A Report on Domestic Violence Universal Screening in Health Care Settings in Alberta

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Introduction and Background to Domestic Violence Universal Screening

Even though the home is often thought of as the safest place, it is believed to be the place with the most common manifestations of violence in many communities across the globe. While victims of domestic violence may be male or female; DeCherney, Nathan, Laufer, and Roman (2012) suggest that between 90-95% of the victims are women. Statistics Canada reported in 2013 that there were 87,820 victims of domestic violence (DV) across Canada, as reported by the police (Statistics Canada, 2013). Violence between spouses or intimate partners is said to be the most common form of DV across Canada with 48% occurring between current or past spouses (married or common law). It is again reported that 68% of DV victims are females making two-thirds of the entire Canadian population (Statistics Canada, 2013). In 2011, intimate partner homicide rate against women grew by 19% from a rate of 4.4% per million women in 2010 to 5.2 per million women in 2011 (Sinha, 2012).Wells, Boodt and Emery (2011) report that the Province of Alberta rates second highest of self-reported spousal violence in Canada and had the fifth highest rate of police-reported intimate partner violence. They also report that there were 121 victims of intimate partner homicides in Alberta between 2000 and 2010.

The health care setting has been viewed as a helpful place for DV victims (Todahl and Walters, 2011). Screening for DV though viewed as a secondary preventive intervention may serve as a key to early detection and prevention. Various researchers have established that screening protocols double the rates of identifying spousal abuse. Thurston et al. (2009) reported that 15% of abused women sought medical care for injuries or illness resulting from abuse. Out of these women, 75% used the Emergency Departments. Screening protocol was able to identify 30% of abuse in trauma patients (Thurston et al. 2009). The above statistics provide the importance of screening for DV in health care settings and the need to have a well-established

system in place where health care providers will be in the known about the adaptation of best screening practices. Even though much of the literature use the terms "domestic violence, family violence, violence against women, and intimate partner violence" interchangeably, this paper will use the term domestic violence to aid in the literature search and will represent the same in the paper.

For definition reference, this paper will use the Calgary Domestic Violence Committee (CDVC) definition of domestic violence as a guide. The CDVC defines DV as

> the attempt, act or intent of someone within a relationship, where the relationship is characterized by intimacy, dependency or trust, to intimidate either by threat or by the use of physical force on another person or property. The purpose of the abuse is to control and or exploit through neglect, intimidation, inducement of fear or by inflicting pain. Abusive behavior can take many forms including: verbal, physical, sexual, psychological, emotional, spiritual and economic, and the violation of rights. All forms of abusive behavior are ways in which one human being is trying to have control and/or exploit or have power over another. (Cited in Wells, Boodt and Emery, 2011, p. 5)

The need to prevent domestic violence in Canada and Alberta in particular has necessitated many policy frameworks by both Federal and Provincial governments. In 2008, a reported 550 emergency shelters and transitional homes were established to house abused women in Canada (Johnson and Dawson, 2011). Pre-charging and pre-prosecution policies to fight DV and specialized DV courts to speed up case processes and hold offenders accountable have been put in place (Johnson and Dawson, 2011).

In 2011, the Brenda Strafford Chair in the Prevention of Domestic Violence at the Faculty of Social Work, University of Calgary, established the SHIFT project: A primary prevention policy framework aimed at reducing DV in Alberta by developing "the capacity of policy makers, systems leaders, clinicians, service providers and the community at large, to significantly reduce the rates of domestic violence in Alberta" (Wells, Booth and Claussen, p. 4). "Family Violence Hurts Everyone: A Framework to End Family Violence in Alberta 2013-2018" was also developed and launched in November, 2012 to provide evidenced-based approaches for the prevention of domestic violence in Alberta (Wells and Ferguson, 2012).

Although these and many policy frameworks have gained some successes in the prevention of DV within the Province, universal screening for DV victims remains a big challenge. Health care professionals are in the best position to diagnose victims of DV and provide victims and their families with the appropriate intervention that is needed.

The purpose of this paper is to:

1. Identify the key elements of social policy plan
2. Provide an introduction and background to universal screening policy
3. Provide literature review and findings
4. Assess the impact of universal screening on clinical practice
5. Suggest policy recommendation on domestic violence universal screening in health care settings.

Key Elements of Social Policy Plan

The success of any social policy implementation depends on its planning. In planning, the stakeholders identify the problem at hand, conduct studies on it and follow up with implementation.

In their book, *Connecting Policy to Practice in the Human Services* (3ed) McKenzie and Wharf (2013) identified five stages or elements in social policy planning. They are:

- Initiation or problem identification
- Formulation or assessment
- Execution or contracting
- Implementation or intervention
- Evaluation (P. 77)

Siu (2014) also identified four elements in social policy planning. These are:

- Identifying the issues
- Conducting research and analysis
- Presenting policy option and recommendation
- Making decisions (p. 30).

For the purposes of this paper, I will be using Siu's elements as a guideline. These elements outline the beginning point of policy development. It provides a careful consideration of both the objective and subjective aspects of the problem (domestic violence universal screening), assess the impact of the problem on individuals, families and society as a whole thereby conducting research and the possible outcomes for beneficiaries. These elements would provide the basis for the policy recommendations.

Literature Review on Universal Screening of Domestic Violence and Findings

Domestic violence has received global attention due to its violation of human rights, its criminality and health factors. Research from various continents: Europe, North America, Asia, Africa, Middle East and Latin America has amazingly reported high incidence of violence in intimate relationships (Cole and Philips, 2008). The health care setting has been seen as a critical area for violence identification and intervention due to the fact that victims seek health care after an abuse has occurred. A universal routine screening for intimate partner violence was recommended by many professional associations, including American Medical Association (AMA), American College of Obstetrician and Gynecology (ACOG,1995), American College of Emergency Physicians (ACEP, 1995), and Physician Assistants (Quillian, 1996) (cited in Phelan, 2007). In 1992, the AMA commented that "the medical community along with the criminal justice system is the most likely to see women victims and such constitutes a frontline of identification and intervention" (Council on Scientific Affairs, American Medical Association, 1992, p. 3184). Various studies have reported the important role of health care settings in the identification and detection of DV victims.

A study to re-evaluate the evidence on program mechanisms of intimate partner violence universal screening and disclosure within a health care context by addressing how, for whom, and in what circumstances these programs work was conducted by O'Campo, Kirst, Tsarist, Chambers and Ahmad (2011). In their review of articles, they identified studies on 17 programs that integrated numerous screening modules at multiple levels and had institutional support inclined to have more successful screening outcome. They found out that six programs took a "comprehensive" approach to DV screening. These included "institutional support, effective screening protocol, providing initial and ongoing training, non-comprehensive approaches to IPV

screening and providing immediate access or referral to on site and /or offsite support services" (p. 861). The researchers discovered that the existence of multiple program components operating at several of levels of influence (institutional, community, and program/provider levels) correlates to the increases in provider confidence and self-efficacy for screening.

In 2012, Trinkley, Bryan, Speroni, Jones and Allen (2012) conducted a study on the "Evaluation of domestic violence screening and positive screening rates in rural hospital emergency departments". The aim of the study was to "quantify rural community hospital overall ED patient DV screening rates and positive DV screen rates. A total of 1,200 0f 13, 336 patients ED visits were randomly selected in a retrospective chart review. The findings revealed that 88% representing 1,056 of rural ED patients in that study sample had been documented for DV screening. Of those documented for DV screening 2% totaling 21patients had positive DV documentation. Among the positives, Trinkley, Bryan, Speroni, Jones and Allen (2012) report that 62% were females and 86% were English speaking patients aged 29 years. The study report again that 86% of the positives reported assault, 33% reported fear and 19% had objective sign of DV. They concluded that the 88% of the total screening rate is an indication that hospitals could ensure a 100% DV screening rate compliance when screening is ensured (Trinkley, Bryan, Speroni, Jones, and Allen, 2012).

Another study by Thurston, Tutty, Eisener, Lalonde, Belenky, and Osborne (2009). 2007 to "describe the screening rates obtained in the first year of implementation of a universal domestic violence screening protocol by nurses in the urgent care of Canadian community health center" revealed that in the first year 39% of patients visits recorded being "asked about DV, 50 % recorded as "not asked" and 3% as "not applicable" (p. 614). A documentation rate of 93% was recorded for the same year with disclosure rate being 15% of the total (*n*=3,101). 19% of

those asked were female while 12% were males. Screening according to them was more common during day shifts (44%) than evening shifts (37%) and night shifts was 33%. Of all 51,271 visits in which the sex of the patient was recorded, 42% were females and 37% were males (Thurston et at. 2007). The study concluded that screening rates at the center increased significantly and was maintained longer than other urgent care centers.

The identification of victims of DV remains an important part of the DV prevention strategy. A research conducted to compare a computer-based method of screening for DV with usual care (UC) in an ED setting was done by Trautman, McCarthy, Miller, Campbell, & Kelen (2007). In that study, they report that in a three separate but two week succeeding periods, patients who reported at the ED were requested to complete a computer-based health survey (CBHS) with or without DV screening questions in addition to receiving usual care. The screening, detection, referral and service rates were compared between patients who completed the computer-based health survey with DV screening questions to the usual care. The results revealed that of the 411 women who completed the CBHS with DV questions, 99.8% were screened for DV as compared to 33% of the 594 women who received usual care. (Trautman, McCarthy, Miller, Campbell and Kelen, 2007). The findings further revealed that the CBHS identified 19% of DV positives while usual care identified only 1%. Referral to social work recorded higher among those who were screened by CBHS (10%) as against usual care. The study concluded that a computer-based approach to screening DV leads to higher DV screening and detection rates as compared to usual care.

The Impact of Universal Screening of Domestic Violence on Clinical Practice.

Screening for DV in health care setting remain an essential component in the DV prevention. In a study to review medical charts of patients numbering 1,302, Morrison, Allan and

Grunfeld (2000) report that by adding one screening question DV detection rate increased from o.4% to 7.5%.

After screening training and individual performance opinion from 12 medical residents in a pre-post study analysis, Duncan, McIntosh, Stayton and Hall (2006) reports an increase of screening from 60% of visits to 90% of visits by the medical students. An identification of effective universal screening practices in the emergency departments will have a major impact on clinical practice when training is provided to providers.

Recommendations for Domestic Violence Universal Screening in Health Care Settings in Alberta

Although many policies have been adopted by the Alberta Government to address DV, including the SHIFT Project, The framework to end violence in Alberta, Alberta still remains the Province with the 5th highest rate of police reported DV and also rates 2nd highest of self-reported spousal violence in Canada (Wells, Boodt and Emery, 2012). The following recommendations are made based on the literature review to provide information to policy makers in the area of DV preventions within the province.

1. Training of health care providers on domestic violence screening.

"Knowledge is power. Information is liberating. Education is the premise of progress in every society, every family" (Kofi Annan, 1938, p.1). Many of the problems with implementation of universal screening of domestic violence and interventions in health care settings could arise from inadequate training of health care professionals, as suggested by many of the studies. A study by Garcia-Moreno (2002) to review the integration of domestic violence in health professionals educational curricula in USA from 1990–1996 revealed that only nine

(38%) of 24 Obstetrics and Gynecology and Nursing texts, six (35%) of 17 primary care, and two (29%) of seven Emergency Medicine textbooks included material on domestic violence.

Guillery, Benzies, Mannion and Evans (2012) report that "knowledge barriers existed, and needed to be addressed prior to any implementation of a screening program" (p. 5). Todahl and Walters (2011) also indicated that lack of training, knowledge and education about DV are barriers to identifying, treating, and referring victims of DV to appropriate interventions. For health care professionals to provide appropriate screening and intervention to victims of DV within the health care sectors, it is recommended that DV screening program be incorporated into the educational institutions curricula of providers that is, medical schools, nursing, social work and other professionals who are directly involved with DV victims within the health care system. It is also recommended that provider development training or in-service training programs on DV screening protocol be initiated by Emergency Departments and other primary health care centers to periodically train health professionals on developing issues surrounding DV. When these are initiated, health care professionals will be knowledgeable about DV and the need to screen patients. This will reduce the severe health implications (injuries, bruises, broken legs, arms and mental health issues) of DV and increase provider's sense of intervention and self-efficacy. It will also increase the frequency of screening, detection and documentation of abuse within the province that will aid in policy planning.

2. Institutional Support and Commitment on Screening Practices

Many providers fail to screen for domestic violence due to lack of institutional support to screen. Health care providers see their institution to be in support of universal screening when appropriate screening policies exist with standardized procedures for screening. Guillery, Benzies, Mannion and Evans (2012) found out in a study on postpartum nurses' perception of

barriers to screening for intimate partner violence that systematic barriers are associated with the low screening rates. Participants at the study indicated that their hospitals did not have appropriate screening protocol that encouraged screening. Again, during the consultation, it was revealed that Alberta Health does not have a screening protocol (personal communication with Linda, June 22). A recommendation is made to this effect that health care institutions in Alberta adopt a standardized universal screening policy, procedure and provider accountability (enforcement) that will be understood and easily implemented by providers. It is also recommended that provider practice environment should include an expectation for screening, like any other medical history taking. Providers are more likely to screen when they believe that DV is a factor in the patient's lives and that screening is their responsibility and within their professional role.

3. Concerns about Time and Privacy

The two most frequently cited barriers to screening DV in health care settings in the literature review was lack of privacy in the health care setting and time constrains. Ellis (199) reports that 60.0% and 25.0 % of participants in a study to explore the barriers that prevent effective screening for DV in women by registered nurses in the ED said they lack privacy and time to screen in. The consultation with Linda again revealed that time was a major factor for DV screening (personal communication with Linda, June 22). It is recommended that health care setting in Alberta should have private areas that would be conducive for screening DV. Also the screening questions should be part of the medical history taking process within the health care system. Patel et al. (2001) report that by adding the screening question to the history and physical form in a family practice clinic increased documented screening from 2% to 92% (cited in Minsky-Kelly, Hamberger, Pape and Wolff, 2005). When this barrier is addressed, early

identification of victims would be easy and the number of victims who repeatedly frequent the ED for abuse related cases will be reduced thereby lessening the workload of ED staff.

4. **Provision of Intervention for Victims by Health Care Settings**

One of the major barriers for DV screening was the fact that providers did not know how to fix the problem once identified. Guillery, Benzies Mannion and Evans (2012) mentioned that post-partum nurses in a study failed to screen for DV stating that they did not know "what to do in the event of a disclosure and fear of shocking the patient (p. 2). Linda during the consultation also mentioned that providers fail to ask about DV because they often said "they can't fix it and will not ask" (personal communication with Linda, June 22). It is recommended that appropriate interventions methods should be instituted within the health care system to increase provider comfort and confidence in intervening for DV after identification. These should include appropriate referral system, information on local and national help and supports and the options available to victims. When health care institutions introduce these interventions or services for victims health care providers will be at peace to screen knowing that they will not cause harm to their patients and that there will be appropriate interventions within the health care system where victims could be referred for help

5. The Use of Computer- Assisted Screening

Many studies have confirmed the benefits of computer-assisted screening as a way to secure disclosure of abuse from victims. Trautman et al. (2007) report that a computer-based screening practice increased the detection of DV victims. The report indicated that 99.8% of victims were screened for DV with a computer-assisted practice compared to 33% of usual care screening (Trautman, McCarthy, Miller, Campbell, and Kelen, 2007). It is un-doubtful that the

computer-Assisted screening will significantly lead to an increase in DV screening, detection and documentation in the emergency departments in Alberta which will reflect in a significant reduction of reported cases DV. It will also help policy makers to take appropriate policy measures to address the DV problem in the Province.

6. The Use of Translators by Health Care Institutions

One of the barriers to the identification of victims of DV was lack of fluency in the victims' language. Guillery, Benzies, Mannion and Evans (2012) report that "nurse's fluency in patient's language was associated with screening for physical, sexual and emotional abuse" (p. 5). They maintained that language was a "strong predictor of the frequency of screening than any Post-partum Nurse characteristics" (p. 6). Language is important tool for communication. An inclusion of such translators will bridge the communication gap between victims and providers and also aid in the identification, disclosure and possible provision of services to survivors.

7. Change of the Term "Screening" to "Assessment"

Much of the problem with screening for DV in health care setting had to do with the term screening. Health care professionals particularly physicians and nurses see DV screening as something outside their professional role and that belong to other care givers. Linda during the consultation mentioned that "screening" in itself was a barrier to DV identification (personal communication with Linda, June 22). It recommended that the term "screening" be changed to "assessment" to make DV identification easy and acceptable to all providers. When the term

screening is changed health care providers will see DV assessment as within the professional duties and will work towards that.

Conclusion

A growing number of research suggest domestic violence has detrimental consequences to individuals, families and society as whole. In Alberta DV remains a threat to the Province affecting more than 740, 000 of the population and costing over $600 million dollars for the government. Universal screening of DV in health care settings is seen by many studies as helpful for the identification, detection, documentation and provision of services to victims. The review suggest that a standardized screening protocol, training of health care providers, organizational support and commitment, and addressing issues of time and privacy could result in higher screening and disclosure rates thereby providing policy makers with accurate information for planning interventions.

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