National Allied Health Conference, 2019, Brisbane.

Breaking the Silence": Exploring Responses to Domestic and Family Violence in Clinical Practice.

Angel Carrasco.
Director of Social Work and Support Services
Gold Coast Health

Kym Tighe
Advanced Social Worker- DFV Co-Ordinator
Gold Coast Health

Kerrie Gillespie
Research Project Officer
Griffith University

Associate Professor Kathleen Baird
Director of Director of Midwifery and Nursing Education,
Women's & Newborn & Children's Services

Dr Jodie Nelson
Lecturer, School of Accountancy and Finance,
Griffith University

Gold Coast Health
www.goldcoast.health.qld.gov.au

Gold Coast Health
Queensland Government

Griffith UNIVERSITY

Queensland Government

Domestic and family Violence in Healthcare Practice.

- Domestic and family Violence is a global health problem of pandemic proportions. Gender based violence is endemic, affecting over a third of women globally (WHO, 2013)
- True extent of problem is under-estimated as family violence is an often "unseen" problem
- DFV health outcomes range from acute consequences (fatality, injury, homelessness) to long term health consequences, including chronic complaints, risk taking behaviors, and mental health issues (headaches , sleep disturbances, genealogical disorders, adverse pregnancy outcomes, IBS, Gastrointestinal disorders, chronic pain, depression , anxiety, PSTD, suicidality, drug and alcohol abuse (Laing et.al 2010, Moraes et.al 2006, Phillips and Vandenbroek, 2014)
- Women who are living with DFV use Hospital Emergency departments 30-50% higher than the general population (Boursnell and Prosser, 2010; Davila and Mendias, 2013)
- **Despite the overwhelming presentations of people, mainly women, who present at our health services that experience DFV, our healthcare response to DFV is inadequate, with family and intimate and family violence unscreened for and undetected.**

"Not Now, Not Ever- Putting an End to Domestic and Family Violence in Queensland Report, 2014

- The Taskforce report identified clear obligations for health and hospital services and identified that "professionals such as doctors, nurses, midwives, social workers and community health services have an important role in providing emotional and practical support to women and their families suggesting that the healthcare system **'when working at its best, saves lives and transforms futures. At its worse, consequences are dire"** (DFV Taskforce, Qld.Govt., 2015)

Background to Current Research Study

- Gold Coast DFV Gap Analysis (HREC/16/QGC/327) 2016
- Baird, Carrasco, Gillespie and Boyd. ***A qualitative analysis of domestic violence detection and response in a tertiary hospital***. Journal of Primary Healthcare, July, 2019:11 (2): 178-184
- **Results of the snapshot demonstrated that there is no one discipline or profession that is more likely to identify DFV.**
- The analysis identified 8 major barriers to providing world-class DFV healthcare within GCHHS:
    1. limited training in DFV
    2. need for access to a specialist DFV member
    3. need for standardised DFV Systems and Processes
    4. communication and patient information systems
    5. DFV data collection across the GCHHS
    6. patient and staff safety issues
    7. DFV resources
    8. Interpreter services and multicultural support for indigenous and CALD people experiencing DFV


ORIGINAL RESEARCH PAPER

ORIGINAL RESEARCH: HEALTH SERVICES

Qualitative analysis of domestic violence detection and response in a tertiary hospital

ABSTRACT

INTRODUCTION: Domestic and family violence is a public health problem of epidemic proportions and a significant issue facing the Australian community. It knows no boundaries, is indiscriminate to geographical location, social class, age, religious or cultural background.

AIM: This study aimed to analyse the processes currently used to identify and respond to domestic and family violence in a large tertiary hospital in Australia, and to classify the benefits and weaknesses of these existing systems.

METHODS: A qualitative method used semistructured, face-to-face and telephone interviews with key informants in 16 key areas across the hospital. Thematic analysis of the interviews was used to define the key issues and areas of interest identified by participants.

RESULTS: There was a dearth of existing guidelines or pathways of care for patients experiencing domestic violence. Several strengths and weaknesses were identified in relation to the protocols and systems used by the hospital, including limited training for staff and a lack of standardisation of processes, workplace instructions and clinical guidelines. With the exception of maternity services, no clinical service area used a guideline or work instruction. Most interviewees highlighted the need for the safety and protection of staff and victims as a priority.

DISCUSSION: Domestic and family violence is an enormous burden on the health system. However, many staff have little or no guidance on dealing with it or are unaware of existing protocols or guidelines for detection or response. Participants recommended further education and training for staff, consistent guidelines, specialist liaison and more educational and information resources for staff and patients. Further investigation and discussions with patients affected by violence is warranted to provide robust recommendations for policy change.

KEYWORDS: Domestic and family violence; domestic violence; family violence; health-care services; research-to-practice.

AIMS:

Breaking the Silence: Exploring Responses to Domestic and Family Violence in Clinical Practice

(HREC/17/QGC/11)

The study aimed to explore the clinical practice of clinicians working with patients experiencing DFV. The project will identify current clinical practices including:

1. Understand the types of interventions clinical health practitioners use in clinical practice
2. Explore the types of community agencies that clinical health practitioners utilise in assisting people experiencing DFV
3. Explore the types of knowledge that clinical health practitioners use in clinical practice
4. Understand the organisational and systemic influences that may influence clinical practice in the area of DFV

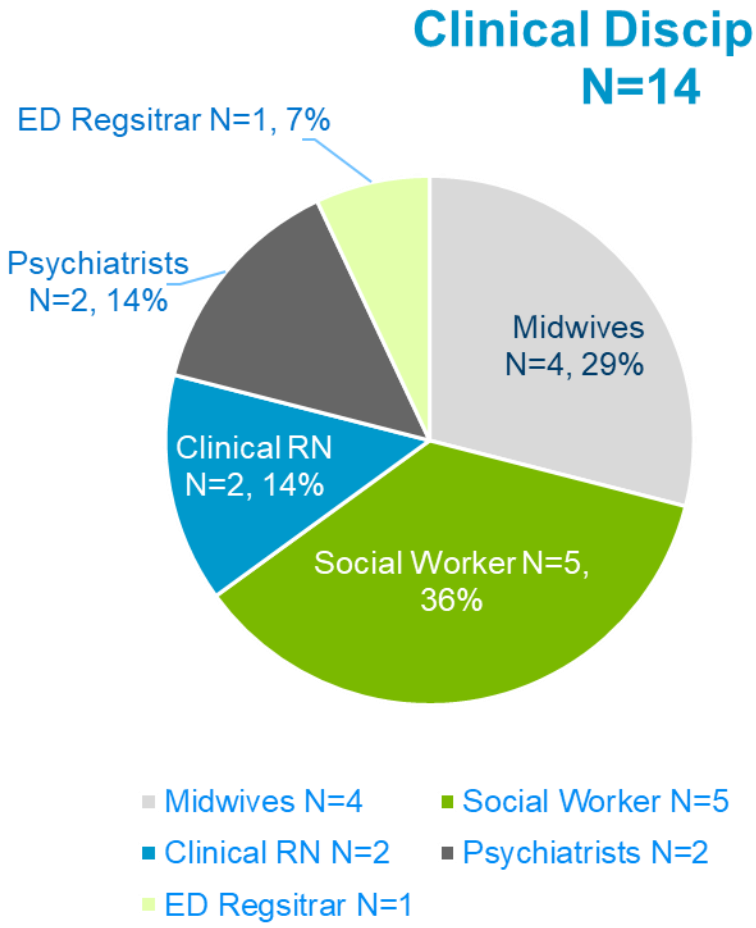
Research Plan Overview

- **Methodology**: exploratory, qualitative methodology using a grounded theory approach.
- **Method:** Purposive sample was used of clinical healthcare staff working (allied health, nursing, medical) at Gold Coast Health that provide face to face services to people experiencing DFV. Main Service areas were identified through the Gap Analysis Project (2016) – ED, Mental Health, Maternity Services, D&Alc services.
- **Semi-structure Interviews** – interviews were taped and transcribed. Coding was undertaken by two coders who coded for themes and subthemes. Interviews ranged from 25 minutes to 1 hour and 10 minutes. Several hundreds of pages transcripts were produced.
- Number of research participants were recruited and interviewed until themes identified reached saturation. Saturation was reached at 14 interviews.

Semi-Structured Interview Questions

- Could you tell me about your role within Gold Coast Health and how your role may involve coming into contact with people that may have experienced DFV?
- Have you had any training regarding DFV?
  - Prompts – When / screening / detection / response / safety management / community / referral.
- From your clinical experience, what have you learnt so far about DFV?
- If you believe a patient/consumer has or is experiencing DFV, what do you do?
  - Designated DFV worker / champion / social worker?
  - Do you follow specified guidelines? Are these monitored?
  - Do you have referral processes? And do you know how to access referral services and community organisations?
- How do you identify DFV in your department?
  - Are there protocols / guidelines in place?
  - Are these enforced / audited / monitored?
  - Tools / instruments used?
- What type of strategies and interventions do you use when working with people experiencing DFV?
- Where and how is DFV information recorded? By whom?
- Are these people followed up? What happens to them from here?
- How do you feel your department handles DFV detection and response?
- What do you feel your department does well in relation to DFV?
- What are the main barriers to responding to people who are experiencing DFV?
- Could you tell me about the range of information and community resources available to you as a clinician and to any patients/consumers who have experienced DFV?
- Do you have any suggestions for improving services?
- Is there anything else that you think is important for me to know about clinical work generally with people experiencing DFV?

Participants



Clinical Area	Number
Antenatal	1
Obstetrics	2
Birth Suite	1
Neonatal Intensive Care	1
Homeless Health Outreach Team (HHOT)	1
Mental Health	2
CYMHS	1
Emergency Department	4
Community Health	1
TOTAL	14

Results- Themes and Subthemes Identified

Training and Education

"…I don't know if I could say I have any training in (DFV). Its not part of our regular sort of assessment…..Then if they do disclose there's DV at home, where do we go from that ?" Consultant Psychiatrist

- Improved DFV Training
- Mandatory training
- Time

Resources and Support

" vulnerable women, like I've got one at the moment who's a young mum, vulnerable, but needs to go back because she can't see a way of leaving at the moment because baby's too young. ….Some people only have their perpetrators to rely on…." SW- Mental Health

- Access to specialist staff eg. Social workers, DFV Co-Ordinator
- Lack of financial, legal, childcare, and housing support
- Lack of services for women from NESB backgrounds
- Lack of services for indigenous women
- Networking with community agencies
- Support for others- families, perpetrators
- Placement of information resources

Perceptions and Attitudes

"I think its partly an extension of misconceptions in the community, yeah definitely. Its seen as the result of personal failure or poor choices, poor decision making. I suppose the hidden assumption is because you chose it, then you need to wear it. Its like you're blaming the victims for their plight" Psychiatry Registrar- ED

- Staff Attitudes
- Community Attitudes
- Fear of "asking the question"

Organisational Approach to Patient Care

"…we're a very target driven emergency department. We try and have patients in and out within four hours so a lot of the time, unless something is triggered, you don't have a lot of time to sit there and chat with patients…" ED RN

- Humanistic vs. Medical Approaches
- Time scarce and target driven – "it takes time"
- Locating of resources – community and organisationally
- Understaffing and staff turnover
- "Patients slipping through the cracks"

Protocols and Guidelines

"we have all had training. But to be honest I'm not familiar if there is actually a guideline regarding how we deal with it. Not sure….." Midwife

- Only maternity services had a screening DFV tool
- Policies and Guidelines difficult to locate when needed
- Integrate discussion of DFV in regular assessments and discussions

Patient Safety

"Because you don't want the situation worse for her" Midwife

- Keeping documentation safe
- Patients and Staff Feeling Unsafe

Gold Coast Health
www.goldcoast.health.qld.gov.au

Domestic and Family Violence Clinical Practice Framework

Training and Education

Resources and Support

Perceptions and Attitudes

Organisational Approach to patient care

Protocols and Guidelines

Patient Safety

CLINICAL PRACTICE IN DOMESTIC AND FAMILY VIOLENCE

Queensland Government

Limitations:

- Sampling – the sample being self selective could resulted in a biased and more engaged sample of health practitioners involved in DFV practice.
- Sample size – results cannot be generalised to broader population
- Semi-structured interview format may have limited the focus of participants way of recalling information from experience and memory.
- Only a selection of clinical professions and clinical areas are represented in the sample.

Summary and Findings

- Clinicians identified access to current education and training provided by the health service as an insufficient basis for informing clinician responses to DFV.
- The organisational context influences DFV practice – professional practice in DFV was seen as a social process by which understanding is interpreted and applied in a social and political context.
- DFV requires a whole of health service approach.
- Clinicians identified challenges in using DFV responses and interventions in mechanistic and formulaic ways in clinical practice.
- Clinicians in the study did not make reference to the knowledge base, theories, evidence based practice that they used in clinical DFV responses and practice
- Uncertainty was identified by all health clinicians in the study as a key issue in DFV clinical practice. The capacity of health practitioners to work within the context of uncertainty is important.

Where to from here ?

- Baird, Carrasco, Fenwick, Creedy., Responding to domestic and family violence in the context of maternity care: Applying a trauma and violence informed care framework to better understand how to optimize an integrated response.

  ($ 100,000.00 Research Grant GC Hospital Foundation)

- Torpie, Baird, Carrasco, Tighe, K. et.al (2017). "DFV Screening in the Emergency Department" (Emergency Medicine Foundation Funding $ 66 976.00)

- Baird, K., and Creedy, J. "Midwives' experiences and perceptions of barriers of asking women about intimate partner violence (IPV) during pregnancy at Gold Coast University Hospital "

- **REFERENCES**

Ambuel B, Hamberger LK, Guse CE, Melzer-Lange M, Phelan MB, Kistner A. Healthcare Can Change from Within: Sustained Improvement in the Healthcare Response to Intimate Partner Violence. *Journal of Family Violence.* 2013;28(8):833-847.

Boursnell M, Prosser S. Increasing identification of domestic violence in emergency departments: A collaborative contribution to increasing the quality of practice of emergency nurses. *Contemporary Nurse.* 2010;35(1):35-46.

Creswell, J.W., Hanson, W.E., Plano Clark, V.L., & Morales, A. Qualitative research design: Selection and interpretation. The Counselling Psychologist, 2001;35:236-264

Creswell, J.W. Five qualitative traditions of inquiry. Qualitative inquiry and research design: Choosing from five traditions. Thousand Oaks, California: Sage Publications. 1998; 51-55

Davila YR, Mendias EP, Juneau C. Under the RADAR: Assessing and Intervening for Intimate Partner Violence. *Journal for Nurse Practitioners.* 2013;9(9):594-599 596.

Dew, K. A health researcher's guide to qualitative methodologies. Australian and New Zealand Journal of Public Health. 2007; 31:433-437

Government V. Preventing violence against women in Australia. In: Health Do, ed. Victoria: Victorian Government; 2016

Krysik, J.L & Finn, J. Research for effective social work practice. Hoboken: Routledge. 2010

Laing L, Irwin J, Toivonen C. Women's Stories of Collaboration between Domestic Violence and Mental Health Services. *Communities, Children and Families Australia.* 2010;5(2):18-30.

Moraes CL, Amorim AR, Reichenheim ME. Gestational weight gain differentials in the presence of intimate partner violence. *International Journal of Gynecology & Obstetrics.* 12// 2006;95(3):254-260.

Phillips J, Vandenbroek P. *Domestic, family and sexual violence in Australia: an overview of the issues.* Canberra2014.

Queensland Government, Not Now, Not Ever Putting an End to Domestic and Family Violence in Queensland Taskforce, Queensland Government, Queensland, 2015.

WHO. *Global and regional estimates of violence against women: prevalence and health effects of intimate partner violence and non-partner sexual violence.* Geneva: World Health Organisation;2013.