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# Family violence screening and disclosure in a large metropolitan hospital: A health service users' survey

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## Abstract

**Objectives:** Assisting patients who are experiencing family violence is an important issue for health services. Rates of screening for family violence in general hospital settings in Australia are unclear. This study was conducted to obtain data on hospital family violence screening rates and health service users' perceptions of the screening process, in a large metropolitan hospital in Australia.

**Methods:** Clients from the clinical caseloads of social work and psychology staff were invited to participate in a tablet administered, online survey of their family violence screening experiences, within the health service.

**Results:** A total of 59 surveys were completed by hospital users, who had been treated in areas including the emergency department, acute inpatient wards, sub-acute and rehabilitation units, and outpatient clinics. Less than half the sample reported being screened for family violence at the health service. One-quarter of the respondents reported disclosing family violence concerns, with one-fifth wanting to disclose, but not feeling comfortable to do so. The majority of respondents who disclosed family violence felt supported by the response of the staff member and were provided with information they found helpful. However, further work could be done to improve screening rates, environmental and organizational factors to promote users feeling comfortable to disclose, and staff responses to disclosures.

**Conclusion:** The results of the survey will be used to inform the development of a hospital-wide family violence training initiative aimed to improve staff knowledge, confidence, rates of screening, and clinical responses to family violence.

## Keywords

disclosure, domestic violence, family violence, health service, hospital, psychology, screening, social work

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## Introduction

Family violence is a significant public health problem. However, rates of screening for family violence in the general hospital context, information about when patients are being screened, and whether an adequate response is provided by healthcare workers to disclosures are unknown. This study sought to examine these factors in a large metropolitan Australian hospital. It was conducted as a baseline study as part of a larger research, training and quality improvement initiative focused on providing a whole-of-hospital response for patients experiencing family violence.

Family violence is most commonly perpetrated against women and children; however, it is known to impact on

elderly persons and people who are identified as lesbian, gay, bisexual, transgender, intersex, queer, and asexual.<sup>1–4</sup> In Australian females aged 15–44 years, intimate partner violence contributes more strongly to death, disability,

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and illness, than any other preventable risk factor.<sup>5</sup> Rates of hospitalization of women assaulted by a partner have risen substantially in recent years with a 23% increase reported between 2014–2015 and 2016–2017.<sup>4</sup> Thus, the need for an adequate response to this issue by the health-care sector is clear.

Globally, there are large differences in the responses of health systems across countries in responding to intimate partner and family violence.<sup>6</sup> Differences also exist between regions within countries when a coherent national response has not been formulated such as in Australia.<sup>7</sup> For example, while one state in Australia (New South Wales) has implemented routine targeted family violence screening for specific at-risk groups (women attending antenatal services, child and family health services, those aged 16 years and above attending mental health or drug and alcohol services),<sup>8</sup> this is not the case in other jurisdictions. A recent study also indicated that routine targeted screening in emergency departments in that state is likely to be both feasible and useful, with an 18% disclosure rate reported in the targeted group (women aged 16–45 years, triaged as category 3–5 priority).<sup>7</sup>

In addition to information about whether and how screening is being conducted, the acceptability of screening to health service users is also an important consideration. Much of the research into healthcare screening rates and acceptability has been conducted in the area of general practice, antenatal, maternal child health, or outpatient specialist clinic settings.<sup>9–14</sup> While the majority of healthcare users indicate that family violence screening is acceptable, rates of acceptability do vary quite significantly across studies and settings, which may relate to differences in study questions' wording, setting, and the survey cohort.<sup>9–11,13</sup> Qualitative research has indicated that the acceptability of screening for family violence in users of healthcare services is dependent on a number of clinician and environmental factors.<sup>15</sup> This includes the use of safe, confidential environments for the screening as well as an empathic and non-judgemental approach from the clinician.<sup>15</sup>

Family violence screening is recommended in antenatal settings across Australia.<sup>16</sup> However, recommendations for screening in the general hospital context have not been provided, and it is unclear whether, how, and at what rate, screening is occurring. This study occurred in the Australian state of Victoria and attempted to provide this information. At the time the data were collected (April–July 2018), there were no legislated or recommended guidelines for general hospital screening in the state and no routinely implemented or utilized tool for screening, within public health services. However, a state-wide public hospital response was being prepared as part of the state governments Strengthening Hospital Responses to Family Violence (SHRFV) initiative, led by the Royal Women's Hospital and Bendigo Health Service.<sup>17</sup>

While several studies have included portions of their samples from hospital emergency departments,<sup>10,11</sup> relatively little is known about the acceptability of screening in the general hospital context and in health service users who are treated across all areas in general adult hospitals. This study was conducted in a large metropolitan hospital in Australia (without antenatal services). The study aimed to provide information about whether clients were being screened for family violence concerns at the hospital, which aspects of family violence they were being screened for, and when they were being screened. Information was also sought regarding the proportion of clients disclosing family violence concerns to hospital staff, their reported comfort with the response of staff to disclosures, the perceived level of support provided, and whether they wanted to disclose, but did not feel comfortable to do so.

## Methods

### *Setting and participants*

An electronic survey of patients/clients aged 18 years and above, being seen by either psychology or social work clinicians at a large metropolitan hospital that services adult clients across the lifespan, was conducted. The survey was localized to the psychology and social work departments, as these were the clinical areas that were best equipped to manage any disclosures that may have occurred, as a result of patients/clients participating in the survey. The research team were aware that disclosures were already likely being received by various types of hospital clinicians. However, previous research at the health service indicated that the majority of clinicians had no or very limited training in the area of family violence and mostly indicated that they did not know how to handle disclosures.<sup>18</sup> There was also no existing procedure or guideline to assist this. As such, the research team attempted to provide the safest clinical environment for this subject to be raised, by appropriately training clinician data collectors, from clinicians in psychosocial disciplines that were provided with extra training in responding to disclosures prior to the study commencing.

Twelve psychology clinicians (clinical neuropsychologists, clinical psychologists, and health psychologists) and 13 social work clinicians participated in the research as data collectors. Clients referred to the disciplines of psychology and social work were all under the care of a medical team (i.e. no clients were being seen exclusively for a psychological or social work issue), and thus a medical reason was the primary presenting problem for all clients. Clients were surveyed from the emergency department, acute and sub-acute medical units, the rehabilitation unit, and several outpatient clinics. The majority of data collecting clinicians (23 out of 25) were embedded within clinical teams (emergency department, acute, sub-acute, and rehabilitation), while the remaining two were situated in a specialist outpatient

neuropsychology clinic where referrals come from a medical or specialist area within the hospital.

**Inclusion criteria.** All patients/clients being seen by psychology or social work clinicians, who were participating in the data collection, were invited to fill in the survey, provided their clinician deemed it safe and appropriate to do so, following consideration of the exclusion criteria. All patient/clients were considered for participation to maximize the diversity of the sample and to attempt to ensure that gender, sexual identity, cultural, racial, ethnic, economic or age factors were not barriers to participation.

**Exclusion criteria.** Patients/clients were not asked to participate in the survey if the clinician perceived any of the following barriers to the safe and appropriate administration of the survey: the clinician and client were not in a confidential environment; the client, who was experiencing an acute crisis, was too distressed or unsettled to participate; concerns about affecting rapport with the client, and the client had cognitive impairment, a known disability or diminished capacity that would prevent them from reading/understanding the survey questions.

### **Study design, study tool, and data collection**

Data were collected for a total of 10 weeks, alternating between the professional disciplines in the following sequence: psychology – 3 weeks, social work – 3 weeks, psychology – 2 weeks, and social work – 2 weeks. The alternating sequence was applied to allow for the refreshment of the clinicians' caseloads, through hospital and outpatient service discharges, to maximize the number of new clients available to be invited to participate. Ten electronic tablet devices were available for patients/clients to complete the survey. When deemed safe and appropriate to do so, clinicians explained the purposes of the study to their patients/clients verbally with the aid of a written information sheet and invited them to fill in the survey. Patients/clients were instructed that the survey was not mandatory and that declining to participate would not affect their treatment at the health service in anyway. Clients were informed that the survey was likely to take between 5 and 10 min to complete. Clinicians were asked to ensure that inviting clients to participate in the survey was kept separate from other consent processes (e.g. consent to medical treatments/procedures or interventions), and it was recommended that staff invite the clients to participate after standard clinical treatment/support has been completed for the session. All clients had already had contact with a treating medical team within the health service, prior to being invited to participate. Thus, all clients had already been exposed to standard clinical care practices, for their condition.

Clinicians remained in the room with clients while they were filling in the survey, but they were directed not to

oversee the clients' survey responses. They were instructed to position the tablet screen towards the client and away from themselves (if possible) and to continue with a quiet task (such as file sorting or notes), while the client was filling in the survey. When the client had finished the survey, the clinician was available to provide support, if required. All clients were offered a resource card, with the contact details of relevant family violence support organizations to take away with them. If clients were distressed as a result of filling in the survey or indicated to their clinician that they would like to receive further support, the clinicians followed a documented support pathway to ensure clients received appropriate assistance. All clinicians involved were trained in the support pathway, to ensure they felt appropriately prepared to support clients, if required. Staff involved in the project were required to fill in a monitoring sheet. The monitoring sheet was used to check the proportion of clients that were/were not asked to participate, the proportion of invited clients who agreed to participate, and the reasons why clients were not asked to participate.

A brief survey was designed to capture information about the health service's family violence screening procedures from a patient/client perspective. The survey was administered via WiFi-enabled electronic tablet devices, via the SurveyMonkey platform (see Appendix 1 in Supplemental material). To reassure clients, the survey did not collect any demographic or identifying information, apart from the name of the hospital department(s) the clients had received care from. Thus, the survey responses were anonymous and not re-identifiable. To help prevent clients from filling in the survey more than once (i.e. if they were involved with more than one clinical sampling area during the survey period), the first survey question asked if they have previously filled in the survey. If a client responded 'Yes' to this question, they were directed to the end of the survey and thanked for their participation.

Feedback on the draft survey was sought from the health service's Allied Health Management and Senior Clinician team (N=40); the Family Violence Steering Committee which included nursing, medical staff, partner site representatives, and consumers (N=16); the health service's Allied Health – Psychology (N=17); and Social Work (N=40) departments and members of the Allied Health Consumer panel (N=2). The survey was edited in response to feedback received as part of this consultation process. The survey has also been used in a group of 15 women engaged with a child and family health service.<sup>19</sup>

### **Ethical considerations**

All of the ethical and safety points outlined in the 'World Health Organization (2001) Putting Women First: Ethical and Safety Recommendations for Research on Domestic Violence Against Women' were considered in designing the study. This included ensuring safety of the research team

and participants, minimizing underreporting, protecting confidentiality, appropriately training data collectors, minimizing distress, providing access to support services, and utilizing the findings to improve policy and intervention development. This study was granted Ethical Approval by the Melbourne Health Human Research Ethics Committee (HREC Project 2017.374). Consent was implied when clients agree to participate in the survey. Clients may have been more reluctant to participate if they were required to provide their name, identifying information, or formal signature of consent. Clients were provided with information about the study by their clinician, and this was restated again on the first page of the survey, to ensure they were fully informed before agreeing to participate in the study.

### Analysis

Descriptive statistics were calculated for all categorical and Likert-type response questions. With secondary group, comparison analysis was conducted in specific areas. The proportion of clients providing information under the optional free text response boxes was low, and thus responses were reported as indicators of client views for descriptive purposes only.

## Results

### Participants

A total of 287 hospital patients were considered for participation in the survey, from the caseloads of the 25 participating clinicians. Of these, 78 clients were invited to participate in the survey, with 60 agreeing to participate (resulting in 59 completed surveys). Sixty percent of the clients who agreed to participate were from the social work caseload and 40% from psychology. The majority of the clients (17 out of 18) who declined to participate were from the social work caseload. Of the remaining 215 patients who were not asked to participate, clinicians endorsed the following exclusion criteria or barriers to participation (with more than one reason provided for some patients): not in a confidential space (35.89%), acute crisis or distress (22.97%), concerns about rapport (10.05%), significant cognitive impairment/reduced capacity (25.84%), and other (14.83%). Responses from the other category included time constraints, the clinician forgetting to ask the client, the client not having sufficient English language skills, the client being aggressive, and the client being too medically unwell.

Demographic data were not collected from participants during the survey (for reasons outlined above). However, clinicians were asked, post-study, about the demographics of the participants they surveyed. The responses of the clinician data collectors indicated that the age range of participants was 23–80 years and that most participants were

female (between 40 and 45 participants). Responses also indicated that clients from a range of cultural backgrounds and diverse sexualities were invited to participate. Participant survey responses indicated that 79.66% of patients had used the hospital's emergency department, 40.68% had had an acute inpatient admission, 10.17% had a sub-acute or rehabilitation admission, and 47.46% had used an outpatient clinic.

### Screening

Table 1 shows that participants had been screened for a range of family violence experiences by hospital staff. The number of times the clients were screened was assessed as clients may be screened in different ways, at different times, and the acceptability of the response to disclosures may have differed across screening/disclosure occasions. Nine different types of family violence experiences were also included, as the research team was aware that staff, who were screening clients, were asking about family violence in many different ways. The family violence experiences included were chosen to map those contained in the Victorian Family Violence Protection Act.<sup>20</sup> Screening rates for each of the specific family violence experiences were generally low. Collated totals indicated that 44.07% (N=26) of respondents had been screened for at least one aspect of family violence, on at least one occasion at the Health Service. Neglect and sexual abuse/violence were the least commonly screened for family violence experiences, followed by financial or economic abuse. As shown in Table 2, a large proportion of clients could not recall when they had been screened. When they could recall, they indicated that screening most commonly occurred during the patients' first admission or session at the health service.

### Disclosure and the clinical response

One-quarter (25.42%, N=15) of the respondents indicated that they had disclosed concerns about family violence issues to a staff member at the health service. Two respondents indicated that they were unsure if they had made a disclosure, while 71.19% indicated they had not disclosed. Seven free text responses were provided in the comment box for this question indicating a diversity of responses about disclosure. Four respondents indicated they had disclosed either to social workers, psychologist, or nursing staff; and one indicated that they would be receptive to disclosing if asked by 'qualified staff'. One respondent stated, 'Every nurse since I have been admitted has asked'.

Of the respondents who had disclosed family violence concerns to a staff member at the health service, the majority (73.33%, N=11) felt very much supported by the response of the staff member. A further 13.33% (N=2) felt mildly supported. One participant (6.7%) felt mildly unsupported, while another (6.7%) felt very much

**Table 1.** Family violence issues screened.

Family violence experience	Percentage of responses			
	Yes, more than once	Yes, once	No	Unsure
Family violence	13.56	13.56	66.10	6.78
Feeling unsafe at home	16.95	11.86	64.41	6.78
Physical violence/abuse	13.56	11.86	67.80	6.78
Sexual violence/abuse	10.17	6.78	79.66	3.39
Emotional or psychological abuse	13.56	18.64	62.71	5.08
Threatening, controlling, or intimidating behaviour	16.95	13.56	62.71	6.78
Financial or economic abuse	8.47	8.47	77.97	5.08
Neglect	6.78	5.08	79.66	8.47
Witnessing or being exposed to family violence	13.56	10.17	69.49	6.78

**Table 2.** When family violence screening occurred.

Family violence experience	Percentage of responses				
	Telephone consultation/ screening	First session/ admission	Second to fifth session/admission	After fifth session/ admission	I cannot recall
Feeling unsafe at home	16.00	40.00	4.00	4.00	36.00
Physical violence/abuse	12.50	29.17	12.50	4.17	41.67
Sexual violence/abuse	4.76	28.57	4.76	4.76	57.14
Emotional or psychological abuse	11.11	37.04	11.11	3.70	37.04
Threatening, controlling, or intimidating behaviour	4.17	29.17	12.50	4.17	50.00
Financial or economic abuse	0.00	30.43	8.70	4.35	56.52
Neglect	4.55	31.82	4.55	4.55	54.55
Witnessing or being exposed to family violence	8.70	30.43	0.00	8.70	52.17

unsupported. Three free text responses were provided to this question, all indicating feeling supported or positive towards the staff. The majority of the respondents who had disclosed family violence concerns indicated that they had been provided with assistance they found helpful (N=12, 80.00%). One respondent indicated that the assistance was helpful on one/some occasions but not others and two indicated that they had not received helpful assistance. One respondent indicated that they had received ongoing psychological support.

Respondents were also asked if they had ever wanted to disclose information about experiencing family violence to a staff member at the Health Service, but did not feel comfortable to do so. A total of 12 patients responded *Yes* to this question (20.34%) with a further 5.08% (N=3) indicating that they were *Unsure*. Three-quarters (8 out of 12) of the respondents who answered *Yes* had indicated, earlier in the survey, that they had never been screened for family violence at the hospital. Of the 12 responding *Yes*, half of these (6 out of 12) had indicated that they had never disclosed family violence concerns to a staff member at the health service. Thus, 10% of the sample had family violence

concerns that they had never felt comfortable to raise, on any occasion, at the health service. Six free text responses were provided for this question, with issues raised including language barriers, situational context, and having not experienced family violence to disclose. Of note, two participants discussed the importance of prior relationships with health professionals as facilitators to disclosure.

The final question in the survey provided an open ended text box, asking respondents to provide any further information that they would like to share about the Health Service's response in assisting with family violence issues. A further six responses were received in this section. These responses included the need for community support services, levels of emotional support and empathy displayed by medical staff, and risk factors when asking sensitive questions in the presence of partners. For example, one respondent required that they would need: 'More empathy and emotional support. Doctors need more empathy and time to interact with their clients'; with another respondent indicating the need for information about screening opportunities, stating, 'I was unaware that any specific protocols such as ph. screening even existed'. The need for

confidentiality in screening was raised by one respondent: 'Everyone has asked about sex (OT (Occupational Therapist), doctors, PT (Physiotherapist)) but not family violence. They asked about sex in front of my husband who could have been abusive sexually'.

## Discussion

At the time the survey was conducted, the health service did not have a policy, procedure, or guideline to assist staff working clinically with patients experiencing family violence, including how to manage disclosures. There was no standardized way of recording, coding, or documenting family violence disclosures. There was also no standardized or systematic training in the area of family violence available at the health service. The research was conducted prior to the roll out of a large transformational change project, funded by the state government, to improve the response of hospitals to patients experiencing family violence.

### Screening and prevalence

The results of the study indicate that only over half of the patient participants (56%) were not screened for family violence experiences at the health service. When participants were asked, this occurred in a variety of ways, and usually during their first session/admission. The proportion of respondents (25.42%) who indicated that they had disclosed family violence experiences to the health service on at least one occasion, were similar to disclosure rates found in the emergency department samples of previous studies in New Zealand and the United Kingdom; two countries with similar cultural and socio-economic demographics to the current Australian sample.<sup>10,11</sup> While this study was conducted across a wide range of hospital areas, 80% of the respondents had visited the hospital's emergency department, at some point, and this may have contributed to similarities with previous samples. Free text responses indicated that clients had disclosed to clinicians from a range of disciplines, including social work, clinical or health psychology, and neuropsychology (the disciplines of the clinician data collectors), as well as to nursing and physiotherapy staff. Thus, disclosures are not limited to any specific clinical professional within the hospital.

Australian data indicate that 23% of women (and 16% of men) have experienced emotional abuse by a current or former partner, and 17% have experienced physical or sexual violence (6% of men).<sup>4</sup> The obtained data in this study, indicating that one in four participants had disclosed experiencing family violence, roughly parallel this, although does not differentiate the rates of abuse, by type. However, a further 10% of participants had wanted to disclose family violence experiences, but had not felt comfortable to do so, at any time-point. This may indicate somewhat higher rates

of family violence experiences in this cohort, relative to other Australian samples.

### Disclosure

The rates of disclosure of family violence concerns to hospital staff in this study are higher than those reported in a recent study of targeted screening in Australian emergency departments in the state of New South Wales.<sup>7</sup> However, the difference in the tools and time-point capture may have contributed to this variation. In this study, participants were asked if they had disclosed family violence concerns at any time-point during their involvement with the health service, not just a single or initial presentation. In the Spangaro et al.<sup>7</sup> study, the 18% disclosure rate occurred in women screened on a single presentation to the emergency department at the health service. Spangaro et al. also utilized the Hurts, Insults, Threatens and Screams or Swears (HITS) tool, which asks four questions designed to capture current/active intimate partner violence situations. This contrasts with the tool used in this study (Appendix 1 in Supplemental material), which may have a higher likelihood of capturing information related to past as well as present situations, and also about situations that extend beyond intimate partner violence into the broader realm of family violence, as defined by the Victorian Family Violence Protection Act.<sup>20</sup>

### Clinician response

The response received from hospital staff after disclosures were made was generally viewed as positive, by most respondents, in regard to support and assistance. However, a sizable proportion (20% and 27%) of the feedback received in these areas indicated that the clinical response was less than satisfactory, and thus, further improvement can be made in these areas. This study was conducted 3 months after the administration of a health service-wide clinician survey<sup>18</sup> in the same hospital. The results of the clinician survey indicated that only 35% of the clinical workforce had undergone any family violence training and that the far majority of this was of short duration (1–3 h). Consistent with recent similar research, this study also found the majority of hospital staff did not rate themselves as being knowledgeable or confident when assisting clients clinically with family violence experiences.<sup>18,21</sup>

### Unmet needs

The finding that one in five respondents had wanted to disclose family violence experiences, but did not feel comfortable to do so, also indicates a high level of unmet clinical need. The data indicated that of those clients who identified feeling uncomfortable to disclosure on at least one occasion, half of them had never disclosed to the

health service at any time-point. This indicates that there are environmental and/or clinical factors within the service preventing clients from making disclosures. Free text responses in the final section of the survey raised issues with the emotional support and empathy of clinicians, risks around asking sensitive questions in front of partners, and difficulty with access to safe community support services. This parallels with other research where victim survivors have indicated their preferences for responses that are individually tailored, not judgemental or directive, and show an appreciation of the complexity of family violence.<sup>22</sup> Research has also indicated that how clinicians respond to a disclosure is a critical factor in determining whether victim survivors will feel comfortable to speak about their experiences in the future.<sup>23</sup> Another barrier may also be the lack of confidential space available for consultations in the hospital, a factor impacting significantly on the provision of social work input, in particular.

The results of this patient study and the staff study<sup>18</sup> indicate that improvements are needed in the clinical response to family violence at Royal Melbourne Hospital. They support the need for a transformational change project to improve staff training and knowledge in the area, including the nature and sensitivity of the clinical response, when family violence disclosures are received. The findings of this study were integrated into a training package to educate staff about assisting patients experiencing family violence within the hospital. Direct patient responses were used to provide a personal voice to the experiences of victim survivors. The findings were also used to address potential misperceptions of hospital staff identified in the staff survey that patients may be reluctant to disclose when asked and assisting with family violence issues was not required in healthcare. The project team involved in this study will conduct 3-year follow-up studies, with both staff and patients to evaluate the impact of the initiative, once it is embedded in the health service.

### Limitations

There are several limitations of this study. Demographic data were not collected about participants, to maximize confidentiality and participation in the project. However, as a result, it is not possible to fully determine the characteristics of the surveyed cohort. The wording of the survey also limits its comparability to previous earlier research in this area, as it did not directly ask clients about how they rated the acceptability of the screening they received at the service. The survey has only been previously used in one other, small patient study to date, and the psychometric properties are not yet known.<sup>19</sup> Furthermore, all of the patient respondents to this survey had had contact with a psychosocial clinician (psychologist or social worker) during their involvement at the health service. Thus, they may have been screened at a higher rate than other patients and may have felt more

comfortable to disclose due to their contact with a staff member with training in a psychosocial discipline. Comfort to disclose may have also been facilitated by receiving 1:1 clinical time that involved a supportive counselling and active listening type approach. Thus, it is possible that the results obtained in this study are not reflective of the total hospital patient cohort, as many Royal Melbourne Hospital patients would not have contact with a psychologist or a social worker. Social work and psychology clinicians were utilized as data collectors to maximize safety and the appropriateness of the clinical response, should disclosures occur as a result of clients participating. Despite all efforts to minimize coercion to participate, given the inherent power imbalance between clinician and client, utilizing clinician data collectors may have impacted on clients' decisions about whether to participate and the responses provided. A higher number of clients from the social work caseload declined to participate in the survey, relative to the psychology caseload. This may reflect the increased capacity afforded to the psychology team to build rapport in a psychological assessment and therapeutic environment, increasing trust and confidence to participate. In the study setting, psychologists generally have sessions of longer duration than social workers (averaging 1 h for clinical/health psychologists and up to 2.5 h for neuropsychology). However, it is also possible that power imbalance between psychologists and their clients was greater (due to the therapeutic and diagnostic context of the psychologist's role) and clients may have felt more pressure to consent to participate, as a result. A follow-up study, 3 years following the implementation of a hospital-wide family violence initiative, is planned to evaluate the impact of the initiative. Many of these limitations will be addressed in the follow-up study design.

Finally, the obtained sample size of 59 completed surveys is also a limitation. The prevalence rates of the exclusion variables were somewhat higher than anticipated, when the study was designed (particularly the rates of lack of access to a confidential space, acute crisis or distress, and significant cognitive impairment). This limited the number of clients who were eligible to be asked to participate. Furthermore, all data collectors were hospital clinicians with busy workloads. Assisting with data collection was additional to their usual tasks, limiting the duration of time it was feasible to ask them to assist. The time frame for data collection as approved in the study protocol by the Ethics committee was also a constraining factor. Several multi-site studies in the area of healthcare family violence screening have been conducted with larger patient sample sizes (total participant numbers between 196 and 1452).<sup>10,14,24</sup> However, there are also a number of studies with smaller sample sizes (total participant numbers of 14 and 36), which have used qualitative approaches to data collection and attempted to directly capture the patient voice. The current single-site study also attempted to provide an avenue to investigate the direct views of patients,

about screening processes, to inform improved practice within a specific hospital.

## Conclusion

Family violence experiences are common in hospital users and rates of disclosure in this Australian sample are relatively high, but consistent with hospital research in other countries. Despite this, rates of screening are suboptimal and many clients who would like to disclose family violence experiences are not being screened. Further work is needed to improve hospital screening rates and the response of clinicians to patients requiring assistance in this area.

## Declaration of conflicting interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

## Ethical approval

Ethical approval for this study was granted by the Melbourne Health Human Research Ethics Committee (HREC Project No. 2017.374).

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## Supplemental material

Supplemental material for this article is available online.

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