situations

Women's experiences of abuse

Eighteen of the women had experienced physical and emotional abuse. Four described only one incident of physical abuse. Two women described emotional abuse only. Serious physical assaults reported included kidnapping, being doused in petrol, punching, breaking furniture and pulling out hair. Commonly women also spoke about controlling behaviour such as control over money, movements and friendships. Disparaging comments about appearance or competence were also common. A number of women talked about their distress at issues which are not commonly thought about as abuse. These included their partner being unfaithful or wanting to end the relationship.

Impacts of the abuse

All of the women described experiencing some form of negative or traumatic effects from the abusive experiences, even those for whom the abuse was short term and for those who had not labelled the experience as abuse. Women who had been in short term relationships spoke of experiencing self-blame and self doubt.

> After we broke up I thought I was fat. I thought maybe I was ugly. Because the way he treated me and certain things he said were quite controlling, I think they did have an impact on me and in such a short time. [ ] I remember saying to my friends. I AM ugly or fat. (F)

Others who had been in longer term relationships experienced depression, anxiety, and also changes to their personality. M experienced extensive physical abuse and stalking from her ex-partner that she said "broke her spirit."

> A lot of people said they saw a change in me. They saw the lights were gone out.(M)

> You've not only got my life you've got my soul. So you do everything… they want to treat you well and they still treat you like sh*t… So it takes a long time to get it back…I had to become someone that I wasn't because you know you've got to change to be someone that they want you to be.(J)

Z talked about how living under her partner's perpetual accusations and control changed how she interacted with people.

> You talk to people differently. You live life differently. You see things differently. (Z)

W described that as a result of her partner's abuse she lost confidence in herself and began to stutter. Nine women also reported that they observed that their experiences had impacted on their children.

Diversity of women's situations

A key finding was that identifying the status of the abuse, was complicated, and not as simple as suggested by a "positive" response to the screening questions. As found in the responses to the surveys, many of the women were not experiencing "current abuse" at the time of screening. Differently to what might be expected, however, this was not tied to whether the women remained in an intimate relationship with the abuser. At the time of the interview, 14 of the women were not currently in the relationship with the abuser. However, a number continued to experience abuse.

For example J, had experienced severe physical abuse from her husband over many years, including being doused with petrol, but had separated eight years earlier. Her ex-husband however knew where she lived and had on one occasion broken in through her roof to demonstrate that locks would not deter him. Although J had previously taken out AVOs against her husband, she believed the latest one was no longer current. Other research has identified that DV often continues after intimate relationships have ended. [87] The distinction between abuse being current or not was also blurred through women who were unsure whether or not the relationship had ended. D reported she would not tolerate further assaults from her boyfriend from whom she was separated, but also spoke of waiting to see what changes he was prepared to make and clearly felt great concern for him.

> He's on his own. He's got no one. He's cut off from his family. His sister was molested by their father and that split the family up. It's left him with lots of issues and he hasn't got anyone to talk to. (D)

A further group of women had remained in the relationship with their partner, but reported they were no longer experiencing abuse. For example, V spoke of her husband's "impatience" and how on one occasion he had pushed and frightened her. However hers was a "love marriage" unlike those of many other women from her culture, and since asking an older male family friend to speak to her husband, she had experienced no further violence. T reported that since her partner had given up drugs he was completely changed, and was now working full time, as well as getting up early to care for their children. While it cannot be assumed that V and T were safe from all further abuse, neither was in fear of their partners and both continued

to value their relationships. Other women appeared to be still experiencing some level of abuse but had taken steps to end it within the relationship. E reported that she was no longer frightened of her husband since taking out a restraining order against him. At the instigation of child protection services she was also attending parenting classes and counselling with him.

These disparate situations were not simply reflections of progression from abuse to safety. It is acknowledged that women's perceptions about whether the abuse had ended would have been influenced by their vantage point and that this perception was subject to change over time. However, the issue here is that the boundaries around where abuse began and ended were far from distinct. As a corollary, the women's narratives also revealed complex relationships with their abusive partners.

P, a seventeen year old antenatal patient had experienced childhood abuse from both parents and had dropped out of school to become the primary carer for her mother, a role she continued to play. She had been hit a number of times by her 19 year old partner but also felt she was calmer and happier when around him and less prone to self-harm behaviours.

Although J continued to receive threats from her ex-husband, who she believed may one day kill her, she simultaneously appreciated other attributes.

> And he used to threaten to bury me in the back yard. He used to dig up the garden. He was a mad gardener. There was a lot of sandstone buried in the back yard, so he used to dig up the sandstone. He made a beautiful rockery.(J)

Another woman, K had attempted suicide following a violent episode that culminated in her husband leaving her. She indicated that her distress was prompted at her grief at his departure, as much as by depression arising from the abuse.

These examples demonstrate the diversity of women's situations and the difficulty of making determinations about safety simply on the basis of the screening result. The women all varied too in the extent to which they had disclosed the abuse and used services. Some women had used multiple services as well as police and court intervention. Others had not previously discussed the abuse with anyone.

4.3 How women decided to disclose abuse

Decisions to disclose abuse

Half of the women indicated clearly in their accounts that they disclosed only because they considered themselves to be now safe from abuse. Use of descriptors such as "*hide*" and "*cover up*" indicated that concealment had been an active decision. Five of the women indicated in

their survey responses that the disclosure at screening was the first time they had told any person about the abuse. Elements of the screening that were found to facilitate disclosure included direct asking and choice.

Direct Asking

Most women were explicit that they would not have disclosed the abuse if the questions had not been put to them directly.

> It's good if someone asks you first, especially in this situation when women are really afraid to talk about something. It's good if someone starts the conversation.(N)

> If I hadn't been asked those questions, who else would I go to? It's not like I'd go and make an appointment with a social worker and say, "I think I've been emotionally abused. Please I need help. I need someone to talk to."(Q)

> She just asked a few questions yes or no. They were good questions. Basically straight to the point. I didn't have any issues.(R)

For some women direct asking on one occasion was not sufficient. Two of the antenatal patients, H and E had been asked the screening questions during earlier pregnancies but both had denied abuse was occurring on the previous occasion. Both women suggested that health workers should pursue the issue more actively, as did a number of other women.

> Persist more. Persist more. Because many keep quiet because they are afraid. And it's only asked once and then it's left. But it's like when you really want something. Just knocking, knocking, knocking. Because you know that when you go to someone's house if you keep on knocking they WILL open the door, no matter if they are angry are like "WHAT do you WANT?" So just keep knocking and don't give up.(E)

> If they get asked those questions and don't feel comfortable saying yes, this is happening to me, you want someone to go a bit further. (H)

At the same time, women's responses indicated that workers who were confident and comfortable with the questions provided reassurance to disclose. Several women reported that workers appeared to be apologetic to be asking about abuse and that this was not helpful.

> She was a little bit… like maybe she felt a bit hesitant. Like maybe she didn't want to be prying? Into my life sort

> of thing. She made me feel like, I have to ask you so please don't feel offended.(W)

A trusted or trustworthy person

A second feature of screening that appeared to prompt disclosure was identifying the asker as a trusted person.

> Should I tell truth or just say "no, no, never" and a little bit lie and a little bit hide? And she said, "We are going to help you." When she said like that I trust her and I tell the story. (V)

Given that the screening questions are generally asked at the first encounter, it seems likely *trustworthiness*, that is, warranting trust, rather than actual trust, was the salient feature. The accounts indicated that health workers were generally seen as trustworthy, particularly midwives.

> But she said... don't be offended. So I just thought okay. Don't. Because she's a midwife, she's a trusted person.(W)

Certain behaviours on the part of health care workers appeared to facilitate trust. Women assessed non-verbal cues and the degree of comfort health workers displayed.

> I didn't feel interrogated. She was casual about it, just in general conversation and she cared. You could see it in her face, the way she was looking at me.(K)

Status as a trustworthy person is not automatic for health workers. At the initial visit when U was screened, the midwife had read U's previous notes and confronted her with her history of drug use, domestic violence and the removal of her first baby. U's comment suggests that the standing of trustworthiness had been transgressed in this encounter.

> But the problem was, when I left, I felt as though she wasn't a midwife at all. She was just someone from child protection coming to see if they could take this child as well.(U)

Choice

Being given choice about whether and how much to say, was also reported as important to women who disclosed. The verbal preamble given before the questions informs women they don't have to answer the questions and that confidentiality is limited.

> She just didn't pressure me about it... allowed me to say what I needed to and then the next time I saw her I could say a bit more.(Z)

Safety

Safety was also identified as necessary for women to disclose abuse. The analysis revealed that safety was not solely from the abuser. Three domains of safety were identified.

Safety from the abuser

A number of women acknowledged that fear of the abuser finding out had deterred them from saying anything earlier.

> Say I was pregnant and he was doing it and I said [so] and he came to the clinic and they said something, then when I went home I would cop it. (T)

It is not surprising that women would not disclose if they considered there was a direct risk from the abuser. However, not all women were currently in fear of the abuser and other types of safety were identified as important to them.

Safety from shame

A second dimension of safety related to embarrassment or shame. One of the women articulated what she described as the everyday shame that abused women carry.

> Women who are abused carry that around a lot. Struggle just taking the kids to school and just seeing the other mothers… you know… great big four wheel drives and you're struggling in the Datsun 120Y, chugging down the road with a nice big black eye.(M)

Shame was identified as a distinct barrier to telling others about abuse

> How can I discuss? I never discuss even my friends, he's gonna hit me. It's shameful. If any husbands hit you or something like that, misbehave. If I tell someone, it's very…[I] feel shy.(V)

Shame was silencing and relieved for some women only when the abuse was no longer occurring or when women had taken steps to address their situation reduced their sense of shame. E felt freer to disclose once she had taken out an apprehended violence order.

> It wasn't really that important to me because I feel like it's something that I'm trying to step up and take care of, whereas before it would have meant a lot to me, but I would hide it.(E)

Safety from losing control

Safety from losing control was the third, and most dominantly featured among the three domains of safety. For some women this related to concerns about staff views and service procedures over-riding their own wishes.

> The reinforcement that the violence counsellors have is very much needed but it also starts to feel like a process, like once you go to that level of getting help, there's no going back because people will stop you going back.(Z)

> I feel, if I tell truth, what's going on in future? Because I'm not stupid, I have to look out for my family. [ ] If I say something, maybe I get trouble, maybe they take action with my husband, I don't want take my husband. Lots of things. Because I am completely new, I don't have any experience. They want to help me. If they want to help me and then it become bad, it's not good.(V)

A number of women spoke of their fears about what the service would do with the information. Fear of losing control was particularly evident in the narratives of women who had previous contact with the statutory child protection agency. The four women to which this applied, all relayed they disclosed only because they regarded themselves as free of abuse. Only when these women felt safe from losing control to the child protection agency, did they decide to disclose.

> My very best friend…Community Services got her file when she was in rehab. And she lost her kids. From being honest in a counselling session. For ever. So I think I've always been careful. (M)

While not all elements were salient for all women at all times, it appeared that a lack of safety on any dimension would have precluded disclosing. During the interviews women were asked whether disclosing on this occasion changed how they felt about talking to other health services about abuse. Almost all indicated that having disclosed on this occasion did not

necessarily increase their willingness to disclose to other health services. This suggests that judgments about safety to disclose are made on a case by case basis.

4.4 Helpful and unhelpful responses to disclosure

Services used

All of the women either had children or were pregnant at the time of interview. Ten of the women were referred to and received a service as a result of the screening. Eight saw a social worker attached to the clinic, two saw perinatal caseworkers. Of those referred to social work services, four were also referred to mental health services and two to substance abuse services. Four of these women also had reports made to the statutory child protection service (Community Services). One woman was referred to the police and another attended a group. It should be noted that all but two of these services were attached to the health service, not external agencies.

A number of women were already using services to help with abuse-related issues and some continued to use these post-screening. Others had previously used services they were not currently using.

Multiple referrals were common. The need for these services is not surprising given the high co-occurrence of DV with both mental health and substance abuse problems and it may be important that all of these are addressed, particularly for pregnant women whose wellbeing becomes important not only for themselves but for their babies. Z's experience illustrates the value of these services.

> But the diversity of the help I got here really helped, because it felt like there was so many things I was dealing with, the moving, the drugs, the violence, the psychological problems and my family. And they were all different levels and I was dealing with them at different times and having the different.. you know the midwife and then the D&A counsellors allowed me to deal with it when I was ready to.(Z)

A number of women faced with the multiple services they were involved with or expected to see, elected to defer use of domestic violence services. P for example who was screened in an antenatal clinic was referred to the substance in pregnancy service, as well as a mental health service to help with her eating disorder and depression. She herself sought out the support of a cannabis specific D&A service. After listing all the services she was attending, she noted that she had been given information about a local DV service and that she still had the information but had not felt the need to contact it. It was important to most women that services took

account of their individual needs and preferences and respected women's choice. Other research has also reported that during pregnancy, abused women often elect to focus on basic needs and the impending birth rather than the abuse, concluding that this was a reflection of their stressful and complex lives.[88]

A number of women expressed the need for information about the effects of DV on children and how to support children who had experienced DV. The accounts of the women with children indicated that the well-being of their children featured prominently in their decisions including those about both ending and continuing relationships.

Unhelpful and helpful follow-up to disclosing abuse

Almost half of the women spoke favourably about the follow up they received from the screening service in response to their disclosure of abuse. Four women reported responses by the health service they described as unhelpful.

Unhelpful experiences included that of P who expressed disappointment at being let down by the social worker who had promised to set up a meeting with Community Services to arrange referral to parenting support services. P reported that she had not heard back about this and presumed the worker "didn't get around to it."

A second woman, T, reported that she had not been informed by the antenatal clinic that they would be making a report to Community Services following her disclosure and she had been unhappy about this. These two cases are discussed further below in relation to responses by referral services.

A third woman described her disappointment with the service follow-up she received. W was told following disclosing to the midwife only that *"she might get a phone call from someone regarding this."* W reported that she received a voicemail message on her home phone from a social worker attached to the antenatal service offering W the opportunity to call back if there was anything she wanted to talk about. This is a questionable response by any service given confidentiality issues, and on further exploration, W revealed that the impersonality of the message deterred any thoughts of returning the call.

> It just felt like a regulation phone call. She had rung. Maybe if she had mentioned just one little thing that was personal to me. Even if she had just mentioned my name. Just something personal that came out of my answers, then maybe I would have rung her.(W)

While W was not currently with her partner, she was still distressed by her experiences, isolated and open to receiving support from a trustworthy source.

> I'm not in that situation any more. But if she'd said, "I think it would be really beneficial for you to come and talk about it" I probably would have.(W)

U reported an unhelpful service response that occurred prior to being asked the screening questions. She relayed how the midwife had read U's medical history prior to her first presentation at the antenatal clinic and identified that U had previously had a child removed by Community Services. U described how the midwife had interrogated her and

> "She was kind of throwing things at me and I was kind of "what's this? This isn't what I'm here for."(U)

Unhelpful aspects to the follow-up did not preclude women simultaneously reporting useful aspects to the encounter. W for example found the information card extremely useful, leading her to recognise that her ex-partner's behaviour had constituted a pattern of abuse. Analysis of the accounts of the women reporting helpful follow-up to their disclosure revealed six actions on the part of the health service that contributed to valuable outcomes. These were: i) providing choice, ii) continuity of care, iii) raising the abuse at subsequent visits, iv) making active referrals, v) providing co-ordinated care and finally,vi) sharing patient summaries with service providers. Each of these is outlined below.

PROVIDING CHOICE

Under the screening protocol, women who disclose abuse are asked two follow-up questions about immediate safety and then whether help is wanted. Unless a child protection risk or other serious immediate risk warranting a police report is required, women who do not want further help are not automatically referred. An exception to this occurs in antenatal clinics. At three of the four clinics participating in the study, positive screens are referred to a case meeting and considered for referral to integrated peri-natal care. At the fourth clinic, a positive screen is responded to with an automatic referral to the social work service. In most instances women are able to choose whether to use a service or not which was clearly important to a number of the women.

> No I've found it's been good. Because it's voluntary, whether I want to do things or if I want to take the help and stuff.(E)

> Yes, she put me in contact with the social worker. So I decided to see her and she came here to the clinic. It was really good. I talked with her and she told me I could talk to her at any time. Or call the number. (N)

At the same time, women described the importance of workers being explicit in what will occur and how help can be provided.

> I think just more clarification on what help CAN be given. Because when you guys say to me "Oh, we can help you", I think, well how ARE you going to help me? Are you going to come in my house and stand there? (E)

CONTINUITY OF CARE

Continuity of care was most relevant to antenatal clinics because usual practice is that patients are seen by any one of the team of midwives. In a departure from this practice, Z described how the midwife to whom she disclosed arranged to continue to see Z at subsequent visits. This was greatly valued by Z, who also used social work, mental health and D&A services, as this strategy minimised the number of health workers with whom she was involved. Such strategies also enable trust to be established.

> When you see them often you kind of get close with them and you feel like you can trust them a bit more. (E)

ASKING AGAIN

Women also valued health workers raising the abuse again at subsequent visits. This achieved two outcomes, firstly it enabled women to tell more of their story and secondly, it provided an opportunity to discuss current safety. A number of women raised the importance of health workers asking and remaining proactive in either repeating the screening or pursuing the issue in other ways. K, who had been admitted following attempted suicide, described how she appreciated the probing questions one of the mental health team.

> And then at one point S. asked straight up, *Can I ask you what happened? Was there something that led up to you doing this and are you able to tell me, like talk about it?* And so at that point I ended up coming out and telling him more and the whole scenario.(K)

One woman observed that the abuse had not been raised again by the midwife following the initial screening and that this would have been helpful. Although she was referred to a number of services, P reported that the issue of DV had not been raised at subsequent antenatal visits.

> But I think they …other than just asking the one thing on that one day, they need to follow up again. [ ] I think they should… closer to when they first ask the questions, they should see if it's still happening.(P)

P had reason to believe that it was pertinent for health workers to follow up the initial screening, as she experienced a further assault by her partner a few weeks after being screened.

ACTIVE REFFERRAL

In light of the many services women need and use following a disclosure, the means by which a referral is made may influence uptake of the service. Women spoke appreciatively of the value of workers not simply recommending services but making active referrals, that is making the contact with the service and making the first appointment or on some way facilitating the contact. L's account indicates that this was for her, both motivating and protective in that the health worker is able to say what is required and not expose her by revealing more of her situation than necessary.

> And actually, they'll even make a phone call for you and get the ball rolling so you can go up there and make more of an effort to do it rather than put it off. You don't really want to go through telling everything and you get mixed up, because so much has happened and you don't know what's necessary to say and what isn't. Because some things they might not need to know. There's that much. Especially when there's children.(L)

L's experience of abuses occurred over many years , despite a number of interventions by police and DoCS. In this she is not unlike many women who experience abuse. As a result their story of abuse is long and "messy," and this potentially contributes to reticence to approach services. Z too spoke of the value of health workers making active referrals and not having to re-tell her story repeatedly.

> Because by the time you get into the hospital and you've told the midwife and then the doctor and another midwife all the rest of it. You've told your story so many times you just… It's hard to talk about to start with. And so try to repeat it all the time. Especially when you are trying not to go through it again and deal with it. To have to repeat it to another person and another person and another person gets really draining and yeah, it almost discourages you from talking about it.(Z)

For Z and others, the disincentive from re-telling their stories were so strong they were tempted to 'shut down' about the abuse. Active referral on the part of the screening health worker protected women from repeating their story and in this aspect appeared to be an important in assisting women to take up referrals.

COORDINATED CARE

Of all the women who were referred to multiple services following the screening, Z's experience stands out as an example of good practice that relieved Z of the burden of re-telling her story and led to a positive outcome.

> She said instead of you talking to this person and that person, we have a staff meeting every Friday or whatever and I can let them know about your case and let everyone know all at once. And that was really good.
>
> She organised everything. [ ] She got me to see the drug and alcohol counsellors and the domestic violence counsellors.
>
> It can be absolutely chaotic out there and they still manage to organise for one midwife to see me, the drug and alcohol counsellor and the social worker to see me, all within my time slot and it really felt that ...people cared. (Z)

Three elements are evident in the response that Z received. These were case planning, that is, Z's case was taken to a planning meeting for discussion and identification of the most appropriate service. Secondly the referral was facilitated, that is the information was passed on to the provider and the appointment scheduled. Thirdly the referral services were provided back to back with her own antenatal appointment on site of the clinic, which meant that she could attend all services in the same visit to the hospital. Not only did this approach ensure that Z received the services, but it translated into Z feeling connected and supported.

None of the other participants appeared to receive the degree of case coordination that Z experienced, although three reported that an antenatal social worker came to see them at the clinic at the time of their appointment on one or more occasion and followed them up post-natally. Others spoke about the value of referrals where they did not have to re-tell their story.

SHARED PATIENT SUMMARIES

In some services it is routine to send a case or discharge summary to patient's General Practitioner or other health care professional. Inclusion of the domestic violence disclosure seemed to be valued by women as a means to avoid re-telling their story.

> Because by the time you get into the hospital and you've told the midwife and then the doctor and another midwife all the rest of it. You've told your story so many times you just… It gets really draining and yeah, it almost discourages you from talking about it.(Z)

-F, an antenatal patient described her experience of attending the early childhood service, which had received a case summary advising of the DV disclosure.

> Yeah she said there was something on my record. I thought that was really good they picked up on it. It was good

> because if she hadn't known the answers I probably would have said no. Other women might think, oh I shouldn't have opened my mouth but its good because if something is continuing they have someone to talk to about it.(F)

F's comment and those made above by L and Z indicate that talking about the abuse is often difficult even after it has been disclosed initially and that women may contemplate denial in preference to re-telling. F's experience also suggests the value of ongoing contacts with providers who can be turned to when women are ready to discuss their situation. Care needs to be taken that women's consent is sought and that the implications of this are discussed with them in order that they can make safe decisions about shared information.

SUGGESTIONS FROM WOMEN IN RELATION TO SERVICE RESPONSES

Two other suggestions for improved responses were put forward by a number of women in the course of the interviews. The first of these was access to information about children and domestic violence. Almost all of the women spoke about how concern for their children had featured in their decisions in relation to abuse they were experiencing. Concern for their children's well being did not immediately resolve issues for them and added to the complexity of their decisions, featuring both as a reason to end relationships as well as a reason to remain in relationships with abusive partners. Some women experienced simultaneous pressure to do both, from different children in the family.

Women identified the need for information to be made available at the time they are experiencing abuse that informs them about the way that exposure to DV can impact on children in the long and short term. They also requested information to guide them in supporting their children to recover from the impact of DV. At the time of conducting the interviews, no suitable publication could be identified that met either of these needs, although there is a large body of professional and academic literature on the impacts on children of abuse.

A second commonly put forward suggestion was for services to offer groups for women who have experienced abuse. Many of the women wanted opportunities to share and hear the stories about abuse and resilience of other women. This applied particularly those using the mental health and D&A services. Program specific support groups appeared to offer women the opportunity to gain support without the additional stigma of introducing themself as a person with mental health or substance problems.

Helpful and unhelpful responses by referral services

Although not directly part of the process, women had diverse experiences in relation to services they were referred to as a result of their disclosure to the screening questions. It was difficult for the interviewer and in some instances the women themselves to distinguish between those accessed before and after the screening. For this reason, the following account includes

descriptions of both. There is not scope here to address the perceived impacts of the range of interventions offered here and others have reported on women's perceptions in this regard, [89-92] so these experiences are addressed briefly here.

Helpful responses described by women included, being reminded that the abuse was not their fault, ongoing active follow-up and efforts to rebuild self-esteem.

A number of women spoke of unhelpful responses by services they had accessed. Several women talked about feeling talked down to , or being given advice that was text book rather than personally relevant, for example, Q., who said she had sought a lot of help but struggled to find any professional she could relate to.

> And I think that a lot of the clients are under-estimated because they actually at times know a lot more than what the counsellor thinks.(Q)

Others talked about workers taking a "by the book" or "cookie cutter" approach, reporting that they did not feel treated as individuals. J. who had ended her marriage six years earlier, but continued to live in fear of him had contacted a domestic violence service on a previous occasion, but had found their advice unhelpful.

> Because they only went on about the AVO which I already knew about. I think they think that if you just leave it will be all over.(J)

Age was a factor for some women in shaping how she saw the help offered.

> And she was younger than me as well. Sometimes you feel you need someone who has the life experience as well as the job description to help. So I didn't feel that was useful. Everything she was saying I already knew. (Q)

Other research has found that women prefer to be screened by someone with maturity. Thackeray et al found that women preferred to be asked the questions by a woman, of the same race, aged 30 to 50 years. [93]

Four women reported that their disclosure of abuse was reported to Community Services. T reported that she had received a phone call from CS to "check that everything was okay." She had not been aware that a report was to be made and described herself as "a bit unhappy about it" as it had been unexpected. Two other women were informed that reports would be made by the midwives and although both were apprehensive, they also both, outwardly at least, expressed understanding for the need to do this. Neither had received any further contact from CS. A report to CS was something viewed with apprehension by three of the four women. Other women indicated that they were cautious about how much and to whom they spoke of the abuse because of fear of CS intervention.

P reported that the social worker informed her she would set up a meeting with CS to arrange support services once the baby was born. In the interview A expressed concern that the social worker had not followed up on this and had let her down. On a subsequent visit to the site, it was learned that P's baby had been removed by CS before she had left hospital. The concerns held by CS were not made known to P during the antenatal period and this action was viewed with great concern by the social worker who believed that more could have been done to give P the chance to care for the baby. A review of P's file suggested that the DV was probably not the sole basis for the decision to remove and that substance use and lack of appropriate family support appeared also to be causing concern.

NEED FOR SERVICES POST ABUSE

The focus of most of the DV specific referrals that women received related to support or advice for ending the relationship. The accounts of the women in this study made it clear that an end to the relationship with the abuser did not mean an end to either risk or trauma. W indicated that she believed the relationship was 90% over but held onto 10% hope. She also displayed evidence of self blame and disrupted self confidence that continued to affect her.

> I thought, how could you get yourself into that kind of situation? The way he made me think. All that control over me… I was quite a confident person before I was with him and then I started stuttering and I'm only just getting over it. It's crazy you think you are a different person. You ARE a different person. (W)

The women identified other issues indicating that active approaches to referral should be considered post-relationship. These issues included: ambivalence towards the relationship, ongoing risk from the offender and the need for information or support for children impacted by abuse.

4.5 Who did screening assist and how?

Who did screening assist?

At the outset of the study it was assumed that screening may assist women by providing referrals to services which would assist them to end abusive relationships. In revealing that the line between being "in" or "out" of abuse was blurred, we realized that this assumption was simplistic. Although some of the women who completed surveys indicated they had ended relationships or taken legal action as a result of the screening, this did not apply to any of the women in the interview sample.

Although none of the women interviewed described adverse effects from the screening process, or objected to it, for some the experience was unremarkable and had minimal impact. These were predominantly women who had previous multiple experiences of police, courts or child protection services. Included in this group were women who were no longer in the relationship with the offender but experienced ongoing abuse. More than half of the women however, described valuable impacts from screening. These were predominantly women who had not previously used services for DV or who had disclosed their abuse for the first time in response to screening. Most had accessed social workers linked to the services where they had been screened, though some described valuable outcomes simply from the responses of the service caseworker. The following sections illustrate the nature of these benefits and the means by which they occurred. Although the women's situations varied, some patterns emerged. Separate consequences appeared to be associated with the two steps in the screening process, firstly, the experience of *being asked,* and secondly *the response of health workers* to disclosures.

Being asked: Naming abuse

In relaying their accounts of abuse, it became clear that only a few women had initially considered their experiences to be "abuse." Constructions were diverse including seeing the abuse as "normal", something that came "out of the blue", as behaviour that was associated with drug use ("when he smokes cannabis he's a different person") or a "bad relationship." For most of the women who described benefits to screening, being asked about abuse in the health setting brought a new frame for reflecting on their experiences. Analysis of the accounts of reactions to being asked led us to conceptualize this as "naming the abuse." Several women indicated that just being asked about abuse made it visible.

> When you are in a relationship, you get used to it and you think it's a normal thing. [ ] And it (being asked) makes it more real.(Q)

Q related how screening led her to see her ex-boyfriend as responsible for his abusive behaviour, instead of herself as the "one with the problem." P recounted that her abuse was triggered by the cannabis and alcohol she and her partner used. When hitting became the subject of her antenatal care, it brought a sense of gravity to the situation.

> If people are taking it this seriously that they have to ask you questions about it, then you should do something about it.[ ]That's what made it click in my head. It's not just a fight. It's domestic abuse.(P)

Like P, giving a name to her experience led Z to see her situation as more significant, rather than something she could deal with herself, privately.

> It seems like an enormous thing. [ ] It's kind of like if you have a major problem with your car, you take it to a mechanic. A mechanic is a business to itself, a major operation and the rest of it. If the car needs an oil change and you do it yourself it's not a car problem.(Z)

Another element of the screening process that appeared to contribute to "naming" was reading the information card, which lists hurting, threats, forced sexual behaviour, control of money and restricted social access as forms of abuse.

> I think not so much when she asked me the questions, as when I read the pamphlet.[ ]I thought, Yes, Yes, Yes, Yes and I thought Ohhhhh… Oh my god.(W)

Realizing that abuse includes controlling behaviour was an outcome described by a number of women, and the information card was commonly the source of this knowledge.

An unexpected finding was that of the six women still in the abusive relationship, four reported that their partners had read the information card. Some partners were given the card directly by the women, others discovered it. Each of the four appeared to have exercised judgment about the safety of retaining the card and actively managed its discovery and interpretation. Allowing their partners to read the information card seemed to operate as an indirect way for the women to name the abuse to their partners. For some, it seemed to be a way of warning partners.

> At least he already knows that if he does something or tries to do something, then maybe I am going to take action. (V)

P reported that screening had prompted her boyfriend too, to look at the situation differently.

> Because I told my partner about it and it got us talking about it. So like for him to actually see it. As in… "people have been asking my girlfriend have I been hitting her and if she's actually saying yes, I need to look at it."(P)

Half of the women reported that naming their experience as abuse prompted them to further consider their situation including some such as P and N, who remained within currently abusive relationships.

> I don't know what's going to happen. But it helped me. When the nurse asked me I think, *Why am I in this situation?* (N)

For others, naming led to a different perspective on a situation they had left behind.

Responses to disclosing: Connection

Turning to women's accounts of their experience of the responses they received to disclosing, the core finding was that screening fostered a sense of connection. This study does not examine the effects of abuse but it is relevant to note that all the women reported traumatic effects from their experiences, including those who had been in relatively short term relationships. The first evidence of "connection" as an outcome was descriptions of feeling cared for. S's comment is typical.

> She was very concerned about me. She gave me the strength. [ ] She just told me, it's not my fault, and there is help out there.(S)

A second form of "connection" was the support women seemed to derive from learning that services are available. Of the social worker she saw at the hospital, N said,

> It's always good to talk and, and to know there are people there to support. Who can do something. That's a good thing that people know there is something happening in my life.(N)

Even when women do not currently want to use services, knowing about their existence and for some such as N, others knowing about the abuse, connects them to other possibilities, providing a sense of "back up." The unifying theme in these descriptions was that the responses were connective, breaking through the isolation of abuse. For women who continued in situations of abuse, they also seemed to provide options for the future, should they be required or wanted.

A final pattern identified for a few women who had recently ended abusive relationships, was the role of the screening and the support offered, in creating new narratives of competence. Z described how her sense of self had been eroded by abuse.

> Your world becomes a different size because you don't have this unlimited belief in yourself that you normally do.[ ]So getting the support that I did and being reassured I was doing the right thing and that I should be proud of what I was doing. It certainly made it start to reverse what had happened to me.(Z)

It was important for Z to be seen at the point of screening, as competent. This was more than simply naming the experience. Rather it was a recognition of an alternative narrative, not a helpless victim, but someone who had made a good decision and shown resourcefulness. Screening played a role in creating this type of narrative for a number of women who had recently exited abusive relationships that had left them questioning their judgment and sense of self.

> It made me go *"Oh, what I was reading had the potential to go further"* and I was smart enough to get out. ...Cause I thought that what I went through was kind of lucky, but what they said was *"You've made a good decision early."* So that's been positive feedback for myself, for how I've dealt with things. (F)

W reported that coming to see her experience as abuse, shifted the sense of control she had over her life.

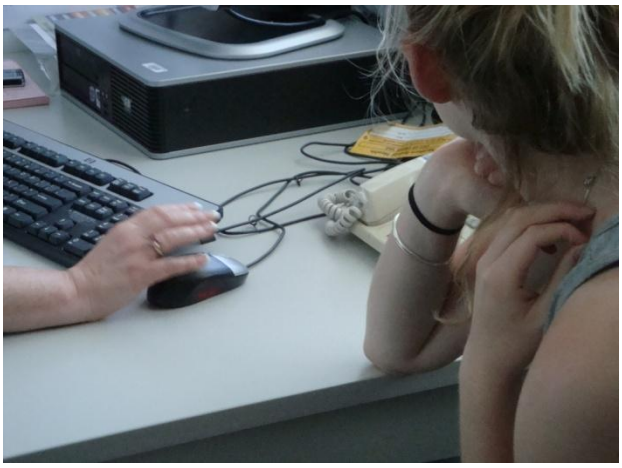
> Just accepting that this is what's happening to me and at the time I felt good because I had left him (tears) and I was strong enough to go through all of that and come out good on the other end. I felt more… Really strong.(W)

None of the women interviewed had accessed DV specific services as a result of screening, although some had used them previously. All the encounters reported in this section occurred with the health worker who asked the screening questions or other hospital-based services, predominantly social workers. The sense of connection reported took different forms for women in different circumstances but was based on one or more of feeling cared for, a sense of future options, and new narratives of competence. Judith Herman, a leader in the field on recovery from trauma arising from interpersonal violence describes "re-connection" as a core stage in recovery.[4]

In the words of N, not speaking about the abuse can be a form of defeat for many women, and conversely disclosing can lead to important outcomes.

> A lot of women don't tell anything. Even to family. They try to cover themselves if they receive a punch. I don't want to get to that point. But I know you *can* get there if you keep quieter and quieter.(N)

The following case studies provide examples of the disparate situations women reported and the diverse ways in which the screening affected them.



4.6 Case studies illustrating experiences of screening

Case study 1: V

V left her family in her home country to marry her husband in what she described to me as a "love marriage." She was asked the screening questions in the context of her antenatal care. Although she was initially hesitant to disclose, fearing that action may be taken against her husband, she was encouraged to by the midwife's offer of help. In the interview she described her husband as "hot-tempered" and on one occasion he had pushed her. A review of her files indicates she said yes to Q 1 of the screen in relation to hitting.

Prior to the screening she had sought intervention from an older male family friend who had spoken to her husband in front of her, about the need to treat her with respect. Since then he had not she had not further difficulty with him, but had valued two meetings with the social worker attached to the antenatal clinic. Although her contacts with the service were brief, she experienced a sense of back up and felt cared about. "I thought oh, behind me someone. Some support." On her survey she had ticked that something useful had occurred as a result of the screening but not elaborated. In the interview when I asked her about this, she recounted that the useful outcome was her husband finding the card in a drawer and reading it. The card formed the dual function of giving her information to get help in the future should she need it, as well as letting her husband know that if he hurt her again, she may take action.

Case study 2: M

M was asked the screening questions at an D&A service about two months after separating from her abusive partner. At that time he was continuing to breach the restraining order which she had taken out against him. M also suffered agoraphobia following controlling behaviour, physical abuse and stalking by her ex-partner and earlier abusive relationships. She stated that at the time she was asked the questions she had made a decision to be open about herself, in order to help herself more, though she also indicated that had the abuse been current at the time she would probably have covered it up. M found the approach of the case worker who

asked the questions very helpful.

"She said we can go through it slowly. You don't have to tell me all today. We can get to know each other. She was lovely."

M also described that the demeanour of case workers had made a big difference to earlier decisions not to disclose when asked. She observed that workers who were apparently well meaning, but appeared never to have experienced any difficulties and promoted their expertise did not invite openness. M's current case worker's understanding about abuse and empathy had a significant impact on her.

Case study 3: N

N had left her husband on several occasions in response to his violent outbursts and physical violence but had returned to him and was now expecting their second child. She felt extremely ambivalent about the relationship and concerned for her daughter about the potential impact of remaining in a volatile situation, as well as the impact of separation. N had suffered anxiety and depression which were initially diagnosed as a cardiac condition.

N was pleased to be asked the questions because she had been thinking of asking to see a social worker at the clinic. Being asked the questions made this much easier for her.

"It's good if someone asks you first, especially in this situation when women are really afraid to talk about something. Its good if someone starts the conversation."

She reported that being asked about the abuse prompted her to reflect on her situation further. She also identified that although she did not plan to take any further action at that point in time, wanting to focus on the impending birth, she valued people know what was happening who could support her if she needed it. The open-ended offers by the midwives and social worker to contact them or come to the hospital if she needed to established a sense of connection to support. This was particularly important for N who is from South America and whose family are distant.

Case study 4: K

K was screened by the mental health team following admission to hospital after she attempted suicide. This occurred after her husband left her. He had physically abused her in the context of his heavy marijuana use over many years. In her survey response she reported that the screening had been useful and elaborated -*"I was able to bring it out in the open. Enabled me to find a counsellor and feel more worthy about being here."*

In the interview she recounted that unless she had been asked specifically about abuse, she did not believe she would have revealed it, attributing her suicide attempt only to the relationship

breakdown. The care shown by the health worker and her informal manner in raising the topic also facilitated her disclosure. K described how useful in particular she found one of the mental health case workers who had gently pressed her to talk in some detail about the abuse she had experienced, which was the first time she had done so.

She related that she believed that without this having taken place she would have attempted suicide again. The experience of talking about the abuse with this case worker prompted her to seek help from a counsellor that she accessed through her GP, and who she continued to see at the time of our interview. As a result of this intervention and that of the mental health team she began to see that the abuse was not her fault and felt freer in talking about it to others.

Case study 5: Z

Z left her home town to get away from her abusive partner after she discovered she was pregnant. She described attending her first antenatal visit soon after being prescribed anti-depressants and feeling very apprehensive about what would happen. The midwife who asked Z the questions offered to co-ordinate some extra support for her, which Z appreciated for not having to tell her story again. In this way the social worker, mental health and also substance abuse service were co-ordinated and most visits timed to co-occur with her antenatal visits.

At the initial screening, the midwife affirmed Z for having extricated herself from the situation, and informed her she was a "success story." In the interview, Z described the importance to her of this description, who began to see herself as competent instead of weak and a failure, which the abuse had left her feeling. She appreciated particularly being told she had "done it" without being told what she should do. The screening also contributed to her naming the experience as abuse.

Section 5: Health workers' experiences: What does screening achieve?

Health workers' views about screening were conducted in ten focus group discussions in September and October 2008. Fifty-nine health care workers participated in the sessions; 29 midwives, 23 substance abuse case workers (predominantly nurses) and seven mental health nurses. Six participants were male and 53 were female. The average length of time since commencing screening was 4.4 years.

5.1 The impact of screening on health workers' practice

All the participants in the focus groups were in favour of routine screening. Many expressed views indicating they were strongly in favour of it. The only dissenting views to this were expressed at one of the D&A services, where several workers indicated that although they were not opposed to screening, it was not in general the way in which instances of DV were revealed in treatment. They suggested that instead women would typically deny any issues at the point of service entry but disclose later when trust had been established and a crisis occurred.

In terms of workers' views of the outcomes of the introduction of screening in health services, two somewhat competing outcomes were identified. Firstly, the introduction of the screening policy has heightened staff awareness about DV and provided tools to respond to it. On the other hand it has also added to the complexity of health worker's roles. There were four consequences of increased awareness about the issue. These were:

i) increased alertness
ii) awareness of links to health;
iii) a sense of providing more comprehensive care; and
iv) identification of appropriate services to which to make referrals.

A number of case workers described increased alertness to indicators of abuse.

> It makes you a bit more aware of noticing things like the husband speaking for the wife. AN2/7[4]

> It has increased my awareness of domestic violence. I am actually actively looking for it; so being alert to other things that might make me suspicious. AN1/4

Several workers related how increased awareness had brought about flow-on effects to their personal lives through increased willingness to intervene with friends and neighbours.

A second aspect of increased awareness was appreciation of the link between DV and health issues. Workers across all sites and programs, described DV as highly relevant to their work, for reasons that varied by program. For example, D&A service workers reported that DV increased substance use and impacted on the safety of clients and their children.

> If there's DV it very much makes it harder for them to move on and deal with their drug problem.(D&A4/1)

Mental health workers identified that DV could be a precipitant of mental illness including the episode that prompted the presentation.

> I have seen great relief in women when they are able to talk openly about DV and come to the conclusion that they do not have a mental illness, but their symptoms are caused by DV.(MH1/8)

They also identified that at times mental illness was claimed as the problem when distress was being caused by experiences of DV.

> It's usually okay for a client to come up to ED and say I'm depressed and anxious, but it's not okay to come up and say I'm being beaten up or I'm being controlled. They may not even have words for the domestic violence.(MH1/1)

Midwives too asserted that DV was a relevant issue in antenatal care because of implications for the woman's ability to plan for the pregnancy, the health of the baby and the midwife's relationship with the woman and her partner.

> It makes a difference. I guess it's the woman's focus; how much she puts into the pregnancy, what her other concerns are.(AN1/1)

[4] Quotations are followed by a unique participant identifier, comprising program (Antenatal/D&A/Mental Health), site number and participant number (within site), ie AN 4/3 refers to Participant 3 at Antenatal Service #4

It appeared that awareness of the relevance of DV to the specific health issue of presentation led some workers to conclude that asking improved the comprehensive nature of the health service response.

> If they say yes then there is a procedure to follow after that, it doesn't just get lost. If it wasn't included in the intake then I don't think that I would think to ask that.(D&A5/3)

> You wouldn't be really covering the whole thing; you wouldn't be providing a comprehensive service. So I guess having those questions there just makes it complete in terms of covering the whole gamut of areas that could be of concern for this person.(D&A1/3)

Confirming this view, a number of workers made the point that asking intrusive or sensitive questions is already an aspect of the health worker role, and asking about DV was simply an extension of this activity and posed few difficulties.

> We leave no part untouched. We ask about sexual activity, sleep habits, appetite, the whole gamut; bowel habits and times, depending on what the clinical picture is giving us. (MH1/6)

The fourth outcome of increased awareness was increased capacity to make appropriate referrals for women.

> That made me think I should use people like the police liaison. [ ] We were amazed at the number of services available for domestic violence.(D&A3/3)

At some services a high degree of collaboration had developed between the health service and DV service providers, which seemed to have occurred as a result of the increased need to make referrals and correspondingly enhanced relationships. This D&A service gave an example of enhanced collaboration.

> Facilitating meetings here with people like the Domestic Violence Liaison Officer. We've done that a couple of times. [ ] And so the woman has heard about what the police actions are likely to be, has been reassured. The DV officer is a female in civvies. It works quite well. (D&A2/7)

Although there was widespread agreement about the relevance of DV and value of screening, there was also a widely held view that screening had increased the complexity of the work. In most of the antenatal clinics, the introduction of screening for IPV occurred simultaneously with

the expansion of assessment for other psycho-social indicators for post-natal depression. As a result of this some saw DV as adding to an ever-expanding list of issues they needed to consider, often drawing them away from their primary role.

> You have 10 minutes at the end where you talk about listening to the baby's heart. (AN3/10)

Concerns about additional workload were expressed more commonly at those sites which both lacked on-site services and had high disclosure rates. Seeing DV as relevant and screening as acceptable, did not preclude workers from also indicating that it increased their workload. While none of the participants suggested workload was a sufficient reason to desist from screening, it highlighted the importance of screening tools and processes that are brief and simple.

5.2 Barriers to implementing screening

Four barriers were identified that pose challenges to implementing screening. The two most dominant barriers identified were lack of privacy, and tensions between trust and limited confidentiality. Lesser issues were health worker's frustration at women who did not apparently wish to take action in relation to the abuse and cultural issues.

Privacy

Establishing privacy in order to ask the questions was a key challenge, particularly in antenatal clinics where partners often attend appointments. The screening protocol directs the questions are not asked in the presence of any person aged over three years and that if privacy cannot be established, screening should be deferred. [11] The process of asking accompanying partners or family members to leave the room remains a challenge to health care workers at these services. In part this is because it is perceived to run counter to maternity service efforts to be family-inclusive. More significantly, midwives felt intimidated when they suspected partners to be abusive.

> Sometimes you get this feeling that there is domestic violence going on, but because you are feeling scared you tend to dance around it and don't find out. (AN4/3)

In such cases the screening was usually deferred, although there was agreement that when this occurred, it was often not addressed later. Participants observed that when partners waited outside the consulting room, few women disclosed. Most midwives had developed creative strategies to gain time alone without raising suspicion, such as inventing urine tests that required visits to the bathroom. Many of the midwives commented that when time alone was

gained, other pertinent information was also often revealed or revised, such as prior pregnancies or sexually transmitted infections.

Excluding family members appeared to pose fewer challenges to D&A and mental health workers who experience less pressure to include family members in treatment.

Tensions between trust and limited confidentiality

The second major barrier to screening was the tension between workers' desire to offer confidentiality to patients, and build trust, against limitations to confidentiality that can be offered. This principally occurs as a result of statutory obligations to make reports to Community Services where a child is at risk of harm. Workers expressed concerns about women dropping out of treatment when reports were required or even threatened.

> I worry about that trust in services. And in midwifery services I want them to continue to engage. Not to think that after the first visit she discloses domestic violence, the next thing I'm ringing DoCS. 'Cause we know what that means for people. [ ] *"You're going to take my kids away from me."* (AN2/5)

Most health workers cited numerous instances of abuse being denied at the time of screening, and then revealed at a later point. Fears of reports to the child protection agency along with lack of trust were seen by workers as key factors for this reticence. Diverse practice in making child protection reports was apparent, with some workers, particularly midwives, making reports following any disclosure of DV. Others, particularly in clinics with continuity of care by health workers, were more reserved about making child protection reports, preferring to wait until the relationship with the patient developed and the picture became clearer. Workers across services reported there was often no apparent response by CS to reports, which seemed to contribute to inconsistent reporting practice. Midwives who had access to perinatal case managers or social workers able to undertake risk assessment and reports to the child protection agency, reported less tension in respect of this issue.

Frustration at women electing not to take action

A third barrier to screening was workers' frustration at women who did not take up offers of assistance or remained with abusive partners.

> Sometimes I think, "Oh I spent a lot of energy to try to give you something that you've asked for, but then you've thrown away." And I know that's completely about me and not about the woman but I still feel it.(AN3/11)

One mental health worker admitted that sometimes her frustration led her to avoid screening.

> I think that there are times when we subconsciously or consciously decide not to do it [ ]. You know that so many people, even if you identify it, are not going to do anything.(MH1/3)

Although most workers were aware of impediments to accepting assistance (citing for example, fear of or dependence on the offender, other priorities, and fear of child protection intervention), this did not prevent frustration from being expressed. Workers appeared to be vulnerable to experiencing this type of frustration even after having received training on the issue. Workers in services with higher case-loads of patients experiencing IPV and also substance abuse services, which have many clients with multiple, complex problems were more likely to express frustration.

Cultural issues

Health workers from the two services with more culturally diverse populations, raised cultural issues as barriers to screening. Three issues were raised. Firstly, language was a barrier that was not always assisted by the presence of an interpreter. Workers were aware that the interpreter as a member of the woman's own community might not be a trusted with knowledge of the abuse.

> I had a Persian interpreter say to me this doesn't happen in Iran, and laughed.(RNS IV 1)

Secondly it was reported that were women from other countries were often unaware of the legal protections against partner abuse offered under Australian law and may operate also under strong cultural prescriptions of loyalty to partner and family. A third issue was the exacerbated isolation experienced by women who did not have family in Australian, leaving them heavily reliant on their husband or partner which limited other options they may have for support or to take action.

5.3 Enablers of screening

Synthesis of the data revealed that over time, different factors were of greater importance in enabling screening. There was also an interactional effect from these elements. Five key enablers of screening were identified.

Especially important when screening commenced were:

i) the scripted questions,
ii) training
iii) access to referral services .

Over time confidence seemed to be reinforced by:

iv) familiarity
v) women's favourable reactions to being asked.

Brief scripted questions

The screening questions themselves were cited as important enablers of implementing the policy, specifically that there are only two of them and they are brief and concrete.

> Because those questions are very straightforward, and I think they're very direct, and I think you can get a fairly good answer. (D&A1/3)

In each service the screening is undertaken as part of a larger assessment for treatment and workers indicated that acceptability of the DV screening questions hinged on not adding too much time and complexity to the process.

> In mental health you're already doing 22 sheets of paper and actually that one's often a lot simpler than the other 21.(MH1/5)

The direct and closed-ended questions were also seen as easier for women to facilitate disclosures.

> It's not like you're drilling them about anything. You're just opening the door for them so that if they want to expand on it, they know they can.(AN1/1)

Having scripted questions served the dual function of relieving workers from framing the questions, as well as providing a visual prompt within the assessment schedule.

> So to be really simple about it, you get the folder, you turn the first page, you ask the questions. It's part of the intake process. (D&A5/3)

A final aspect to the scripted screening questions for both patients and workers, that facilitated their use, was that all women are asked the questions.

> It's easier that in the beginning everyone is asked this stuff. We haven't looked at you and thought, "Oh you look like you're being smacked around. We will ask **you.**" We tell them everyone's asked.(AN4/6)

Demonstrating to patients that the questions were standard, added to their legitimacy.

> The fact that it's on the form, because you can say "Oh look, you know, I have to ask these questions."(MH1/3)

To be *standard practice* from the perspective of patients requires that screening is *prescribed practice* from the perspective of workers. This simplified the task, as it became routine and extinguished dilemmas about whether to ask.

> I think you worry about how you are going to handle it probably less-because you know you have to do it.(AN 4/4)

Two other elements of the process, training and access to services, were also identified as enablers, although they were raised less frequently.

Training

The four hour training course which all staff are supposed to attend prior to asking the questions covers the prevalence, nature and effects of DV as well as the screening protocol which addresses the conditions for asking about and responding to abuse, assessing risk and making referrals [6 11]. Elements of the training that seemed to contribute to willingness and capacity to ask included: prevalence data, services available and strategies for assisting women to take up referrals. A further key message that some participants derived from training was that they were not responsible for "fixing" the situation. There was evidence in several of the discussions that one or more staff members acted as informal champions of IDV screening by playing more prominent roles, solving challenges posed by screening, and developing relationships with referral sources. Most of these staff members had done extended DV training. At two sites staff also had access to regular group consultation sessions with an expert DV practitioner. These provided valued opportunities to extend learning and resolve problems.

Availability of referral services

Being able to refer women to services, contributed to the sense of "back-up" health workers experienced. Referral services were predominantly located externally to the health services, although most antenatal clinics had access to on-site social workers who were extensively used. At one clinic this service was available on-call. Availability of social work back–up also helped relieve some of the burden of responsibility for solving the problem of DV.

> I was able to ring the social worker after the woman accepted, and she dropped everything and came immediately. That made me straight away feel, "Oh it's okay". All I had to do was ask and respond in a really supportive way. Whereas before I felt like I had to sort it all out and make sure that nothing happened.(ANC2/6)

This same worker also identified that the alacrity of this response made it clear to women that that the service took DV seriously.

Familiarity with protocol

With time and experience of using the protocol, two other enablers of screening emerged, which were familiarity, and women's favourable reactions.

> It's the familiarity with it and getting used to asking the questions that makes it easier. You realize it's not that difficult.(AN 1/1)

Familiarity was particularly likely to be put forward as an enabler by those who had attended training.

> When you first start doing it, it can be uncomfortable. Obviously you become more comfortable as you grow into the role. But I think also training, when you become aware of how prevalent it is. So you feel that – you cross that boundary from prying to actually genuinely enquiring. (AN 4/6)

Women's favourable responses

A final but critical enabler of screening, was the frequency of favourable reactions to the questions from women. Although one worker reported an instance in which a woman who attended with her partner had a hostile reaction, the remainder indicated that women were predominantly very positive about being asked, whether or not they disclosed abuse. Such reactions were not merely lack of offence but stronger reactions of approval or gratitude, which seemed to strongly reinforce workers sense of the value of asking. Three examples below illustrate the depth of feelings reported and health workers reactions.

> It's almost like a flood gate has opened, that "you've now given me the opportunity". So that's what I meant by it's very positive.(D&A1/1)

> How many other times in their life have they had the question asked? And they're like I've been waiting for someone to ask me and no one asks me.(AN 2/6)

> They've said "this is the first time I've been asked" and they've broken down. And they've expressed that yes, it has been happening and they had no one to tell and thought no one would believe them.(AN 2/2)

A related experience for health workers was the phenomenon of disclosures from women that were unexpected, that came from "the well groomed, professional mother, who's being honest for the first time in her life." This was a tangible lesson for health workers in the extent of DV and the need to avoid making judgments about the type of women who experience it. Disclosures at a subsequent visit, following initial denial were also common.

> But because you've done the form they know they can come to you if things are really serious. Which has happened to me a lot.(SA4/3)

These types of experience seemed to affirm for workers the value and longer term impact of screening for domestic violence.

The enablers identified here resonate with other findings. A Canadian review of 11 DV screening programs found four elements that facilitated the the building of provider DV screening self-efficacy, and subsequently increased screening. These four elements were: immediate access to onsite or offsite referral, institutional support for DV interventions, thorough and ongoing provider training, and effective screening protocols. [94]

Several managers who participated in the focus groups also identified organizational level supports as important to introducing and maintaining screening by creating prominence and accountability. These included the formalized process for implementation as part of the state-wide policy, and centralized annual monitoring.

5.4 Gaps in policy implementation

Preamble to the questions

There was general support for the preamble which workers are supposed to read or recite to women before asking the questions (see Box 1, page12.). Workers identified that it reassured women that the questions were standard practice. Many workers however abbreviated the preamble. The element most commonly included was the statement that "all women are asked." Furthermore some workers seemed unaware that it was a part of the questions. The element that workers seemed least aware of was the section on the limits of confidentiality. To the contrary, the interviews with women revealed that some workers inform women that their

answers will be confidential, which is not in line with policy and may create difficulties if a report to Community Services or Police is deemed necessary. It appeared that some workers took this position deliberately to encourage women to feel safe enough to disclose.

> If you throw that in there first, [ ] she might think well *"I won't tell you"*. Whereas if she opens up the discussion first and initiates it then you can say "*Well these are the other things that will happen from this information*." So it's not like you're not telling her, but you're letting her open the conversation with what she wants to tell you, rather than throwing the outcome at her before she has even answered the question.(ANC1/1)

Some workers expressed the view that women would be aware of worker obligations to report and would not be making any disclosures unless they wanted action taken.

> But if someone is disclosing something that's really quite frightening they would indicate by the fact that they're saying it, [ ] they want to do something about it either protecting themselves or, their child. (D&A5/1)

While workers who had experience in making child protection reports acknowledged that this was a difficult task and often distressing to clients, a number also spoke about how clients often understand the need for this action. Several workers spoke of strategies they had developed to create positive outcomes such as making plans to stay drug-free or for safety.

> And try to turn it into a positive. Look, I'm going to have to let Community Services know - you know we're mandatory reporters. Now we've got to work together and make sure you've got clean urines, you're safe, and get a little plan happening so that they don't feel you're against them. (D&A 2/5)

At two antenatal clinics women now sign a form at the outset of the first visit that acknowledged they have received an explanation about the health services responsibility to make child protection reports. *"My information will be forwarded to other relevant agencies if I or my child, or children or others are identified at risk of harm."* At some of the D&A clinics there is also a provision in the client contract around reporting obligations so that clients are aware from the outset of the limits to confidentiality.

Distribution of the information card

According to the policy an information card in a wallet sized fold out format titled *"Domestic Violence Hurt Your Health"* is given to all women who are screened, including those who do not disclose.

All of the comments made in the focus groups on the content of the card were favourable, particularly in relation to the information about the diverse actions that can comprise abuse (eg controlling money and social access) and the 1800 number. Some of the workers noted that the card may be too confronting for some women and it was often left behind. Late in the life of the study, partly in response to feedback provided through this project, the cover of the card was re-designed. All wording was removed from the cover and the design comprised only flowers in order to heighten the unobtrusiveness of the card. The re-designed cover was distinctly preferred by workers.

The rate of card distribution reported in the surveys was raised during the focus groups. (Recalled receipt by positive screen group = 56% (68/121): for negative screen group 55% (133/241). At almost half the sites it was reported that supplies of the card have been exhausted at times and the process for re-ordering is cumbersome. At many sites, the card is now included in a new patients information pack along with other information on for example HIV, breastfeeding and privacy. Many of the workers, particularly at the D&A services remarked that women often left the information packs behind. There was diverse practice in relation to whether staff drew attention to the existence of the card or not. Some staff made no mention of it, others removed it or drew attention to it in some way. The focus group sessions prompted discussion amongst the health workers at most sites about discrepant practices as well as on options for ensuring that women received and were aware of the card.

Attendance at training by all screening staff

Of the 59 health workers who participated in the focus groups, 48 (81%) had attended the mandatory training for domestic violence screening. Seven had received further DV-specific training. Participants who had not received training in screening, were all employed subsequent to the commencement of the policy. Those who had not attended training described more difficulties with conducting screening, and were less clear about its purpose. Additionally they reported more instances of practice which departed from the protocol, including distribution of the information card and the need for active referrals. Breaches in policy were also revealed in the survey responses and interviews. These included screening in front of partners, asking the questions on paper instead of face to face, not distributing cards to all women and not making active referral efforts.

Although the focus group participants are not necessarily a representative sample of all health workers undertaking the screening, they do indicate that coverage of training is less than 100%. Across the two AHS that participated in the study different strategies to train new staff were employed. Some sites relied on one to one updating of new staff. In SESIAHS and the Central Coast sectorof NSCCAHS, training positions for DV are responsible for coordinated calendars of regular hospital- based training courses which are publicised to service managers. These seemed to result in greater saturation of training but at only one site had all staff attended the four hour minimum training course.

5.5 Program specific issues with screening

Additional issues for Antenatal services

Issues of privacy were heightened in antenatal clinics due to partners being present at visits more commonly than for other programs. Attendance at antenatal visits by partners is for most women, a valued support. However it has also been found that partners who accompany women to health visits are twice as likely to be interfering in the woman's access to health care, [95] and midwives have expressed concerns that "velcro partners " are those most likely to be abusing women.[53] Some of the partners midwives ask to leave while the screening questions are asked are abusers, resulting in potential for conflict or intimidation.

A second issue in the antenatal clinics arises from the inclusion of the questions into *ObstetriX* the computerised booking-in schedule used in antenatal clinics since 2006. There are significant advantages in integrating the screening questions into the assessment schedule however the computer based module has introduced some difficulties as reported by midwives at all four clinics.

The most commonly reported problem was a disruption to the sequencing of the questions. These were apparently previously placed with questions about childhood abuse which created a good flow of questions that no longer occurs.

A second issue reported by a number of midwives was that the introduction of the computer screen created a physical barrier which had resulted in the provision of less information by patients. This was attributed both to the disruption of open body language created by the need for the worker to face the keyboard, as well as concerns on the part of patients about their information being shared widely following entry into a computerised system.

Midwives also suggested it would be useful to determine in cases where abuse was reported whether the abuser was a former or current partner, as these suggested different levels of risk. Several patients had objected to having information recorded that related to a former partner, as it was not seen by them as relevant. This is a complex issue as it cannot be assumed that former partners pose no risk. It was suggested that determining whether the woman had children with ex-partners reported as having been abusive would be a useful way to determine whether this was relevant. This issue suggests the value of one or two supplemental questions to screening that could be considered in antenatal clinics or through the statewide shared risk assessment tool for DV.

Additional issues for Drug and Alcohol services

Case workers from the D&A services reported that current or previous experiences of DV were common among their client group. At one site it was estimated that the majority of their female clients would have experienced IPV during their time as clients of the service.
Most of the services participating in the study were opiate dependence treatment services. These services typically provide long term treatment and there was widespread agreement of the value of re-screening women annually or more often, which two sites had commenced doing.

D&A caseworkers reported that clients first presentations to the service are typically at a time of crisis, either in the form of threatened or actual statutory agency actions, job loss or relationship breakdown. Workers observed that the crisis for some acted as impetus for greater honesty, whereas for others the lack of trust led to circumspect responses to the screening questions. It was further observed that when the screening questions are asked at a point when clients are in withdrawal, it is preferable to provide pharmacotherapy prior to asking the more sensitive questions, including the DV screening questions. This was predicted to result in more considered responses to the screening questions.

Additional issues for Mental Health services

Only one mental health service participated in the study, however participants in the focus group included staff members working across different teams including the in-patients and Emergency Department assessment team. Several issues specific to mental health were identified.

Firstly some mental health clients are not screened at the time of first assessment if they are unwell. This is consistent with the policy. The documentation passed on to the team providing follow-up enables this gap to be identified and addressed, although this does not always occur. Participants in the focus group also reported that when assessments are done by Medical Officers, the questions are often not asked.

The screening questions have been incorporated into the Mental Health Outcomes Assessment Tool which seems to facilitate them being asked. Attention needs to be paid to ensuring that the questions remain embedded in updated versions of MH-OAT and that this remains an appropriate way to administer the questions.

Early Childhood Services

Early childhood services were not included in this study and the findings need to be tested against this population. There is cause to look more closely at this sector in light of data from

the NSW Department of Health annualised snapshot for 2008 which indicated that the screening rate for ECH was less than 50% (4579/9581 ; 47.7%), [23] well short of the universal coverage that screening is supposed to address. Other research points to the need to pay attention to this sector in light of the finding that women who gave birth in the preceding three months often experience worsening levels of abuse.[96]

Section 6: Discussion & Recommendations

6.1 Discussion

This study found that routine screening for intimate partner violence can reach many women who have not previously disclosed their abuse, that women who have been asked the screening questions, support the practice, and that the experience appears to increase rather than diminish their agreement with it, particularly women who have experienced abuse. It appears that screening was able to assist women in diverse circumstances and assisted some women to address traumatic impacts from abuse. These findings should encourage health workers in NSW and elsewhere to have confidence in the value of routine screening for IPV and regard identifying and responding to abuse as central and legitimate areas of practice. The findings also suggest that the NSW Health routine screening for domestic violence policy has become well- established in practice and improves the responses to DV by health workers undertaking screening. It is also associated with potentially valuable effects for abused women who do not disclose, as well as women who have not experienced abuse. These disparate outcomes point to the conclusion that the DV screening acts as a complex health intervention, whether it is defined as one made up several components,[97] or as one producing phenomena not explained by analysis of the component parts. [98]

The following section considers the implications of key findings with reference to relevant international research on DV and DV screening.

A key finding among women who disclosed abuse was that **23%** were **doing so for the first time**, when they responded to the screening questions. Disclosing abuse has previously been found to break the isolation that many victims experience and provide opportunities for validation, information, and access to services.[17 41 99] This is supported by the outcomes from this study. Linked to the results regarding first disclosures of abuse, was the finding that many

women elected not to disclose the abuse they had experienced. The high rate of under-disclosure was corroborated by the interviews and accounts of health workers who reported that many of the women who initially denied abuse, revealed it at a later visit. The interviews also revealed that women made active decisions about whether to disclose abuse or not and that direct asking, trust and choice were all influential factors in the decision.

When the positive screened women were given information at the point of screening **most read it** and many made further use of it by talking to another or passing the card on. It is important to ensure that not only are all women **given written information**, but that staff draw specific attention to it. Health promotion theory now recognizes that behaviour changes are not brought about solely as a result of transmitting information and that those receiving information need to be active participants in the process. [100 101] From a safety perspective, this also enables women to dispose of the card if discovery by an offender puts them at risk.

If behavioural intentions are influenced by attitudes, as health promotion theories suggest,[100 102] then **changed attitudes** in relation to abuse are useful outcomes from screening. Although there were limitations to the way attitude change was measured it s noteworthy that the women who screened positive were more than twice as likely to report attitude change than the women who screened negative for abuse, with almost half of the positive screened group reported changed attitudes or greater awareness about abuse. The study design does not enable this shift in attitudes to be attributed to the screening of itself. However the strong support for screening reported by participants six months after screening, suggests that the experience enhances rather than reduces abused women's support for it. Previous studies have found that those who have actually been screened are usually in favour of asking. [22 34 103-105]

The finding of a **significant reduction in reported current abuse six months** after screening cannot be attributed to the screening. However it is welcome information, and runs counter to longstanding findings that the prevalence and intensity of DV tends to escalate during pregnancy.[66 68 106-107] and abuse is more often chronic than short term with a mean duration of 4.5-4.6 years.[3 5] This study did not find any association between reduced abuse and receipt of a service, use of the information card or first disclosure. A number of intervention studies for DV have been unable to establish a link between reduced abuse, or other abuse related outcomes and interventions. Each found that improvements were experienced by control groups as well as intervention groups. [37 88 108] It may be unrealistic to expect to find explicit links between interventions and the measurable outcomes for a majority of study participants. It has been noted that women's feelings about abuse are complex [99] and also that the process of making decisions about safety is gradual. [109] Women's responses to abuse are characterized by ambivalent feelings towards the abuser, uncertainty as to the nature of their experiences, stigma and shame. [91 110-112]Further, women's needs vary depending on their life circumstances, as well as the nature and duration of the abuse and it is too much to expect that a single intervention directed at victims will have a direct measurable impact.[31] As a result it seems likely that researchers will continue to be challenged in attempting find conclusive evidence for single effective interventions for DV.

Although quantitative research findings are challenged to provide conclusive evidence in relation to screening and DV interventions, studies incorporating qualitative components, such as this one offer opportunities to understand women's experiences and perspectives of screening and its influence. The interviews revealed that the experience of screening was unremarkable for some women, but that for others important effects included **naming the abuse, re-connection to others and creation of new narratives of competence.**

The work of psychiatrist Judith Herman provides insight as to why these outcomes- resonate with women who have experienced abuse. Herman documents the impact of psychological traumas, such as DV and concludes that helplessness and isolation as their core experiences.[4] She argues that traumatic effects call into question basic human relationships and shatter the construction of self. Recognizing that one has been a victim of abuse is argued by Herman to be a stage in recovery. This equates to the process of *naming* identified here. Herman suggests that "reconnection" is one of the core components of recovery. A sense of being cared for, knowing services are available and having others know about the abuse, are not dramatic changes but, operate as forms of *re-connection*. Creation of new narratives too, fits Herman's description of the need for trauma survivors to "reconcile with the self," a point at which they begin to take pride in themselves and move "beyond the constricted stance of the victim" (p. 202). The links between the effects reported here and stages in recovery from trauma point to the capacity of screening to bring about transformative outcomes for some women.

This study found that a small number of women reported negative outcomes from screening. Two studies investigating this possibility, found that women reported no harms from screening.[15 113] Another study found that harms that occurred were not associated with screening per se but with breaches of confidentiality and other failures to follow policy.[96] Those negative outcomes reported in this study were predominantly limited to emotional reactions rather than threats to safety and custody of their children. It is possible that these reactions may in part be prompted by the wording of the second screening question, *Are you frightened of your partner or ex-partner?* Several of the women who reported negative effects alluded to being reminded of events in their past. The framing of this question focuses on an emotional state, that is, "fear." It is possible that in asking patients to review how they *feel*, as opposed to events which have taken place, negative emotional reactions were more likely to be triggered. A revision of the wording of this question to focus instead on "*whether a partner or ex-partner has done anything in the past 12 months to make you frightened*." may both reduce the scope from long past events that are less relevant and prevent triggering flashbacks. A further issue in relation to that question is that inclusion of "fear of an ex-partner" elicited disclosures from women who had ended relationships some years previously. Some women for whom the abuse was in the past, may have continued to be at risk from these partners and for this reason the wide scope of the questions is relevant. It has been argued that wide screening tools can identify abuse that may intensify.[40]

The brevity and directness of the questions appeared to be important to their uptake and sustained use. Without suggesting the addition of any additional questions any review of the screening tools could also take account of two other emerging issues. Firstly, consideration

could be given to including "controlling behaviour" in the listed types of abuse. This reflects both the literature on the prevalence of control as a form of DV,[114] as well as widespread recognition by workers in this study of *control* as common and debilitating for women. A second issue is the evidence that choking can be a hidden yet widespread form of abuse. Among a sample of 1000 pregnant women, 34% of those reporting DV described being choked.[115] Choking has been identified as a risk for murder and is included on the Danger Assessment Screen, a tool designed to assess this risk.[116] The authors of the study on pregnant women strongly urged choking be added to routine screening questions used during pregnancy.

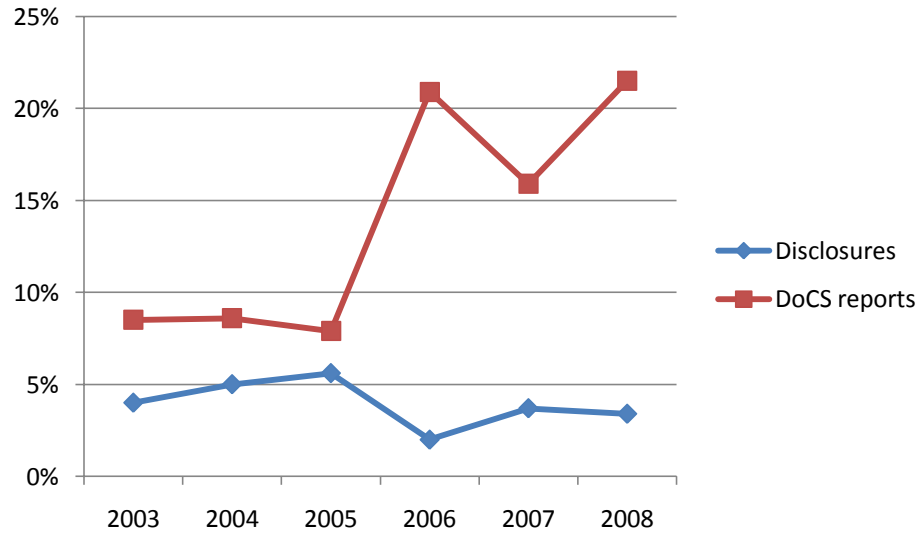
The findings on the complexity and diversity of women's situations chimes with the growing recognition that many women grapple with **multiple challenges** in their lives simultaneously to dealing with abuse. Poverty, class and minority ethnic status create vulnerabilities to violence [117] and in turn, DV can lead to poverty, homelessness, [118] mental health [119-120] and substance abuse problems [78 121]. These are challenges that sometimes threaten to overwhelm women, particularly given the evidence that they often occur simultaneously. [122-123] This work on how DV intersects with disadvantage, recognises that trauma pervades the lives of marginalised women and that specialised interventions for single problems are unlikely to be effective [124] because they are insufficiently sensitive to the woman's whole situation. Those authors propose instead, that advocacy services operate with women's needs as their starting point and find ways to work across services to deliver integrated responses to women experiencing IPV and accompanying chronic problems. [118]

From the perspective of the health workers, privacy, tensions between trust and limited confidentiality, and frustration at women in ongoing risk, remain challenges to the continued implementation of screening in an established program. Factors facilitating uptake included brief scripted questions that are embedded in assessment schedules, training, access to services for referral, familiarity with the process, and women's favourable reactions. The barriers and enablers identified here, echo those found by others. Lack of privacy, particularly in maternity services, when family or partners are often present, was found to be an impediment to screening by a number of studies other than this one. [49 96 125 50] This has led a number of researchers and other bodies to recommend that patients be given time alone as a matter of course, including the UK Confidential Inquiry into Maternal Deaths 1997-1999 [96]and authors of a study on DV presentations to EDs who suggested that excluding partners as standard flags individuals who refuse, as potentially of concern.[125]

Staff anxiety or fearfulness has also been identified as a barrier [126] The intimidation reported in this study, by midwives when asking partners to leave, is validated by research reporting that partners who accompany women to health visits are twice as likely to be interfering in the woman's access to health care [95]. On the other hand, personal experience may also enhance preparedness to screen. Gutmanis et al [127] found that those most willing to screen had a combination of both training and some personal experience of abuse involving self, family or friends. The results from this study point to the combined value of both training and screening experience in promoting practice.

Another key finding from the reports from health workers was the tension created between on one hand, their desire to establish trust and on the other, limited confidentiality. Health worker obligations to make child protection reports, mean that some scrutiny for risk will be inevitable when DV has occurred. However child protection reports have elsewhere been found to be a barrier to disclosure [115] and it is important that risk is assessed transparently and respectfully. [115] Our findings that women who had previous contact with statutory agencies were less likely to report benefits from the experience of screening under-score the importance of care in this area. These tensions have led others to suggest that child protection reports in the context of IPV should be made selectively, rather than as a form of early intervention, with emphasis given to thorough risk assessment. [128] Unless care is taken in use of child protection reports, there is a risk of women either not attending services, or refraining from disclosing abuse they have experienced. The data from the NSW Health annual routine screening snapshot indicates that in years where reports to CS by screening services have increased, there have been simultaneous declines in the proportion of women disclosing abuse when screened (see Figure 4).

Figure 4 : Disclosures and reports to Community Services as a percentage of all women screened in antenatal clinics



Fear of losing control due to child protection reports was a deterrent to some of the women in this study from disclosing abuse earlier. It would be easy to assume that women experiencing abuse have little autonomy, given that controlling behaviour is often a feature of DV. [1 114] However for these women, a sense of control was not readily relinquished. This points to the importance of health workers not directing women to end abusive relationships, which is a not uncommon response,[129] that can be experienced as exchanging one form of coercion for another. [129-130]

Although barriers to screening were detected, reports from health workers also indicated that the introduction of screening had built capacity in services to detect, understand and respond to DV, through a practice that has widespread acceptance among the sites studied. The

screening rate in this program which has had been sustained at 62%-75% across six years is higher than that found in many other routine screening programs for DV in the United States and elsewhere. A review of 44 studies found the median screening rate was 23%. [52], More recently, rates of 5%-47% have been reported. [34 96 127 131] These suggest that the NSW Health program which is supported by a training program, requirement for referral pathways, scripted questions and central monitoring provides an example of good practice for screening programs.

6.2 Policy proposals arising from the research

The following recommendations derive from the study findings and relevant evidence from peer-reviewed published research.

Context for undertaking screening

Proposal 1: Mandated screening should continue in the four programs and consideration be given to extending mandated screening for DV to additional programs including post-natal wards, gynaecology, sexual health and oral health clinics.

RATIONALE: Women's positive reactions to screening and the enhanced responsiveness to DV apparent at the services in this study, suggest that the screening policy could be extended to those specialty areas associated with the heaviest burden of disease from DV. [13]

Proposal 2: Routine screening for DV should also be introduced in private antenatal, mental health and substance abuse clinics.

RATIONALE: Women who attend private facilities currently remain excluded from the DV screening policy. This group of women are at no less risk of abuse and deserve the opportunities provided by screening that public patients receive. [13]

Proposal 3: Provision needs to be made in the over-arching NSW Health privacy policy that all episodes of care of adults should automatically include time alone with the health provider.

RATIONALE: While statewide legislation [132] and the NSW Health Privacy Manual (PD 2005-593) provide thorough guidance with respect of written information, they do not address patients need for time alone with health providers. Many patients have information or questions they prefer not to raise in the presence of their kin. Making time alone creates unobtrusive opportunities to ask or share sensitive information, possibly increasing the accuracy of patient histories. Individuals who are experiencing coercion or other forms of abuse by a family member can then be asked about abuse in real privacy. This action also removes the burden from health workers who ask the screening questions, of creating privacy without suspicion. The UK Confidential Inquiry into Maternal Deaths 1997-1999 recommended that every woman is interviewed alone at least once during the antenatal period.[96]

Screening tools

Proposal 4: The brief screening tool comprising two questions and embedded into assessment schedules should be sustained and the preamble positioned prominently in the tool and emphasised in training.

RATIONALE: Both patients and health workers support the brief direct questions used in the existing protocol. The narrow focus and simplicity of use were not over-burdensome for health workers. There was little support for extending screening to males, lifetime, or other forms of abuse amongst either patients or health workers. Other research has found that programs targeting both sexes have lower screening rates among males than females, (49% vs 68%),[96] suggesting lack of widespread support by health workers. The preamble informs patients about the implications of asking and its use recognises women's rights to make decisions about disclosing. Under utilisation in practice warrants attention to its full implementation.

Proposal 5: Minor amendment of the questions should be considered and tested, to include choking, controlling behaviour and actions that create fear.

RATIONALE: The literature in this area points to the prevalence of choking and controlling behaviours as forms of abuse, warranting consideration of their specific mention in the screening questions. In one study, 34% of pregnant women screened positively for DV, on further assessment indicated that choking had been one of the forms of abuse, leading to those authors to recommend that choking be added to routine screening questions used during pregnancy.[115] Coercion and control are becoming widely accepted as the most common forms of DV.[133-134]

The negative emotional reactions reported by a small number of women suggest that rather than focussing on an emotional state, ie "fear", the second question be amended to *Has a partner or ex-partner done anything in the past 12 months to make you feel frightened?* This amendment would both maintain a focus on actions rather than feelings and introduce a more current focus than the existing question.

Proposal 6: An information resource needs to continue to be provided to all women who are screened and systems should be established so that renewal of supplies of the resource to sites, occurs on an automatic basis.

RATIONALE: Under-disclosure and the strong use of the card by women who had disclosed abuse, along with their positive feedback about the card's content signal the value of distributing a written resource to all women at the point of screening.

The frequency with which it appears that cards are depleted at sites and not distributed point to the need to establish systems for automated re-ordering of cards to reduce staff burden and instances of supplies being exhausted and therefore not distributed.

Proposal 7: The protocol should be revised to include a requirement for repeat screening of all patients at a specified interval. Among mental health patients this should occur prior to discharge and among long term D&A patients this should be annually at least.

RATIONALE: Some D&A services in this study had already introduced this practice, in recognition of under-disclosure and women's changing situations. Re-screening has also been recommended by other studies. [65 135-137]

Proposal 8: Statewide policy should be amended to introduce assessment of new patients in all antenatal and D&A services as a split process, over two sessions, provided by the same health care worker. The DV screening questions and other sensitive questions will be asked at the second visit.

RATIONALE: Challenges establishing privacy with antenatal patients at the initial visit and the high level of under-disclosure point to the need to consider deferring screening questions until the subsequent visit,[14] when trust may be further developed and fewer partners are in attendance. This will also relieve stress on midwives required to ask for privacy and is likely to lead to increased accuracy of other sensitive health history data that may be more openly provided without others present.

Proposal 9: In any revision of the protocol, consideration should be given to the presence, influence and needs of partners who are abusive.

RATIONALE: Given that a number of women allowed partners who had abused them to read the card and also given the likelihood of many women maintaining ongoing relationships with partners who abuse them, opportunities to provide information to this group should be further explored. For example the design of information resources should reflect them as secondary audiences.

Service responses to disclosures of abuse

Proposal 10: The screening protocol should be amended to direct that disclosures of current abuse in response to screening should be responded to with a formalised risk assessment process.

RATIONALE: The brief screening questions do not provide information about the degree or immediacy of risk sufficient to guide decisions about child protection reports or the degree of assertiveness required in the follow-up. The Danger Assessment tool and other risk assessment tools such as the Cross Agency Risk Assessment and Management Framework – Domestic and Family Violence (CARAM-DFV) currently being trialled, can provide more objective evidence for the need for statutory reports and relieve workers of a high burden of responsibility to make determinations with insufficient information.

Proposal 11: Dedicated social work positions with capacity to respond at the point of disclosure need to be attached to all public antenatal clinics.

RATIONALE: The findings indicate that social work positions provide an important role with women who disclose abuse, contributing to therapeutic and safety outcomes. These roles are well placed to provide risk assessment and co-ordinate inter-agency/ service responses often required by women experiencing abuse. The establishment and maintenance of generalist social work positions has been recognised as critical to supporting women who experience abuse [117] and access to immediate referral services to increasing screening behaviour.[94]

Proposal 12: Antenatal clinics need to provide case management for all women where abuse is identified by screening so that intervention by eg D&A, mental health and child protection services is managed as a coordinated, single site response.

RATIONALE: Many women reporting DV experience multiple simultaneous problems. Co-ordination of many services and re-telling the story of DV act as powerful disincentives to using needed services.

Proposal 13: Hospital based DV Clinical Improvement positions are required in all hospital facilities over 200 beds in order to provide staff consultation, training, and practice improvement.

RATIONALE: Enhanced capacity to identify and respond to DV is required across screening services but the prevalence of DV and links to a range of health services indicate the need to build capacity across health services.

Monitoring the policy

Proposal 14: The annual one month snapshot should continue, with reporting back to AHS within six months of data collection. Consideration should to be given to extending the monitoring to include training coverage.

RATIONALE: Important data and visibility to the DV screening program trends are provided by the data snapshot. Prompt reporting enables AHS and services to act on issues raised while they are current and underscore the value of the strategy.

Proposal 15: All hospitals should ensure that staffing in all antenatal clinics follows a model where continuity of care is provided, so that patients are seen by a one or at two midwives only through the course of their antenatal care.

RATIONALE: The prevalence of and risks from DV for antenatal patients, which are shared with children as well as the mother, require strenuous efforts to improve outcomes for antenatal

patients experiencing DV. Under-disclosure and the importance of trust in women's decisions to disclose the abuse they experience also point to the importance of taking steps to build trusting relationships with the health worker.

Proposal 16: Area Health Service protocols should be reviewed to ensure consistency with the statewide policy and screening protocol.

RATIONALE: Consistent practice across Area Health Services is required in order that the policy be implemented safely and as intended.

6.4 Practice Proposals

Proposal 17: All women need to be asked and responded to in ways that that are respectful, caring, promote choice and minimise shame, without making assumptions.

RATIONALE: The findings about the proportion of women disclosing abuse for the first time, impediments to disclosing and impacts brought about by screening workers responses, point to the importance of health workers' initial approach and response.

Proposal 18: The screening information card needs to be given to and also discussed with all women who are asked the screening questions, regardless of disclosure

RATIONALE: The rate of under-disclosure also reiterates the need to ensure that all women are given the card which is currently not being universally distributed. Health workers need to draw attention to the card and discuss it with women to address possible safety issues and maximise the impact of the health promotion messages.

Proposal 19: Referrals need to be actively facilitated, in order to promote uptake

RATIONALE: There is considerable drop-out between referral to and uptake of services. Women in this study appreciated health workers playing an active role in assisting them to access services including relating the woman's circumstances to the referral services.

Proposal 20: Referrals should also be offered to women no longer experiencing current abuse

RATIONALE: Ongoing traumatic effects reported here by women who were no longer in abusive relationships indicate the need for workers to consider the needs of this group for referrals to counselling, as much as those who appear to be currently at risk. This need is heightened by the challenges distinguishing whether women are free from abuse or not.

Proposal 21: Reports to Community Services need to be based on assessment of risk rather than presumed as automatically indicated when DV is disclosed and women informed that a report has been made unless this is not possible.

RATIONALE: The challenges to women's sense of trust and control posed by the possibility of reports to Community Services and the decreased likelihood of women disclosing because of this perceived threat indicate that such reports should not be routine. Reporting should be based on assessment of risk, ensuring open communication and the provision of additional support when it is required. The screening questions also include in their scope abuse which may not pose any current risk to a child. Best practice dictates workers should be transparent about their intentions when reports of risk of harm are required.

Proposal 22: All health workers who ask the domestic violence routine screening questions need to complete at least four hours of screening training in order to undertake screening without error.

RATIONALE: Focus group results suggest that 20% of staff undertaking screening have not attended the mandatory training. Lack of training was associated with more difficulties with conducting screening, lack of clarity about its purpose and breaches in the protocol. In the UK evaluation of screening found that health workers reported that attending a full day of training enabled them to be fully confident in undertaking the screening.

6.5 Training Proposals

Proposal 23: Each Area Health Service should establish area-wide strategies to ensure that all new staff attend the training course within six months of commencement of their role.

RATIONALE: Discrepancies across sites and AHS in the uptake of training point to the value of coordinated strategies for training drawing on the resources of the combined programs where screening is implemented. Some AHS already use computerised tracking tools to monitor coverage of DV training.

Proposal 24: Each Area Health Service should establish a process for monitoring completion and currency of staff training in screening for DV.

RATIONALE: The annualised one month snapshot of screening maintains the visibility of the policy. Similar attention is required to re-establish and maintain coverage of staff training.

Proposal 25: Training courses need to alert health workers to the importance of asking and responding in ways that that are respectful, caring,

promote choice and minimise shame, without making assumptions and the need for practice to respond to the implications of disclosures of abuse.

RATIONALE: The findings about the proportion of women disclosing abuse for the first time, impediments to disclosing and impacts brought about by screening workers responses, point to the importance of health workers' initial approach and response.

Proposal 26: Training courses need to present more complex stories about women's experiences of abuse reflecting the diversity of their situations.

RATIONALE: Formula stories of DV have shaped thinking and responses to the problem. Presentation of more realistic scenarios in which women experience abuse will build more realistic expectations on the part of health workers and discourage simplistic or prescriptive responses to women.

Proposal 27: Staff undertaking screening should renew their training every three years and NSW Health should pursue the option of including training on DV screening as an element of accreditation for nurses, psychiatrists, medical officers and social workers.

RATIONALE: In recognition of the additional complexity to workers roles that DV screening confers, it is important that staff remain current in their training and also have the opportunity to update their learning as new research on DV and screening is available. Triennial renewal of training is consistent with industry standards on training currency.

Proposal 28: Staff undertaking screening should have access to expert consultation on responding to DV.

RATIONALE: The risk of burn-out when staff are dealing with a high volume of disclosures also points to the need to provide access to consultation as is currently provided in a number of services.

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Appendix 1 Further explanation of Methods and Analysis

Survey methods

A.1 Participant recruitment

Two different strategies were employed to recruit and survey participants. In the antenatal and D&A clinics, self-administered questionnaires were offered by the health worker in the course of a regular health appointment, where the patient could be approached and complete the survey in private.

Recruitment and survey of the mental health patients required a different approach because the nature of the treatment offered is short term (up to two months) which precluded administration of the survey at six months. For this group, consent was sought by the regular health worker at the time of treatment for re-contact for a study on the mental health assessment process. Six months later, all who gave initial consent were telephoned by a clinician experienced in both mental health and DV who informed participants about the specific focus of the study and ascertained willingness and wellness to participate. Preferred safe contact details without identifying information were then passed on to the researcher and surveys were undertaken by telephone. Prior to commencing the survey, participants were reminded that the surveys were confidential and strategies for dealing safely with any interruption were discussed. It is recognised that the different methods of recruitment and survey may affect the comparability of the data, so results are reported by program as well as combined. The separate strategy for mental health participants was required because this group of clients typically have short term contact only with the mental health team which precluded recruitment six months post screening with current clients. This fact would have led to the exclusion of this group from the study, however the literature indicates that mental health patients are at high risk of DV ,[77] and are often excluded from research on DV screening,

so need to be prioritised.[36] In addition requests were made from local mental health advocates to include women from these services, for the same reasons.

A.2 Strategies to assist recall and participation

Recall bias is a risk in this design. Explicit cues to aid memory can however reduce over and under-reporting.[138] Three strategies were adopted for those completing the questionnaire to promote recall. A copy of the information card distributed at screening was attached to the survey as a visual prompt. The survey was sequenced to match the steps in the screening and the surveys were completed in the same setting as the original screen, drawing on the evidence that recall is enhanced by measurement in the same environment in which the learning occurred.[139] The visual prompts were not available for the mental health patients. To address this, additional questions were asked about the screening setting and context to assist participant recall. Selection bias was addressed through the use of a one-off survey to reduce refusals and loss to follow-up and by drop outs. Participation was encouraged through making strenuous and visible efforts to establish confidentiality. Strategies included recruitment away from the waiting room and in private, using locked boxes for survey return and for the telephone surveys, discussion of privacy strategies and minimising identifying information. Response bias was a further risk through selective reporting due to fears about confidentiality or social desirability factors.[31 125] Strategies to address these included minimising intrusiveness and the time and effort required to complete the survey.

All eligible women who screened positive were to be invited to participate. As many more women were available who screened negative than needed, sites were asked to recruit these women only until the site target number was reached. Target numbers were based on the results for each site from the NSW Health annual audits from the previous two years.

A.3 Survey for women who screened positive for abuse

The outcomes of interest included reported attitude changes and abuse levels between screening and survey and reported adverse and positive effects from screening. The survey contained 23 mostly closed ended items. Abuse status was assessed using the four item HITS tool which was chosen for ease of completion and fit with the NSW Health screening questions. This tool asks respondents to rate the frequency of four behaviours from their partner: physical hurting, insults, threats and screaming / swearing. Scores are summed as follows: never=1, rarely=2, sometimes=3,fairly often=3, frequently=5 and totalled to derive a possible maximum score of 20[86]. A score of >10.5 identifies women experiencing current DV (validated against the Conflict Tactics Scale and Index of Spouse Abuse). [86] The survey asked participants to complete the tool twice, firstly for the present time and a second time to describe their situation at the time of screening, to their best recollection. Using the same “then and now” strategy, agreement with five attitudes relevant to the messages in the information card and the screening process were also measured. Reliance on recall to complete the surveys was

undertaken to eliminate the possibility of a research or Hawthorne effect occurring as a result of undertaking base-line measures as outlined in our paper on obstacles to evaluating routine screening.[30] Participation in follow-up studies has also been found to be low in research in this area,[31] reinforcing the choice of cross-sectional surveys to undertake this study. A number of strategies were undertaken to prompt recall and attention was paid to confidentiality to promote participation (?ref to Women and Health paper)

A.4 Survey for women who screened negative for abuse

In order to avoid any confusion amongst participants who may not have re-collected how they answered the screening questions, a separate survey was used for the women who screened negative for abuse. It was printed on paper of a different colour to enable easy distinction to be made by health workers. Both surveys contained 23 items, with 16 common to both.

The survey for those who screened negative for DV included an item to identify instances in which women who had experienced abuse, as defined by the NSW Health protocol, had decided not to disclose their abuse at that time This was elicited by explaining "*Some women decide not to tell that they have been hurt or are frightened even if they have been. There are lots of reasons why"* and then re-posing the screening protocol questions for the time of first asking, reminding women their survey responses were confidential.

A.5 Survey analysis

Data were analysed using SPSS 17. Percentages were calculated on available categorical data for each item; denominators varied slightly due to missing data. Change in attitudes was measured using the sign test for paired samples, against increased agreement with each statement. As the HITS tool has only been validated for use as a dichotomous measure with "current abuse" indicated for scores of >10.5, [14] the HITS scores were dichotomized, and changes in reported abuse status (from time of screening to current) were tested using McNemar's continuity corrected chi square test. In reporting the results of the McNemar's and sign tests, the binomial distribution was used when fewer than 25 cases changed status, and p values only are provided. Logistic regression was used to evaluate factors potentially associated with i)change to current abuse status six months after screening, ii) first disclosure and iii) "intentional false negative responses."

On the first regression model, adjustment was made for abuse at baseline by including HITS categorized as > or < 10.5 at screening as an independent variable in the model. In determining the factors of interest, we reasoned that women who received a service, read the information card or were disclosing for the first time, might be more likely to be assisted than those who did not. In all three models program was also included as a potential factor of interest, dichotomized as antenatal and "other programs." The backward elimination method of model selection was performed using the likelihood ratio test for inclusion or exclusion of other

potential demographic confounders (viz. indigenous status, ethnicity and age, ≤or>.30 years of age) from the final models (p-values for exclusion and entry were 0.10 and 0.05, respectively).

Brief responses to the open-ended question on benefits were qualitatively coded by the first author and confirmed by the second author.

A.6 Sample size

The original target sample size for the positive screened group was 230 though the actual number of surveys returned was 130. A probability sample of 100 would provide estimates of proportions answering yes or no to particular questions within a ±10% level of confidence for each service. However the challenges of researching this group outlined above necessitated a non-probability sample and so the primary criterion was a sample size providing sufficiently robust numbers for group comparisons between the three different programs. The target sample size was not reached for three reasons, Firstly, according to snapshot data, in the main year of data collection there was a decline in abused identified at screening in three sites compared to the previous year. Secondly three of the antenatal sites shifted to delayed antenatal booking for parts of the study period in order to cope with increased demand. This resulted in an insufficient lapse of time for surveys to be completed while women remained patients during these periods. Finally high patient volumes at times and use of temporary staff, who were not briefed about the project, at five sites, reduced the pool of health workers recruiting participants.

Interview methods

The interviews were conducted with women who had screened positive for DV at one of the participating NSW health services, six to eight months previously. Volunteer sampling [140] for the interviews occurred via a consent form attached to a survey distributed to the antenatal and substance abuse patients at a regular appointment. To maximize safety, women could choose to be contacted by telephone at a stipulated time or provide consent to be interviewed at their next appointment. Mental health patients were offered the opportunity to participate at the end of a telephone survey, to which they had agreed six months earlier, after being screened. Full written consent for all participants was obtained at the time of interview, along with consent for review of clinical notes, to ascertain referrals and child protection reports. Diversity was achieved by excluding volunteers in the later stages, with characteristics similar to those already interviewed.

The interviews were conducted by JS, a social worker experienced in counselling women for the traumatic effects of abuse.

Interview analysis

After verbatim transcription, a preliminary coding list was developed by JS and coding and querying applied utilizing QSR NVIVO Version 8 software. The coding tree was reviewed by AZ who cross-coded four transcripts with resultant discussion leading to the identification of four new codes. Using inductive analysis as described by [141], description and linking of patterns classified by the codes was followed by comparison of differences between individuals and groups. This led to identification of the constructs relating to: defining abuse, the decision to disclose, and impacts from screening. Matrix and text queries assisted the identification of the conditions giving rise to each construct and informed synthesis of a model for understanding women's experience of disclosure and the effects of screening. A reference group of DV practitioners and researchers assisted to refine the initial coding list, cross-coded and discussed extracts from seven interviews, and confirmed the plausibility of the constructs and model. The validity of the findings in relation to disclosure, naming of abuse and connection were confirmed in group discussions with health professionals from participating services.