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Research paper

Ready, willing and able? A survey of clinicians' perceptions about domestic violence screening in a regional hospital emergency department

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ABSTRACT

Background: Domestic violence (DV) has significant health impacts for victims and their families. Despite evidence that routine screening increases the identification of DV and opportunities for support; routine screening is uncommon in Australian emergency departments (EDs). This study explored ED clinicians' level of support for DV screening; current screening practices; and perceived barriers and readiness to screen prior to a pilot intervention.
Methods: Census survey of 76 ED clinicians. A number of questionnaire items were generated through a review of the literature, with readiness to screen for DV assessed through the short version of the Domestic Violence Healthcare Provider Scale [1]. The confidential and anonymous online survey was hosted on the Qualtrics platform. Descriptive and comparative statistical analysis was performed using IBM SPSS version 22.
Results: Most clinicians supported screening for DV in the ED. In the absence of protocols, 72.3% (n = 55) of clinicians reported currently engaging in case-based screening, which preferenced women with physical injury. The majority did not always feel comfortable screening for DV (79.7% n = 59) and reported they had received insufficient training for this role (88.7% n = 55). Lower perceived self-efficacy and fear of offending were statistically associated with discomfort or negative beliefs about DV enquiry (p = < 0.05).
Conclusion: Emergency department clinicians reported feeling ill-equipped and under-prepared to inquire about and respond to DV. These findings provide valuable insight about the training and support needs of ED clinicians prior to the commencement of routine screening in EDs.

Introduction

Domestic violence (DV) is well recognised as a complex public health issue that has profound and harmful effects upon victims and their families [2,3]. Global prevalence data indicates that close to one third of women have experienced DV and this is associated with immediate and significant health effects including injury, poorer birth outcomes, psychological distress and sexually transmitted disease [3] as well as huge costs to the health system and national economies [4,5]. Given the prevalence and impact of DV it is imperative that health professionals across all healthcare settings are competent in identifying and responding to this form of violence.

Routine inquiry about DV can assist in identifying those at risk. A recent meta-analysis reported that screening for DV increased identification by 133% compared with usual care [6]. Identification creates opportunities for women to access education, support, referral and safety planning. Additionally, screening as an intervention has subtle but important benefits for women experiencing violence regardless of whether the violence is disclosed [7]. Research repeatedly demonstrates that screening by healthcare professionals is acceptable to women and, importantly, women are unlikely to disclose their experience of violence unless directly asked [8–11]. There is growing awareness of violence against men committed by their domestic partners, with the scale of the problem also likely to be under reported [2].

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Survey section	Item type
Demographic characteristics	I item - current role classification
Is screening warranted in ED	1 yes/no item 1 item – in what circumstances is screening warranted in ED (*routinely all woman; routinely all men; in certain clinical circumstances; for high risk groups of patients*) 1 item - which patient groups could be screened (for example: *women who have an unexplained injury or an injury that may have resulted from violence; men who have an unexplained injury or an injury that may have resulted from violence; patients with a history of drug and alcohol misuse*)
Current screening practices	7 items – circumstances in which screening (for example: *women who have an unexplained injury or an injury that may have resulted from violence; men who have an unexplained injury or an injury that may have resulted from violence; patients with a history of drug and alcohol misuse*)
Comfort in screening	4 items- comfort in screening (*yes, always, no never, in some circumstances; have you had sufficient training for DV; have you had specific training on cultural issues and DV; do you feel comfortable identifying cultural issues in screening for DV*)
Factors limiting screening	3 items plus open ended response item (for example: *lack of privacy for patients; I do not know how or who to refer to in situations of DV; I would find it difficult to cope with the personal emotional burden of screening*)
Role most suited to screening	5 items listing categories of health professionals in the ED
Domestic Violence Healthcare Provider Scale (short)	3 items - Perceived self-efficacy *(I feel confident that I can make the appropriate referrals for abused patients)*; 3 items - Fear of offending patients (*I am afraid of offending the patient if I ask about DV)*; 3 items- Professional role resistance (*Investigating the cause of DV is not part of medical or nursing practice)*
Social worker support	I item – (*I have ready access to social workers or community referrals to assist in the management of DV)*

Fig. 1. Summary of survey sections and example items.

Screening for DV in health care settings is recommended in Australia and internationally [12,13]. In Australia, routine screening occurs predominantly in services specifically identified as women's and children's services [12]. Rates of routine inquiry about exposure to DV are reported as low in emergency settings, ranging from 2% to 13%.[14]. However, the ED is the first point of contact for many health service users and therefore provides an important opportunity for screening and identification. It is estimated that women experiencing violence attend EDs three times more frequently than those who have not experienced this form of abuse [15]. A recent Australian study reported that 12% of women presenting to EDs did so as a result of an acute episode of DV but less than one in seven of these women were asked about exposure to violence [14]. Whereas data from the United States confirmed that 20% of men attending the ED disclosed DV from a partner in the previous year [16].

A number of studies have examined clinicians' attitudes, beliefs and knowledge about screening for DV [17–19]. Common barriers to screening identified by clinicians include unease about disclosure leading to further violence, concern about infringing on patient autonomy or causing offence, and lack of evidence on the effectiveness or outcomes from screening [19]. Other reported barriers include inadequate knowledge and lack of education; lack of systems level support and referral systems; environmental factors such as waiting room pressures, throughput targets and medical models of care delivery; insufficient time and lack of privacy; and professional role resistance [17,18].

This study explored ED clinicians' level of support for DV screening in the department; current screening practices; perceived barriers and enablers to screening; and readiness to screen in an Australian regional hospital ED. The purpose was to identify training, education and support needs for clinicians prior to the implementation of a DV screening pilot intervention.

Methods

A cross-sectional sample of nursing and medical staff employed in one regional public hospital ED in New South Wales, Australia, were recruited for this exploratory survey study. The total possible study sample of staff in the ED was 95.

Questionnaire items were generated through a review of the literature, with health care providers' readiness to screen for DV assessed through items taken from a shortened version of the Domestic Violence Healthcare Provider Scale (short DVHPS) [20]. The DVHPS and short DVHPS have been previously validated in populations similar to those of this study, with demonstrated structural validity and reliability [19,20]. The short DVHPS examines six factors: 1) perceived self-efficacy; 2) fear of offending patients; 3) perceptions about victims/personality traits; 4) professional role resistance; 5) perceptions of victim disobedience; and 6) psychiatric support [19]. For this study, items related to perceptions about victims personality traits and disobedience were excluded as the study was focused upon perceptions about screening rather than healthcare professionals' perceptions about victim characteristics. For items related to 'psychiatric support', wording was changed to 'social worker support' to reflect the Australian regional ED context for this study. The questionnaire structure is summarised in Fig. 1, and was as follows: current role classification (1 item); perceptions as to whether screening for DV is warranted in the ED