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REPORT
DOMESTIC VIOLENCE VICTIMS IN A HOSPITAL EMERGENCY DEPARTMENT

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The study was supported largely by grants from the Queensland Department of Family Services and Aboriginal and Islander Affairs. Other bodies which have funded this project are the Criminology Research Council and Queensland Health. Gratitude is expressed to all these bodies for resourcing this project.

The views expressed in this report are the responsibility of the author and are not necessarily those of any of the above bodies.

FRONTISPIECE AND GRAPHICS by Mr.David Crouch

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P.A.H. – Princess Alexandra Hospital

R.B.H. – Royal Brisbane Hospital

S.R.O. – Senior Research Officer

TERMINOLOGY

The term used in this study is "domestic violence". It has been criticized because it masks who is the victim and who is the perpetrator(Morris,1987). However, it was chosen because: a) In policy making circles it is the term in common usage; b) The term "domestic" emphasizes the problematic nature of the privacy aspect of these events. (It is not used in any perjorative way to connote that it is less important or less serious than other forms of violence); c) The term "violence" incorporates the seriousness and often prolonged nature of the phenomenon.

The author acknowledges that many people who have experienced domestic violence prefer to be called "survivors". Indeed, there are numbers of survivors of domestic violence who took part in this study. However, the word "victim" has been used generally in this study for two reasons. Firstly, the term "victim" conveys the seriousness of domestic violence and secondly, it describes the condition of some people who display the symptoms of victimization when they come to the Emergency Department.

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1. PLAN OF REPORT

The first chapter outlines how this project was conceived. A literature review describes the historical aspects of how doctors and nurses have responded to the problems of domestic violence. The difficulties of domestic violence research and the ethical issues of the research are discussed. The rationale for doing this particular study, its aims and the hypotheses tested are described.

Chapter 2 outlines the design of the study and the methods by which it was carried out. Chapter 3 describes the domestic violence education program which was conducted with doctors and nurses in the Emergency Department. This educational intervention was integral to measuring the outcome of the study in Emergency Department.

Chapter 4 describes an exploratory study which was conducted before the main studies commenced. Qualitative data from this study include comments made by participants in the study and brief case histories from victims of domestic violence.

In Chapter 5 the findings of the main studies – prevalence studies and case–control studies – are outlined.

Chapter 6 contains the conclusions and description of the outcome of the study.

In Chapter 7 recommendations are made which relate to the findings of the study.

1.1 INTRODUCTION

This study has grown out of the recommendations from Beyond These Walls, Report of the Queensland Domestic Violence Task Force (1988).

In 1988 Associate Professor Joan Lawrence, from the University of Queensland, made a comprehensive submission to the Queensland Domestic Violence Task Force. She proposed the establishment of a domestic violence clinic, staffed by a multi–disciplinary team, to be located within an Emergency Department of a public hospital.

The aim of such a clinic was to gather data to assist in the planning of appropriate interventions, evaluate victims, abusers and their children, to provide a range of interventions including aggression control groups and substance abuse groups and to allow referral and follow-up to services such as refuges and legal services.

The Task Force responded to Associate Professor Lawrence's submission and made the following comments in their Report (pp.252-253):

> *"The Task Force considers that this proposal, if it were to be implemented, would provide a focus within the hospital for the treatment of victims and would thereby contribute to the education of a range of medical professionals concerning domestic violence. The proposal also has the potential to be a reference point for non-hospital based health professionals seeking information.*
>
> *Task Force members believe that family doctors and health professionals in hospital and community settings have a critical role in the identification, treatment and prevention of domestic violence.*

We have drawn this conclusion because:

* *doctors are the service provider to whom victims most frequently first turn to for assistance;*
* *most victims (70% to 80%) seek medical assistance for the violence at least once;*
* *about one-quarter of all injuries presented by women to hospital emergency services are by battered women;*
* *victims of domestic violence have been found to present frequently and disproportionately at non-trauma services including medical clinics, psychiatric services and women' clinics;*
* *doctors through early identification and appropriate referral can contribute to:*
* *the prevention of the damaging effects to victims and other family members of continuing and escalating violence;*
* *limiting the likelihood of the repetition of violence in future generations;*
* *reducing the health costs associated with chronic domestic violence.*

The Task Force believes that a number of strategies can be adopted by both individual health professionals and by hospital and community based services together with initiatives by professionals and training auspices".

The Task Force recommended the establishment of a Queensland Domestic Violence Council as an on-going body to advise the Minister for Family Services and Welfare Housing on the problem of domestic violence and progress in addressing the problem. It was suggested that a medical practitioner be a member of this Council.

The Task Force outlined a Domestic Violence Awareness Program to provide a mechanism by which educational resource materials could be developed by professional bodies for their members. It was suggested that priority be given to the development of resource materials for medical practitioners, and that brochures suitable for distribution to patients at hospitals, clinics, health centres and doctors surgeries might be produced.

In addition to the initiatives that were discussed above, the Task Force made three specific recommendations which they believed were important initial steps that needed to be taken (p.253).

44 *That the proposed Queensland Domestic Violence Council initiate, in association with the Queensland Faculty of the Royal Australian College of General Practitioners, the preparation and dissemination of guidelines to assist medical practitioners in the identification and management of cases of domestic violence.*

45 *That the proposed Queensland Domestic Violence Council initiate, in association with the Queensland Department of Health, the development of a protocol for* ***hospital personnel*** *to assist in the identification and management of cases of domestic violence.*

46 *That the Queensland Department of Health implement as a priority a special training programme for appropriate* ***public hospital personnel*** *regarding the phenomenon of domestic violence, the relevant law, the needs of victims, perpetrators and their children and the services available to them.*

Successful applications were made by Professor Beverley Raphael (Chair, Department of Psychiatry, University of Queensland) and Associate Professor Joan Lawrence to two funding bodies – Queensland Department of Family Services and Aboriginal and Islander Affairs and the Criminology Research Council – to conduct this study in the Emergency Department at Royal Brisbane Hospital. Funding for the final part of the project was provided by Queensland Health.

1.2 DOMESTIC VIOLENCE AND THE MEDICAL PROFESSION

There was little research interest in adult domestic violence before the 1970's although there was a burgeoning interest in child abuse, commencing with the publication of a seminal article by Kempe et al which appeared in the *Journal of the American Medical Association* in 1962. Dexter (1958) noted that the issue of family violence, other than child abuse, suffered from "selective inattention" prior to 1970, and that scholarly and popular literature on domestic violence was virtually nonexistent in the sixties. O'Brien (1971) observed that the Index of the *Journal of Marriage and Family*, from its inception in 1939 through 1969 did not include even one article with the word "violence" in the title. O'Brien was writing in the first scholarly reporting of family violence in a special issue of that journal.

There were no reliable statistics on the incidence of domestic violence in the 1960's and it was assumed that child abuse and other forms of family violence were a rare occurrence. When it did occur it was considered to be the product of mental illness or psychological disorder. Men who batter were presented as mentally ill, neurotic or disturbed; female victims were also regarded as neurotic or mentally ill (Schultz,1960; Snell et al, 1964; Faulk, 1974; Scott, 1974; Marsden and Owen, 1975; Gayford, 1975a, 1975b, 1979).

Storr (1974) wrote that nagging, aggressive women are often unconsciously seeking what they fear most; they need to be hurt. The notion that women want to be hit was given great prominence by Pizzey and Shapiro (1981,1982). They speculated that both husbands and wives in domestic assaults are violence prone and asserted that female victims of domestic violence become addicted to violence. Smith (1989,p.24) argues that one of the principal problems of this type of explanation is that it seeks "an exceptionalistic explanation of a universalistic problem", and that while it may be

useful in understanding a few specific cases it cannot provide a broad theory to explain the general phenomenon.

In the 1970's research was confined to singular and narrow theoretical and methodological approaches to the problem. Those studies which were carried out by clinicians in clinical settings were small and had no control groups. This resulted in not knowing whether the characteristics identified were not also present in those who did not commit or experience acts of domestic violence. Gelles (1987) suggests that many studies concentrated on individual pathology because this perspective was carried over from earlier studies of child abuse. The latter were strongly influenced by a medical/psychoanalytic model which focussed on the individual, and had either used clinical samples or officially reported cases of child abuse.

It is considered by some writers that psychoanalytic thought became a means of social control in the early 20th century (Fleming,1979; Pleck,1987). Domestic violence[1] was absent during this period as an issue of public concern. However, later the psychoanalytic approach became the basis of public policy about domestic violence. There are a large number of scholarly and journalistic articles which have critiqued psychoanalytic theory and that area's negative stance concerning women and women's problems (Dobash and Dobash,1979). In 1930, Helene Deutsch, one of Freud's disciples, expounded the theory of female masochism in women who were beaten or raped, in a lecture entitled "The Significance of Masochism in the Mental Life of Women". Deutsch's theory became the dominant psychoanalytic explanation for the victimization of women and changed the nature of the debate about why women remained in violent relationships. Whereas pre-Freudian psychoanalysts believed that women remained with men who mistreated them because they were stupid or feeble-minded, psychoanalytic theory suggested that women derived psychic and sexual gratification from being beaten and humiliated. From this theoretical approach the attitude of "blaming the victim" derived. Similar theories were prevalent in papers written by psychiatrists in the 1960's and 1970's, a legacy of the influence of psychoanalysis in the early 20th century[2] (Snell et al, 1964; Scott, 1974; Faulk, 1974; Lion, 1977)

Deutsch's ideas had a large, direct influence on psychiatric practice. The first psychoanalytic articles on rape which appeared in the 1940's (Albin, 1977) noted the

victim's unconscious desire to be raped.[3] When interviewing women who had been physically or sexually abused, health professionals concentrated more on the dysfunction of a woman's family of origin rather than asking direct questions about the extent of the abuse. What was considered as male brutishness of the 19th century was now seen as the proof of female frigidity, and perpetrators of family violence were no longer held responsible for having committed illegal or immoral acts. The result was that in exploring other areas which they believed caused psychological problems, psychiatric professionals ignored or minimized the seriousness of family violence.

These attitudes have carried over to the present day. Hotaling et al (1988,p.13) make these comments: "Hospitals and doctors have often avoided these problems [of family violence] entirely or looked at them from a narrowly medical angle. The mental health system has had a tendency to treat victims as though they were responsible for their own abuse".

1.3 DOMESTIC VIOLENCE AND THE NURSING PROFESSION

The nursing profession has come later than other disciplines in addressing the topic of domestic violence. In 1984 Campbell and Humphreys published a comprehensive text on the subject, *Nursing Care of Victims of Family Violence.* The major purpose of the book was to integrate nursing practice in family violence with existing theory and research. The authors saw that nursing had a limited knowledge in this area, with other disciplines such as the law and social work conducting the majority of analysis and study. They consider that a discrepancy exists between the potential magnitude of the role of nursing in the care of violent families and the amount of nursing knowledge and research available. Increasing the latter is a consistent theme in their book. They quote the definition of nursing given by the American Nurses Association in its Social Policy Statement which is, "the diagnosis and treatment of human responses to actual or potential health problems" (p.4). They consider that this definition can well be applied to the prevention of family violence as well as to its detection and treatment.

Campbell and Humphreys say that, for nurses, awareness of the problem of family violence is not enough and that they should extend their role to that of victim advocates. From the time of Florence Nightingale, the professional nurse has been concerned with the individual, the family, and the community. The nursing profession sees that the primary focus has always been the client rather than "the problem", and

such a focus allows the nurse to better assist clients who experience family violence than many other professionals. Nurses are in an ideal position to take action to decrease the likelihood of family violence and mitigate against its effects because of their sheer numbers, predominantly female gender, variety of practice locations, and in particular the nature of their practice. They note that medicine has become aware of family violence, but they are critical of the emphasis on physical symptomatology to alert physicians to the presence of family violence. In the Introduction to their book they say (p.7), "The medical model generally leads to assumptions of pathology in victims as well as perpetrators, and treatment recommendations are usually in terms of psychiatric care. A nursing perspective would appropriately emphasize the healthy aspects of the families experiencing violence, an approach well supported by actual research on victims".

The Nursing Network on Violence Against Women in the U.S.A. exists as a loose coalition of nurses and other concerned advocates and health professionals. One of the main activities of this organisation is the ongoing collection of protocols and training manuals for care of battered women in health care settings. Many training manuals on identification and treatment of battered women have been prepared by nurses in the U.S.A. (Sheridan et al,1985; Wilcoxen,1985; Braham et al,1986; Esposito,1986; Helton,1986; Varvaro and Cotman,1986; King et al,1987)

In Australia nursing research is taking place at the Royal Women's Hospital in Brisbane. Webster et al (1993) interviewed 1, 014 women in the prenatal clinic and found that 30 per cent reported a history of adult domestic violence. Also, 8.9 per cent of these women had been abused during their current pregnancy. Currently, a 'pregnancy outcome' study is being conducted. All charts of women who participated in the prevalence study are being reviewed and pregnancy and birth outcomes will be compared between abused and non-abused women.

In another study at the Royal Women's Hospital staff have been surveyed about their knowledge and attitudes to domestic violence A series of inservice workshops have been offered based on the results of the staff survey (McCosker and Duncan,1993).

1.4 RESPONSE BY DOCTORS IN AUSTRALIA

In the last decade it has been recognised that domestic violence is a major public health problem in western societies, including Australia. One of the recommendations of the National Committee on Violence in Australia (1990) was that medical education, whether undergraduate, postgraduate or continuing, should include components dealing with all aspects of violence.

The Australian Medical Association stated in 1989 (*Australian Medicine*) that domestic violence is not well recognised as a medical issue and that there is no relevant research in Australia on medical aspects of the problem. They recognised that the medical profession has a great opportunity and responsibility for the early detection of marital violence with the prospect of early intervention and tertiary preventive measures. The AMA supported the following policies:

* Recognition that the medical profession has a significant role to play in campaigns against domestic violence, so as not to dismiss it as a social problem not meriting medical attention.
* Widespread education of the profession, based on existing knowledge of the importance of early detection of the victims of domestic violence by primary health care providers (especially general practitioners and accident and emergency department medical officers).
* Greater education, through the undergraduate curriculum, as well as continuing medical education programs of the medical, surgical and psychiatric problems affecting women and children as a result of domestic violence.
* Supporting more research in the area of domestic violence to establish, for Australian conditions, its true prevalence, its medical, surgical and psychiatric complications, and to develop and evaluate intervention programs.
* Collaboration with other community agencies in a coordinated approach to dealing with the problems of domestic violence.
* Development of intervention programs for both offenders and victims, where appropriate, in collaboration with other social services.

The AMA concluded that, in the current climate of increasing acceptance of the special health needs of women, domestic violence provides an opportunity for the

medical profession to improve its tarnished image in the eyes of some community groups and to make a major contribution to the welfare of the community through longer term prevention.

In a policy statement in 1990 the Public Health Association of Australia called on the Australian College of General Practitioners, the Australian Medical Association and University medical schools to inform members and students on this issue, and develop effective treatment and referral protocols.

Despite these public statements by official health care organisations it was reported by Easteal in a small survey of General Practitioners in the Australian Capital Territory area in 1990 that most GPs do not appear to be adequately trained to deal with domestic violence issues.

A survey by the Victorian Community Council Against Violence was reported in the *Australian Doctor Weekly* (Vale,1992). It was found that 81 per cent of women who were victims of domestic violence described their General Practitioner as "not very helpful". They reported the failure of general practitioners to identify and record instances of domestic violence and the inappropriate and sometimes judgmental treatment provided. There were complaints about the lack of information about support, legal and housing options and failure to refer to other services or give practical assistance. More than 90 per cent of victims in the survey were dissatisfied with emergency or outpatient facilities at hospitals.

It would appear that some doctors are still defensive about the inadequacies of the medical profession in addressing domestic violence. Former AMA President, Dr Bruce Shepherd, is reported in the *Australian Dr Weekly* (June 28,1991) as saying that the professions's role in any program addressing domestic violence must be "carefully balanced" and avoid the occurrence of a "witch-hunt" involving families. In the same issue of the Australian Dr Weekly, Dr Tony Buhagiar, President of the Royal College of General Practitioners, said that GP's are "well and truly alert for signs of domestic violence and sexual abuse in patients".

1.4.1 EDUCATION OF DOCTORS ABOUT DOMESTIC VIOLENCE

An early voice drawing attention to the need for the medical profession to address the problems of domestic violence was that of Associate Professor Joan Lawrence. Speaking at the National Domestic Violence Training Forum in Adelaide in 1990, as a representative of the Australian Medical Association she said. "There are many who will say that violence in the family...is only a social problem and not a medical one...the medical profession, particularly in recent decades, has become increasingly aware of the major role that psychological and social factors play in the development, manifestation, aggravation or amelioration of illness and the disability that may result...The doctor, for a variety of reasons, may be the person best placed to initiate intervention. Many of the women who are the victims of violence are terrified, terrorised, intimidated, depressed, isolated socially, economically, and sometimes culturally, without resources to turn to. The medical profession therefore has the opportunity to identify and to intervene at a stage where action may be effective in changing the situation and preventing more severe or entrenched morbidity from developing".

In 1991 the Australian Medical Association, through its President's Advisory Group on Women in Medicine, investigated the adequacy of coverage of the topic of domestic violence in the curricula of Australian medical schools (Lawrence,1992). A questionnaire about domestic violence was circulated to the deans of the ten medical faculties in Australia. Information was sought about whether child abuse, spouse abuse, sexual abuse (child and adult) and elder abuse were covered in the existing curricula, with details as to timing, form and departmental responsibility. All medical schools responded to the questionnaire.

Child abuse and child sexual abuse were covered by all medical schools, with time allocation varying from 1 to 21.5 hours for child abuse, and 1 to 14 hours for child sexual abuse.

Much less attention was paid to spouse abuse. Three universities had no reference to spouse abuse. In others, the topic was referred to at various times throughout the preclinical and clinical years for fewer than three hours. One university provided one lecture and another a part of one lecture. Three used seminars, tutorials and ad-hoc

teaching from departments of psychiatry, community medicine or behavioral science and medicine.

Adult sexual abuse was much less well covered, with 5 universities making no reference to this topic. Elder abuse received even less recognition, with 6 universities omitting it from their curriculum. Most responses indicated receptivity to the issues and several indicated that domestic violence and sexual assault would be included in curriculum reviews. There was only one faculty which indicated that the inquiry represented yet another impossible intrusion into an already overcrowded curriculum. The Advisory Group concluded that increased training in the early identification, intervention, assessment and management of family violence and sexual violence was necessary. They recognised that, whilst current levels of training were inadequate, there was promise that there would be increasing attention paid to these significant public health problems in modern Australian society.

1.4.2 HEALTH SERVICES USED BY VICTIMS OF DOMESTIC VIOLENCE

There is a typical sequence of help-seeking followed by victims of domestic violence (Smith,1989). There is a marked reluctance to initiate any help-seeking after the first experience of a domestic violence incident. The most inhibiting factor is the sense of shame experienced by victims (Dobash and Dobash,1979; Borkowski et al, 1983; Bowker,1983; Dobash et al,1985; Pahl,1985). As the violence continues and increases, although the inhibiting factors remain, help is sought. Almost all women turn to families and friends first. Only as the violence increases, especially in a time of crisis, is help sought from more formal agencies. At the same time, there is continued use of family networks (Carlson,1977; Flynn,1977; Binney et al,1981; Dobash et al, 1985; Pahl,1985). Initially, family members are approached for emotional support with a view to stopping the violence. It is only later, when the violence fails to end, that practical help and assistance are sought.

A number of small surveys have shown that doctors, and especially general practitioners, are the first formal agencies to which victims turn for help (Smith,1989). Most of these studies have relied on accounts of victims themselves and most of the samples have been drawn from women who have used refuges, either currently or in the past. Estimates of the extent to which victims of domestic violence seek help from doctors vary. American research (Pagelow,1981) shows lower rates than British

research. Pagelow's study of 157 battered women showed that less than half had consulted a doctor. Two thirds said they needed medical attention but had not sought it, largely because they were forbidden by spouses. The following studies have been conducted in the United Kingdom. Dobash and Dobash (1979) found that of 109 women living in refuges 80 per cent had consulted a doctor at some point but only for 3 per cent of all the violent attacks experienced. In a longitudinal study of 50 battered women from refuges, Pahl (1985) showed that over 60 per cent had consulted their general practitioners about the violence. Binney et al (1981) found that approximately half of 656 women from refuges had consulted general practitioners.

1.5 RESEARCH IN AUSTRALIA

Research in Australia has provided very little empirical data on domestic violence and the literature has been largely confined to essays and discussion papers[4], literature reviews[5] workshop manuals[6], policy statements[7], conference proceedings[8], and government task force submissions and reports. In the 1980's books about domestic violence, with a feminist theoretical basis, began to be published. These books have been written or edited by academics (O'Donnell and Craney, 1982; Scutt, 1983; Horsfall,1991). They address issues such as historical aspects of domestic violence (Allen, 1990) and movements for social change (McGregor and Hopkins, 1991) and have been presented as text books for professionals on family violence (Family Violence Professional Education Task Force,1991).

The limited amount of research in Australia has mainly been restricted to small samples of female victims of domestic violence. There have not been any Australian representative community surveys of the incidence or prevalence of domestic violence or the measurement of variables which could be understood as socio-cultural correlates of domestic violence. The only community survey in Australia about domestic violence was an attitudinal study conducted in 1987 by the Public Policy Research Centre in Canberra. The study found that 19 per cent of people consider that the use of physical force by a man against his wife is acceptable under some circumstances. The findings of this research are relevant to health professionals. It was noted by Mugford (1989) that "In the absence of appropriate training with respect to domestic violence, practitioners assume the broader community values....."

Easteal (1988) reviewed studies of attitudes to domestic violence. She found that most research in Australia involved small victim surveys mainly of women in refuges. There has been little research of the attitudes held by the professionals to whom victims turn for assistance. Most of the attitudinal findings have been abstracted from victims' surveys; they are implied from practitioners' behavior as reflected in their records; they are inferred from theoretical discussions, or they come from overseas research. Easteal recommended that future research about domestic violence in Australia include a three-pronged methodology – attitudinal studies of service providers, case record analysis and victims' perceptions of professionals. She suggested that one group of service providers would be preferable to surveys which include respondents from varying occupations. This current study on domestic violence and health professionals fulfils all the criteria suggested by Easteal.

Domestic homicide research in Australia has been limited. Studies have been restricted to individual states rather than national surveys (Rod,1979;S165 Wallace,1986; Bonney,1987; Polk and Ransom,1991a, 1991b; Kapardis and Cole,1988; Grabosky et al,1981). Sources of data for these studies have been restricted to police and court records. There are problems in different sample selection methods and definitions of 'intimate homicides' which make comparisons between the studies difficult. In spite of the methodological difficulties, their findings have relevance to health professionals. Australia-wide studies conducted by Strang (1991, 1992) found that between 25 and 31 per cent of homicides in Australia involved either spouses or 'sexual intimates'. In Easteal's (1993) study she conveys both quantitative data about the people who are killed by sexual intimates and, through some of their stories, aspects of their lives. These studies emphasize the serious nature of domestic violence and the responsibility of health professionals, especially those who are in the front line of health care such as staff of hospital emergency departments, general practitioners or community nurses, to assess dangerous situations which may occur for their clients.

1.6 ETHICAL ISSUES IN DOMESTIC VIOLENCE RESEARCH

There are many ethical problems in studying domestic violence related to the sensitive and "taboo" nature of the topic. The family has long been regarded as essentially a private institution. Also the family is an intimate social group. This privacy aspect has limited research to surveys rather than experimental methods. The tendency to view

the family as sacred, private and intimate leads many individuals to take an adamant stand against uninvited intrusions by investigators of domestic violence.

The first ethical issue relates to the protection and safety of human subjects This introduces special ethical considerations for the investigator researching violent populations. Random selection of subjects may place the abused wife at risk if, for example, her husband suggests that selection was a result of the wife's report rather than a random occurrence. Even when the couple has voluntarily agreed to participate in research, there may be coercion, with suppression of information regarding spousal or child abuse. Providing experimenter supervision may increase the probability of accurate reporting by reducing overt coercion. However, the possibility of later interrogation regarding the responses to various questions remains a problem. In any study design the issue of exacerbation of the violence as a result of the research must always be considered.

The investigator must consider the confidentiality of the subject, particularly with regard to informed consent. Informed consent should specify whether the investigator is obligated to report certain information to the appropriate authorities e.g. child maltreatment or impending violence disclosed in the course of research participation. Consideration must always be given to the constraints on subjects when disclosing sensitive and potentially reportable information. Research on a particular subject should be terminated if that person's safety is being compromised. It is the researcher's ethical and moral responsibility to abandon the research protocol and help the threatened person to find protection.

There is a particular need in domestic violence research to screen potential interviewers for their maturity, attitudes, integrity and the ability to handle high stress material and interactions. Walker (1984.p.216-218) outlined the criteria which were established prior to hiring interviewers for an in-depth study of 403 self-identified battered women. Hiring senior research assistants of this calibre may make these kind of projects more expensive. Standardized training protocols for research assistants and interviewers are necessary. There are particular issues of training and on-going supervision of research staff and this is well described in Walker's study (p.218-221).

1.7 RATIONALE FOR THE CURRENT STUDY

There have been no previous studies in Australia which have investigated the presentation of victims of domestic violence to the Emergency Department of a public hospital. The rationale for this study is largely based on overseas studies, as well as a small amount of Australian research. Other studies on which the current study is based are described in the following sections.

1.7.1 HIGH RATES OF VICTIMS OF DOMESTIC VIOLENCE AT EMERGENCY DEPARTMENTS

Studies conducted in the U.S.A. metropolitan general hospitals show high prevalence rates of victims of domestic violence at Emergency Departments. A cross-sectional survey of 492 patients by Goldberg and Tomlanovich (1984) in the Department of Emergency Medicine at Henry Ford Hospital, Detroit, found that 22 per cent of patients reported being victims of domestic violence. They surveyed men and women and found that the majority of victims were women (62 per cent) although there was no statistically significant difference between the number of male and female victims.

Stark et al (1981) did a retrospective study at an urban hospital in New Haven.They studied a random sample of 2,676 medical records of women who presented to the hospital's Emergency Surgical Service with injury or complaint of injury during a single year. For each woman, all presentations with trauma after the age of sixteen were assessed and assigned to one of four groups, based on the relative probability or risk that it resulted from assault by a social partner. During the sample year, 6.4 per cent of women presented with injuries that were attributed to assault by a male intimate. Very few of these cases were recorded as "battering". They were categorised as "positive" in the research design, and these were the most obvious cases. An additional 5.1 per cent of the women sought aid during the sample year for injuries that were the result of an assault, but did not differentiate whether the assault was by an intimate or an anonymous assailant. These were described as probable instances of battering. Another 2.3 per cent of the women provided explanations for their injuries which were inconsistent with the type or location of injury. Such cases were classified as suggestive of domestic violence.

Stark at al consider that these figures are underestimates since analysis of a single injury episode may not reflect a woman's history of domestic violence. Their sample

showed that 21 per cent of the women who use the Emergency Surgical Service during the year had a life-time history of domestic violence and that 17.4 per cent had experienced violence in the previous 5 years. Eighty-three per cent of the women who had ever been abused still appeared to be in violent relationships. This indicates that abuse is typically an ongoing problem rather than a single incident.

From this caseload they conducted a case-control study of subjects taken from their retrospective review of medical records. They compared the number of trauma-induced visits of 564 battered women (cases) with 591 non-battered women as controls. Although battered women accounted for 26 per cent of the sample who had presented with trauma, they accounted for 46 per cent of all visits to the Emergency Service. Non-battered women, comprising 51 per cent of the sample, presented with only 26 per cent of the injuries. The average at-risk woman had a trauma history of approximately 7 years, compared to only 3.7 years for non-battered women, reflecting the longer term use of the service by at-risk women.

A representative community study of 1,793 Kentucky women (Schulman,1981) who were married or living with a male partner found that 21 per cent reported life-time experience of domestic violence. Almost 10 per cent of these women reported incidents of domestic violence requiring medical attention. When treatment was sought, in 59 per cent of cases it was to the hospital emergency department that these victims presented.

Another study of 57 women at a refuge in Los Angeles (Star,1978) estimated that 50 per cent had used emergency medical services while the remainder reported that they required such services periodically but were afraid to report their problems.

1.7.2 LOW DETECTION RATES BY MEDICAL STAFF

Goldberg and Tomlanovich (1984) reviewed the medical records of each subject regarding the nature of the emergency health care rendered. They reported that doctors identified only 5 per cent of domestic violence victims in the medical record. Those who were severely abused were more likely to be identified as domestic violence victims than those who were less severely abused.

Stark et al's case–control study, referenced above, found that only 15 per cent of the trauma incidents recorded for the battered women resulted in a diagnosis of physical abuse. They concluded that, using present identification techniques and symptomatic diagnoses, medical personnel trace only a very small proportion of injuries reported by abused women.

Hilberman and Munson (1978) studied 60 battered women who were referred by the medical staff of a rural health clinic for psychiatric evaluation. Fifty–six of these 60 women had not been identified as victims of domestic violence by the referring practitioner.

1.7.3 MEDICALLY ILL PATIENTS CONSTITUTE THE LARGEST PROPORTION OF DOMESTIC VIOLENCE VICTIMS

In Stark et al's study (1981) at–risk women accounted for 78 per cent of the total visits by women to the Emergency Medical Service. Moreover, at–risk women used the service almost twice as often as non–battered women. The former averaged 1.79 visits per year prior to their first recorded battering incident and 1.95 visits per year after their first identified incident of abuse, while non–battered women averaged 1 visit per year. Their findings challenge the assumption that battered women are most likely to present to an Emergency Department with physical injuries. They found that the battering syndrome included multiple medical and psychosocial problems in addition to injury so that battered women frequently and disproportionately utilized non–trauma medical resources as well.

Goldberg and Tomlanovich (1981) found that for 53 per cent of their sample the main complaint was medical. They concluded that, besides querying trauma patients about the circumstances surrounding their injuries and asking psychiatric patients about their domestic situation, medically ill patients' complaints of "pain" should be explored to screen for abuse.

1.7.4 HIGH ASSOCIATION BETWEEN DOMESTIC VIOLENCE AND PSYCHIATRIC ILLNESS, PARA-SUICIDE, ALCOHOL AND DRUG ABUSE

Battered women comprise a significant number of those women referred to the psychiatric emergency service or institutionalized in psychiatric facilities (Hilberman and Munson,1977; Post et al,1980; Jacobsen,1989).

In Stark et al's (1981) case-control study the investigators created a general diagnostic category consisting of vague medical complaints that included diagnoses such as hysteria, neurosis, hypochondriasis, and psychosomatic disorders. These diagnoses doubled for at-risk women using the Emergency Service after the first reported battering incident. In the Medical Emergency Service 11 per cent of pre-battering at-risk women received diagnoses concerning depression, anxiety, and family, marital or sexual problems This increased to 19 per cent for post-battering at-risk women. In contrast, only 8 per cent of the non-battered women received these diagnoses. Prior to the onset of abuse, at-risk women receive very similar diagnoses to non-battered women at non-trauma medical facilities. The study also indicated that the mental health and psychosocial problems of at-risk women increase markedly with the onset of abuse. They concluded that abuse appears to be the context for many of these secondary problems, rather than the reverse.

In a study of 40 black and 20 white rural women who were referred for psychiatric evaluation Hilberman and Munson (1980) described a uniform psychological response to violence that was identical for the entire sample of battered women. These women experienced paralyzing terror that was reminiscent of the rape trauma syndrome, as described by Burgess and Holmstrom (1974), except that the stress was unending and the threat of assault ever present. The researchers stated that victims' psychological problems typically occurred after the onset of abuse. They consider that psychiatric diagnoses may be used as punitive labels rather than as accurate assessment of psychiatric or psychosocial problems.

In psychiatric literature female suicide attempts and family conflict have been associated. Early studies explained the link by predisposing traits such as rigid personality or general hostility that make these women unable to cope with family tension (Vinoda,1966). More recent studies have attempted to demonstrate that, in the

presence of family conflict, battering is the most frequent precipitating cause of female suicide attempts. Domestic violence probably precipitates depression and general hostility as well. In Stark et al's study (1981) 12 per cent of the at-risk women had been treated for at least one suicide attempt, compared with only 1 per cent of the non-battered women. Moreover, 40 per cent of the positive and probable women who attempted suicide reported that their attempt was related to being battered. The battered woman's suicide attempt is less a failed suicide than a complex response to battering that may even help protect her physically by removing her from the home.

Stark et al reported that, prior to the first identified incident of abuse, alcoholism was no more common among battered women (3 per cent) than non-battered women (2 per cent). After the first reported incident, however, alcohol abuse climbed to at least 15 per cent among the battered women, suggesting that alcoholism is a consequence of abuse. Although very few of the women were diagnosed as drug addicts, this diagnosis trebled after the first identified battering incident. Seventy per cent of alcohol and drug-related problems in at-risk women were identified after the onset of abuse.

1.7.5 ASSOCIATION OF DOMESTIC VIOLENCE WITH INCREASED RISK OF BEHAVIORAL AND EMOTIONAL PROBLEMS IN CHILDREN

Although the primary victims of domestic violence are the wives, recent empirical studies suggest that children who witness a parent being abused may be particularly vulnerable to a variety of behavioral and emotional difficulties, including psychosomatic disorders, anxiety disorders, and aggression (Hilberman and Munson,1977; Rounsaville,1978; Hershorn and Rosenbaum,1985; Wolfe et al,1985; Levine,1985; Jaffe et al,1986; Hughes,1988).

Hilberman and Munson (1977) studied 60 battered women referred by the medical staff of a rural health clinic for psychiatric evaluation, and found physical and/or sexual abuse of children in a third of the families. They observed that, whether the children were themselves battered or were onlookers to parental violence, they were deeply affected by the climate of violence in which they lived. Emotional neglect, abuse and frequent separations were the norms - the children were never certain who would leave and when. Thus, children in violent homes, as witnesses and targets of abuse, are vulnerable.

From Hilberman and Munson's qualitative data the following portrait of the children emerges. Pre-school and young children displayed somatic complaints, school phobias, enuresis and insomnia. The insomnia was often accompanied by intense fear, screaming, and resistance to going to bed at night. This behavior seems time-related, much of wife-beating occurring when the children were in bed. Older children began to show behavior patterns which divided along sex lines. Aggressive disruptive behavior, most usually fighting with siblings and schoolmates and temper tantrums when frustrated, was the most frequently reported response of male children. In contrast, female children continued to have an increasing array of somatic symptoms and were likely to become withdrawn, passive, clinging and anxious. This pattern also occurred with a smaller number of males. Most children had impaired concentration spans and difficulty with school work. Adolescent girls further suffered from the perpetual surveillance and accusations of sexual activity by their fathers who were seductive if not overtly incestuous.

A study by Wolfe et al (1985) of 198 children (4 to 16 years old) from violent and non-violent families indicated that children of battered women had significantly higher behavioral problems and lower social competence ratings than those in the comparison group. Of 102 children from violent families, 34 per cent of the boys and 20 per cent of the girls fell within the clinical range of behavior problems. Multiple regression analysis revealed that maternal stress and family violence variables combined accounted for 19 per cent of the variance in child behavior problems and accounted for 16 per cent of the variance in social competence.

There is empirical evidence which suggests that the negative effects of parental marital violence may persist into adulthood. Forsstrom-Cohen and Rosenbaum (1985) conducted a study of 3 groups of college students - those who had viewed parental violence, those who had viewed nonviolent discord and those whose parents were satisfactorily married. Their findings indicated that exposure to marital violence was associated with increased levels of anxiety for both males and females; however, females showed elevated levels of depression and aggression.

1.7.6 FINANCIAL COSTS OF HEALTH SERVICES USED BY VICTIMS OF DOMESTIC VIOLENCE

In a study by Roberts (in Beyond These Walls: Report of the Queensland Domestic Violence Task Force,1988) the costs of community services for female victims of domestic violence in Queensland were estimated. It was found that the greatest costs incurred were for health care services.

1.8 AIMS OF THE CURRENT STUDY

This study was designed to achieve the following aims:

* To develop methods of screening attendees at Emergency Department for a history of domestic violence.
* To measure the prevalence rates of victims of domestic violence presenting at an Emergency Department of a major public hospital in Australia.
* To determine the detection rates of domestic violence victims by doctors in the Emergency Department.
* To determine the barriers to disclosure by domestic violence victims to health professionals.
* To enhance the management of domestic violence related problems through the education of doctors and nurses.
* To describe the characteristics of victims of domestic violence who attend the Emergency Department.

1.9 HYPOTHESES

The following specific hypotheses were developed and they are grouped according to the aims of the study.

GROUP ONE - VICTIMS OF DOMESTIC VIOLENCE AT EMERGENCY DEPARTMENT

* That prevalence rates of victims of domestic violence who present to Emergency Department will be similar to findings in Emergency Departments in the U.S.A. Their findings are that 22 to 24 per cent of female attenders at the Emergency Department have a history of domestic violence (Stark et al,1981; Goldberg and Tomlanovich,1984)
* Greater numbers of women than men present as domestic violence victims to Emergency Department.

GROUP TWO - RESPONSE OF HEALTH PROFESSIONALS

* Medical and nursing staff in the Emergency Department do not recognise victims of domestic violence. Detection rates may be as low as 5 per cent.

GROUP THREE - BARRIERS TO DISCLOSURE OF DOMESTIC VIOLENCE

* The most common barriers to the disclosure of domestic violence by victims are guilt, shame and embarrassment; fear of a perpetrator who may be accompanying the victim to the Emergency Department; and the victim's perception that it is their problem and do not ask for help.

GROUP FOUR - EDUCATION PROGRAMS ABOUT DOMESTIC VIOLENCE

* An education program will be able to be implemented for doctors and nurses who staff an Emergency Department.

* Education programs will enhance the management of domestic violence problems by doctors and nurses.

* The impact of an education program will result in change of attitudes, knowledge and practices by staff.

* The outcome of an education program will result in greater detection rates of domestic violence by doctors and nurses.

* The outcome of an education program will result in increased numbers of referrals to social work services in Emergency Department.

* The outcome of an education program will result in increased numbers of referrals to community services e.g. police.

GROUP FIVE - COMPARISON OF VICTIMS AND NON-VICTIMS WHO ATTEND EMERGENCY DEPARTMENT

* Victims will attend the Emergency Department more than non-victims.

* Victims will have more medical presentations than trauma presentations to Emergency Department.

* Victims of domestic violence will have greater rates of psychiatric index presentations than non–victims.

* Victims of domestic violence will have more recorded psychiatric history than non–victims.

* Victims of domestic violence will have greater rates of attempted suicide than non–victims at presentation to Emergency Department.

* Victims of domestic violence will have more recorded history of attempted suicide than non–victims.

* Victims of domestic violence will have higher rates of alcohol problems than non–victims at presentation to Emergency Department.

* Victims of domestic violence will have more recorded history of alcohol problems than non–victims.

The next chapter describes how the project was designed and outlines the procedures used to carry out the study.

ENDNOTES

1. The terminology used for violence in family or intimate relationships varies by time period in history and also varies by user of the terminology. In the early 1900's wife-beating was called "domestic disturbance" by the police and "family maladjustment" by marriage counsellors and social caseworkers.
   Currently, there is a plethora of terms - domestic violence, family violence, domestic disputes, domestics, spouse abuse, wife abuse, woman abuse, battered wives, battered... Usage of terminology has become politicized.

2. In an article by Snell et al in 1964, "The Wifebeater's Wife", the authors make this judgment about the battering relationship, "The periods of violent behavior by the husband served to release him momentarily from his anxiety about his effectiveness as a man, while, at the same time, giving his wife apparent masochistic gratification and helping probably to deal with the guilt arising from the intensity expressed in her controlling, castrating behavior". Implicit in this statement are assumptions about the characteristics of being male and female, and the masochism of female victims of wife abuse.

3. Pleck (1976) notes that in 1970 a therapist in training at an eminent psychiatric hospital in Boston was advised by his psychiatric supervisors that a patient who had been violently raped two days before and complained of terrifying flashbacks of the event, would continue to do so until she could acknowledge the parts of herself that found the rape gratifying.

4. Crancher et al,1981; Dimitripoulous,1981; Egger & Crancher,1982; Stewart,1982; McIntyre,1984; Hatty,1987; Hatty,1989; Mugford,1989; Raphael,1989; Knowlden & Frith,1993

5. Allen,1982; Bates,1985; Girdler,1982; Easteal,1988

6. Domestic Violence Workshop Manual for counsellors, health and welfare workers (1990)

7. Policy statements have been issued by the following bodies in Australia:
   Public Health Association of Australia - Policy Statements (1990);
   Australian Medical Association in *Australian Medicine* (1989).

8. The following proceedings from national conferences on domestic violence held in Australia have been published:

   Chappell D, Grabosky P, Strang H, eds. (1991) *Australian Violence: Contemporary Perspectives*. Canberra: Australian Institute of Criminology.

   Hatty SE. (1985) (ed.) *National Conference on Domestic Violence*. Canberra: Australian Institute of Criminology, Vols 1-2.

   Office of the Status of Women. (1990) *Report on the National Domestic Violence Training Forum*. Canberra: Office of the Status of Women, Department of the Prime Minister and Cabinet.

2. METHOD - DESIGN, PROCEDURES, DATA AND ANALYSIS

In this chapter the design of the study and the procedures which were followed are outlined. Explanations are given as to how and why the original study design was revised. The procedures of how the data were collected, how the quality of the data were assessed and how the data were analysed are described.

2.1 DEFINITION OF DOMESTIC VIOLENCE

For the purpose of this study a victim of adult domestic violence was defined as any adult in a family or intimate relationship e.g. legal marriage, de facto, boyfriend/girlfriend, siblings, child–parent, other relatives, who has suffered physical, sexual or emotional abuse during or after the relationship. The operational definition included abuse of an adult 16 years or over, during or after a family or close relationship, where one partner was afraid of and/or being physically hurt by the other. It was considered more than a heated domestic argument. The latter was the definition used on the screening questionnaire which was presented to attendees at Emergency Department.

2.2 DESIGN OF THE STUDY

Figure 1 shows diagrammatically the design of this study. Using random time period sampling methods, a screening questionnaire was administered to male and female attendees to the Emergency Department of Royal Brisbane Hospital in two prevalence studies conducted 12 months apart, in 1991 and 1992. An educational program about domestic violence for doctors and nurses who staff the Emergency Department was conducted between the two prevalence studies. Knowledge, attitude and practice surveys of the staff were conducted pre- and post–intervention to measure the effectiveness of the education program. An identical survey was carried out at the same time with a group of doctors and nurses at Princess Alexandra Emergency Department who had received no educational intervention. To determine detection rates by doctors at Royal Brisbane Hospital, two case–control studies of victims compared their self–report on the questionnaire with their medical record. In the case–control studies victims were matched on their sex, age and point of entry to the

Emergency Department with non-victims, and their medical records were examined to determine whether there were any differences between the characteristics of the two groups e.g. do victims of domestic violence present more to the Emergency Department than non-victims? The outcome of the educational program for doctors and nurses was measured by the difference in the detection rates of the first and second case-control studies.

DESIGN OF DOMESTIC VIOLENCE PROJECT

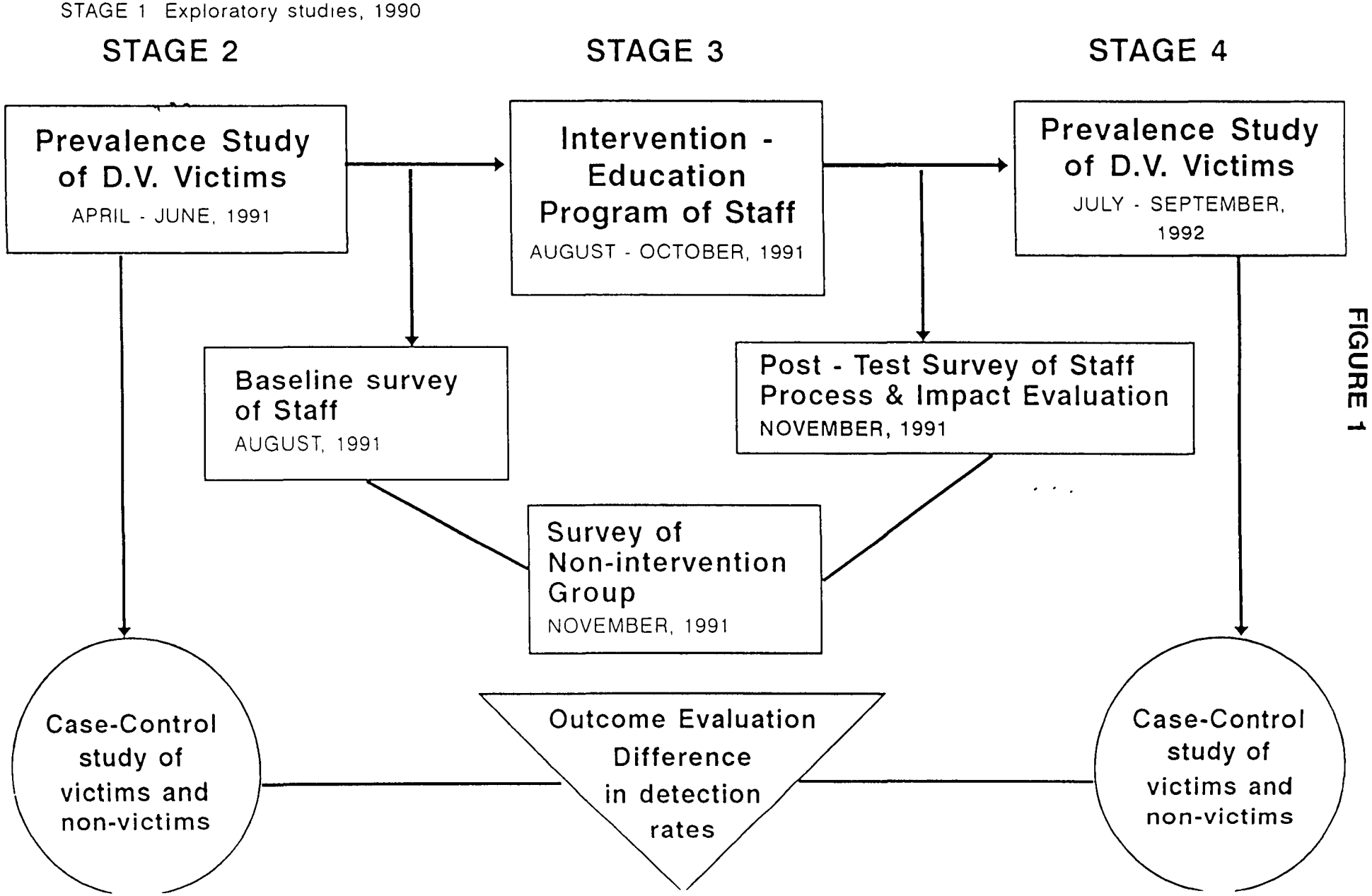


FIGURE 1

2.2.1 STAGE 1 - EXPLORATORY PREVALENCE STUDY AND CASE-CONTROL STUDY

In 1990 exploratory studies were conducted in Emergency Department to test instruments and methods which could be used in the main prevalence studies and the case-control studies. These were conducted in the Acute section which caters for greater severity of illness (operating 24 hours, including overnight stay in Ward 3A) and the Non-Acute section which offers ambulatory care services (9am to 5pm). Before the studies commenced the SRO held meetings with the Medical Director and Charge Nurse to inform them about the aims of the project, procedures for the prevalence study to be conducted in Emergency Department, and to establish rapport and cooperation with them. Once this was established, meetings were held with the SRO and medical and nursing staff in the Emergency Department. The purpose of these meetings was to inform the staff regarding the domestic violence project, to brief them regarding the procedures which would be used to conduct the study in the Emergency Department and to answer any questions which they may have regarding the project. Information about the topic of domestic violence was kept to a minimum because of the pre-intervention prevalence and case-control studies which were planned to take place in the Department (refer to FIGURE 1). We did not wish to influence the results of these studies which were conducted before the interventional education took place with Emergency Department staff. The social worker from the Emergency Department was present at these meetings.

The meeting of the SRO with medical staff was attended by senior staff and resident medical officers and had a generally negative tone. The impression was given that there was a general reluctance for doctors to be involved in this part of a patient's history. They were concerned about whether the questionnaires about domestic violence would be administered before or after patient's medical assessment, and how that would affect patients' emotional states in relation to their medical assessment. One female doctor gave an example of a female patient who might present to the Department with vaginal bleeding and how questioning about domestic violence might affect her emotional state. Doctors were concerned that patients would be threatened by being asked these questions, and they were concerned about the negative effects of the study on patients (although these effects were not articulated by the doctors). Overall, the doctors displayed a general lack of knowledge about the topic of domestic violence and did not expect that we would find many victims of domestic violence

attending the Emergency Department. Their questions were answered with information from the domestic violence literature and from the SRO's own experience of domestic violence research.

The SRO also held a meeting with the Registered Nurses and Enrolled Nurses who staffed the Emergency Department. The nurses were interested in the domestic violence topic and appeared to have some insights and experience of patients who had experienced domestic violence. They expressed their willingness to assist in the project.

During the last week of February, 1990, a pilot study was conducted. Self-administered questionnaires were given to attendees (n=201) who came to the Royal Brisbane Hospital Emergency Department by nursing staff, 24 hours a day. The brief screening questionnaire asked whether people had ever experienced domestic violence; the type of violence; the last time of the abuse; and which services they would recommend for a friend with domestic violence problems. A protocol was developed for the administration of questionnaires by nursing staff. A second protocol was developed for nurses and doctors if victims of domestic violence wished to speak to someone in-hours and out-of hours (i.e. when Emergency Department social work staff were not available), during the administration of the questionnaire. The method by which the Emergency Department Social Worker was to be contacted was contained in this protocol. The week's pilot study proved that having questionnaires administered by the nursing staff was not an effective way of conducting a prevalence study in Emergency Department: because of the busyness of nurses in a major public hospital too few questionnaires were administered; there were also high rates of incomplete questionnaires because nurses did not have the time to check for completeness of questionnaires as well as attend to their other nursing duties. A meeting was held with nursing staff following the week's pilot study to receive feedback on running the questionnaire.

A second pilot study was conducted by the SRO on the project from March 5 to 16, 1990. This study was conducted in the first two weeks of March, 1990 and gave the SRO the opportunity to ascertain the conditions for running the study in Emergency Department. The SRO was well received by staff, possibly because of her own nursing background and ability to work in an Emergency Department. The response of

the attendees was sufficiently high to render a full scale study feasible. In this study, if respondents (n=238) identified positively as victims of domestic violence (n=48) they were asked if they were willing to be interviewed while they were in the Department. An in-depth semi-structured interview was conducted by the SRO with 12 people (9 females, 3 males). A consent form was devised for all patients who agreed to be interviewed. Respondents signed a written consent form which indicated strict confidentiality, assurance that no further contact would be made with the respondents, and that their medical records would be examined.

An exploratory prevalence study was conducted by the SRO for 12 weeks from April 2 to June 30, 1990. A sample of 985 attendees (507 men and 478 women) at Emergency Department was screened for a history of domestic violence. They were screened on alternate weeks in the Acute section and the Non-Acute section. There were two simultaneous parts to this study - a screening questionnaire which was given to all participants and a semi-structured in-depth interview was offered to those who identified as victims of domestic violence. The interview questionnaire was modified to collect more information from victims of domestic violence. A series of case-reports was obtained through the in-depth interviews which were conducted with 41 female and 7 male victims of domestic violence.

An exploratory case-control study was conducted in September, 1990, to develop methods for the main case-control studies which were to be conducted subsequently. Victims and non-victims were selected from the prevalence study to compare the self-report of victims who disclosed domestic violence in the prevalence study with their medical records. Each victim was matched for age, sex and point of entry to the Emergency Department with a non-victim from the prevalence study. The medical records of victims (n=120) and non-victims (n=120) were examined by a Medical Record Administrator who was supervised by a senior psychiatrist and the SRO. The aim of the study was to determine detection rates by doctors of victims of domestic violence i.e. whether they had ever been recorded in their medical history as victims of domestic violence. When the medical records of those who had experienced domestic violence in the last 12 months were examined it was found that the detection rates in Emergency Department by medical staff were 16.7%. This finding was the basis on which the original design of the study was altered. We found clearly a very significant difficulty in ensuring that patients presenting with domestic violence in this setting

would have their social emergency recognised and then be referred for appropriate management. A one to one intervention program in a Domestic Violence Clinic proved extremely difficult to implement and evaluate in light of the failure to detect and manage the social emergency of domestic violence. So intervention was diverted towards enhancing the detection and first line management skills of medical and nursing staff in Emergency Department. It was considered necessary to obtain more information about the prevalence of domestic violence victims and in particular its prevalence in association with the current presentation. It was believed that this might provide more realistic opportunities for detection and management, so efforts could be concentrated on the immediate presentations and a referral process for social, psychological and medical management could be provided and coordinated.

2.2.2 STAGE 2 - PREVALENCE STUDY ONE AND CASE-CONTROL STUDY ONE

In April to June 1991 the first prevalence study was conducted in the Acute and Non-Acute sections of the Emergency Department. Forty-nine out of the 126 nursing shifts (7am-3pm, 3pm-11pm, 11pm-7am), covering a continuous 6-week period, were randomly selected. This enabled representation of attendees to the Emergency Department at all hours. People excluded from the study were those under age 16, those who were too ill, those who were unrouseable, mentally retarded, confused, senile or illiterate, those from non-English speaking background or those who were accompanied by a person who would not leave their side. The latter consideration was that the subject would not give valid answers to the questionnaire. The confidentiality of the questionnaire was emphasised to all who were approached. The study comprised 1214 attendees which represented a response rate of 93 per cent of those who were approached in the Department.

It was noted in the exploratory study that some of the reported domestic violence may have been previous child abuse. Since this study was investigating adult domestic violence the screening questionnaire was modified to ascertain the relationship of the victim to the abuser (APPENDIX A).Those who self-reported domestic violence were asked further questions regarding their usage of health services in relation to domestic violence (APPENDIX B). If they had revealed domestic violence to health professionals they were asked to give their perception of the response of health

professionals, ranking the response from "advised me what to do" to "said or did things that upset me".

A case-control study was conducted in which the self-report of victims of domestic violence recorded on the questionnaire in the prevalence study was compared with their medical records. Each victim was matched for age, sex and point of entry to the Emergency Department with a non-victim from the prevalence study. The medical records of victims (n=141) and non-victims (n=141) were examined by a senior psychiatrist, who was "blind" to the status of the subjects. The self-report of victims was compared with their medical records over a period of 5 years. The aim of the study was to determine detection rates by doctors of victims of domestic violence i.e. whether they had ever been recorded in their medical history as victims of domestic violence, and to compare their characteristics e.g. do victims present more to the Emergency Department than non-victims?

2.2.3 STAGE 3 - EDUCATIONAL INTERVENTION

A full description of the education program, its evaluation and results will be described in Chapter 3.

2.2.4 STAGE 4 - PREVALENCE STUDY TWO AND CASE-CONTROL STUDY TWO

A second prevalence study was conducted in Emergency Department from July to September, 1992 over a period of 8 weeks, under the same conditions as the first prevalence study. It used the same random time sampling procedure (53 nursing shifts out of 168 were chosen), the same exclusions in the selection process of eligible subjects and the same screening questionnaire as in the first prevalence study. An extra question was included in this study which asked victims if they were presenting with domestic violence to the Emergency Department at the same time as they completed the questionnaire (APPENDIX C). Those who self-reported domestic violence were asked further questions regarding their usage of health services. There were some slight modifications to the questionnaire used in prevalence study one. The sample comprised 670 men and 553 women.

A second case-control study was conducted with subjects extracted from the prevalence study, with the same aims and methods being used as in the first case-

control study. The medical records of victims (n=183) and non-victims (n=183) were matched on age, sex and point of entry to Emergency Department and were examined by a senior psychiatrist who was "blind" to the status of victims. The aim was to determine the detection rates of victims of domestic violence by doctors and to examine characteristics of victims of domestic violence as compared to non-victims.

The outcome of the educational intervention with doctors and nurses in Emergency Department was evaluated in the following way. The results of the first case-control study were compared with the second case-control study, with the differential domestic violence detection rates by doctors being the measure of the effectiveness of the educational intervention program with doctors and nurses.

2.3 ETHICAL CLEARANCE FOR THE STUDY

Prior to commencement of this study approval was obtained from the Research Ethics Committee, Royal Brisbane Hospital. It was agreed that all investigations would be carried out according to the "Declaration of Helsinki, 1976" and the National Health and Medical Research Council's Statement on Human Experiments, 1982 which states: "The research protocol should always contain a statement of the ethical considerations involved and should indicate that the principles enunciated in the present declaration are complied with". Ethical clearance was also obtained from the Behavioral and Social Sciences Ethical Review Committee, University of Queensland for the prevalence and case-control studies and the surveys of doctors and nurses.

2.4 DATA QUALITY

Confidence in the conclusions of this study are a direct function of the quality of the data which was collected. In this section quality control measures are described including selection and training of research assistants and participation rates.

2.4.1 SELECTION AND TRAINING OF RESEARCH TEAM

PREVALENCE STUDY ONE AND TWO

Data collection for these studies was done by a staff of carefully chosen research assistants. The first prevalence study was conducted in the Emergency Department by the SRO (a registered nurse), a social worker and a registered nurse. All staff were

external to the hospital and were employed by the Department of Psychiatry, University of Queensland. It was necessary that staff were able to work in the environment of a busy Emergency Department and to conduct themselves in such a way that the research procedures did not interfere with the routine functions carried out by doctors and nurses in the Department. The first two staff had previous experience in interviewing victims of domestic violence and extensive knowledge about the topic. The third member was provided with selected reading material from the domestic violence literature. In the second study two senior social workers were added to the team of research assistants who administered the questionnaire in the 1991 study. These social workers had previous experience in working with domestic violence victims.

Staff were chosen according to the following criteria. It was decided that female interviewers were preferable because it was anticipated that the majority of victims disclosing domestic violence would be women and previous experience has shown that female victims are more likely to disclose domestic violence to other women (Walker,1984). Skills which were required of the research assistants were establishing rapport with people, active listening, ability to set limits, sensitivity while eliciting emotionally charged data and understanding of the need for anonymity and confidentiality. Ability to handle high stress material and interactions was a critical factor because of the nature of the data collected. Potential burn–out was addressed by instructing the staff to discuss the research regularly with the Chief Investigator or SRO on the project. The SRO was available by telephone at all times for the research staff. Staff were instructed to attend carefully to the details of the administration of questionnaires. Protocols were set in place which gave clear instructions regarding the conduct of the project and details which ensured the completeness of the information on the questionnaire (APPENDIX D).

EDUCATION PROGRAM

The education program was devised by the SRO and a research assistant on the project, Ms Theresa Stolz. The latter was a former social worker in the Emergency Department at Royal Brisbane Hospital and had extensive input into the design of the training program. Ms Stolz had previous experience in training doctors and nurses in the topic of domestic violence and was Chairperson of a women's refuge in the Brisbane metropolitan area. The education program was set up through consultations

between the research team and the Medical Director and the Senior Nursing Staff in the Emergency Department at Royal Brisbane Hospital, at separate meetings. The education program will be fully described in Chapter 3.

CASE-CONTROL STUDIES ONE AND TWO

The administration of the case-control studies comprised selection of the medical records of victims and a random selection of non-victims from the prevalence studies, and was carried out by the SRO. The actual examination of the medical records was carried out by a senior psychiatrist, Associate Professor Joan Lawrence, who had extensive experience in treating domestic violence victims and a particular interest in the forensic and legal aspects of domestic violence. The examiner was "blind" to the status of the subjects i.e. victim or non-victim, whose medical records were chosen. This was an attempt to minimise the influence of observer bias.

2.4.2 PARTICIPATION RATES IN THE STUDY

This section describes the participation rates of subjects for each of the individual studies conducted within this larger study.

PREVALENCE STUDY ONE (1991)

In the first prevalence study in 1991 the hospital attendance records were checked manually by the SRO and showed that 1996 people attended during the selected shifts (49). Research assistants approached people for participation when they were alone, so that the confidential screening questionnaire could be completed in privacy. Patients who were too ill (n=101), unrouseable (n=21), or who were accompanied by another person who did not leave their side (n=23), were not approached for inclusion in the study.

TABLE 1.

RESPONSE RATES IN PREVALENCE STUDY, 1991, ROYAL BRISBANE HOSPITAL EMERGENCY DEPARTMENT

TARGET POPULATION	People who attend the Emergency Department of a major urban public hospital in Australia
SOURCE POPULATION	**1851** people who attended Royal Brisbane Hospital Emergency Department in April to June 1991, during 49 randomly selected nursing shifts 62 previously answered the questionnaire 40 were under age 16
ELIGIBLE SUBJECTS	**1749** 23 mentally retarded 21 confused 34 non-English speaking 57 senile **1614 - POTENTIAL STUDY POPULATION** 313 missed
STUDY PARTICIPANTS	**1301** **93%** (1211) of those approached **75%** (1211) of eligible population

Table 1 shows that among the 1749 eligible subjects there were people who were mentally retarded, confused, non-English speaking or senile. Of the potential study population of 1614 there were 313 people who were missed, including those who were in the resuscitation area of Emergency Department or those who attended at busy times. During busy times the many exits and entrances in the Emergency Department, combined with the rapid turnover of attendees, made it difficult for the Research Assistants to ensure that all people were approached.

PREVALENCE STUDY TWO (1992)

In 1992 the Royal Brisbane Hospital Emergency Department recording system was computerised, and the SRO was able to check the attendance records for the second prevalence study from computer lists.

TABLE 2.

RESPONSE RATES IN PREVALENCE STUDY, 1992, ROYAL BRISBANE HOSPITAL EMERGENCY DEPARTMENT

TARGET POPULATION	People who attend the Emergency Department of a major urban public hospital in Australia
SOURCE POPULATION	2062 people who attended Royal Brisbane Hospital Emergency Department in April to June 1991, during randomly selected nursing shifts 52 previously answered the questionnaire 49 were under age 16
ELIGIBLE SUBJECTS	1961 7 mentally retarded 44 confused, drunk or affected by an overdose of drugs 45 non-English speaking 38 senile 4 illiterate 9 very deaf 3 suicidal or aggressive 2 psychiatric illness 3 too emotional 1806 - POTENTIAL STUDY POPULATION 463 missed
STUDY PARTICIPANTS	1343 93% (1225) of those approached 62% (1225) of eligible population

DISCUSSION

From Tables 1 and 2 it can be seen that similar numbers of people were screened in the Emergency Department in the two prevalence studies - 1851 (Prevalence study - 1991) and 2062 (Prevalence study - 1992). The number of exclusions in both studies was very similar - 7.7 per cent (1991) and 7.9 per cent (1992). The main difference between the two studies was the number of eligible subjects who were missed and therefore not interviewed by the research assistants - 18 per cent (1991) and 24 per

therefore not interviewed by the research assistants – 18 per cent (1991) and 24 per cent (1992). This may be accounted for by the more accurate recording of attendees at the Emergency Department in 1992 when the hospital system became computerised; or it may be that greater numbers of people attended the resuscitation area in 1992 and were not able to be interviewed by the research assistants. The response rates for people who were approached to complete the questionnaire were the same in both studies – 93 per cent.

CASE-CONTROL STUDY ONE AND TWO

In the first prevalence study (1991) there were 170 people who self-reported domestic violence as a life-time experience. The Medical Records Department at Royal Brisbane Hospital were unable to supply the medical records of 29 (17 per cent) of the total sample. The victims of domestic violence (n=141) were separated into strata according to age, sex and point of entry to the Department, and matched as pairs with 141 non-victims who were randomly selected from the prevalence study. The difficulty in obtaining the medical records of 17 per cent of the victims was due to a change in the medical records system. Prior to 1992, when the system changed, people who attended the Emergency Department and were not admitted to hospital were given a Casualty Card and did not receive a hospital chart. In 1992 the system changed and all attendees were given a hospital chart. Because this case-control study was conducted during the change of recording system, a number of Casualty Cards were not able to be obtained.

In the 1992 case-control study, there were much better participation rates (97 per cent compared to 83 per cent in prevalence study one), following the change of the Emergency Department admission record system. There were 183 medical records examined out of 189 victims of domestic violence who self-reported in the 1992 prevalence study. These victims were matched with 183 non-victims on the same criteria as for the first study.

2.5 DATA ANALYSIS

Double entry of data was carried out and verified on the EpiInfo computer program. Data editing included range and consistency checks. Data manipulation consisted of re-coding of categorical variables and grouping of continuous variables. Checks were made for missing variables. The data were analysed using **SPSS for Windows.**

In this study results were considered statistically significant if the p-value was less than or equal to 0.05.

Chapter 3 describes the education program which was conducted with doctors and nurses at the Royal Brisbane Hospital Emergency Department. This education program was integral to assessing the outcome of this project.

EDUCATION PROGRAM FOR DOCTORS AND NURSES IN EMERGENCY DEPARTMENT 3.

The education program described in this chapter was directed towards all doctors (including senior staff specialists, visiting general practitioners and resident medical officers) and all nurses (registered and enrolled) who worked in the Emergency Department at Royal Brisbane Hospital at the time that the study was conducted, August to October, 1991. We expected that an education program on domestic violence would increase the rate of detection of victims of domestic violence by medical and nursing staff and result in more appropriate management of these victims through referrals to social work staff and reporting of criminal assaults to police.

The evaluation of the education program used a similar design to McLeer et al (1989) with pre- and post-intervention surveys and case-control studies to provide process, impact and outcome evaluations. A knowledge, attitudes and practices survey of the staff was conducted before and after the education program. Another group of doctors and nurses from Princess Alexandra Hospital, Brisbane, with similar characteristics to the Royal Brisbane Hospital group, were surveyed using the same knowledge, attitudes and practices questionnaire in November, 1991.

3. OBJECTIVES OF THE EDUCATION PROGRAM

The objectives of the education program were:

* To increase the knowledge of doctors and nurses about the topic of domestic knowledge.
* To increase the knowledge of doctors and nurses about the community resources available for victims of domestic violence.
* To change the attitudes of doctors and nurses towards victims of domestic violence who come to the Emergency Department.
* To increase awareness of the legal options available for victims of domestic violence.
* To increase awareness of the obligation that doctors have to report suspected criminal assault (including domestic violence) under the Medical Act.

3.1 GOALS OF THE EDUCATION PROGRAM

The goals of the education program were:

* To enhance the recognition and detection of victims of domestic violence who come to the Emergency Department.
* To develop appropriate and acceptable referral and specialist processes for victims of domestic violence.

3.2 PREPARATION OF THE EDUCATION PROGRAM

As part of planning the education program, the SRO held extensive consultations with the Medical Director and senior Nursing staff to determine how best to maximise the participation of staff. Planning issues discussed included which educational programs would work best, how to build on the present education structures, who should present the program and who had the most credibility with the staff. Use was made of the schedule of times allotted for the existing compulsory one-hour sessions of in-service education of all staff which took place during working hours. In-service training was chosen as a means of education because of its compulsory nature. It was considered that less staff would be reached through a voluntary arrangement. Even so there were some difficulties in getting staff to attend these workshops.

The SRO convened planning meetings with all those who would be presenting the education program. This included senior medical, psychiatric, nursing and social work staff and a police officer, in addition to the research team. The education program received strong support from the Medical Director and Clinical Nurse Consultant.

3.3 CONTENT OF THE EDUCATION PROGRAM

The education program was conducted as part of the regular in-service training of medical and nursing staff in the Emergency Department. It was designed specifically to fit the ethos of the Emergency Department and consisted of the following components:

* Workshops of one hour's duration were given separately to doctors and nurses by research staff, social workers and police.
* Case presentations of one hour's duration, taken from the prevalence study, were given by a senior psychiatrist, to doctors and nurses.
* A protocol (A4 poster) which had been developed by Queensland Health was evaluated in this study. It was placed on notice boards in the Emergency Department.
* The research team developed a pocket card (8 by 12 cm) which was an *aide memoire* to the information presented in the workshops and case presentations.
* A literature kit containing relevant information was sent to all participants in the program.

Because of the brevity of the education program emphases were made on teaching staff about identification and appropriate referral of victims, and on legal aspects of domestic violence especially the obligation that doctors have under the Medical Act to report suspected criminal assault (including domestic violence).

Each of the components of the education program and its implementation is now discussed.

3.3.1 WORKSHOPS

A total of 6 workshops, 3 for doctors and 3 for nurses, were given separately to each group as part of their in-service training. Each group participated in a workshop of one hour's duration, consisting of a lecture and slide presentation. The presenters included the SRO from this project, a research assistant, Ms Theresa Stolz (social worker) who had previous work experience in the Royal Brisbane Hospital Emergency Department, and a police officer. The social worker from the Emergency Department was present at all workshops. It was planned to cover the following topics:

* the research findings of a recent prevalence study of domestic violence victims in the Emergency Department at Royal Brisbane Hospital, as a rationale for the education program;
* community statistics on domestic violence – incidence of domestic violence, rates of domestic homicides, incidence amongst pregnant women, an Australian national survey of community attitudes towards domestic violence and costs of community services for victims of domestic violence;
* historical background to domestic violence as a public issue and an issue for health professionals;
* definitions of domestic violence as issues of power and control;
* the many different forms of domestic violence, using diagrams illustrating the typical escalating nature of domestic violence and its potential lethality;
* identification and management of domestic violence victims. The following components were emphasised – the necessity to ask suspected victims when they were alone; acceptance of their story; where to refer victims for help with community services e.g. Crisis Care; referral to the hospital social worker; documentation of the history of domestic violence; ensuring safety of the victim on returning home.
* information from the police officer on the Queensland Domestic Violence (Family Protection) Act – who can apply for a Protection Order and explanations from legal booklets for victims published by Department of Family Services and Aboriginal and Islander Affairs. The topic of legal obligations for doctors to report suspected criminal assault under the Medical Act was also discussed.

In spite of the compulsory nature of the program there were some difficulties in getting staff to come to the workshops because of the problems of shift work and shortage of relief staff. Some staff did not remain for the full duration of the workshop because of calls made on them, particularly doctors, to return to the Emergency Department. There were also problems with punctuality.

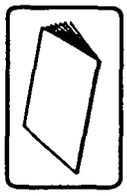
3.3.2 CASE PRESENTATIONS

Four case presentations, 2 for doctors and 2 for nurses, were given separately by Associate Professor Joan Lawrence. These took the form of case histories of actual victims who self-disclosed in the recent prevalence study in Emergency Department. The format was a presentation of the medical history by Associate Professor Lawrence followed by discussion with the staff about the identification and management of the patient.

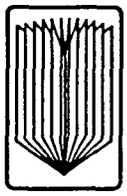
Similar problems were experienced as have been mentioned in conducting the workshops such as shortage of relief staff, late arrival of staff and staff being called away to Emergency Department during the case presentation.

3.3.3 LITERATURE KIT

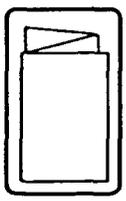
A literature kit consisting of the following items was sent to each participant in the program (Visiting General Practitioners were given the literature kit but not included in the workshop and case presentation program because of their sessional work).



BOOKLET "Domestic Violence: A guide for management of domestic violence in Queensland health facilities". This booklet was produced by Queensland Health and was a supporting paper for the protocol.



LEGAL BOOKLET "The Domestic Violence Family Protection Act, 1989". This booklet, produced by Department of Family Services and Aboriginal and Islander Affairs, was intended for the use of victims. It was considered to contain enough information for staff concerning the Act.



BROCHURE "Who are the victims?"

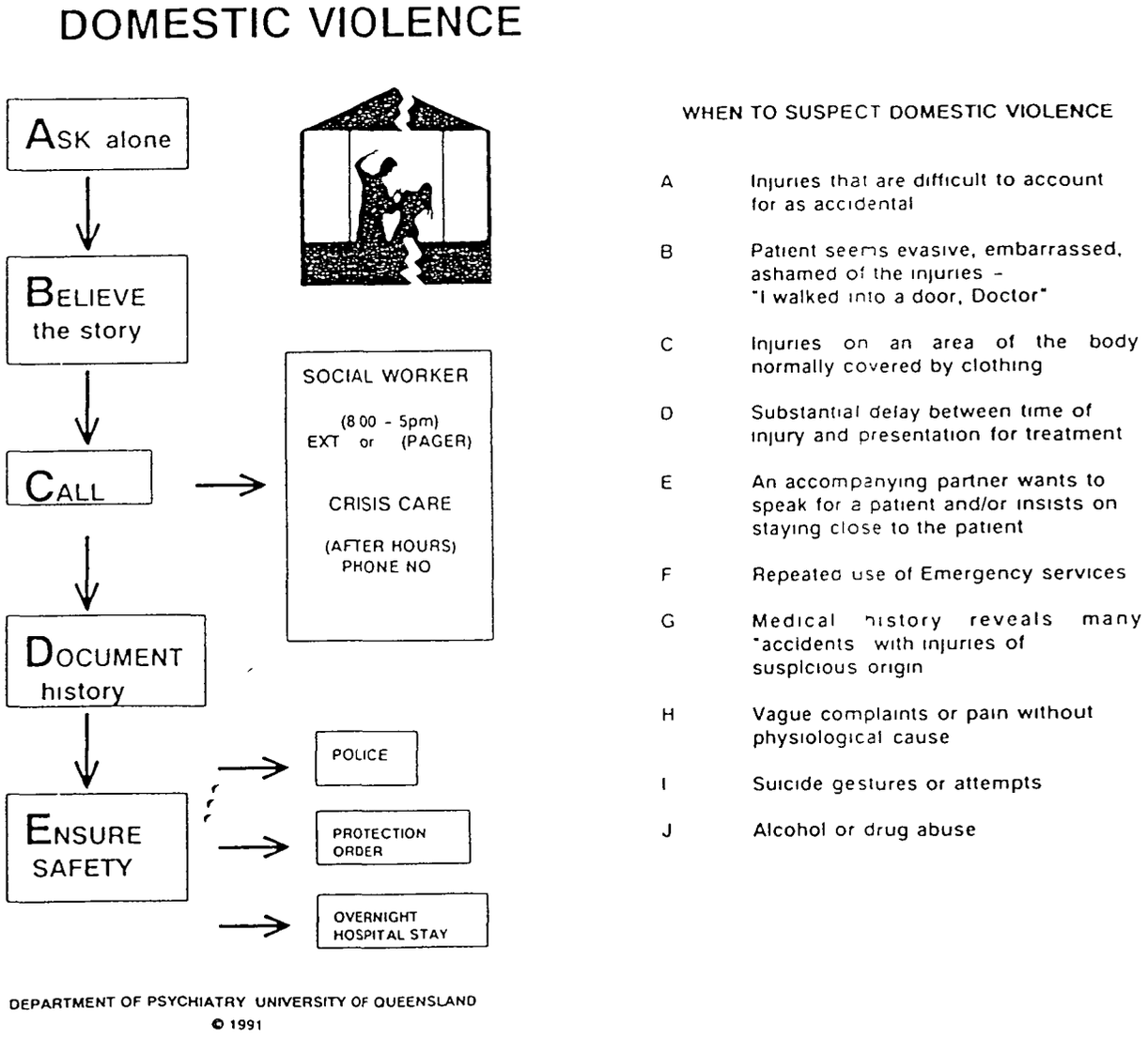
This brochure, produced by the Department of Family Services and Aboriginal and Islander Affairs was given to staff. It contained a list of community services to deal with the problems of domestic violence and it was intended that staff make the booklet available to patients.

3.3.4 POCKET CARD

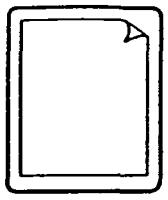
Included in the literature kit was a pocket card (Figure 2) which was developed by the research team with a similar format used for medical policies and procedures in Emergency Department (i.e in flow-chart form). This card contained minimal information on management of domestic violence problems and was intended as an adjunct and *aide memoire* to the information given in the workshops and case presentations. Staff were encouraged to keep the card with them because the card included important information about contact for emergency accommodation for victims. During the first prevalence study research assistants had noted that staff did not have the knowledge of who to contact after-hours for emergency help e.g. when victims presented in the middle of the night and no social work staff was available.

FIGURE 2

TWO SIDES OF THE POCKET CARD



3.3.5 POSTER



As part of the evaluation of the education program, a recognition and management protocol was trialled for Queensland Health with a view to introducing it into all Queensland public hospitals. The protocol took the form of a poster (A3 size) which was developed by Queensland Health. It was placed in prominent positions in the Emergency Department, from the commencement of the education program. Regular checks were made to ascertain that the protocols remained on the notice boards. Individual participants in the program were notified by letter of the protocol and were informed that their opinions would be sought regarding the usefulness of the protocol.

3.3.6 ON-GOING EDUCATION OF STAFF

Following the formal education program conducted by the research team, educational materials (slide set and literature kits) were supplied for the on-going education of staff in Emergency Department by their own trainers in the ensuing months. Material on education about domestic violence problems was inserted in the manual for new Resident Medical Officers at the commencement of their year's employment and in the Emergency Department manual for Medical Officers.

3.4 PROCESS EVALUATION OF PROGRAM

The education program ran from August to October 1991 and was directed towards 88 doctors (5 staff specialists, 10 registrars, 58 resident medical officers, including 2 groups on rotational terms, 15 visiting general practitioners) and 91 nurses (74 registered nurses and 17 enrolled nurses). The staff were from all sections of the Emergency Department, including the overnight stay and the emergency psychiatry section. There was little movement of staff during this time except for the 58 resident medical officers who comprised 2 groups on rotational terms.

The aim of the process evaluation reported here was to ascertain the parameters recommended for use in evaluating health promotion projects (Hawe et al, 1991):

reach	–	how many participants in the target group received which parts of the program;
implementation	–	were the full activities of the program being implemented;
participant satisfaction	–	which aspects of the program were satisfactory and which not;
quality control	–	were all of the materials used of the highest possible quality.

While some of these are qualitative and somewhat impressionistic, others can be quantified.

3.4.1 PROGRAM REACH

We were able to determine how many doctors and nurses participated in the education program in two ways. Firstly, the research team recorded the numbers of staff who attended workshops and case presentations, and secondly, through a questionnaire which was sent to all Emergency Department staff (except General Practitioners) two weeks after the last formal workshop and case presentation. This page was added to the second knowledge, attitudes and practices questionnaire given to doctors and nurses (APPENDIX E). Returns were received from **44 doctors (63%)** and **67 nurses (77%)**. Results of the second method are recorded in Table 3 which shows the attendances at workshops and case presentations and also shows the exposure to the literature kit and poster. The latter method was considered to be a more accurate record of the program reach because information from the

questionnaire was the only way of determining whether staff had received the literature sent to them.

TABLE 3

PROGRAM REACH TO DOCTORS, NURSES AND THE TOTAL EMERGENCY DEPARTMENT STAFF OF EACH OF THE PROGRAM COMPONENTS

	DOCTORS (n = 44) %	NURSES (n = 67) %	TOTAL (n = 111) %
Attended workshops	39	55	47
Attended case presentation	23	39	33
Received literature	77	80	80
Received pocket card	80	93	88
Noticed poster	61	84	75

Workshops and case presentations were poorly attended by doctors and nurses in spite of strong support from senior nursing and medical staff and the fact that the domestic violence training was considered part of in-service training and hence compulsory. Very few staff from the emergency psychiatry department were able to attend training sessions. (It was acknowledged by staff from that section that many victims of domestic violence used the psychiatric service.) Literature was sent to all participants in the education program but more nurses than doctors appear to have received and viewed the literature. This was the same for the poster: fewer doctors than nurses recalled sighting it.

3.4.2 PROGRAM IMPLEMENTATION

Information about implementation and helpfulness of the education program was obtained from the questionnaire. Implementation questions were framed as statements, calling for strength of agreement (or disagreement) on a 5-point scale. Table 4 shows the responses from the questionnaire regarding questions of implementation and helpfulness of the program's components.

TABLE 4

DOCTORS (n=44) AND NURSES (n=67) WHO ATTENDED WORKSHOPS AND CASE PRESENTATIONS ON DOMESTIC VIOLENCE AND WHO AGREED WITH EACH EVALUATIVE STATEMENT.

	DOCTORS %	NURSES %	TOTAL %
a) WORKSHOP			
The workshop increased my knowledge about domestic violence.	88	82	84
Information was presented in a coherent and organised manner.	63	77	72
The length of the program was adequate	56	69	64
The workshop gave me sufficient information to know what to do for victims of domestic violence in Emergency Department	56	70	65

	DOCTORS %	NURSES %	TOTAL %
b) CASE PRESENTATION			
The case presentation increased my knowledge about domestic violence	80	79	79
Information was presented in a coherent and organised manner	80	79	79
The length of the program was adequate	60	71	68
The case presentation gave me sufficient information to know what to do for victims of domestic violence in Emergency Department	70	54	59

Generally, respondents reported that workshops and case presentations increased their knowledge about domestic violence problems. However, the results in Table 4 indicate that both the workshops and case presentations did not give the participants enough knowledge of what to do for victims of domestic violence in Emergency Department. This is also reflected in the results which show that only **66 percent** of participants thought that the length of workshops and case presentations were

adequate. The inadequate length of the program was commented on by several participants. One nurse suggested that interviewing a victim of domestic violence would be useful in a case presentation and would provoke more realistic questions and answers. There were no statistically significant differences between doctors' and nurses' assessments of the program, which is not unexpected given that they received virtually the same presentations.

3.4.3 PARTICIPANT SATISFACTION

Participant satisfaction was assessed by questions which asked each participant in the questionnaire how helpful each component was perceived (4-point scale from "Not at all" to "Very"). Table 5 illustrates the perceived helpfulness by doctors and nurses for each component of the education program.

TABLE 5

DOCTORS (n=44) AND NURSES (n=67) IN EMERGENCY DEPARTMENT WHO RATED EACH COMPONENT OF THE EDUCATION PROGRAM AS HELPFUL.

	DOCTORS %	NURSES %	TOTAL %
WORKSHOPS	81	97	92
CASE PRESENTATIONS	80	80	80
POSTER – "Detection and Management of victims of domestic violence" (on Notice Boards)	89	91	90
POCKET CARD – "When to suspect domestic violence"	75	94	88
BOOKLET – "The Domestic Violence (Family Protection) Act 1989"	83	95	91
BOOKLET – "Who are the Victims?"	78	93	88

While the program was generally well received by the doctors and nurses who attended, more nurses than doctors rated the literature as helpful.

3.4.4 QUALITY CONTROL

The quality of the materials used in the workshops and case presentations generally was good, as acknowledged by the recipients, who commented particularly on the relevance of case material from the prevalence study in the Emergency Department. While the information contained in the poster was accurate, there were problems in its presentation. The layout was judged to be overly wordy and lacked eye-catching graphics which may have resulted in low visual impact. The poster needed to be simplified while retaining the essence of the information. It was not considered necessary to have social work management information included, but given as separate information. The poster did not contain information on contact phone numbers for 24 hour referral (which would need to be regionalised). Finally, the management steps in the poster did not coincide with the management steps as listed on the pocket card. For educational purposes, the one needs to reinforce the other. In contrast, the visual impact of the pocket card was good and its information, presented schematically, was easier to assimilate. The phone number for after-hours referral was problematic because it was locked in the duty nurses's drawer and not readily accessible.

The knowledge content of the workshops e.g. community statistics and research findings, were reduced drastically due to time constraints. Therefore emphasis had to be made on the skills of detection and management.

3.5 IMPACT EVALUATION OF THE EDUCATION PROGRAM

The impact evaluation was concerned with the immediate effects of the program and was designed to measure whether the program objectives, as outlined on page 40 were achieved.

The impact evaluation was measured by a self-administered questionnaire which assessed changes in the knowledge, attitudes and practices of doctors and nurses before and after the education program. (APPENDIX F). The same questionnaire tested their knowledge about victims and perpetrators of domestic violence, their attitudes regarding management by health professionals and their own level of clinical and social contact with victims and perpetrators. The baseline questionnaire was administered in August, 1991 and the post-education questionnaire in November, 1991.

Response rates to the questionnaire were: **doctors – 43% baseline, 63% post-education; nurses – 75% baseline, 77% post-education**. These differential response rates may reflect the itinerant nature of resident medical officers who have 6 weeks' rotational terms in the Emergency Department compared to the more stable complement of nursing staff. They may also reflect a greater interest by nurses than doctors in the topic of domestic violence. In Tables 6 and 7 the response rates are given according to the status of medical and nursing staff.

TABLE 6

RESPONSE RATE OF DOCTORS TO BASELINE (August 1991) AND POST-INTERVENTION (November 1991) SURVEYS, EMERGENCY DEPARTMENT, R.B.H.

	SENIOR STAFF SPECIALISTS(n=4) %	REGISTRARS (n=10) %	RESIDENT MEDICAL OFFICERS (n=58) %
BASELINE QUESTIONNAIRE No. of respondents	25.0	60.0	41.0
POST-INTERVENTION QUESTIONNAIRE No. of respondents	75.0	70.0	59.0

TABLE 7

RESPONSE RATE OF NURSES TO BASELINE (August 1991) AND POST-INTERVENTION (November 1991) SURVEYS, EMERGENCY DEPARTMENT, R.B.H.

	REGISTERED NURSES(n=74) %	ENROLLED NURSES (n=17) %
BASELINE QUESTIONNAIRE No. of respondents	74.0	76.0
POST-TEST QUESTIONNAIRE No. of respondents	76.0	88.0

3.5.1 RESULTS OF THE KNOWLEDGE SURVEYS OF DOCTORS AND NURSES

In the pre- and post-intervention questionnaires which were self-administered, doctors and nurses were asked to register their knowledge by circling either "true", "false" or "don't know" about these components of the topic of domestic violence (the detail of the components may be found on the questionnaire in APPENDIX F):- facts about the topic of domestic violence (9 questions in SECTION 1); questions relating to victims (11 questions in SECTION 2); questions relating to perpetrators (8 questions in SECTION 3); one question about contact for emergency accommodation (SECTION 6B - the correct answer was "Crisis Care"); knowledge of legal aspects of domestic violence (5 questions in SECTION 6C).

The results were analysed using t-tests for independent samples of continuous variables and chi-square (with continuity correction) for dichotomous variables. Table 8 illustrates where there were significant changes in the correct answers for particular areas of knowledge about domestic violence for the whole sample of doctors and nurses.

TABLE 8

CHANGES IN COMBINED KNOWLEDGE OF DOCTORS AND NURSES BEFORE (n=99) AND AFTER (n=112) EDUCATIONAL INTERVENTION, 1991

TOPIC AREA	BASELINE	POST-EDUCATION	CHANGES - PRE AND POST EDUCATION
CRISIS CARE (1)# % Correct Answer	16.2	34.8	X^2=8.55 p=0.003 1df
Knowledge about victims (11) Mean No. Correct Answers	7.6 (S.D.1.7)	8.6(S.D.1.5)	t = -4.47 200.79df p<0.0001
Knowledge about perpetrators (8) Mean No. Correct Answers	4.6 (S.D.1.0)	5.1 (S.D.1.3)	t = -3.61 207.84df p<0.0001
Total answers (34) Mean no. Correct Answers	22.0 (S.D.3.2)	24.2 (S.D.3.3)	t = -5.04 207.44df p<0.0001

The number after each topic indicates the number of questions asked in the topic area. Areas excluded from the table which did not have significant changes are: facts about domestic violence (9) and legal aspects (5).

There were significant changes for doctors in their total knowledge (t–value=–2.49, 68.12df, p=0.02). Even though doctors increased in all areas of knowledge, in no particular areas were the changes statistically significant.

However, for nurses there were significant changes in a number of areas of their knowledge and this is illustrated in Table 9.

TABLE 9

CHANGES IN NURSES' KNOWLEDGE BEFORE (n=68) AND AFTER (n=68) EDUCATIONAL INTERVENTION, 1991 SURVEY

TOPIC AREA	BASELINE	POST–EDUCATION	CHANGES – PRE AND POST EDUCATION
CRISIS CARE (1)# % Correct Answer	20.6	44.1	X^2=7.55, p=0.005, 1df
Knowledge about victims (11) Mean No. Correct Answers	7.5 (S.D.1.7)	8.7(S.D.1.5)	t = –4.39 130.17df p<0.0001
Knowledge about perpetrators (8) Mean No. Correct Answers	4.5 (S.D.1.1)	5.1 (S.D.1.1)	t = –3.14 132.40df p=0.002
Total answers (34) Mean No. Correct Answers	21.7 (S.D.3.3)	24.2 (S.D.3.4)	t = –4.31 133.89df p<0.0001

The number after each topic indicates the number of questions asked in the topic area. Areas excluded from the table which did not have significant changes are: facts about domestic violence (9) and legal aspects (5).

3.5.2 RESULTS OF THE ATTITUDE SURVEYS OF DOCTORS AND NURSES

In the pre– and post–intervention questionnaires doctors and nurses were asked to express their opinions about domestic violence which were framed as statements,

calling for strength of agreement (or disagreement) on a 5-point scale (APPENDIX F, Section 4).

When attitude changes were measured for the total sample of doctors and nurses there was a significant improvement in the attitudes of the whole group ($t = -2.10$, $p=0.037$). The mean number of positive attitudinal statements for the whole group was **8.2** at baseline survey and **8.6** at follow-up (out of **10** positive attitudinal statements). These results show that generally nurses and doctors had positive attitudes towards the topic of domestic violence.

Between the surveys doctors' attitudes improved in most areas, although no changes were statistically significant.

Nurses had a significant improvement in their attitudes overall ($t = -1.90$, $p=0.05$) between surveys. One area in which there was a significant improvement for nurses was their belief that doctors and nurses can be involved in stopping violence ($X^2 = 6.52$, $p=0.03$).

When attitudes were analysed by gender, there were no significant differences in the overall attitudes of women and men. However, there were several specific areas in which women's and men's attitudes differed. In the baseline study more women than men believed that medical students and student nurses needed more training in the topic of domestic violence (not statistically significant).

In the post-education survey more men than women believed that domestic violence problems needed to be taken more seriously by police ($X^2 = 6.96$, $p=0.03$), although in the baseline survey there were no differences.

3.5.3 HOW WELL DOCTORS AND NURSES RECOGNISED DOMESTIC VIOLENCE

On the survey questionnaire doctors and nurses were given a list of signs and symptoms which might give an indication that a person was a victim of domestic violence (APPENDIX F, Section 6A). They were asked to rank each sign or symptom from "very sure" to "not at all" that they would suspect the person had experienced domestic violence.

The symptoms and signs which the researchers considered indicated high levels of suspicion were: injuries to face, neck or throat; frequent visits to Emergency Department; presence of a dominating partner; pain with no apparent physical cause; overdose of tranquillisers and substantial delay between time of injury and presentation at Emergency Department. Respondents were considered to have a high index of suspicion of domestic violence if they had a cluster of 4 answers correct out of the 6 mentioned above. In the baseline sample **12.0 per cent** of the total sample of doctors and nurses had a high index of suspicion for domestic violence. This had risen to **20.0 per cent** of the sample in the post-education survey, but the difference was not statistically significant.

3.5.4 DOCTORS' AND NURSES' CLINICAL AND SOCIAL CONTACT WITH VICTIMS AND PERPETRATORS OF DOMESTIC VIOLENCE

Doctors and nurses were asked about their extent of social and clinical contact in the last year with victims and perpetrators of domestic violence, also children who witnessed domestic violence. Table 10 shows the extent of their social contact.

TABLE 10

PROPORTION OF DOCTORS AND NURSES WHO HAD SOCIAL CONTACT WITH DOMESTIC VIOLENCE, BASELINE SURVEY, 1991

CONTACT GROUP	DOCTORS (n=31)	NURSES (n=68)	SIGNIFICANCE
Adult victims	22.6	44.1	$X^2 = 3.34$, p=0.06
Perpetrators of domestic violence	6.5	22.1	Not significant
Children who witness violence between parents	9.7	11.1	N.S.

Table 11 shows the extent of clinical contact which doctors and nurses had during the last year with the various groups of people who experience domestic violence.

TABLE 11

PROPORTION OF DOCTORS AND NURSES WHO HAD CLINICAL CONTACT WITH DOMESTIC VIOLENCE, BASELINE SURVEY, 1991

CONTACT GROUP	DOCTORS (n=31)	NURSES (n=68)	SIGNIFICANCE
Adult victims	51.6	69.1	N.S.
Perpetrators of domestic violence	38.7	26.9	N.S.
Children who witness violence between parents	9.7	7.4	N.S.

When doctors' and nurses' levels of social and clinical contact were tested in the post-education survey there were no significant differences between their levels of

contact with victims and perpetrators of domestic violence or children who witness domestic violence between parents. However, nurses still had higher levels of contact with most groups, particularly social contact with victims and perpetrators of domestic violence.

3.6 DOCTORS AND NURSES - PRINCESS ALEXANDRA HOSPITAL

A survey using the same knowledge, attitude and practices questionnaire to test doctors and nurses at Royal Brisbane Hospital was carried out with a group of doctors (n=22) and nurses (n=40) at the Emergency Department of Princess Alexandra Hospital in November,1991. The response rates were very good - doctors **91 per cent;** nurses **83 per cent.**

When the doctors' and nurses' knowledge about domestic violence was compared there were no significant differences in the results. In fact, their knowledge was similar, except that more nurses (**33 per cent**) knew where to send victims for emergency services i.e. Crisis Care than doctors (**10 per cent**).

Doctors and nurses scored highly on attitude tests about domestic violence and the two groups showed similar results. Out of **10** positive attitudinal statements doctors scored a mean of **8.5** and nurses scored a mean of **7.9.**

3.7 OUTCOME EVALUATION OF THE EDUCATION PROGRAM

The outcome evaluation was concerned with the subsequent effects of the program in the longer-term, and this was designed to measure the achievement of the program goals as outlined on page 41. The outcome was measured by the changes in detection rates of victims of domestic violence as recorded by doctors on the medical records, in the 1991 and 1992 case-control studies.

In the first case-control study the detection rates of victims of domestic violence were **6.4 per cent**. In the second case-control study the detection rates were **4.4 per cent**. Thus the rate of detection of victims of domestic violence on the medical record had decreased by **2 per cent** from the medical records examined in 1991 to those examined in 1992.

3.8 DISCUSSION

Previous research has shown that merely offering education programs alone is not sufficient to increase detection of victims of domestic violence in Emergency Department. A study by McLeer et al (1989) showed that the introduction of a protocol for detecting victims of domestic violence increased the identification of battered women from **5.6 per cent** to **30 per cent** in one year. An 8-year follow-up study of the same Emergency Department demonstrated that only **7.7 per cent** of battered women were identified. This study suggests that without institutional policies and procedures for detecting and treating victims of domestic violence, many victims will pass through Emergency Departments unidentified.

To augment education programs, systems also need to be instituted in Emergency Department for identification of victims of domestic violence, such as routine assessment of those patients who are suspected to be victims of domestic violence (Tilden and Shepherd,1987). This may be a specialist area for nursing staff with the training of clinical nurses for these positions (Brendtro and Bowker,1989; Varvaro and Cotman,1991.

A further factor raised by the participants in this study was the matching of back-up resources in conjunction with increasing the skills of staff in detection and management of victims of domestic violence. The need for adequate referral systems including after-hours social work staff and knowledge of community resources

became very obvious to researchers during the course of study as the responses of staff to victims of domestic violence were observed.

Research staff observed that most doctors and nurses were aware of domestic violence problems but felt inadequate to deal with them and felt helpless and overwhelmed especially when there were no social workers available for referral. This was further complicated by the fact that often they were extremely busy with urgent cases which took priority. The small amount of time which doctors and nurses could give to each person in a busy Emergency Department – an average of 15 minutes[1] – was a source of frustration in dealing with victims of domestic violence.

In the study, a small number of staff were noted to avoid looking for the problem, and if confronted, ignored it. Indeed, in one instance medical staff were observed to be putting pressure on a nurse to leave a female patient she was attempting to assist who had come in late at night with injuries highly compatible with domestic violence, who was accompanied by two small children, and who seemed fearful of returning home. This is difficult to legislate against, as it may involve conflict in perceptions of role and responsibilities and attitudinal obstacles. One doctor who felt that the pocket card had insufficient information to be worthwhile carrying was noted not to know where to refer victims in the middle of the night, although this very information was present on the pocket card and displayed on the poster.

Overall, we conclude that the program was moderately successful, and has shown the way to improvements that can be initiated for overcoming the difficulties encountered. The description of this education program for doctors and nurses in Emergency Department shows that the program was not conducted under ideal conditions. Firstly, two hours of training on domestic violence problems is insufficient to cover adequately all aspects of the topic, causing significant trimming of important material, selecting those directly relating to Emergency Department. The time constraints particularly dictated that focus on any attitudinal material be relinquished. The presentations were only partially successful, as shown by the results that 35 percent of those who attended the workshops thought that they were not given sufficient information to help

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[1] Personal communication (1991), Medical Director, Royal Brisbane Hospital Emergency Department.

victims of domestic violence in Emergency Department. A similar result was obtained for those who attended case presentations (41 percent). We believed that the time equivalent of at least a full day's seminar would be more desirable for training staff.

It is clear from the evaluation that there are difficulties in reaching a target population of doctors and nurses who work in an Emergency Department even when the program is included as part of regular in-service training and receives the full support of senior nursing and medical staff. The reasons for the low attendance at workshops and case presentations became apparent as the program progressed and from comments on the questionnaires. These comments pointed to the itinerant nature of resident medical officers in Emergency Department, the problems of shift work and the shortage of staff to relieve other staff members. In addition, a small number of staff resented the fact that the training program sometimes extended into their own time.

There were problems with the distribution of literature to staff, not all of whom recall receiving it. This suggests either problems with the internal mailing system or the failure of those who received literature to either open it, read it, or recall it. In addition, it was noted that a significant proportion of staff did not see the poster showing the protocol for management of domestic violence victims on the notice boards in the Department. This indicates the limited effects of a poster that has minimal visual impact on staff. By contrast the pocket card, which was devised for this program, was noted by more staff than noticed the poster.

While this particular education program appears to have been successful in increasing knowledge and improving attitudes of doctors and nurses, the outcome of the education, as indicated by change in detection rates has had limited success. However, there are a number of positive features of the outcome of this program.

As a result of this research an after-hours on-call social work service has been instituted in the Emergency Department as a referral service for victims of domestic violence. This service which commenced in November, 1992 has received a consistent number of referrals from doctors and nurses in Emergency Department (one of the senior medical staff commented on the tremendous increase of awareness of domestic violence by staff in Emergency Department as a result of the research). In

the period January to December 1993 there were 119 referrals of victims of domestic violence victims between 5pm and 8am, and 1 to 3 victims were seen per week in normal working hours (8am to 5pm). The consistent number of referrals by doctors and nurses to this service indicates that one of the goals of the research has been achieved i.e. appropriate referral and specialist processes for victims of domestic violence have been set up in Emergency Department and are being used.

Recommendations made by the research team as a result of the study were taken up by the Queensland Health Department. Queensland Health has redesigned the poster, including some of the elements of the pocket card. This augments and reinforces the message on the card. Members of the research team were involved in the first program in June 1992 for training health professionals in Queensland public hospitals and materials from the research project (slides and pocket card) were used in that training. Following that program requests have come from various health and community agencies for permission to use the pocket card and for the use of materials produced by the research project for training health professionals in Queensland public hospitals. Materials from the research project have been used for joint publications by Queensland Health and Department of Psychiatry, University of Queensland.

The results of this education program point to the necessity for introducing training programs for health professionals on domestic violence problems and also show the need for materials to be developed specifically for health professionals. At the same time, attention needs to be given to instituting policies, procedures and referral services which ensure ongoing attention to domestic violence problems in Emergency Department.

In Chapter 4 the results of the exploratory study conducted in the Emergency Department at Royal Brisbane Hospital in 1990 are described.

4. STAGE 1

There were four parts in Stage 1. The first part was a pilot study conducted to determine the feasibility of a full-scale prevalence study in Emergency Department at Royal Brisbane Hospital. The second part was an exploratory prevalence study of women and men with a history of domestic violence in which a screening questionnaire was administered to attendees at the Emergency Department. Those who identified as victims of domestic violence were asked if they were willing to participate in the next part of the study while they were in the Department. This third part consisted of an in-depth interview of one hour's duration. A fourth part was a case-control study in which methods were developed for the main studies. Victims were matched with non-victims in the study and their medical records were compared with their self-report questionnaire to determine detection rates of victims of domestic violence by doctors.

4.1 PILOT STUDY (1990)

During the pilot prevalence study (n=238) semi-structured interviews were conducted by the SRO with 9 females and 3 males who identified as victims of domestic violence on the screening questionnaire. All female victims were in marriage or de facto relationships and had suffered physical and emotional abuse. One man reported that he was a victim of spouse abuse (emotional and physical); another man was abused by his mother whom he described as an alcoholic; a third man reported that he had been physically abused by girl-friends.

The male victims in this sample appeared to be able to leave the situation more easily than the female victims. Two women had fled from interstate, and had changed names for themselves and their children. Three of the female victims had experienced abuse while living in country areas and described the particular problems for victims in

rural areas – the difficulties in getting help and in leaving the abusive situation in isolated places.

4.2 EXPLORATORY PREVALENCE STUDY (1990)

Although this exploratory study was not a random sample of those who came to the Department there were indications that there could be high rates of victims of domestic violence in Emergency Department. Fourteen per cent of attendees who were surveyed in this study (n=985) disclosed a history of adult domestic violence. When child abuse was included there were 17.5 per cent who had been abused in their lifetime.

In this section, some of the qualitative data which were gathered from respondents in the study are described.

HOW PEOPLE RESPONDED TO THE QUESTIONNAIRE

Generally, people in Emergency Department were willing to answer a screening questionnaire about domestic violence (there was a 95 per cent response rate), and this was borne out by some of the remarks which were made on the questionnaires.

> *"Something that requires assessment. Prevalent in any socio-economic class".* (An 18 year old female non-victim)

> *"Pity on society".* (A 61 year old male non-victim)

> *"I appreciate your concern for people who are victims of domestic violence. Keep up the good work".* (A 21 year old male non-victim)

> *"I am most thankful that this work is being done".* (A 69 year old female non-victim)

> *"Good to see someone trying to do something about abuse".* (A 27 year old female non-victim)

"It's about time someone's doing something to stop it!". (A 17 year old male non–victim)

"Violence is the symptom. One has to look much deeper to find the base triggers". (A 50 year old male non–victim)

"My girlfriend would not hit me and I wouldn't hit her. We communicate with each other". (A 24 year old male non–victim)

"A lot needs to be done to help victims of domestic violence and more needs to be done to give harsher punishment to the offender". (An 18 year old female non–victim)

"If a woman is from ethnic background she should have help from an interpreter – somebody from her community, somebody who knows law, regulations etc". (A 45 year old woman born in a central European country)

COMMENTS MADE BY VICTIMS IN THE EXPLORATORY STUDY

In the exploratory study the distinguishing characteristic for the female victims was the terror they experienced during and after the abuse stopped.

"Emotional abuse is far worse than physical abuse, because you can retaliate with physical abuse. If they don't get you one way, they'll get at you through children. Self–esteem is damaged through the abuse. Even after 50 years one is still affected. The only thing that helped my self–esteem was my nurse's uniform". (A 79 year old woman who had been abused 50 years ago)

"My mother is a victim of domestic violence, and the situation is continuing. My mother is not allowed by my father to see me, and so we have to meet secretively". (A 42 year old woman who had been abused as a child and adult by her father)

Other comments were made by victims in the study.

"Usually doctors are the best to talk with because they know the family history so they can work out what the problem is caused by e.g. alcohol or drugs, money, too many children in family or stress, mental problems, etc..." (A 17 year old woman who had been physically and emotionally abused by her mother).

"My problem was different as there was no one to tell because I was gay and male". (A male who had been physically abused by a gay male partner)

EXCLUSIONS FROM THE STUDY

There were 9 people in this exploratory study who had to be excluded from the study because their questionnaires were incomplete. There were indications from all of them that they had been victims of domestic violence. Several were identified as victims of domestic violence and referred to the research assistants by resident medical officers, but refused to complete the questionnaires. This indicates that any estimates in a prevalence study of domestic violence victims will be underestimates of the true prevalence.

REFUSAL TO BE INTERVIEWED

Of the 134 people who identified as adult victims of domestic violence, 67 (50%) were willing to be interviewed. There were various reasons for this low response. Reasons given were that the violence had happened a long time ago or that people did not want to be reminded about the violence. Situational factors which arose were: time constraints, intervening treatment e.g. a general anaesthetic was given or the patient was transferred to another part of the hospital. The following comments were made by people in this study who identified as victims of domestic violence but did not wish to complete the second part of the study which consisted of an in-depth interview.

"After 9 years I left and want to forget about it". (A middle-aged woman who had experienced having petrol poured over herself and attempts to set her alight)

"I would rather put it in the past". (A 52 year old female victim of more than one year ago)

"I am too ill and it happened so recently I don't want to talk about it. I have had good support from doctors (private) and police, also my colleagues in the teaching profession". (A 22 year old woman from a de facto relationship)

"It was too long ago. Husbands of previous generations married a woman to be an unpaid servant whom some even begrudged the cost of the food they ate and thought the wife should not ever even want any money only house necessities. I have been hit a few times, sexually and emotionally abused. I was treated as if I have no brains and am very inferior even though better educated and have more friends". (A 76 year old woman)

"My husband is dead now. I just want to forget about it". (A 53 year old woman who was physically abused and not allowed to see her parents, friends, sisters and brothers)

"I do not want to complete the questionnaire. It doesn't interest me". (A 24 year old man who said that his ex-wife had tried to stab him and he jumped over the balcony, sustaining a fractured hand)

SEEKING HELP FOR DOMESTIC VIOLENCE

Respondents in this study were asked what community services they would recommend for a friend who was experiencing domestic violence. The following are some of the comments which were made in response to this question.

"I think that the public should be more informed of places in which they could seek advice in such circumstances". (A 20 year old female non-victim)

"Nobody should stay a victim – help is knowingly available. More publicity on where to get help is needed". (A 47 year old female non–victim)

"More attention needs to be paid to places where people can get some help". (A 22 year old female non–victim)

"There seems to me that knowledge of community services that could help are not publicised enough for the public to readily contact them if they had trouble". (A 19 year old male victim)

"More awareness of services available would help the community in need". (A 22 year old female non–victim)

"Perhaps the general public should be better informed. Speaking for myself, I am not sure how to advise anyone who comes to me with this problem". (A 64 year old female non–victim)

"I know about those community services e.g. lifeline, rape crisis centre, through bus advertising only. I would encourage that advertising to continue". (A 20 year old female non–victim)

"More public awareness will help remove guilt from preventing getting help. Education is needed in schools on relationships and what is acceptable behaviour. Long–term problem". (A 43 year old female non–victim)

"Even though I personally have not been a victim, I feel there is not enough help for those afraid to report it". (A 23 year old male non–victim)

The involvement of family and friends is also an important source of help for victims of domestic violence, as is made clear from the following comment by a respondent in the study:

"It'd probably be easier if the victim moved to a good friend's house where he or she would have time to collect their thoughts. I'm not too sure what the community services are like (and I'm sure they're excellent) but a friend who knows the people involved and the situation could be more of a help". (A 19 year old male non–victim)

Other respondents mentioned a combination of professional help, and friends or family, which is illustrated in the following comments:

"A close friend of mine was a victim of domestic violence but her husband went to a psychiatrist and is now showing improvement. It helped her a lot to talk to me about it, but it's hard to know what to say". (A 20 year old female non–victim)

"I've seen neighbours hitting each other. It's terrifying, once having had to ring the police and ambulance for them. Drinking was their main problem I think and a child who was handicapped". (A 37 year old female non–victim)

VIEWS FROM PERPETRATORS OF DOMESTIC VIOLENCE

During the course of the study there were a small number of men who admitted to being perpetrators and made the following remarks on the questionnaires.

One man who had suffered child abuse and admitted to being a perpetrator said:

"I believe that hitting women is the way to treat them because I have copied the models which I have seen. Men and women cannot communicate. Women communicate with women, but not with men". This man had received psychiatric treatment for an alcohol problem.

Another man who admitted to being a perpetrator said:

"The whole problem with my wives was over sex. No sex normally. Was never over unfaithfulness. As I see it with lots of my work mates and their wives the problem is with Australian wives. After have baby they feel they have done their job. No sex, very rarely. Only when he might buy new

lounge suite or something big she likes seeing! Sex is on for about a month, then off again. This in my opinion is the main cause of family breakup, no sex normally. I mean even once a month. Filipinas make good wives until they get to Australia and see the great social security, so lots 18 to 25 marry old Australians to get out of their mess Country and once in Australia cause husband to hit them, mainly because their sending money home to Philippines. Not asking husband and family here are short..."

4.3 CASE HISTORIES OF VICTIMS OF DOMESTIC VIOLENCE IN EMERGENCY DEPARTMENT

In the exploratory study in 1990 there were 35 men who identified as adult victims of domestic violence and 19 (54%) indicated that they were willing to take part in an in-depth interview about the experience. Ninety-nine women identified as victims and 48 (48%) were willing to be interviewed. Finally, there were 48 interviews conducted (41 women and 7 men) which indicates attrition rates for women of 15% and for men 63%. These attrition rates indicate the difficulty the SRO experienced in getting men to speak of their experiences.

The age range of the sample of women who were interviewed was from 19 to 73 years, with a mean age of 44.5 years (SD=15.8). The age of the men ranged from 20 to 76 years, with a mean age of 56.1 years (SD=19.4).

Table 12 shows the marital status of those who were interviewed.

TABLE 12

MARITAL STATUS OF INTERVIEWEES (n=48)

MARITAL STATUS	%	NO.
Divorced/separated	46.0	22
Married	30.0	14
De facto	10.0	5
Single	10.0	5
Widow/widower	4.0	2
TOTAL	100	48

The following case histories of victims of domestic violence are taken from those who were interviewed during the exploratory study. The case histories are a combination of interviews with the victims and information obtained from their medical records. It should be noted that not all of these people are presenting to the Emergency Department with complaints due to domestic violence at the time of interview by the research team.

Gloria is a 40 year old woman, a legal typist, who had attended the Emergency Department for several years with complaints of nausea, vomiting, headaches and intermittent deafness and ringing in the ears. Gloria had been to the Emergency Department in the previous year with an overdose of tranquilliser tablets, and stated that *"I just wanted a good sleep and when awake all the problems would be gone".* It was noted in her medical record that this event occurred within a background of problems with her family members and the church. Gloria was fearful that her husband would harass her and beat her. She was given a diagnosis of personality dysfunction viz. hostile, dependent, histrionics, suppresses, split (*sic*). Subsequently she was under psychiatric care for 12 months as an outpatient and had been helped to develop some assertiveness skills. Gloria's body language was noted by the SRO. She cowered throughout the interview, her head and shoulders drooped, she looked away, rarely had eye contact with the interviewer, rarely smiled, and cried at times as

she thought about the past and the injustices which she had suffered. This is how Gloria told her story:

I was living in a small country town. I was being abused daily by my husband, physically, verbally and sexually, and he had multiple affairs. He humiliated me and would call me a 'bitch', 'whore', 'slut' and so on. He often beat me around the ears. Two years ago he tried to strangle me and this happened twice. There was one time in the country I had a miscarriage (and I blame him for losing the child) and I wasn't even allowed to go to a doctor. There was no help in this small country town, and I wouldn't have told anyone in any case. No-one would have believed me, and my priority was to keep the family together rather than protecting me (I had a child). My husband and I were heavily involved in Church work, but I became "burnt out". I felt a great shame that I had been "knocked around". The Church knew about my husband's behavior but I could not talk to anyone in the Church about it. The message to me was that I was to pray, go back to my husband, and glorify God in my persecution. I once told a doctor that my husband was very angry, but I made excuses for him and I played it down. I am now in a process of divorce after 10 years of marriage. There are many things unresolved in my life, and I feel confused".

Madeleine is a 63 year old woman, a pensioner, formerly a printing bindery assistant. She had a history of chest pain, back pain and some post-menopausal symptoms. Madeleine was described as "a worried looking lady" and "a very introspective person". She presented to the Emergency Department with abdominal pain, but was well enough to tell her story to the interviewer.

"I lived in a country town, married to a man for 30 years who was violent to me. It started with the first pregnancy. There was some physical abuse but it was mainly emotional abuse and that happened every day. He used to tell me. 'all you are fit for is the mental hospital'. He wouldn't let me have any friends, and my family didn't believe that he was violent. So I got no support from them. I was too frightened to divorce him, and when I finally did, he harassed me with strange knocks on the door, persecution by phone calls,

and even being subjected to investigation by a private detective. I ended up living a refugee's life, in exile. When I did mention my plight to a doctor I felt betrayed because the doctor believed my husband. Even though my husband did not believe in any of the professionals, especially doctors, when he knew that I was finally leaving him, he threatened to ring a psychiatrist to prevent my going. My own doctor was disgusted. Even my adult children want nothing to do with me and my greatest desire now is for my family to believe my story".

Gregory, is a 20 year old university student, who came to the Emergency Department with a fractured arm which he had sustained while fighting with his brother. He told his story of how he had been abused by several members of his family and how alcohol and other drugs can affect a family.

"I am living at home and have been abused by my mother and my brother. Both my parents are working professionals, but my mother is an alcoholic. My mother is provocative and then when the abuse starts that seems to justify her drinking. My mother and father were previously domestically violent, but my father has learned how not to respond to my mother's provocation. And therefore she takes it out on her children. When my brother takes my things, then the physical fights start. I also stand up for my sister, and then I get beaten. I have not told any health professionals about my family problems because I didn't see it as their job. I have had support from a group which assists the families of alcoholic parents and I feel that I am getting enough help from them. I think there should be greater public awareness of how badly alcohol and other drugs can affect families".

Malcolm is a 35 year old man who came to the Emergency Department for observation following a fall from a ladder at his workplace where he was a carpenter. He had been to the Department previously with tiredness, sweats and tenderness in the lymph nodes. His general practitioner noted that he was going through a very unhappy marriage breakdown and thought that his symptoms may be psychosomatic in relation to this. However, Malcolm denied this. Here is Malcolm's story.

"I have been married for 16 years and have recently been separated from my wife. I have suffered physical and mental abuse which was initiated by her. She would emotionally blackmail me about the children and about money. She was not a drinker. The abuse always arose out of conflict, and I have retaliated several times. Although my wife was not as strong as me, I saw that it could be life-threatening because she used to say, 'I'll get you while you're asleep'. We both went to counselling but my wife would not accept the help. I lived in fear of the next confrontation. I found my family doctor supportive".

Dorothy is a married woman who had moved from interstate, terrified of her husband. She came to the Emergency Department with a viral illness. She had previously attended with numerous small incidents such as insect bites and had a previous history of headaches and seizures which had been investigated. Her CT scan report was negative, and it was queried that there was an element of functional overlay. There appeared to be no real reason for her functional symptoms. Dorothy said that this was not her real name and told her story.

"I lived with a violent man in the country where there was no support. My husband was jealous of me and my education. I suffered from isolation in the country and was virtually kept a prisoner, as my car was taken from me. I have not found health professionals helpful. A doctor believed my husband when he told the doctor that he was worried about my sanity. At the time of the abuse a mother needs help, but she is not the only one suffering. Children do not get help because they do not show the suffering. They blame themselves, live with the guilt, and it comes out as aggression because children blame the mother for what's happened to them. Don't let children bury it, but let them talk about it. I couldn't find good professional counselling for my children, but have had to do it myself. I still need help for my children as they are violent. The school system is not much help. Labels of 'single parent' and 'abused child' - they just cannot handle them. It's not the physical abuse which is worst but the terror which follows - the emotional abuse. I am still angry and terrified".

Diane was a business professional. She presented to the Emergency Department with bruising to her head, neck, shoulder and buttocks and a stab wound to her head, as a result of a domestic violence incident. She had been seen previously by her general practitioner who had prescribed tranquilliser tablets for her.

"I have been married to a man for 30 years who has been extremely jealous and possessive of me. I am the sole income earner and am progressing in my career. I was not abused as a child, but my parents were physically violent with one another. There was much violence in the early years of my marriage but the physical abuse eased later (although there was abuse during my pregnancy) – until today! However, I have been subjected to emotional abuse daily. I have had to account for every minute away from home. My husband is very unpredictable and maintains a secret life. I have tried to share my feelings about our marital problems and have not been abusive or accusing. However, he believes that sex is the only answer to any problems . I have been able to control the abuse by offering affection, being submissive, not being argumentative or provocative and not having visitors in the home. I have stayed in the relationship because of my children. I fear the violence will happen again. I am emotionally attached to my husband and I feel that he could not cope without me. I was prescribed tranquillisers by my general practitioner, but he did not enquire about any underlying emotional problems. I feel that he missed the point. When I came to the Casualty I found that the doctors and nurses were supportive. The doctors treated my symptoms and they did ask me if it was domestic violence, but I was confused and said, 'I walked into a knife'. They knew very quickly that it was domestic violence. They were accepting, non-judgmental, sympathetic and professional but I think that doctors do not know what to do about domestic violence. They need to realise in the Casualty Department that the problems must be addressed immediately and that the prime concerns for a woman and her children are safety. I was sent home after a violent episode without any links being made with the community. I reported the assault to the police and they told me about the legal help available for victims of domestic violence. But their help was inappropriate for a person who wished to remain

in her home. I was not ready to make such big decisions at that point. I would have loved someone to talk to in the Casualty Department. I would have liked all the options explained to me before I returned home. I feel tired and depressed at this point".

Diane was admitted to the hospital soon after this violent episode with an overdose of the tranquilliser tablets which had been prescribed for her depression, and subsequently admitted to psychiatric care.

James was an elderly man (76 years) who came to the Emergency Department for treatment for a wound infection following abdominal surgery. When his wife died he went to live with his eldest son and daughter–in–law.

"I lived with my son for a period of 6 years. He used to abuse me physically and emotionally every week and on the rare occasion he abused me sexually. It was mainly alcohol which triggered the abuse and mostly on weekend nights. I think the reasons that he abused me were a head injury that my son had suffered in a car accident and alcohol, although he wasn't always drunk when he abused me. I stayed there because I wanted to save enough money so that I could leave and be independent. I did once tell the doctor about the violence my son was doing to me, but I don't think he believed me. I have left and I only see my son once in a while. He abuses me only when he is drunk so I have stopped going to his house. I do miss seeing my grandchildren. I would like to persuade my daughter–in–law to get counselling for my son".

Louise was a 35 year old woman who had been abused by her stepfather as a child and her former husband when she was very young. She came to the Emergency Department for treatment for a knee injury which was unrelated to domestic violence.

"I was married when I was 16 and I suffered hell from my husband for 3 years, before I could leave. He would abuse me physically – tie me up, beat me, and rip my clothing off. Then he would abuse me sexually – he once

pushed a broom into my vagina. My 3 year-old daughter once witnessed him raping me. He would keep me awake by singing all night, 'You're mad'. Sometimes he was drunk when he abused me, but not always. I think that he had a psychiatric condition, although he was holding down a good job in the armed services. I wanted to leave but I had no money and no transport. I was terrorised by him, but I couldn't go back to my own home where my stepfather had raped me. I spoke to my doctor once and he supported me, but he didn't really know where I could go. He was helpful because he believed my story, and reassured me that I wasn't going mad. I really needed someone to take me to a safe place. I was so scared because I knew that my husband had weapons ready. Women are not stressing how badly they need help. They are too scared. They need to be more assertive. There is more help available now. I have drawn strength from my relationship in the last 3 years with my present husband who was a foster child and understands my situation. At first I was frightened to let him touch me, but now it is OK. I haven't received any professional help, but I have been able to pull myself through this".

Mary was a pensioner, aged 67. She was legally separated from her husband for 2 years, after a marriage of 45 years. Mary had a heart complaint, but she appeared to be a strong woman who had survived much. She had cared for 2 grandchildren for 12 years and also her father.

"Usually the arguments would start when he had been drinking and he would push me around. I fought back. I was often left on the farm on my own to milk the cows while he went off drinking with his mates, even when I was pregnant. I was never frightened of him and I would thump him when he became 'stroppy'. He abused me emotionally all the time and made fun of me in public. He was bigoted and thought there was nothing wrong with him. It was all my fault! He used to interfere with my car so he could stop me from going out. I told the doctor about what was going on. He wanted me to leave, but that was unrealistic because I was supporting my father and 2 grandchildren. Doctors are unrealistic. They listen to your story and give you

something to sleep. I was on large doses of tranquillisers which become habit-forming. My health was certainly deteriorating. Two years ago, on April 1st, I took out a restraining order against him and he received a court order to leave. My son helped me to do this. My granddaughter said, 'He thought it was an April fool's day joke, but we were serious'. I feel that the whole system is structured against the injured person. The onus of proof in on the victim because she is a woman. I now live in peace. I feel a lot better healthwise and have freedom since I left my husband'.

Jane was a 22 year old woman who reported that she had been abused by her father as an adult. Her mother had received permanent injuries as a result of a domestic violence incident with Jane's father. Jane had been witness to drunken rages and violence in the family and she made these comments.

"My father has never had to admit to causing the damage to my mother, and it is psychologically disturbing as the other members of my family do not discuss or acknowledge it. I hope one day to feel comfortable that some justice will be made (although I don't know how)".

Jane's comments raise several issues. One is her own psychological problems, including witnessing violence, and these are often poorly acknowledged by helping professionals. This has been called the "second injury" which is the victim's perceived rejection by, and lack of expected support from the community and agencies as well as family and friends. Raphael (1992) considers that this traumatisation is powerful and may contribute as much if not more to the final illness outcomes of traumatic experiences, as the original event. Another issue which is raised by Jane relates to justice and its resolution. It is critical that all those interacting with the victim understand the victim's search for justice and help her towards the optimal integration of what has happened in the way that is possible for her. As Raphael says, if this does not happen, the search for justice may dominate, preventing the victim's resolution of and recovery from the experience.

Irene was a 70 year old woman who was brought by ambulance late one evening by ambulance. She had suffered burns when her husband poured boiling water over her

that evening, and had a past history of serious domestic violence. Irene had been to the Emergency Department on previous occasions with injuries which were suggestive of domestic violence but had not been recorded as such on the medical record.

> *"I told the doctors what was happening this time, but I haven't told them before this. I felt too scared of my husband to ask for help. I felt ashamed and embarrassed, and I didn't think that anyone would believe me. I just went away hoping that it would get better each time".*

Irene was given assistance by the police at the Emergency Department. However, it was noted by the research assistant who administered the questionnaire that an after-hours social worker was needed to advise staff regarding a course of action for Irene, as even the police were not sure of what to do.

Marie came to the Emergency Department with abdominal pain. She had experienced domestic violence in three relationships as well as being a victim of child sexual abuse. Marie had experienced physical, sexual and emotional abuse, including being kept away from family and friends, allowed no money and having pets killed in front of her.

> *"After I left my marriage I saw several psychiatrists because I had bad nerves, but none of the psychiatrists ever touched on the abuse. I am now happy in a relationship but I fear that the past is getting in the way. I am still scared of a man I left 20 years ago. I cannot talk to my partner about a lot of the past and I would like some counselling help. I think that my stomach pain today is related to my past history".*

Doreen was a middle-aged woman who had been married for 38 years, living in a country town. She had suffered physical and emotional violence from her husband over a period of 17 years after which the violence ceased.

> *"I knew that my husband had been violent to his mother before I married, but I thought he wouldn't abuse me. So when he did lash out at me I didn't tell anyone because I didn't want to admit my mistake in marrying him. One day I took my children to the doctor for their complaints. The doctor noticed how uncomfortable I was and noticed that I had discomfort when breathing. He*

asked to examine my chest and noticed the bruising there. I said that I was branding cattle and was crushed. The doctor didn't believe my story, and told me so. He suggested that I leave my husband, but I didn't want to do that. I was too proud and liked the country life. I had good family support and never lost my self confidence through all this. When my boys were teenagers they said to their father that this had to stop".

4.3.1 EXPLORATORY CASE-CONTROL STUDY (1990)

A case-control study which was carried out in September, 1990 to devise methods for the main studies has been described in Chapter 2. The findings of this examination by the Medical Record Administrator indicated a very low rate of detection of domestic violence in the medical record (16.7 per cent of the 42 victims). A quality control check by a senior psychiatrist in November, 1990 revealed the same result.

In Chapter 5 the findings of the main studies which followed the exploratory studies are described.

In this chapter the findings of the main studies conducted in Stages 2 and 4 of this project are described separately (refer to Figure 1 in Chapter 2). Stages 2 and 4 comprised two prevalence studies conducted 12 months apart and two case-control studies, involving victims and non-victims from the prevalence studies. Stage 3 consisted of an educational intervention program for doctors and nurses. Its content and findings have been fully described in Chapter 3.

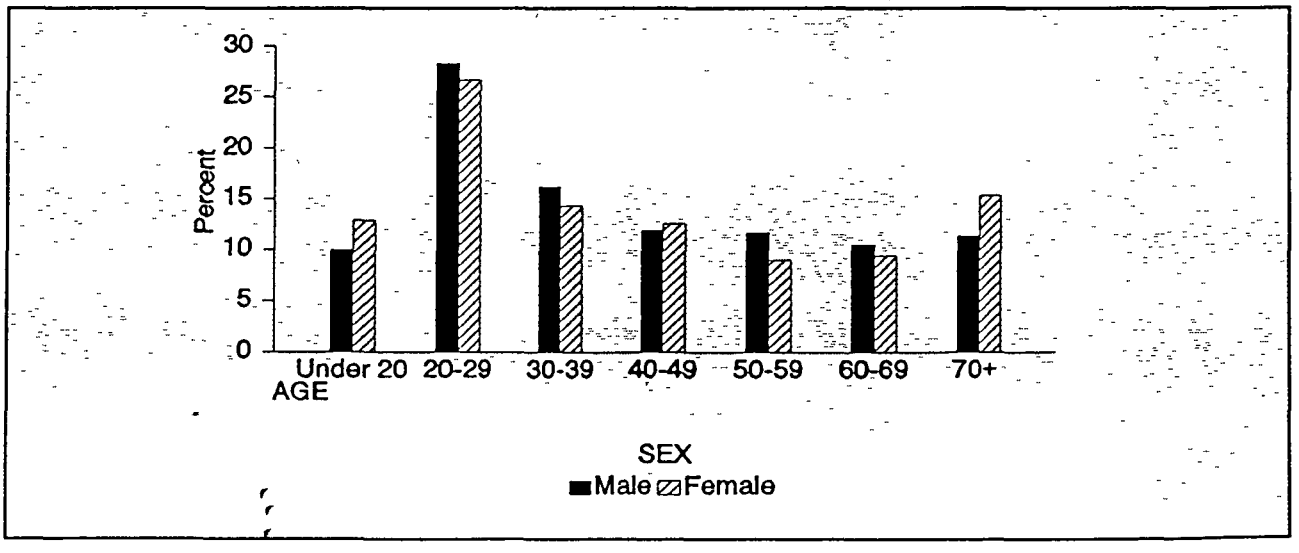
5. CHARACTERISTICS OF THE PEOPLE IN THE MAIN STUDIES

SEX AND AGE OF ATTENDEES AT EMERGENCY DEPARTMENT

During the 6 weeks from April 29 to June 9, 1991, there were **1214 people** who completed questionnaires in the Emergency Department. There were **656 men (54 per cent)** and **557 women (46 per cent)**, with the sex of one person unrecorded. The age distribution of the men and women in the sample is shown in Figure 3. The mean age of the men was 41.2 years (SD 19.4 years), and the age range was 16 to 87. The mean age of the women was 41.8 years (SD 20.9 years) and the age range was 16 to 92.

FIGURE 3

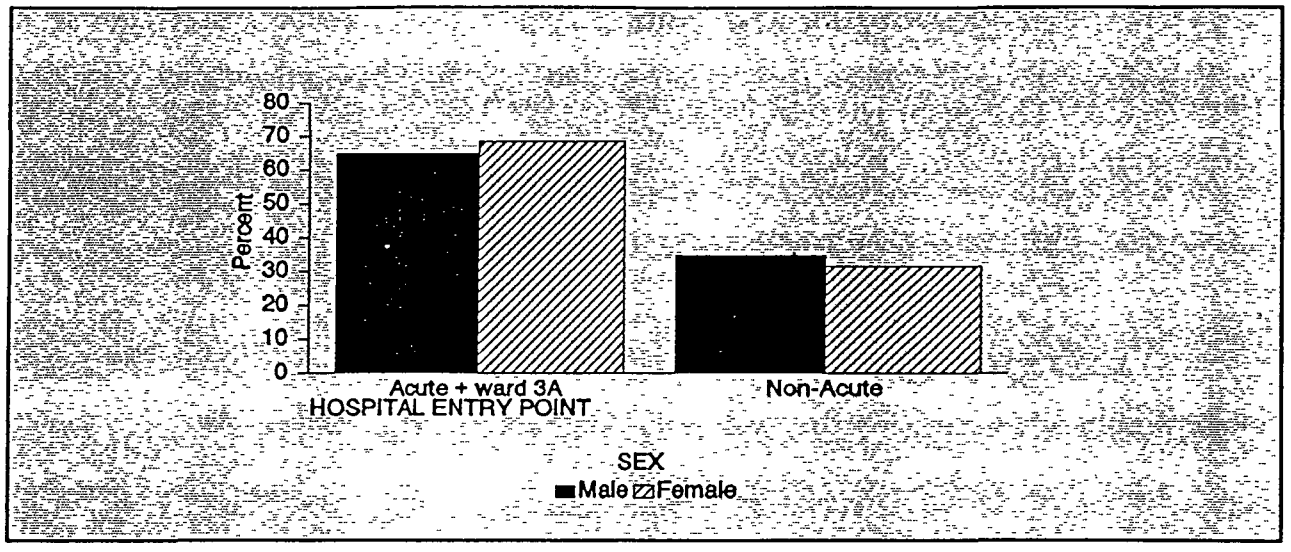
AGE GROUPS OF WOMEN (n=555) AND MEN (n=652)[1]
EMERGENCY DEPARTMENT, R.B.H.,1991



[1] Numbers of subjects will vary in each table in this chapter due to missing values.

FIGURE 6

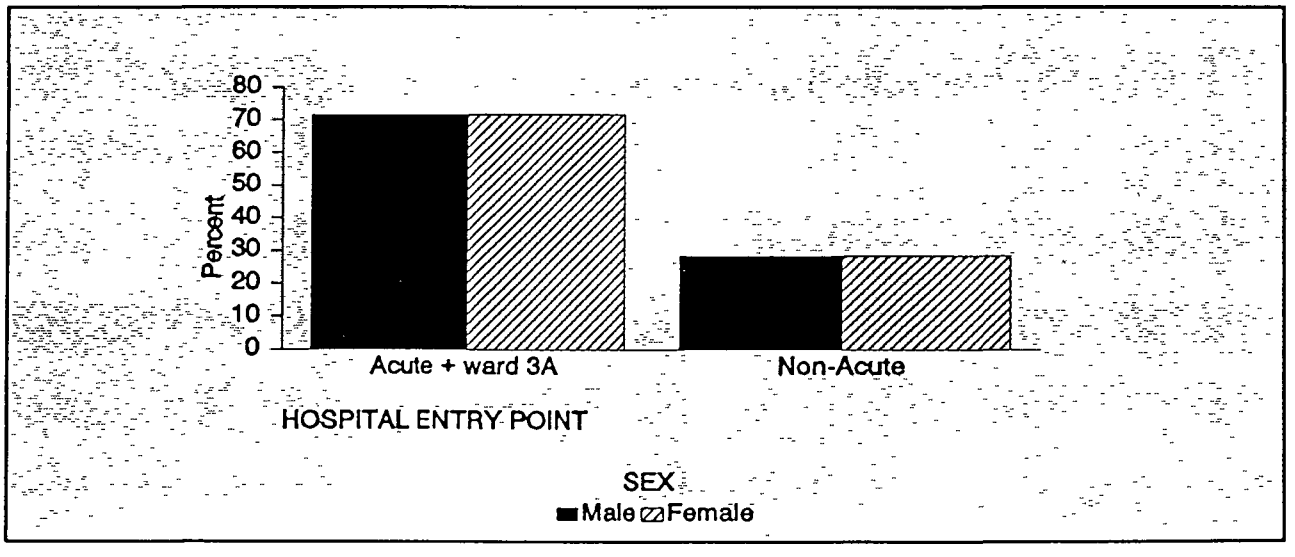
ENTRY POINT OF WOMEN (n=556) AND MEN (n=651) TO EMERGENCY DEPARTMENT, 1991



Ward 3A is the overnight accommodation in Emergency Department

FIGURE 7

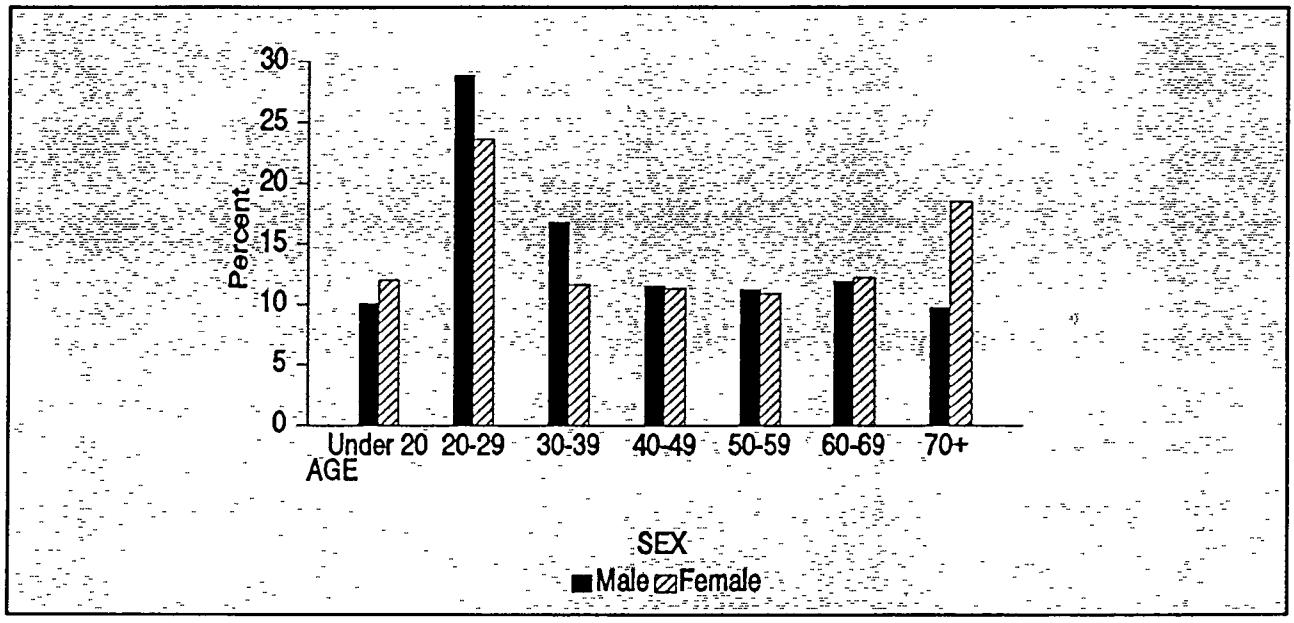
ENTRY POINT OF WOMEN (n=552) AND MEN (n=672) TO EMERGENCY DEPARTMENT, 1992



A similar number of people (n=1223) completed questionnaires in the Emergency Department during the period of 8 weeks from July 20 to September 13, 1992. The sample comprised **670 men (54.8 per cent)** and **553 women (45.2 per cent)**. Figure 4 illustrates that the number of attendees within age groups across the samples were very similar. There was a slightly higher number of people over age 50 in the second study (3 per cent) than in the first study. The mean age of the men in the sample was 40.6 years (SD 19.2) and the age range was 16 to 92. The mean age of the women was 45.19 years (SD 21.85) and the age range was 16 to 94.

FIGURE 4

AGE GROUPS OF WOMEN (n=551) AND MEN (n=672)
EMERGENCY DEPARTMENT, R.B.H., 1992

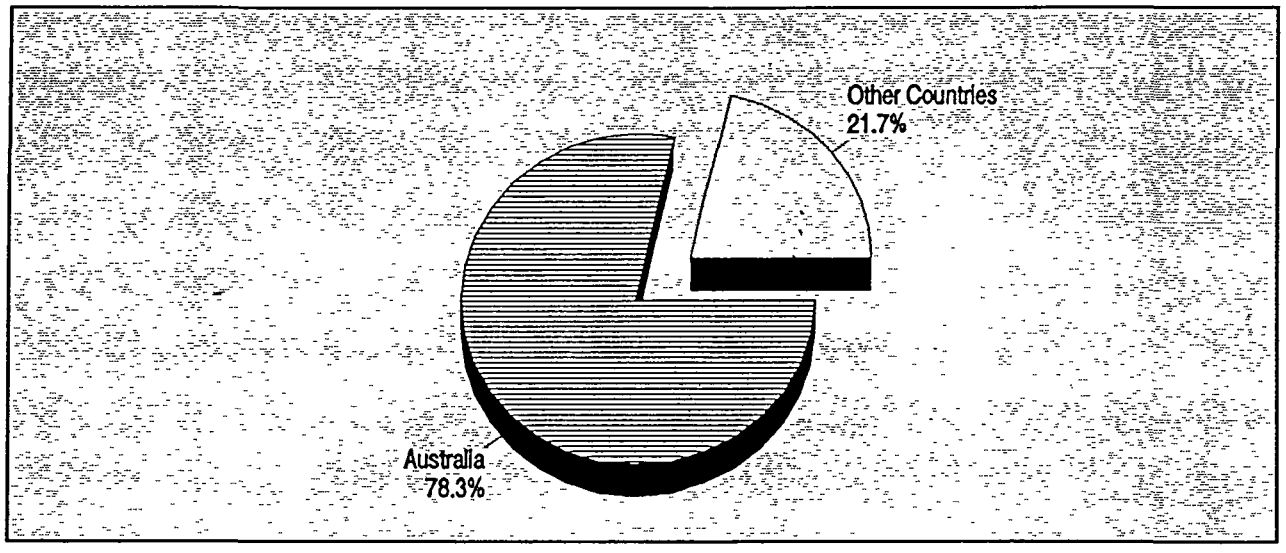


COUNTRY OF BIRTH OF ATTENDEES AT EMERGENCY DEPARTMENT

Figure 5 shows that **22 per cent** of the attendees were born in countries other than Australia. This does not include non-English speaking people. Only people who spoke English were able to be interviewed. In the second study, which was conducted under the same conditions, it was found that the same proportion of attendees were born overseas.

FIGURE 5

COUNTRY OF BIRTH OF ATTENDEES (n=1216)
EMERGENCY DEPARTMENT, R.B.H., 1992



TIME OF PRESENTATION OF ATTENDEES TO THE EMERGENCY DEPARTMENT

In 1991 there were 49 nursing shifts during which the screening questionnaire was administered and this covered all times of the day when people attended the Emergency Department. There were **52.8 per cent** of attendees screened from the hours of 8am to 5pm and the remaining **47.2 per cent** were screened from 5pm to 8am. Therefore there was an equal representation of both time periods. In the 1992 study there was a greater representation of attendees screened between the hours of 8am and 5pm (**65.4 per cent**), with **34.6 per cent** of attendees screened between the hours of 5pm and 8am. These two time groupings were chosen because when this study commenced there was no social work service available between the hours of 5pm and 8am, and this had implications for the referral and management of victims of domestic violence who came to the Emergency Department after-hours.

POINT OF ENTRY TO THE DEPARTMENT

Figures 6 and 7 show that in the 1991 and 1992 studies there was a similar representation of attendees in the acute and non-acute sections of the Emergency Department.

5.1 PREVALENCE STUDY ONE (1991)

SEX OF VICTIMS AND TYPE OF ABUSE

The study sample of 1214 attendees at Emergency Department (April to June 1991) comprised 656 men and 557 women. Among the respondents, 170 (14.1 %) disclosed a history of adult domestic violence: 129 women (23.3%) and 41 men (6.3%). Figures 8 and 9 show that **30 per cent** of women reported some kind of abuse in their lifetime, with **13 per cent** of men reporting abuse during their lifetime.

FIGURE 8
CATEGORIES OF ABUSE FOR FEMALES AT EMERGENCY DEPARTMENT, 1991 (n = 552)

ADULT ABUSE \ CHILD ABUSE	YES	NO
YES	8%	15%
NO	7%	70%

FIGURE 9
CATEGORIES OF ABUSE FOR MALES AT EMERGENCY DEPARTMENT, 1991 (n = 649)

ADULT ABUSE \ CHILD ABUSE	YES	NO
YES	2%	4%
NO	7%	87%

When the relative risks of abuse for women and men were calculated (with 95% confidence intervals) it was found that women were 2.31 (1.83–2.91) times more likely to report any kind of domestic abuse during their lifetime than men; women were 3.69

(2.24–5.0) times more likely to report adult abuse than men; and women were 5 (2.57–9.39) times more likely to report being abused both as a child and adult than men. Women and men were equally likely to have reported abuse as a child.

Logistic regression modelling was used to estimate the relative risks for each of the variables of sex, age, birthplace and history of child abuse after accounting for the effects of each of the other variables in the analysis. These results are given in Table 13. For further detail about the analysis see APPENDIX G.

TABLE 13

RESULTS OF LOGISTIC REGRESSION MODELLING AGE, SEX, COUNTRY OF BIRTH AND HISTORY OF CHILD ABUSE AS PREDICTORS OF DISCLOSURE OF DOMESTIC VIOLENCE #

VARIABLE	VALUES OR RANGE	ESTIMATE (SE)	RELATIVE RISK (95% CI)
(Constant)	–	1.717(0.588)	–
SEX Male Female	 1 0	-1.505(0.203)	0.22(0.15–0.33)
AGE Linear trend Quadratic trend	16–90	1.034(0.326) 0.988(0.301)	2.81(1.48–5.33) 2.69(1.49–4.85)
BIRTHPLACE Australia Elsewhere	 1 0	-0.004(0.233)	1.00(0.63–1.57)
CHILD ABUSE Yes No	 1 0	1.466(0.222)	4.33(2.80–6.69)

The table shows the range or value of each variable together with its parameter estimate ± its associated standard error, the relative risk for people differing by one unit of each variable and the 95% confidence interval for each relative risk.

The "adjusted" relative risk of adult domestic violence for women compared to men was **4.50 (95% CI, 3.02–6.71)**, after accounting for the effects of all the other variables. Victims of child abuse had **4.33** times the risk of disclosing domestic violence as those without such a history (95% CI, 2.80–6.69). Those born in Australia had the same risk as those born overseas.

5.2 PREVALENCE STUDY TWO (1992)

SEX OF VICTIMS AND TYPE OF ABUSE

A second prevalence study (July to September, 1992) of domestic violence victims was conducted under the same conditions as the first prevalence study. The study sample of 1223 attendees at the Emergency Department comprised 670 men and 553 women. Among the respondents, 189 (15.5%) disclosed a history of adult domestic violence: 132 females (23.6%) and 57 males (8.8%). Figures 10 and 11 show that **31 per cent** of women reported some kind of abuse in their lifetime, with men reporting **16 per cent** of abuse during their lifetime.

FIGURE 10

CATEGORIES OF ABUSE FOR FEMALES AT EMERGENCY DEPARTMENT, 1992 (n = 549)

ADULT ABUSE \ CHILD ABUSE	YES	NO
YES	8%	16%
NO	7%	69%

FIGURE 11

CATEGORIES OF ABUSE FOR MALES AT EMERGENCY DEPARTMENT, 1992 (n = 670)

ADULT ABUSE \ CHILD ABUSE	YES	NO
YES	4%	5%
NO	7%	84%

When the relative risks of abuse for men and women were calculated (with 95% confidence intervals) it was found that women were twice (1.54–2.39) as likely to

report lifetime domestic abuse than men; women were 3.27 (2.20–4.87) times more likely to report adult abuse than men; and women were 2.03 (1.25–3.29) times more likely to report being abused as a child and adult than men. Women and men were equally likely to have reported abuse as a child.

The results of prevalence Study One are very similar to prevalence Study Two, and some comparisons are made in the next section.

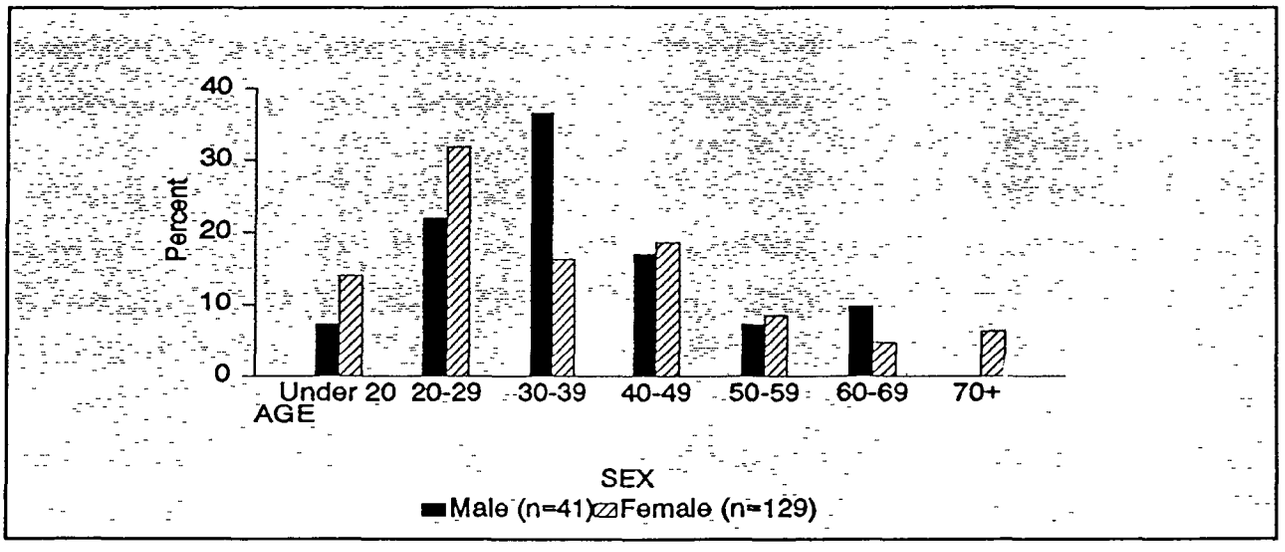
5.3 COMPARISON OF PREVALENCE STUDY ONE AND TWO

AGE OF VICTIMS OF DOMESTIC VIOLENCE

Figure 12 shows the age groups of men and women who self-reported lifetime adult domestic violence in prevalence study one.

FIGURE 12

AGE GROUPS OF DOMESTIC VIOLENCE VICTIMS, 1991



The age distribution was not uniform among women, with more women aged **20 to 30 years** reporting lifetime domestic violence, and more men **30 to 40 years**. Even in the highest age group (over 70 years) 6 per cent of women reported domestic violence while there were no men in that age group.

Table 14 shows the relative risks of domestic violence for women and men within each age group when the specific prevalence rates were calculated for each group within the total sample.

TABLE 14
AGE SPECIFIC PREVALENCE OF DISCLOSURE OF DOMESTIC VIOLENCE AND RELATIVE RISK FOR WOMEN COMPARED WITH MEN, 1991

AGE GROUP	MEN n=654 % #	WOMEN n=557 %	RELATIVE RISK (CONFIDENCE INTERVAL 95%)
Less than 20	4.4	26.5	5.49 (1.70–17.79)
20–29 years	5.0	27.3	5.63 (2.83–11.21)
30–39 years	14.2	27.8	1.86 (1.03–3.37)
40–49 years	9.1	34.8	3.83 (1.76–8.32)
50–59 years	4.0	22.0	5.57 (1.64–18.99)
60–69 years	6.0	9.8	1.96 (0.58–6.59)
Over 70 years	0	9.4	Not calculable

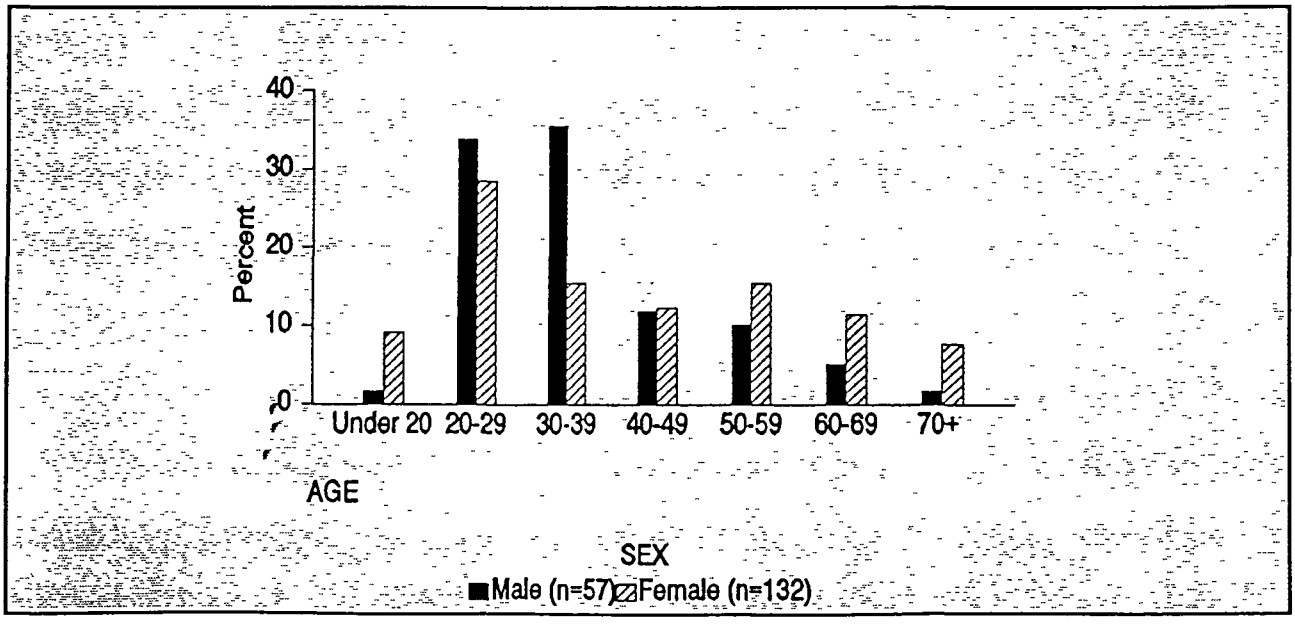
The percentages in this table are calculated from the numbers within each age group; hence, the columns do not add to 100%.

The relative risks for women compared with men were significantly greater than 1.0 for all age groups except 60–69 years, which had a confidence interval including 1.0.

Figure 13 shows the age groups of men and women who self-reported lifetime adult domestic violence in prevalence Study Two.

FIGURE 13

AGE GROUPS OF DOMESTIC VIOLENCE VICTIMS, 1992



The age distribution was not uniform among women or men, with more women aged **20 to 30 years** reporting lifetime domestic violence, and more men **20 to 40 years.** In the second study the number of men in the **16 to 30** age group who reported domestic violence increased significantly by **12 per cent** (X^2=54.61, p<0.0001) compared to prevalence Study One. The numbers of women victims in each age group in this study were similar to prevalence study one, with rates in the higher age groups remaining higher for women than for men.

Table 15 shows the relative risks of domestic violence for women and men within each age group when the specific prevalence rates were calculated for each group within the total sample.

TABLE 15

AGE SPECIFIC PREVALENCE OF DISCLOSURE OF DOMESTIC VIOLENCE AND RELATIVE RISK FOR WOMEN COMPARED WITH MEN, 1992

AGE GROUP	MEN n=672 % #	WOMEN n=553 %	RELATIVE RISK (CONFIDENCE INTERVAL 95%)
Less than 20	14.7	18.2	12.36 (1.65–92.43)
20–29 years	10.3	28.5	2.76 (1.68–4.54)
30–39 years	18.6	31.7	1.71 (1.01–2.90)
40–49 years	9.1	25.8	2.84 (1.25–6.46)
50–59 years	8.0	33.3	4.17 (1.79–9.72)
60–69 years	3.7	22.4	5.97 (1.80–19.75)
Over 70 years	1.5	9.8	6.37 (0.84–48.62)

The percentages in this table are calculated from the numbers within each age group; hence, the columns do not add to 100%.

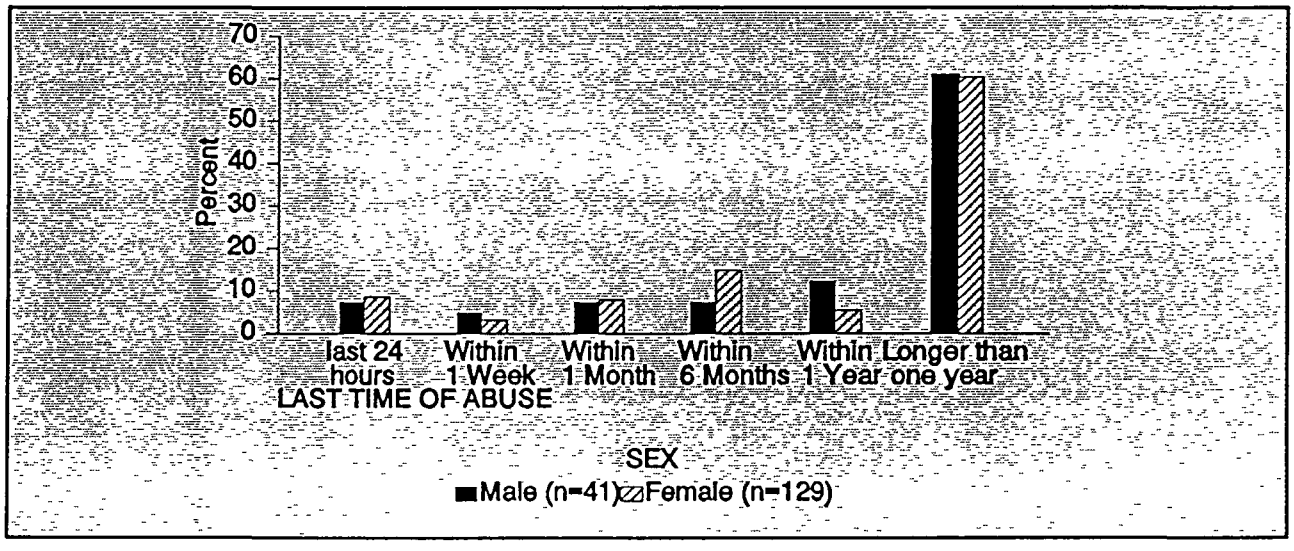
The relative risks for women compared with men were significantly greater than 1.0 for all age groups except in the 30 to 39 years group and the age group over 70 years, which had a confidence interval including 1.0.

HOW RECENTLY DOMESTIC VIOLENCE VICTIMS EXPERIENCED ABUSE

Figure 14 shows how recently men and women had experienced domestic violence in prevalence Study One from the time of screening.

FIGURE 14

RECENCY OF EXPERIENCED DOMESTIC VIOLENCE, 1991



Most of the disclosures concerned episodes that had occurred more than a year previously, although for **8.3 per cent** of all the victims, it was within the past 24 hours. In the total sample the prevalence of recently experienced domestic violence was **1.1 per cent**. This indicates that their presentation at the Emergency Department may be the result of domestic violence which would suggest that 1 in 100 attendances (male and female) at the Emergency Department is the result of domestic violence.

There were **79 per cent** of those who said that they had experienced domestic violence within the last 24 hours who attended between the hours of **5pm and 8am**.

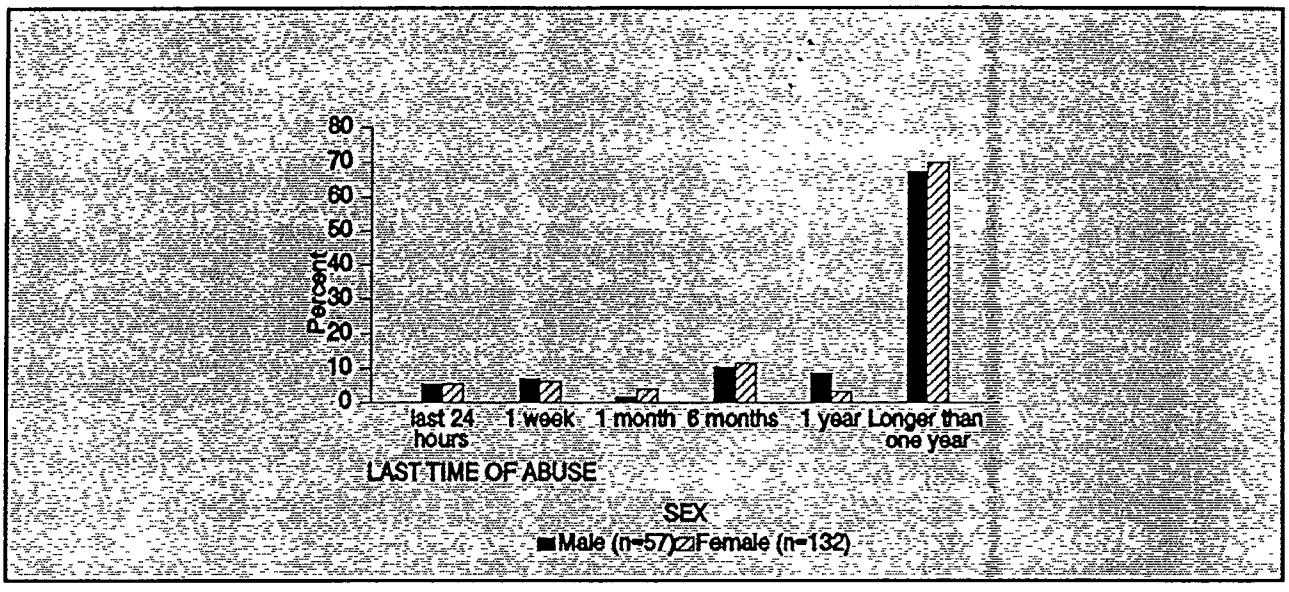
These figures have obvious implications for management of domestic violence victims. Most of them come to the Emergency Department between 5pm and 8am when staff

who deal specifically with domestic violence (principally social workers) are not available.

Figure 15 shows how recently men and women had been abused in prevalence Study Two.

FIGURE 15

RECENCY OF EXPERIENCED DOMESTIC VIOLENCE, 1992



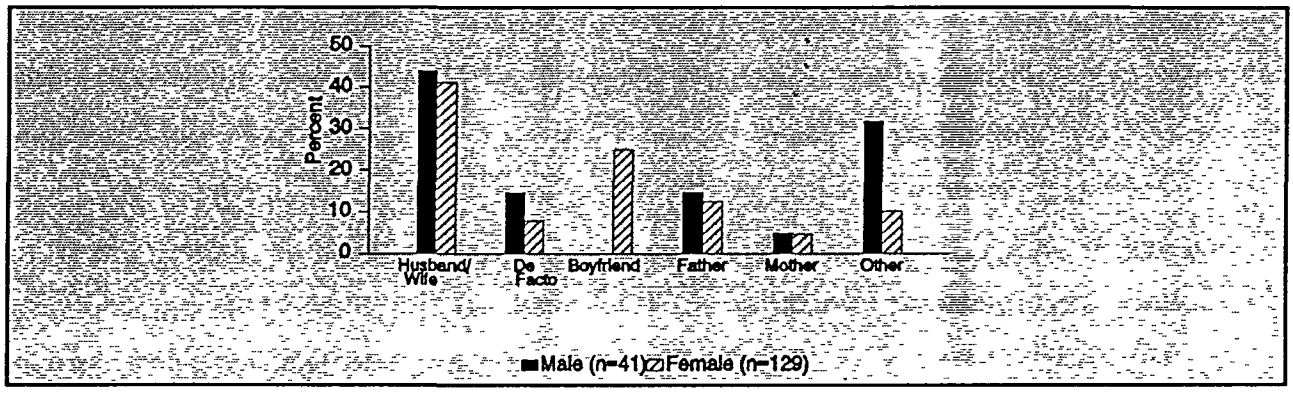
In prevalence Study Two the majority of victims **(69%)** reported that the last episode of abuse occurred more than 1 year ago. In the second study **5.3 per cent** reported that they had experienced domestic violence in the last 24 hours, compared to **8.3 per cent** in prevalence study one. However, in the second study respondents were asked if they were coming to the Emergency Department as a result of domestic violence problems, at the same time as the screening questionnaire was administered. There were 15 attendees (representing 8 per cent of the victims and **1.2% of the total sample**) who answered in the affirmative to this question. This question was not asked in Study One and may have been a more accurate estimate than was made in prevalence study one, that 1 in 100 attendances (male and female) at the Department was a result of domestic violence. Since 80 per cent of those who said that they were attending with domestic violence problems were women, it is estimated that **1 in 50** women i.e. approximately every 50th woman, is a current domestic violence victim.

IDENTITY OF THE ABUSERS

Respondents were asked the identity of their abuser. Figure 16 shows that women in prevalence study one were more likely to report violence from a spouse, boyfriend or father, while men were more likely to report violence from a spouse, de facto, father or other relative.

FIGURE 16

IDENTITY OF ABUSERS OF VICTIMS OF DOMESTIC VIOLENCE, 1991

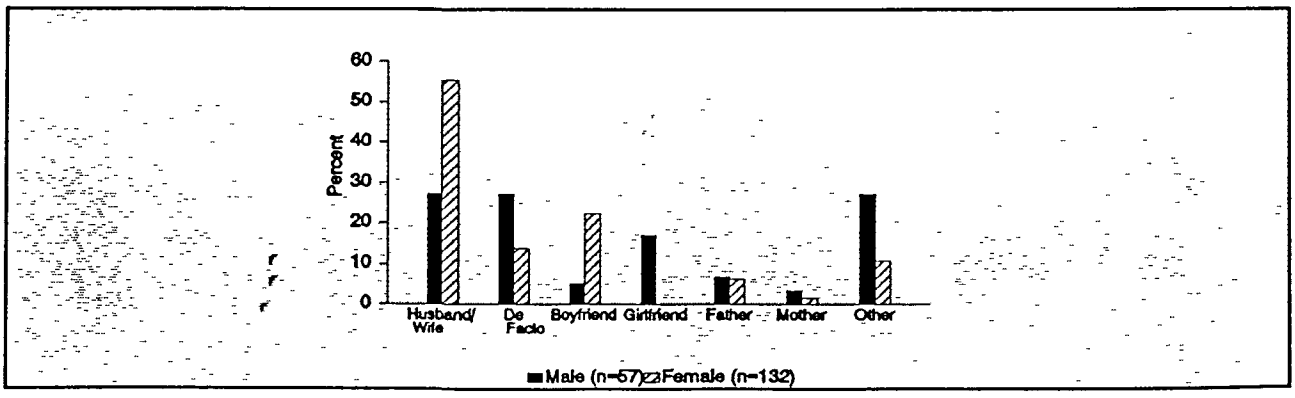


The relative risks of abuse by each category of person were similar for women and men except that women were much more likely to report violence perpetrated by boyfriends than men were by girlfriends (relative risk, 10.17; 95% confidence interval, 1.43–72.14). Also men were more likely to report abuse by other people such as brothers, male relatives and sons (relative risk, 3.15; 95% confidence interval, 1.59–6.23).

Figure 17 shows the identity of the abusers in the second prevalence study. In this study men were significantly more likely to report abuse from girl friends (X^2 = 3.83, p=0.02) than they were in prevalence study one.

FIGURE 17

IDENTITY OF ABUSERS OF VICTIMS OF DOMESTIC VIOLENCE, 1992



In the second prevalence study women were more likely to report abuse by a spouse than men (relative risk, 1.94; 95% confidence interval, 1.25–3.03). Men were more likely to be abused by a de facto than women (relative risk, 2.06; 95% confidence interval, 1.13–3.74), and men were more likely to be abused by other relatives than women (relative risk, 2.12; 95% confidence interval, 1.3–3.46). The relative risks for men and women being abused by girlfriends and boyfriends were similar in the second study.

TYPES OF ABUSE EXPERIENCED BY VICTIMS

Those who disclosed domestic violence were asked to identify the type of violence which they had suffered. Tables 16 and 17 show the proportion of men and women in the total sample who reported experiencing each abusive act in the 1991 and 1992 studies. It should be noted that there are limitations in interpreting the types of abuse reported here because they do not take into account the impact and injuries sustained by the victims, nor do they measure the psychological problems experienced by victims of domestic violence.

TABLE 16

PROPORTION OF MEN AND WOMEN EXPERIENCING EACH TYPE OF ABUSIVE ACT, AND THE RELATIVE RISK FOR WOMEN COMPARED TO MEN (with 95% confidence interval), 1991 #

REPORTED EXPERIENCE	WOMEN (n=557) %	MEN (n=656) %	RELATIVE RISK (95% confidence interval)
Pushing, shoving, grabbing, slapping	17.8	3.8	4.66(3.05–7.13)
Kicking, biting, hitting	15.6	3.8	4.27(2.76–6.61)
Throwing objects at victim	10.8	3.3	3.21(2.00–5.17)
Choking, strangling	7.2	1.6	4.28(2.22–8.27)
Beating up	11.7	2.2	5.10(2.94–8.85)
Using a knife, gun or other weapon	3.5	1.6	2.14(1.04–4.43)
Serious threat to victim or victim's children	7.2	1.1	6.73(3.04–14.90)
Sexual abuse	7.0	0.5	15.31(4.76–49.28)
Emotional abuse (incl. financial deprivation and social isolation)	16.7	4.0	4.21(2.77–6.41)

Multiple responses; hence columns do not add to 100%.

TABLE 17

PROPORTION OF MEN AND WOMEN EXPERIENCING EACH TYPE OF ABUSIVE ACT, AND THE RELATIVE RISK FOR WOMEN COMPARED TO MEN (with 95% confidence interval), 1992 #

REPORTED EXPERIENCE	WOMEN (n=553) %	MEN (n=670) %	RELATIVE RISK (95% confidence interval)
Pushing, shoving, grabbing, slapping	19.0	6.2	3.03(2.16–4.25)
Kicking, biting, hitting	17.2	6.1	2.81(1.98–3.98)
Throwing objects at victim	10.5	5.4	1.95(1.31–2.91)
Choking, strangling	7.8	1.5	5.21(2.64–10.27)
Beating up	13.0	2.8	4.59(2.80–7.52)
Using a knife, gun or other weapon	5.1	3.1	1.62(0.93–2.81)
Serious threat to victim or victim's children	8.7	3.3	2.64(1.62–4.32)
Sexual abuse	6.9	1.0	6.58(2.96–14.61)
Emotional abuse (incl. financial deprivation and social isolation)	19.2	5.7	3.38(2.37–4.81)

Multiple responses; hence columns do not add to 100%.

When the 1991 and 1992 studies are compared it can be seen that women are at significantly greater risk for all types of abuse. The one exception is the use of weapons against victims in study two, where women and men are equally likely to have weapons used against them.

HOW DOMESTIC VIOLENCE VICTIMS PERCEIVED THE RESPONSE OF HEALTH PROFESSIONALS

Those who reported domestic violence on the screening questionnaire were asked further questions regarding their usage of health services in relation to domestic violence. The replies to these questions are summarized in Table 18.

TABLE 18

USAGE OF HEALTH SERVICES BY VICTIMS OF DOMESTIC VIOLENCE

QUESTION	1991 STUDY (n=170) %	1992 STUDY (n=189) %
During the last year,did you have injuries or health problems caused by domestic violence?	35.3	33.9
During the last year, did you receive medical treatment for those injuries or health problems?	27.6	19.6
During the last year, did you see a mental health professional for health problems caused by domestic violence?	Question not asked	19.6
Would you like help in relation to the violence now?	12.9	6.9

In the 1991 and 1992 prevalence studies similar numbers of victims reported that they had domestic violence related injuries or health problems (**35 and 34 per cent**). However, less people reported in the 1992 study than the 1991 study that they had received medical treatment of those domestic violence related problems (**28 and 20 per cent**). Although no comparison can be made with the 1991 study, **20 per cent** of the 1992 victims reported that they had seen a mental health professional. There were less victims in the 1992 study than the 1991 study who required help at the Emergency Department for domestic violence problems (**13 and 7 per cent**) at the time the questionnaire was administered.

Those who received medical treatment for injuries or health problems during the last year were asked where they went for that treatment. In Table 19 their answers are summarized.

TABLE 19

WHERE VICTIMS WENT FOR TREATMENT BY HEALTH PROFESSIONALS #

WHERE VICTIMS WENT	1991 STUDY (n=47) %	1992 STUDY (n=37) %
GENERAL PRACTITIONER	51.1	54.1
ROYAL BRISBANE HOSPITAL	40.4	40.5
OTHER HOSPITAL	10.6	21.6
PSYCHIATRIST	10.6	21.6
OTHER HEALTH PROFESSIONAL	2.1	29.7

Multiple responses were made to various health professionals.

Half of the victims in both studies used general practitioner services. Hospital services were used by **51 per cent** of victims in the 1991 study and **62 per cent** in 1992. We cannot generalize these figures to the community usage of health services for victims of domestic violence because these people were sampled in the hospital system.

If people reported injuries or health problems during the last year they were asked whether they had told the health professional that the problem was caused by domestic violence. In the 1991 study there were 74 occasions on which a victim had seen a health professional and **32 per cent** reported that they had told the health professional about the domestic violence. In the 1992 study victims reported 95 occasions on which they saw a health professional and **42 per cent** told the health professional about domestic violence.

Figures 18 and 19 show how victims perceived the response of the health professionals whom they had told about the domestic violence they had experienced.

FIGURE 18

HOW DOMESTIC VIOLENCE VICTIMS PERCEIVED THE RESPONSE OF HEALTH PROFESSIONALS, 1991#

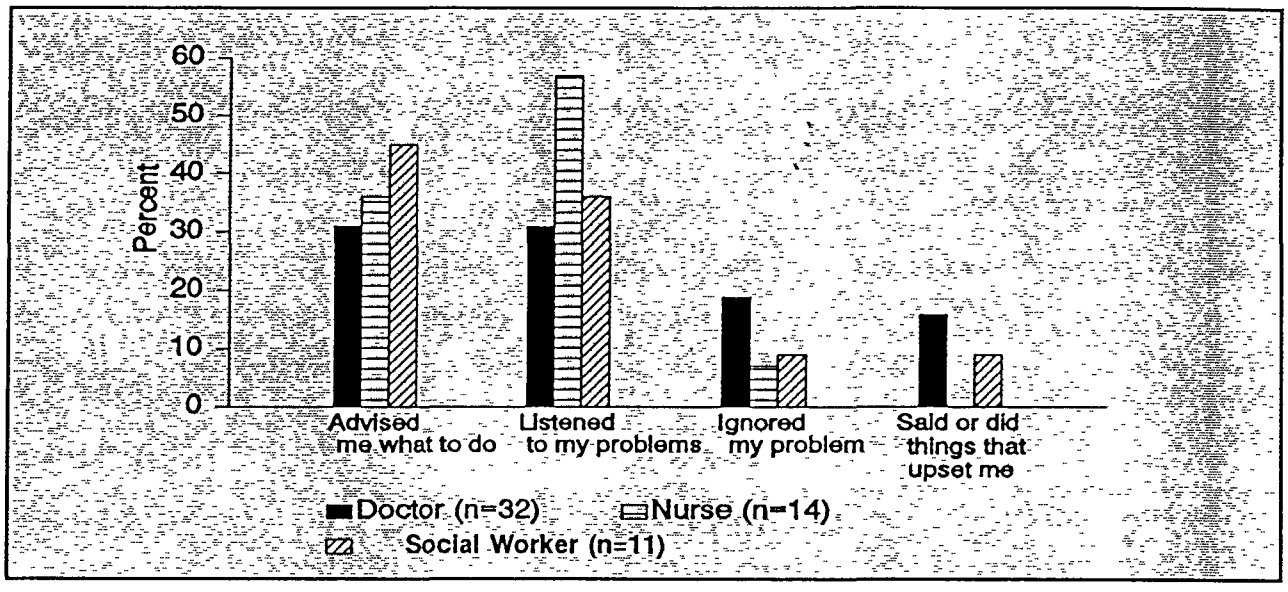
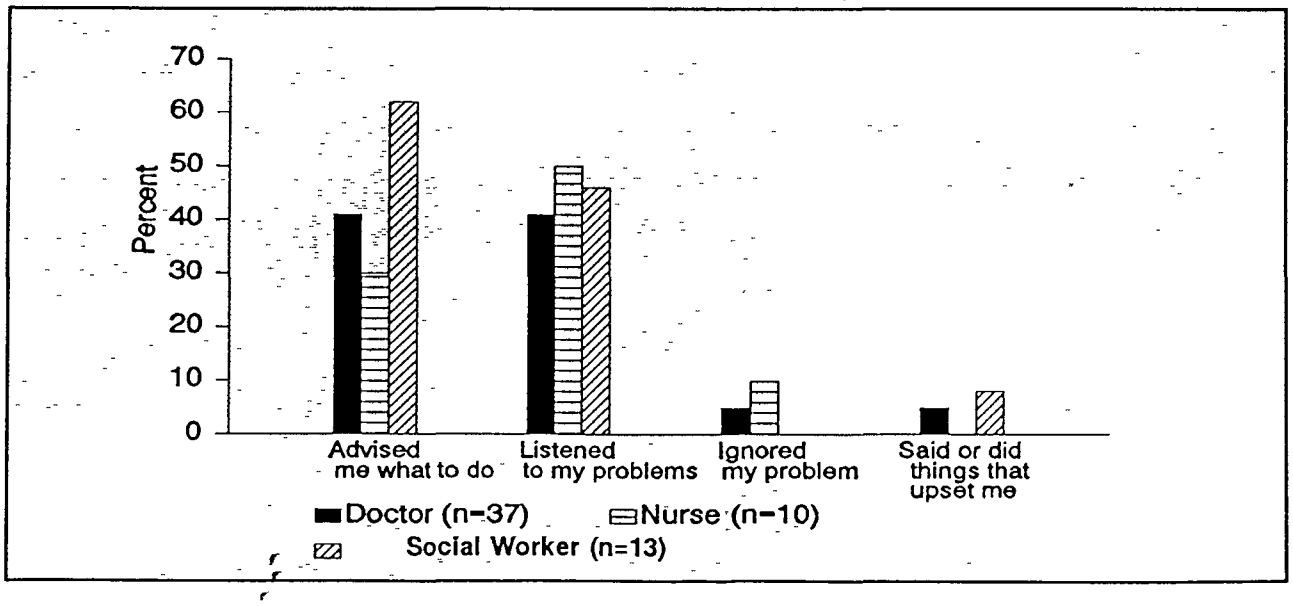


FIGURE 19

HOW DOMESTIC VIOLENCE VICTIMS PERCEIVED THE RESPONSE OF HEALTH PROFESSIONALS, 1992



Multiple responses.

It can be seen from the 1991 results that victims perceived doctors as being the least helpful of the health professionals they consulted. However, this situation appears to have improved in the 1992 study where victims perceived the responses of doctors as comparable to other health professionals. The perception that social workers were best at giving advice to victims may partially reflect their counselling role in domestic violence problems. Equally, the perception that victims have that nurses listen best to their problems may reflect the larger amounts of time which nurses spend with victims than other health professionals, and possibly the predominantly female gender of nurses.

Those who reported that they did not tell a health professional were asked the reason/s why. Table 20 shows the most common reasons why people did not tell a health professional about domestic violence.

TABLE 20

REASONS VICTIMS DID NOT TELL HEALTH PROFESSIONALS ABOUT DOMESTIC VIOLENCE #

REASON VICTIM DID NOT TELL	1991 STUDY (n=17) %	1992 STUDY (n=14) %
I felt it was my problem	53.0	35.7
Shame, guilt, embarrassment	29.4	35.7
I felt too scared of my partner to ask for help	29.4	28.5
No one would have believed me	29.4	0.0
My partner was with me	23.5	7.1

Multiple responses

There were no statistically significant differences between the reasons given for victims not disclosing domestic violence to health professionals in the 1991 and 1992 studies. However, more victims in the first study appeared reluctant to disclose to health professionals because they thought it was solely their problem, and that no one would believe them even if they did disclose. The fear of a partner preventing a victim from disclosing domestic violence was similar in both studies, although less people in the second study seemed to have the problem of disclosing domestic violence because a partner was present. Shame, guilt and embarrassment on the part of the victim was similar in both studies.

5.4 CASE-CONTROL STUDY ONE (1991)

The medical records of 141 people (34 men and 107 women) who self-reported adult domestic violence in their lifetime were matched with 141 people who self-reported as non-victims on sex, age and point of entry to the Emergency Department. The examination was carried out by Associate Professor Joan Lawrence who was "blind" to the status of the victims and non-victims. There were 2 aims in this examination of medical records:

1) To determine the rates of detection of domestic violence victims as recorded on the medical record.

2) To compare the characteristics of victims and non-victims of domestic violence over a 5 year period e.g. the type of presentations which they make to the Emergency Department - trauma, medical, surgical, psychiatric, obstetric/gynaecological or other presentations.

The findings from the medical records (examined for the 5 years prior to their screening at the Emergency Department by the Research Team) were that **6.4 per cent** of those who self-reported domestic violence on the screening questionnaire were recorded on the medical record.

Demographic characteristics of the subjects were recorded from the medical record (age, marital status, occupation and religion). No significant demographic differences were found between victims and non-victims. Again it should be noted that this is not a representative community sample.

Details of the index presentation to the Emergency Department i.e. at the same time as the screening questionnaire was administered, were recorded on a double-sided pro forma (APPENDIX H). These same pro formas were used to record details separately for each presentation in the previous year to the Emergency Department, and also for the previous 1 to 5 years.

A judgment was made by the examiner on the basis of what was recorded in the medical record by medical and nursing staff as to whether the person was a victim of domestic violence or not. The following categories were used:

POSITIVE - in the medical record the injuries were attributed to assault by an intimate and regarded as domestic violence, or a positive history of domestic violence had been recorded at some time.

PROBABLE - the person sought aid for injuries that were the result of an assault, but these incidents were not described as due to domestic violence.

SUGGESTIVE - in the medical record the explanations were inconsistent or inadequately explained their anatomic injuries, and other attendances were similarly suggestive of abuse.

NEGATIVE - there is no suggestion of domestic violence.

PERPETRATOR - the person has admitted perpetrating domestic violence.

The findings by Associate Professor Lawrence are given in Table 21

TABLE 21

EXAMINER'S JUDGMENT OF VICTIMS AND NON-VICTIMS OF DOMESTIC VIOLENCE, EMERGENCY DEPARTMENT R.B.H., 1991

EXAMINER'S JUDGMENT	VICTIMS (n=141) %	NON-VICTIMS (n=141) %
POSITIVE	19.8	2.1
PROBABLE	4.3	1.4
SUGGESTIVE	9.9	3.5
NEGATIVE	66.0	93.0
TOTAL	100.0	100.0
PERPETRATOR	3.5	4.3

The characteristics of victims (cases) and non-victims (controls) were analyzed by using McNemar's X^2 for dichotomous variables e.g. sex. Continuous variables e.g. number of presentations to Emergency Department in one year, were analyzed using t-tests for paired samples.

Tables 22 and 23 show the items where statistically significant differences were found between victims and non-victims.

TABLE 22

DIFFERENCES BETWEEN VICTIMS (CASES) AND NON-VICTIMS (CONTROLS) EMERGENCY DEPARTMENT R.B.H., 1991

CHARACTERISTIC	PREVALENCE AMONG CASES %	PREVALENCE AMONG CONTROLS %	DIFFERENCES CASES AND CONTROLS
Trauma diagnosis recorded as domestic violence at index presentation	4.3	0.0	McNemar's test (binomial) p=0.0313
Surgical diagnosis at index presentation	12.8	25.5	McN X^2=6.2826 p=0.0122
Index presentation as suicide attempt	6.4	0.7	McNemar's test (binomial) p=0.0078
History of bruising in 5 years prior to index presentation	16.3	6.4	McN X^2=6.0357 p=0.014
History of lacerations 5 years prior to index presentation	17.0	8.5	McN X^2=3.7813 p=0.0518
History of fractures in 5 years prior to index presentation	12.1	5.0	McNemar's test (binomial) p=0.0525
History of alcohol/drug problem in year prior to index presentation	5.7	0.7	McNemar's test (binomial) p=0.0391

Table 22 shows the difference in index presentations of victims and non-victims. In this study there were significantly more cases (victims) than controls (non-victims) who presented with trauma which was recorded as being caused by domestic violence. None of the controls (non-victims) who had a trauma presentation were recorded as being a result of domestic violence. There were significantly more victims than non-victims who came to the Emergency Department who had attempted suicide. Victims had significantly greater histories of bruising, lacerations and fractures in the 5 years prior to presentation at the Department. Victims also had more recorded history of alcohol and drug problems than non-victims in the year prior to the index presentation.

TABLE 23

TABLE 23

DIFFERENCES BETWEEN VICTIMS (CASES) AND NON-VICTIMS (CONTROLS) EMERGENCY DEPARTMENT R.B.H., 1991

CHARACTERISTIC	MEAN IN CASES	MEAN IN CONTROLS	DIFFERENCES CASES AND CONTROLS
No. of trauma presentations in last 1 to 5 years prior to index presentation	1.0	0.5	t = 2.07 140df p=.04
No. of records of trauma caused by domestic violence in year prior to index presentation	0.04	0	t = 2.15 140df p=0.033
No. of records of trauma caused by domestic violence in 1 to 5 years prior to index presentation	0.03	0	t = 1.91 140df p=0.059
No. of psychiatric presentations in the last year prior to index presentation	0.23	0.03	t = 2.54 140df p=0.012
No. of psychiatric presentations in 1 to 5 years prior to index presentation	3.2	0.69	t = 1.90 140df p=0.059
No. of psychiatric referrals in last year prior to index presentation	0.04	0.007	t = 1.91 140df p=0.059
No. of psychiatric referrals in 1 to 5 years prior to index presentation	0.09	0.03	t = 1.91 140df p=0.059

Table 23 shows that victims made a greater number of trauma presentations to the Emergency Department in the 1 to 5 years prior to index presentation than non-victims. Also, in the 5 years prior to index presentation more victims than non-victims had been recorded as having trauma caused by domestic violence. More victims than non-victims had received a psychiatric diagnosis in the 5 years prior to index presentation and had received more psychiatric referrals.

5.5 CASE-CONTROL STUDY TWO (1992)

A second case-control study used the medical records of victims and non-victims from the second prevalence study and was conducted under the same conditions as the first case-control study. This enabled comparisons of the two studies to be made.

Associate Professor Joan Lawrence examined the medical records of 183 victims (127 women, 56 men) who were matched with non-victims on sex, age and point of entry to the Emergency Department. The examiner was "blind" to the status of victims and non-victims.

The findings from the 1992 study were that **4.4 per cent** of those who self-reported domestic violence on the screening questionnaire were recorded on the medical record.

A judgment was made by the examiner (using the same categories as in the 1991 study) on the basis of what was recorded in the medical record by medical and nursing staff as to whether the person was a victim of domestic violence or not. Table 24 shows the results of this examination.

TABLE 24

EXAMINER'S JUDGMENT OF VICTIMS AND NON-VICTIMS OF DOMESTIC VIOLENCE, EMERGENCY DEPARTMENT R.B.H., 1992

EXAMINER'S JUDGMENT	VICTIMS (n=183) %	NON-VICTIMS (n=183) %
POSITIVE	14.2	1.1
PROBABLE	2.1	0.0
SUGGESTIVE	13.7	6.1
NEGATIVE	70.0	92.8
TOTAL	100.0	100.0
PERPETRATOR	4.4	1.6

The characteristics of victims (cases) and non-victims (controls) were analyzed in the same way as in the 1991 study. Tables 25 and 26 show where there were statistically significant differences between the characteristics of victims and non-victims. McNemar's X^2 was used for dichotomous variables and t-tests for paired samples were used for continuous variables.

TABLE 25

DIFFERENCES BETWEEN VICTIMS (CASES) AND NON-VICTIMS (CONTROLS) EMERGENCY DEPARTMENT R.B.H., 1992

CHARACTERISTIC	PREVALENCE AMONG CASES %	PREVALENCE AMONG CONTROLS %	DIFFERENCES CASES AND CONTROLS
Trauma recorded as domestic violence at index presentation	3.8	0.0	McNemar's test (binomial) p=0.0156
Index presentation - psychiatric diagnosis	6.1	1.1	McNemar's test (binomial) p=0.0225
Index presentation - alcohol/drug problem	3.8	0.0	McNemar's test (binomial) p=0.0156
Psychiatric history in last 1 to 5 years prior to index presentation	6.6	0.5	McNemar's test (binomial) p=0.0034
History of alcohol/drug problem in last 1 to 5 years prior to index presentation	8.7	2.2	McNemar's test (binomial) p=0.0118

Table 25 shows that, at index presentation, victims had more trauma recorded as domestic violence, greater numbers of psychiatric diagnoses, and more alcohol and drug problems than non-victims. Victims also had a greater amount of recorded psychiatric history in the 1 to 5 years prior to index presentation.

TABLE 26

DIFFERENCES BETWEEN VICTIMS (CASES) AND NON-VICTIMS (CONTROLS) EMERGENCY DEPARTMENT R.B.H., 1992

CHARACTERISTIC	MEAN IN CASES	MEAN IN CONTROLS	DIFFERENCES CASES AND CONTROLS
No. of visits to Emergency Department in 1 to 5 years prior to index presentation	2.3	1.4	t = 2.08 182df p=0.039
No. of outpatients visits to Royal Brisbane Hospital in 1 to 5 years prior to index presentation	3.6	2.0	t = 2.47 182df p=0.014
No. of records of trauma caused by domestic violence in 1 to 5 years prior to index presentation	0.03	0.0	t = 2.69 182df p=0.008
No. of medical visits in 1 year prior to presentation	1.2	0.6	t = 2.42 182df p=0.016
No. of psychiatric presentations in 1 to 5 years prior to index presentation	1.3	0.2	t = 2.8 182df p=0.006

Table 26 shows that victims made a greater number of visits to the Emergency Department and the Outpatients' Department in the 1 to 5 years prior to their index presentation than non-victims. Victims also had more trauma recorded as caused by domestic violence in those years. Victims made more visits to the Emergency Department for medical reasons than non-victims in the year prior to index presentation, and received more psychiatric diagnoses in the 1 to 5 years prior to index presentation.

In Chapter 6 conclusions are made which are based on the findings of these studies.

CONCLUSIONS 6.

This study shows that it is possible to conduct research with victims of domestic violence in the Emergency Department of a major public hospital in Australia. The study at Royal Brisbane Hospital Emergency Department has had an impact on the awareness of health professionals within the health system about domestic violence. It has also exposed the lack of resources available in hospital services in Queensland for victims of domestic violence.

The randomised design of the study and the high participation rates of people who attended the Emergency Department during this study are likely to make the results generalisable to emergency departments in major public hospitals in Australia. The design of the study has enabled the aims and hypotheses which were outlined in Chapter 1 to be addressed. The findings which have been described in Chapters 3, 4 and 5 are relevant to these specific aims and hypotheses, and the conclusions are based on these findings.

6. EXPLORATORY STUDIES (1990)

The exploratory studies conducted in 1990 enabled us to assess the feasibility of doing studies with victims of domestic violence in the Emergency Department. It is possible for trained research assistants who are experienced in the topic of domestic violence to administer screening questionnaires in the Emergency Department. The quality of the research is largely a function of the cooperation of medical and nursing staff in the Department with the research team, the calibre of the research assistants, and the response of those people who attend the Emergency Department. These studies showed the difficulties arising with the administration of questionnaires by Emergency Department staff who are often very busy and so confirm the need for external research assistants.

Methods and procedures which were developed in these studies were used in the main prevalence and case-control studies. Qualitative data were obtained from the exploratory studies and this data gave a basis on which future studies could be

conducted. This is the only part of the project where in-depth information was gathered from victims in the Emergency Department.

6.0.1 RESPONSE RATES

The high response rates in the exploratory study (**95 per cent**) indicate that people who attend the Emergency Department of a major public hospital are willing to participate in a study on domestic violence. Some of the remarks about the acceptability of this study have been recorded in Chapter 4 of this report. The high participation rates were borne out in the subsequent prevalence study in **1991** where **93 per cent** of those approached responded to the screening questionnaire. A similar response (**93 per cent**) was received in the **1992** prevalence study.

6.0.2 PREVALENCE ESTIMATES

Qualitative data from this study indicate that estimates of people with a lifetime history of domestic violence may be underestimates. It was noted that some people who did not complete the screening questionnaire indicated that they were victims of domestic violence and did not wish to talk about it. The various reasons included the experience being too long ago, wanting to forget about it, and the death of the abuser (these reasons are recorded in Chapter 4).

6.0.3 QUALITATIVE DATA

Participants in the study often recorded remarks on the screening questionnaire thereby giving useful insights into the experience of victims. Even though this study did not focus on perpetrators there was a small amount of information gathered from perpetrators of domestic violence. Because this study was conducted with men and women it was possible to make some comparisons between male and female victims.

Interviews which were conducted with victims of domestic violence (41 women and 7 men) have been described in Chapter 4 as case histories. These case histories describe victims' positive and negative experiences with health professionals. They explain some of the coping mechanisms which victims of domestic violence use and give some insights into their psychological state. They also describe the severity of the violence which some victims experience. They expose the injustices to which

victims attest and the experiences which may affect them psychologically for the rest of their life.

Comments were made by victims about the kind of help they would like to receive from health professionals. Generally, they would be pleased to talk about the violence, but require sensitivity from staff in addressing these issues. Victims want health professionals to believe their stories. The advice given by professionals may not always be acceptable to the victims at that time e.g. suggesting that the victim leaves the abuser. Always, the victims' own opinions and situations need to be taken into account in discussing future options for their life. Another issue which was raised by victims was their safety when they leave the Emergency Department. It is important for staff to address these problems of safety for victims and their children before they leave the Department.

We asked people if they were prepared to give in-depth interviews about their experience as domestic violence victims. There were much higher attrition rates for men (63 per cent) than there were for women (15 per cent). This indicates that women were much more willing to talk of their experiences.

Qualitative data which were gathered both from the screening questionnaires and the in-depth interviews indicate that, for men generally, there is not the dynamic of fear operating within a domestically violent relationship which there is for women. For example, there were no male victims observed to be in a cubicle at the Emergency Department saying that they were fleeing interstate from an abuser who might kill them, or that they were giving a fictitious name for fear of being located by the abuser. This was observed for a small number of female victims in this study. Also, women demonstrated that there were often economic difficulties for them in leaving a domestically violent relationship whereas men did not generally reveal these difficulties. There were obvious grieving situations for both men and women in their broken relationships.

Because this was an exploratory study, all of these conclusions form hypotheses which still need to be tested in future research.

6.1 PREVALENCE STUDIES (1991 and 1992)

In the prevalence studies mostly quantitative data were gathered. However, some qualitative data about peoples' experiences of domestic violence and their encounters with health professionals were obtained from the screening questionnaires. The size of the two prevalence studies was very similar, as were the characteristics of the respondents – sex and age distribution, country of birth, point of entry to the Emergency Department and time of entry to the Department.

6.1.1 PREVALENCE RATES OF DOMESTIC VIOLENCE

The high prevalence rates were comparable to research findings in Emergency Departments in the U.S.A. (Stark et al,1981; Goldberg and Tomlanovich,1984). In the first prevalence study **30 per cent** of women and **13 per cent** of men reported a history of domestic violence (including child abuse). A history of adult domestic violence was disclosed by **23 per cent** of women and **6 per cent** of men. The double victimisation of adult and child abuse had been experienced by **8 per cent** of women and **2 per cent** of men.

In the second prevalence study **31 per cent** of women and **16 per cent** of men reported a lifetime history of violence (including child abuse). A history of adult domestic violence was experienced by **24 per cent** of the women and **9 per cent** of the men. The double victimisation of adult and child was reported by **8 per cent** of women and **4 per cent** of men.

The prevalence rates in both studies were very similar for women. The prevalence rates for men experiencing adult domestic violence and the double victimisation of adult and child abuse had increased in the second study and both of these results were statistically significant.

6.1.2 CURRENT VICTIMS OF DOMESTIC VIOLENCE

Victims in the second study were asked if they were coming to the Emergency Department as a result of domestic violence at the same time as they completed the screening questionnaire. This revealed that **1.2 per cent** of the sample were there as a result of domestic violence (80 per cent were women). So it was estimated that **1 in**

50 women were coming to the Emergency Department as a result of domestic violence.

It was found that the majority of these victims came to the Emergency Department between 5pm and 8am when no social work referral service was available. It was observed by the research team that some staff were not aware of community resources for victims who came "after-hours" e.g. referral to emergency accommodation, nor did they have the time to attend to their domestic violence problems in a busy Emergency Department.

6.1.3 RISK FACTORS FOR DOMESTIC VIOLENCE

It was estimated in prevalence study one that the risk factors for being a victim of domestic violence were being female (**4.5** times greater than men) and having a history of child abuse (**4.3** times those not abused as children).

6.1.4 AGE OF VICTIMS

In the first study women aged **20 to 30 years** were most likely to report a history of adult domestic violence and this remained the same for the second study. Men aged **30 to 40 years** were most likely to report adult domestic violence in the first study but in the second study the age group widened to include men aged **20 to 40 years**.

Women had greater risks for being victims of adult domestic violence in most age groups, except those over 60 years. However, women in the 60 to 69 years age group in the second study had a greater risk of being abused than men in that age range.

6.1.5 TYPE OF ABUSE EXPERIENCED

In both studies women were at greater risk for all types of abuse – pushing, grabbing, slapping, kicking, hitting, biting, throwing objects at the victim, choking, strangling, beating up, serious threat to the victim's life or victim's children, sexual abuse and emotional abuse (including financial deprivation and social isolation). The only area in which women and men were equally likely to experience abuse was when weapons were used.

6.1.6 USAGE OF HEALTH SERVICES

In both studies a similar proportion of victims said that they had injuries or health problems due to domestic violence during the previous year (**35 per cent – 1991; 34 per cent – 1992**). A greater proportion of victims had received medical treatment for those problems in the first study (**28 per cent**) than in the second study (**20 per cent**).

The services which had been used most by the victims were general practitioners and hospital services.

It should be noted that these figures come from a hospital population and may not reflect the usage of health services by victims of domestic violence in the wider community.

6.1.7 PERCEPTIONS OF HEALTH PROFESSIONALS BY VICTIMS

In the first study doctors were perceived by victims as being the least helpful of health professionals when domestic violence was disclosed to them. This situation had improved for victims in the second study where victims perceived the response of doctors as comparable to other health professionals.

Nurses were perceived as being the most helpful in listening to victims of domestic violence. This may reflect the larger amount of time which nurses spend with people and may also be a function of the nursing profession being predominantly female.

Social workers ranked higher than other health professionals in giving advice to victims and this may reflect the counselling role which is taken by social workers in addressing domestic violence problems.

6.1.8 BARRIERS TO DISCLOSURE OF DOMESTIC VIOLENCE TO HEALTH PROFESSIONALS BY VICTIMS

These studies found that the most common barriers to victims' disclosing domestic violence were: feeling that it was no one else's problem but their own, being ashamed, guilty and embarrassed about the violence, feeling too scared of an abusive partner to

ask for help, feeling that their story would not be believed and the presence of an abusive partner when seeing a health professional.

6.2 CASE-CONTROL STUDIES (1991 and 1992)

The aims of the case-control studies were to determine the health professionals' detection rates of domestic violence i.e. whether those who self-reported domestic violence on the screening questionnaire had ever been recorded as a victim on the medical record. A further aim of the case-control studies was a comparison of the characteristics of victims and non-victims.

6.2.1 DETECTION RATES

It was found in the first case-control study that **6.4 per cent** of those who self-reported domestic violence had been recorded on the medical record. In the second case-control study it was found that **4.4 per cent** of those who self-reported domestic violence had been recorded. This change in detection rates was not statistically significant.

These low detection rates are comparable to detection rates in U.S. studies which reported that 5 to 20 per cent of victims of domestic violence were recorded on the medical record (Hilberman and Munson,1978; Stark et al,1981; Goldberg and Tomlanovich,1984).

6.2.2 CHARACTERISTICS OF VICTIMS

In the case-control studies it was found that more victims than non-victims presented to the Emergency Department with suicide attempts. More victims than non-victims had a psychiatric diagnosis at index presentation i.e. the presentation at which the screening questionnaire was administered. Victims also presented with greater amounts of alcohol and drug problems. They had more recorded psychiatric history and more history of alcohol and drug problems than non-victims in the 5 years prior to index presentation. Consequently they were given more psychiatric referrals than non-victims.

trying to contact Resident Medical Officers after they completed their 6 week's term in the Emergency Department.

Because of the time constraints of this brief training program the factual content of the training e.g. community statistics was reduced drastically. Emphases were placed on teaching staff about identification and appropriate referral of victims, and on the legal aspects of domestic violence e.g. the requirement by doctors under the Medical Act to report suspected criminal assault.

6.3.1 EVALUATION OF THE EDUCATION PROGRAM

The impact of the program was evaluated using a survey of doctors and nurses before and after the educational program. In evaluating the process, it was noted how many staff the program had reached. There were low participation rates by doctors and nurses in workshops and case presentations. Those who attended the program considered that generally the program increased their knowledge, but did not consider that the length of the program was adequate. This indicated the willingness of those who attended to learn more about the topic of domestic violence.

The quality of the materials in the training program was evaluated by the participants. A pocket card which had been developed specifically for this program, with a similar format used for medical procedures in Emergency Department was well received. The evaluation of a protocol (poster) which had been developed by Queensland Health proved that materials used with staff in Emergency Department need to be succinct and contain eye-catching graphics (the poster was subsequently revised). Materials in flow-chart form, as used for other procedures in the Emergency Department, were the most acceptable.

6.3.2 IMPACT EVALUATION - KNOWLEDGE, ATTITUDES AND PRACTICES OF DOCTORS AND NURSES

The impact of the education program was measured by changes in the knowledge, attitudes and practices of doctors and nurses, as assessed by a self-administered questionnaire before and after the education program. Participation rates of doctors were low in this survey, but those for nurses were higher. This may reflect the

Even though detection rates of victims on the medical record were low, victims had more trauma recorded as being caused by domestic violence than non-victims, both at index presentation and in the 5 years prior to index presentation.

Victims were found to make more visits to the Emergency Department and the Out Patients' Department than non-victims in 1 to 5 years prior to their index presentation.

When victims' presentations were compared within their own group they were found to have more medical than trauma visits at index presentation to the Emergency Department. When compared with non-victims they had more visits to the Emergency Department with medical problems in the year prior to index presentation.

Even though victims had more medical presentations than non-victims they were still found to have a greater history of bruising, lacerations and fractures than non-victims.

On the basis of the above findings, health professionals may suspect that people are victims of domestic violence if there is a cluster of the following symptoms and signs - repeated use of the Emergency services, vague complaints or pain without physiological cause, a medical history which reveals many "accidents" with injuries of suspicious origin, suicide gestures or attempts and alcohol or drug problems.

6.3 EDUCATION OF DOCTORS AND NURSES IN EMERGENCY DEPARTMENT (1991)

The first goal of the education program was to enhance the recognition of victims of domestic violence who came to the Emergency Department. Subsequent to this, it was necessary to develop appropriate referral and specialist processes for these victims of domestic violence.

The research team experienced some difficulties in conducting an inservice education program in this busy Emergency Department. Reasons for this included the problem of shift work, shortage of relief staff during training sessions, calls made upon staff during training (particularly doctors) to return to the Department, and the difficulties of

itinerant nature of the resident medical officers on rotational terms in the Department as compared to the more stable complement of nursing staff. It may also reflect the interest that nurses have in the topic of domestic violence or that their profession is predominantly female. It is possible that some nurses may have been personally affected by domestic violence at some time.

The overall knowledge of doctors and nurses about domestic violence increased after the education program. Staff had more knowledge about victims and perpetrators of domestic violence and where to send victims for emergency accommodation and help in the community. More significant changes were made for nursing than medical staff.

When attitudinal changes were measured, there was a significant improvement in the attitudes of the whole group. Again, there were more significant changes for nurses. When attitudes were analysed by gender there were no statistically significant differences between men and women. Therefore we conclude that the attitude change is a function of the profession rather than the gender of staff members.

Doctors and nurses were tested about their level of suspicion that a person may be a victim of domestic violence. It was found that the level of suspicion was raised after the education program, but it was not statistically significant.

Nurses reported higher levels of clinical contact and social contact with victims and perpetrators of domestic violence than doctors. However, the only statistically significant difference was found between nurses' and doctors' social contact with adult victims of domestic violence where nurses had twice as much contact with victims.

6.3.3 OUTCOME EVALUATION OF THE EDUCATION PROGRAM

The outcome of the education program was measured by the change in detection rates of victims of domestic violence before and after the education program. This was carried out by examination of the medical records by a senior psychiatrist in two case-control studies. The self-reports of victims and non-victims were compared with their medical records.

In the first case-control study it was found that **6.4 per cent** of victims were recorded as such on the medical record. This detection rate had decreased to **4.4 per cent** in the second case-control study. It has been noted that these findings are comparable with overseas studies.

The second case-control study was conducted 6 months after the education program with doctors and nurses by the research team, and there was a new complement of doctors in the Emergency Department, particularly resident medical officers. Recognition of domestic violence victims depends on the initial contact with first-line staff i.e. resident medical officers and nurses. As the new doctors had not participated in the education program, this may explain why detection rates did not improve. Even though there was no comparable change of nursing staff, the low participation rates by nurses in the training program may have contributed to the low detection rates. The conclusion to be drawn is that training needs to be ongoing with each new group of staff changes.

Previous research has shown that merely offering education programs alone is not sufficient to increase detection of victims of domestic violence in emergency department (McLeer et al,1989). To augment education programs, systems also need to be instituted in emergency department for identification of victims of domestic violence, such as routine assessment of people who are suspected to be victims (Tilden and Shepherd,1987). This may be a specialist area for nursing staff with the training of clinical nurses for these positions (Brendtro and Bowker,1989; Varvaro and Cotman,1991).

A further issue which was raised by participants in this study was the provision of back-up referral resources to which victims could be referred. As a result of the research, a social work on-call service was instituted in the Emergency Department at Royal Brisbane Hospital between 5pm and 8am and at weekends. This service which commenced in November, 1992 has received a consistent number of referrals from doctors and nurses in Emergency Department. From January to December 1993 there were 119 victims of domestic violence who were referred "after-hours", with 1 to 3 victims seen per week in normal working hours (8am to 5pm). Each person takes 2 to

5 hours for a social work consultation. In this year there were 3 re-presentations at the Emergency Department by victims of domestic violence. Only one victim was admitted to the overnight stay ward in the Emergency Department for non-medical reasons during this period (Prior to the commencement of this service it would be practice to admit some victims of domestic violence to the overnight stay ward for assessment by a social worker the next day). The guidelines which have been set for this service cover a broad range of domestic violence situations, including "dating" violence and child abuse (APPENDIX I).

It appears from the outcome of this service that doctors and nurses in the Emergency Department at Royal Brisbane Hospital are identifying and referring victims of domestic violence for appropriate management.

6.4 LIMITATIONS OF THE STUDY

6.4.1 MEASUREMENT OF TYPES OF VIOLENCE

One of the limitations of this study is that measurement of the types of violence is inconclusive. It does not take into account the intensity, frequency, meaning and impact on the victims of various types of violence; the context in which the violence takes place; and the injuries suffered by victims. A study by Berk et al (1983) showed that violence by men against women is more severe and results in greater physical injury than the violence of women towards men. Another study by Cascardi et al (1992) also found that women were more likely than men to sustain severe injuries, and women were more likely to report depressive symptomatology.

The study at Royal Brisbane Hospital was an epidemiological study which focused on the measurement of prevalence rates of victims of domestic violence. The screening questionnaire which was used in the prevalence studies did not encompass in-depth data which would be required to explore further the types of violence which victims experienced and their effects.

6.4.2 EXCLUSION OF NON-ENGLISH SPEAKING BACKGROUND ATTENDEES AT EMERGENCY DEPARTMENT

People who were of non-English speaking background were unable to be included in this study because we lacked resources to provide interpreters. The researchers noted that up to 25 per cent of people who attended the non-Acute Emergency service were unable to speak English. The investigators made application for further funding in 1990 to the Commonwealth Department of Community Services and Health to include NESB people but the application was unsuccessful.

6.5 OUTCOME OF THE STUDY

This study has provided the first Australian data on domestic violence victims in the Emergency Department of a large public hospital. The study has provided a stimulus to research in other emergency departments of hospitals in Australia. Staff at the Northern Sydney Area Health Service have expressed their interest in replicating the Royal Brisbane Hospital research. Studies on domestic violence are being carried out at the Accident Research Centre, Monash University, Melbourne.

The findings from the Brisbane research have been used as part of training materials in other States e.g. N.S.W Health Media produced a video, "Hitting Home: Responses to Domestic Violence by Emergency Staff", for the training of doctors and nurses.

As mentioned above, an outcome of the findings of this research has been an after-hours social work service which commenced in November,1992 at the Royal Brisbane Hospital Emergency Department. This service has been supported by the Executive of the Royal Brisbane Hospital and funded as a permanent service. The Brisbane North Regional Health Authority has noted this service in the list of highlights of the region's achievements. This was noted as improving service access for clients.

The principles of education for doctors and nurses about domestic violence which were established in this project have been adopted by Queensland Health in the training programs for doctors and nurses in Queensland public hospitals which commenced in 1992.

Materials which were developed for the education program of doctors and nurses in the study at Royal Brisbane Hospital e.g. slide package, pocket card and reading lists have been adapted and produced jointly by Queensland Health and Department of Psychiatry, University of Queensland.

Community and hospital presentations of the study have been made in the Brisbane metropolitan area.

The research has been presented at the following Australian venues:

National Forum on Domestic Violence Training, Adelaide – 1990

Australasian Society of Traumatic Stress, Sydney – 1991

Second National Conference on Violence, Australian Institute of Criminology, Canberra – June, 1993

Healthsharing Women's Health Resource Service, Melbourne, seminar "Research Issues in Women's Mental Health" – 1994

Monash University Accident Research Centre, Melbourne – 1994

Presentations of the research have been made to the following international bodies:

Fourth World Congress of Behaviour Therapy, Gold Coast – 1992

International Women's Medical Society, Guatemala – 1992

International Traumatic Stress Studies Conference, Amsterdam – 1992

International Epidemiology Conference, Sydney – 1993

There have been two publications in the Medical Journal of Australia from this study – "Domestic Violence Victims in a Hospital Emergency Department" (Roberts et al, 1993 – see APPENDIX G) and "Domestic violence and health professionals" (Roberts et al, 1993).

7. RECOMMENDATIONS

7.1 It is recommended that this report be circulated to all organisations of health professionals to inform them that the results of this research show high prevalence rates of victims of domestic violence in a hospital emergency department population. Two aspects of the seriousness of domestic violence should be emphasised. The severity and amount of injury, particularly for women, is of particular interest for front-line health professionals such as doctors, nurses and social workers in emergency department, general practitioners and community health workers. Psychological trauma which is sustained by victims needs to be addressed by all health professionals, but more particularly by mental health workers.

7.2 It is recommended that this report be circulated to all directors of emergency medicine, nursing, mental health and social work services in Queensland.

7.3 This study has shown the high rates of psychiatric services used by victims of domestic violence and points to the need for further longitudinal and in-depth research. A firmer scientific basis needs to be established for the recognition of post traumatic psychiatric illness associated with domestic violence than currently exists. There is a lack of good systematic studies in this field, and therefore a lack of knowledge of the specific problems faced by victims of domestic violence.

7.4 Medical Colleges and Associations should be encouraged to address the issues of awareness and education of their various members about domestic violence. The findings of the study which show that general practitioner services are utilised by a large proportion of victims of domestic violence is particularly relevant information for the Royal College of General Practitioners and the Family Medicine Program. Other

colleges such as the Royal Australian College of Obstetrics and Gynaecology should be encouraged to address the issue of domestic violence as it affects women's health.

7.5 The nursing profession should encourage colleges and Associations such as the Australian College of Nursing, the Australian College of Midwifery and the Queensland Nurses' Union to address the issue of domestic violence. A model for nurses has been provided by the Nursing Network on Violence Against Women in the U.S.A. This organisation exists as a loose coalition of nurses and other concerned advocates and health professionals.

7.6 The Australian Dental Association needs to address the issue of domestic violence because of the facial injuries sustained by victims.

7.7 It is recommended that training about domestic violence be included in the undergraduate curriculum for all health professionals. All health workers need a basic understanding of the dynamics of intimate, violent relationships; legal aspects of domestic violence; and a knowledge of community resources for domestic violence problems.

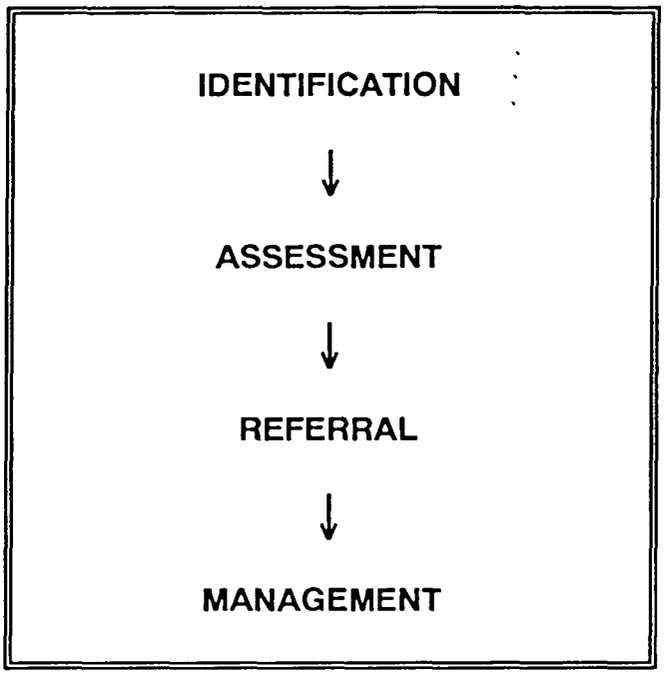
7.8 Attention should be given to the training of staff and production of materials in particular areas e.g. rural areas and places where there are significant aboriginal populations and non-English speaking background people.

7.9 In-service training about domestic violence is necessary for medical and nursing staff of emergency departments. Clerical staff also need to have some training about domestic violence problems because they are often the first point of contact which a victim has with the hospital. The education program needs the support of senior staff to ensure that it becomes part of the ongoing in-service education program for staff in emergency department.

Figure 20 provides a model for training of health professionals which could be followed in an Emergency Department.

FIGURE 20

A MODEL FOR MANAGEMENT OF VICTIMS OF DOMESTIC VIOLENCE BY HEALTH PROFESSIONALS



7.10 Protocols need to be set in place in emergency departments of public hospitals to ensure that on-going systems address the issues of management of domestic violence victims.

7.11 Attention needs to be given to instituting systems which ensure the detection of victims of domestic violence in emergency department. Since all staff are being trained to detect victims it is recommended that special staff be designated to whom suspected victims are referred for initial assessment. This may be a specialist area for nursing staff with the training of clinical nurses for these positions.

7.12 The establishment of after-hours social work services in public hospital emergency departments is a necessary resource for referral of victims of

domestic violence who come to emergency departments. This study demonstrated that the majority of victims come to the Department between 5pm and 8am when social work staff are not generally available for referral.

7.13 It is recommended that research be conducted to investigate clients' patterns and responses, following an educative and preventive social work service in the Emergency Department at the point of crisis. For example, do they access community resources? Are there changes in their attitudes and behaviors in relation to being a victim of domestic violence? Does the violence cease?

7.14 Emergency departments need an inter–disciplinary committee comprising medical, nursing and social work (where available) to address the in–service training and institution of procedures to deal with problems of domestic violence.

7.15 Hospitals need to establish links with agencies who deal with the problem of domestic violence in the community.

7.16 It is recommended that the development and evaluation of systematic approaches to the prevention of domestic violence be made within the health care system.

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6. VIDEO

Hitting Home: Responses to Domestic Violence by Emergency Staff. (1992) *Health Media*, Health Promotion Unit, Department of Health, N.S.W.

STRICTLY CONFIDENTIAL – for Research only

We are giving this questionnaire to **ALL** people who attend the Accident and Emergency Department at Royal Brisbane Hospital. We would like to learn more about domestic violence between **ADULTS** in families and close relationships. When we talk about domestic violence, we are talking about more than just a heated domestic argument. We are talking about **PERSISTENT** abuse, with one partner being afraid of and/or being hurt by the other. Please assist us by completing the following questions.

1) Have you EVER been a victim of domestic violence as an ADULT? Tick one box ☑

Yes ☐ 1 No ☐ 2 (26)

If YES, go to Q2 *If NO, go to Q5*

2) If YES, have you suffered any of the following at the hands of a family member or close friend? *Tick one or more*

- *Pushing, shoving, grabbing or slapping* ☐ (27)
- *Kicking, biting or hitting with a fist* ☐ (28)
- *Throwing objects at you* ☐ (29)
- *Choking, strangling* ☐ (30)
- *Beating up* ☐ (31)
- *Using a knife or gun or other weapon* ☐ (32)
- *Serious threat to your life and/or children* ☐ (33)
- *Sexual abuse* ☐ (34)
- *Emotional abuse* ☐ (35)
  (including verbal abuse; allowed no money or being kept away from family and/or friends)
- *Other – specify* _____ ☐ (36)

3) If YES, when was the last time you were abused? *Tick one only*

- *Within last 24 hours* ☐ 1
- *Within 1 week* ☐ 2
- *Within 1 month* ☐ 3
- *Within last 6 months* ☐ 4
- *Within 1 year* ☐ 5
- *Longer than 1 year* ☐ 6(40)

4) If YES, who abused you? *Tick one or more*

- *Wife/Husband* ☐ (41)
- *De facto* ☐ (42)
- *Boy friend/Girl friend* ☐ (43)
- *Other – specify* _____ ☐ (44)

5) If a friend asked you about help for domestic violence what community services would you suggest?

a) _____ (52-53) c) _____ (56-57) e) _____ (60-61)

b) _____ (54-55) d) _____ (58-59) f) _____ (62-63)

6) Have you been a victim of child abuse? ..... Yes ☐ 1 No ☐ 2 (65)

COMMENTS _____

_____

_____ ***Thank you for your cooperation***

TO BE FILLED IN BY STAFF

DOMESTIC VIOLENCE RESEARCH PROJECT

U.R.NO. ☐☐☐☐☐☐

OR

MASTER PATIENT NO. ☐☐☐☐☐☐☐☐ (7–14)

Day Month Year

Date: ☐☐/☐☐/☐☐ (1–6)

Time ☐☐☐☐ am 1 pm 2 (15–18,19)

SEX M 1 F 2 (20)

Country of Birth ☐☐☐☐☐☐☐☐☐☐ (21)

ACUTE 1 NON-ACUTE 2 3A 3 (22)

Aboriginal 1 Torres Strait Islander 2 (23)

AGE ☐☐ (24–25)

INTERVIEWER ☐☐☐☐☐☐☐☐☐☐

IF YOU HAVE EXPERIENCED DOMESTIC VIOLENCE WOULD YOU ASSIST US BY ANSWERING THE FOLLOWING QUESTIONS?

1) DURING THE LAST YEAR, did you have injuries or health problems caused by domestic violence?

Tick one box ☑

Yes ☐ 1 No ☐ 2 (21)

2) DURING THE LAST YEAR, did you receive medical treatment for physical injuries or health problems caused by domestic violence?

Yes ☐ 1 No ☐ 2 (22)

If NO, DO NOT ANSWER ANY MORE QUESTIONS

3) If YES, where did you go?

Tick one or more

Doctor – GP ☐ (23)

Royal Brisbane Hospital ☐ (24)

Other – specify _____ ☐ (25)

4) Who did you see?

Tick one or more

Doctor ☐ (28)

Nurse ☐ (29)

Social worker ☐ (30)

Other – specify _____ ☐ (31)

5) Did you tell them that the injury or health problem was caused by domestic violence?

Yes ☐ 1 *No* ☐ 2 (34)

If NO, GO TO QUESTION 7, PAGE 3 →

6) What did the health worker do?

You may answer for one or more health worker

DOCTOR

Advised me what to do ☐ (35)

Listened to my problem ☐ (36)

Ignored my problem ☐ (37)

Said or did things that upset me ☐ (38)

NURSE

Advised me what to do ☐ (39)

Listened to my problem ☐ (40)

Ignored my problem ☐ (41)

Said things that upset me ☐ (42)

SOCIAL WORKER

Advised me what to do ☐ (43)

Listened to my problem ☐ (44)

Ignored my problem ☐ (45)

Said or did things that upset me ☐ (46)

OTHER - specify _____

Advised me what to do ☐ (47)

Listened to my problem ☐ (48)

Ignored my problem ☐ (49)

Said or did things that upset me ☐ (50)

GO TO QUESTION 8 →

7) If NO, what was the reason you didn't tell them the cause of your injuries or health problem was domestic violence?

I didn't know I had a problem ☐ 51

I didn't know how they could help ☐ 52

I didn't think they were interested or cared ☐ 53

I felt too scared of my partner to ask for help ☐ 54

I couldn't talk to a male doctor ☐ 55

I felt it was my problem ☐ 56

Shame, guilt or embarrassment ☐ 57

Staff were too busy ☐ 58

No one wanted to listen to me ☐ 59

No one would have believed me ☐ 60

Nowhere private ☐ 61

My partner was with me ☐ 62

Priority was to keep the family together rather than protecting me ☐ 63

I was not allowed to go to the Doctor ☐ 64

I was too sick ☐ 65

Language barrier ☐ 66

I was too far away from the Doctor ☐ 67

Other - specify _____ ☐ 68

_____

8) Would you like help in relation to the violence NOW?

Yes ☐ 1, No ☐ 2 Maybe ☐ 3 (75)

OTHER COMMENTS _____

_____

_____

_____

TO BE FILLED IN BY STAFF

UR NO. ☐☐☐☐☐☐

MASTER PATIENT NO. ☐☐☐☐☐☐☐☐ (1-8)

Social worker referral ☐ (9)

Personal trauma clinic card given ☐ (10)

Legal booklet given ☐ (11)

List of services given ☐ (12)

Social work card given ☐ (13)

– STRICTLY CONFIDENTIAL – for Research only – University of Queensland

We are giving this questionnaire to **ALL** people who attend the Accident and Emergency Department at Royal Brisbane Hospital. We would like to learn more about domestic violence between **ADULTS** in families and close relationships. When we talk about domestic violence, we are talking about more than just a heated domestic argument. We are talking about **PERSISTENT** abuse, with one partner being afraid of and/or being hurt by the other. Please assist us by completing the following questions.

1) Have you EVER been a victim of domestic violence as an ADULT? Tick one box ☑

Yes ☐ 1 No ☐ 2 (29)

If YES, go to Q2 *If NO, go to Q6*

2) If YES, have you suffered any of the following at the hands of a family member or close friend? *Tick one or more*

Pushing, shoving, grabbing or slapping ☐ (31)

Kicking, biting or hitting with a fist ☐ (32)

Throwing objects at you ☐ (33)

Choking, strangling ☐ (34)

Beating up ☐ (35)

Using a knife or gun or other weapon ☐ (36)

Serious threat to your life and/or children ☐ (37)

Sexual abuse ☐ (38)

Emotional abuse ☐ (39)
(including verbal abuse; allowed no money or being kept away from family and/or friends)

*Other – specify*_____ ☐ (40)

3) If YES, when was the last time you were abused? *Tick one only*

Within last 24 hours ☐ 1

Within 1 week ☐ 2

Within 1 month ☐ 3

Within last 6 months ☐ 4

Within 1 year ☐ 5

Longer than 1 year ☐ 6(44)

4) If YES, who abused you? *Tick one or more*

Wife/Husband ☐ (45)

De facto ☐ (46)

Boy friend/Girl friend ☐ (47)

*Other – specify*_____ ☐ (48)

5) Is domestic violence your reason for coming to Emergency Department today?

Yes ☐ 1 No ☐ 2 (51)

6) If a friend asked you about help for domestic violence what community services would you suggest?

a)_____ (52-53) c)_____ (56-57) e)_____ (60-61)

b)_____ (54-55) d)_____ (58-59) f)_____ (62-63)

7) Have you been a victim of child abuse? ..... Yes ☐ 1 No ☐ 2 (65)

COMMENTS_____

Thank you for your cooperation

I.D. (1-4)

TO BE FILLED IN BY STAFF

DOMESTIC VIOLENCE RESEARCH PROJECT

U.R.NO. ☐☐☐☐☐☐ (5-10)

Day Month Year

Date: ☐☐ / ☐☐ / ☐☐ (11-16)

Time: ☐☐☐☐ am 1 pm 2 (17-20)

SEX: M 1 F 2 (21)

Country of Birth: ☐ (22-23)

ACUTE 1 NON-ACUTE 2 3A 3 (24)

Aboriginal 1 Torres Strait Islander 2 (25)

AGE: ☐☐ (26-27)

INTERVIEWER: ☐ (28)

DEPARTMENT OF PSYCHIATRY, UNIVERSITY OF QUEENSLAND

GUIDELINES FOR ADMINISTERING QUESTIONNAIRES - PREVALENCE STUDY JULY 1992

1) It is essential that the questionnaires be administered to respondents **ON THEIR OWN** e.g. in Non-acute the respondents should be asked to fill them in at the central desk; in the Sub-acute waiting room (Acute section) ask respondents to come inside the Acute department.

2) Please ensure that the questionnaire has the correct UR number on the back. There may be some difficulties obtaining this in Acute section. If there is any doubt about the number, please record the respondent's full name and date of birth on the back of the form (in pencil) and it will be erased later (after the UR number has been obtained) as per ethical requirements.

3) Please ensure that respondents have completed the form when you receive it back. Glance quickly to see if question 1 is positive. If so, give the respondent the further questionnaire. They may need some assistance with this questionnaire.

4) Please record any observations which you make yourself. It is **ALL USEFUL DATA** which may be used in a qualitative sense e.g if the respondent denies victimization and it becomes clear to you that the person has been victimized, please record your observation.

5) When working in the Acute section it is useful if you can make regular checks on Ward 3A as some patients may be missed in the Acute section.

We would like to ask your opinions about the EDUCATIONAL PROGRAM for STAFF in EMERGENCY DEPARTMENT which was carried out from August to October 1991.

8) **Did you attend a WORKSHOP on domestic violence conducted by Gwen Roberts, Theresa Stolz and Police?**

(TICK ONE BOX) ☐ YES ☐ NO (35)

If YES, we are interested to know whether you were satisfied with the WORKSHOP
(PLEASE CIRCLE ONLY ONE NUMBER FOR EACH STATEMENT)

	STRONGLY DISAGREE	DISAGREE	NEUTRAL	AGREE	STRONGLY AGREE	
The WORKSHOP increased my knowledge about domestic violence	1	2	3	4	5	(36)
Information was presented in a coherent and organized manner	1	2	3	4	5	(37)
The length of the program was adequate	1	2	3	4	5	(38)
The WORKSHOP gave me sufficient information to know what to do for victims of domestic violence in Emergency Department	1	2	3	4	5	(39)

9) **Did you attend a CASE PRESENTATION on domestic violence conducted by Dr. Joan Lawrence?**

(TICK ONE BOX) ☐ YES ☐ NO (40)

If YES, we are interested to know whether you were satisfied with the CASE PRESENTATION
(PLEASE CIRCLE ONLY ONE NUMBER FOR EACH STATEMENT)

	STRONGLY DISAGREE	DISAGREE	NEUTRAL	AGREE	STRONGLY AGREE	
The CASE PRESENTATION increased my knowledge about domestic violence	1	2	3	4	5	(41)
Information was presented in a coherent and organized manner	1	2	3	4	5	(42)
The length of the program was adequate	1	2	3	4	5	(43)
The CASE PRESENTATION gave me sufficient information to know what to do for victims of domestic violence in EMERGENCY DEPARTMENT	1	2	3	4	5	(44)

10) **We would like to know how helpful you found each part of the education programme.**
(PLEASE CIRCLE ONLY ONE NUMBER FOR EACH ITEM)

	DID NOT ATTEND OR RECEIVE	NOT AT ALL HELPFUL	NOT HELPFUL	HELPFUL	VERY HELPFUL	
WORKSHOP on domestic violence (Gwen Roberts & Theresa Stolz)	1	2	3	4	5	(46)
CASE PRESENTATIONS on domestic violence (Dr. Joan Lawrence)	1	2	3	4	5	(47)
PROTOCOL - "Detection and Management of victims of domestic violence" (on Notice Boards)	1	2	3	4	5	(48)
POCKET CARD - "When to suspect domestic violence"	1	2	3	4	5	(49)
BOOKLET - "The Domestic Violence (Family Protection) Act 1989"	1	2	3	4	5	(50)
BOOKLET - "Who are the Victims?"	1	2	3	4	5	(51)

ANY OTHER COMMENTS -

UNIVERSITY OF QUEENSLAND
DEPARTMENT OF PSYCHIATRY

DOMESTIC VIOLENCE RESEARCH PROJECT
SURVEY OF HEALTH PROFESSIONALS

PLEASE COMPLETE THE FOLLOWING DETAILS

SEX MALE 1 FEMALE 2

AGE (IN YEARS) _____

a) IF ENROLLED NURSE, NO OF YEARS SINCE GRADUATION _____

b) IF MEDICAL OFFICER NO OF YEARS SINCE GRADUATION _____

CURRENT POSITION IN HOSPITAL _____

c) IF REGISTERED NURSE, NO OF YEARS SINCE GRADUATION _____

CURRENT POSITION IN HOSPITAL _____

1 THE FOLLOWING QUESTIONS RELATE TO FACTS ABOUT THE TOPIC OF DOMESTIC VIOLENCE

(PLEASE CIRCLE THE APPROPRIATE NUMBER) (22-30)

	TRUE	FALSE	DON T KNOW
Up to one-third of intimate adult relationships are affected by domestic violence	1	2	3
Serious domestic violence is a rare occurrence	1	2	3
There is a high level of community acceptance in Australia of at least some forms of domestic violence	1	2	3
Three out of four female victims of murder are killed by a family member or sexual partner	1	2	3
There are more domestic homicides in metropolitan areas than in rural areas	1	2	3
Most individuals abused as children will maltreat their adult partners	1	2	3
One of the causes of domestic violence can be seen as a power imbalance between men and women	1	2	3
Domestic violence is a significant public health problem	1	2	3
Doctors are required by law to report suspected criminal assault	1	2	3

DEFINITION OF DOMESTIC VIOLENCE -

Domestic violence is defined as the physical, sexual or emotional abuse of one adult by another adult in a close relationship.

2. THE FOLLOWING QUESTIONS RELATE TO VICTIMS OF DOMESTIC VIOLENCE (32-42)

	TRUE	FALSE	DON T KNOW
Five % of victims of domestic violence are male	1	2	3
Victims consult doctors more often than police, or any other group of professionals	1	2	3
There is a "typical" violence-prone victim	1	2	3
The greatest proportion of medical visits by victims do not involve trauma but medical behavioural and psychiatric presentations	1	2	3
Most female victims choose to leave a violent situation when the violence begins	1	2	3
Domestic violence is responsible for more injuries to women than motor vehicle accidents reported rape and street violence combined	1	2	3
Many women are socialised to believe that when things go wrong in a relationship it's their duty to stay and to make the relationship work	1	2	3
Most victims do not want to discuss domestic violence with a health professional	1	2	3
Generally victims state that emotional abuse is worse than physical abuse	1	2	3
Women who are abused usually provoke the violence	1	2	3
Many of the maladaptive behaviours observed in victims have been demonstrated to be the consequence of victimisation not the cause	1	2	3

3 THE FOLLOWING QUESTIONS RELATE TO PERPETRATORS OF DOMESTIC VIOLENCE (44-51)

	TRUE	FALSE	DON T KNOW
Most perpetrators are mentally ill or have severe personality disorders	1	2	3
Abusers commonly deny responsibility for their actions by blaming behaviour of the victim for the abuse	1	2	3
Women who perpetrate domestic violence often do so in self-defence or retaliation for previous abuse	1	2	3
Most perpetrators of domestic violence are affected by alcohol at the time of the abuse	1	2	3
Men who physically abuse their partners are usually violent to people in the public arena	1	2	3
Most perpetrators are from lower income groups	1	2	3
Perpetrator characteristics are far more predictive of violence than victim characteristics	1	2	3
Arrest of perpetrators has been shown to be an effective deterrent to further domestic violence	1	2	3

4 THE FOLLOWING QUESTIONS ARE DIRECTED TOWARDS YOUR VIEWS ON DOMESTIC VIOLENCE

(PLEASE CIRCLE THE APPROPRIATE NUMBER) (53-62)

	Strongly Agree	Agree	Disagree	Strongly Disagree	Undecided
There is little a doctor or nurse can do to stop domestic violence	1	2	3	4	5
Doctors and nurses should only get involved if the patient directly requests help	1	2	3	4	5
Domestic violence is a behavioural pattern not amenable to change	1	2	3	4	5
Domestic violence is unlikely to occur amongst more affluent patients	1	2	3	4	5
Domestic violence problems need to be taken more seriously by police	1	2	3	4	5
Medical facilities should have a protocol for handling cases of domestic violence	1	2	3	4	5
Medical facilities should liaise with community agencies in the prevention and treatment of domestic violence	1	2	3	4	5
It should be required that doctors report suspected adult abuse just as they are required to report child abuse	1	2	3	4	5
Doctors and nurses cannot be expected to do more than treat the physical injuries of domestic violence victims	1	2	3	4	5
Medical students and student nurses need more training in the topic of domestic violence	1	2	3	4	5

5 THE FOLLOWING QUESTIONS RELATE TO YOUR CONTACT WITH VICTIMS AND PERPETRATORS OF DOMESTIC VIOLENCE

(PLEASE CIRCLE THE APPROPRIATE NUMBER)

1) In the course of your clinical work over the last 12 months, have you had occasion to interview/manage any of the following? (64-69)

	NEVER	RARELY	SOME-TIMES	OFTEN	VERY OFTEN
a) Adult victims	1	2	3	4	5
b) Perpetrators of domestic violence	1	2	3	4	5
c) Children who witness violence between parents	1	2	3	4	5

2) In the last 12 months, are you aware of having contact with any of the following in a social or non-clinical context

a) Adult victims	1	2	3	4	5
b) Perpetrators of domestic violence	1	2	3	4	5
c) Children who witness violence between parents	1	2	3	4	5

6 THE FOLLOWING QUESTIONS RELATE TO YOUR PERCEIVED ABILITY TO DEAL WITH VICTIMS OF DOMESTIC VIOLENCE

A) How sure are you that each of the following signs and symptoms would cause you to suspect that a person was a victim of domestic violence? (70 78

	VERY SURE	SURE	NOT SURE	VERY UNSURE	NOT AT ALL
Injuries to neck face or throat	1	2	3	4	5
Frequent visits to the Accident and Emergency Department	1	2	3	4	5
Injuries to the extremities	1	2	3	4	5
Sprains or strains	1	2	3	4	5

	VERY SURE	SURE	NOT SURE	VERY UNSURE	NOT AT ALL
Presence of a dominating partner	1	2	3	4	5
Pain with no apparent physical cause	1	2	3	4	5
Abdominal pain	1	2	3	4	5
Overdose of tranquilizers	1	2	3	4	5
Substantial delay between time of injury and presentation at Accident and Emergency Department	1	2	3	4	5

B) Name ONE community agency you would contact to arrange emergency accommodation for a victim of domestic violence who wanted to leave the violent situation.

.....

(79-80)

C) The following statements relate to the Domestic Violence (Family Protection) Act, 1989.

(PLEASE CIRCLE THE APPROPRIATE NUMBER) (1-5)

	TRUE	FALSE	DON'T KNOW
The legislation covers all intimate and adult family relationships	1	2	3
A perpetrator of domestic violence can be charged with criminal assault	1	2	3
Only police can apply for a Protection Order for a victim of domestic violence	1	2	3
A Protection Order can be granted even if there are only threats to injure a victim of domestic violence	1	2	3
Police can enter premises if necessary, if they suspect that domestic violence has occurred or is occurring	1	2	3

7. THE FOLLOWING QUESTIONS ARE DIRECTED TOWARDS THE DISSEMINATION OF INFORMATION ABOUT DOMESTIC VIOLENCE

(PLEASE TICK ONE OR MORE BOXES)

1) To date, where has most of your knowledge about domestic violence come from? (6-15)

a) Public media ☐
b) Books/Journal articles ☐
c) Lectures during training ☐
d) In-service training ☐
e) Ward rounds ☐
f) Government education ☐
g) Other health professionals ☐
h) Friends ☐
i) OTHER - Specify ☐

2) Of the following, to which would you refer for further knowledge about domestic violence? (17-24)

a) Public media ☐
b) Books/Journal articles ☐
c) Lectures during training ☐
d) In-service training ☐
e) Ward rounds ☐
f) Government education ☐
g) Other health professionals ☐
h) Friends ☐

3) In which of the following areas related to domestic violence would you be interested in obtaining more information? (26-32)

a) Interviewing techniques for detection of domestic violence ☐
b) Directory of community services for domestic violence victims ☐
c) Management of domestic violence ☐
d) Legal aspects of domestic violence ☐
e) Counselling skills ☐
f) Other - Specify ☐

THANK YOU FOR YOUR ASSISTANCE.

Domestic violence victims in a hospital emergency department

Gwenneth L Roberts, Brian I O'Toole, Joan M Lawrence and Beverley Raphael

Objective: To determine the prevalence and predictors of domestic violence victims among attenders at the emergency department at Royal Brisbane Hospital in 1991.

Design: Cross-sectional study in which randomly selected nursing shifts were used to screen attenders

Results: Of all attenders at the emergency department, 14.1% disclosed a history of domestic violence. Women were more likely than men to disclose domestic violence ("raw" relative risk, 2 31; 95% confidence interval [CI], 1 83–2.91; relative risk adjusted for age and history of child abuse, 4.50; 95% CI, 3 02–6.71). The greatest risks for being an adult victim of domestic violence were being female and having experienced abuse as a child. Most of those who had experienced domestic violence within the last 24 hours (1.1% of attenders) came to the department after-hours when social work staff were unavailable for referral.

Conclusions: The prevalence and risk factors have implications for the training of doctors and nurses in domestic violence problems and for the provision of adequate resources to deal with the psychosocial aspects of domestic violence

(Med J Aust 1993, 159 307-310)

It has been recognised that domestic violence is a major public health problem in western industrial societies, including Australia, which often leads to major adverse psychological consequences [1-15] Victims of domestic violence consult doctors more often than they consult police social workers or any other group of helping professionals [16,17] Studies in the United States suggest that one in five women who present at the hospital emergency department has a history of domestic violence [18,19] However, the prevalence of domestic violence in a medical setting is uncertain, since most clinical studies of domestic violence have used non random samples usually derived from observations of authors' clinical practices In one of the few not to do so, Stark et al [18] randomly sampled the medical records of 2676 women treated in the emergency department of a Yale teaching hospital and found that five times as many abused women as non abused women used the psychiatric emergency service Non-random samples which have concentrated on "battered women" in United States mental health settings have shown consistently that they comprise a significant number of those women who use psychiatric health services [1,20,21]

United States studies show that detection rates for victims of domestic violence by doctors are very low [18,19,22] While these low rates of detection may partly be attributed to low rates of disclosure, inappropriate attitudes of health professionals towards victims and lack of education and training regarding domestic violence problems may also play a role [1,22,28] Health professionals tend to reflect dominant social values in their responses to domestic violence [29] and therefore often fail to respond adequately to the needs of either victims or perpetrators [30]

It is likely that domestic violence presents a different face among men than among women However since the literature on domestic violence has focused almost exclusively on the problems of women who are beaten by their husbands, there are few studies which describe male victims In their study in a hospital emergency department, Goldberg and Tomlanovich[19] demonstrated some differences between the perceptions and experiences of male and female victims For example female victims tended to view their relationships more negatively and to request counselling services more than male victims

As part of a larger study aimed at increasing recognition and detection rates in a hospital emergency department, this study screened all patients for a history of domestic violence This gave the opportunity to estimate the prevalence of domestic violence among such patients

It is likely that prevalence estimates may reflect the stringency of the definition and the view of its two components — the terms "domestic" and "violence" In epidemiological research into domestic violence there have been two major problems how should violence (or abuse) be defined and which relations should be included as domestic?[22] Definitions that have been used range from physical criteria for abuse and current relationships (e g , "at some time my boyfriend/husband or girlfriend/wife pushed me around, hit me kicked me or hurt me")[19] to inclusion of emotional abuse and past relationships (e g "the physical and emotional maltreatment of a woman by her husband or ex-husband or even male companion or boyfriend") [31] Stark and Flitcraft[2] have argued that domestic violence may involve from 5% to 20% of the United States population depending on the criteria used

Because violence can be experienced even following the termination of an intimate relationship, our definition was broadened to be congruent with the definition used by the Centers for Disease Control [32] which includes emotionally intimate relationships at the time of or before the abuse (e g legal marriage de facto, boyfriend/girlfriend, siblings, child/parent, other relatives) However, we extended their definition to include emotional and sexual abuse The operational definition for a victim of domestic violence, therefore, was persistent abuse of an adult 16 years of age or over, during or after a family or close relationship, where one partner was afraid of and/or being physically hurt by the other The underlying assumption was coercive control by one person over the other in an intimate relationship [33] so domestic violence was considered more than merely a heated domestic argument

Methods

An exploratory study was carried out in 1990 at the emergency department of the Royal Brisbane Hospital Queensland to test instruments and methods A self-administered questionnaire, which screened for a history of domestic violence, was

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completed by 985 people attending the department 17 5% disclosed a history of domestic violence This finding prompted a decision to repeat the study using appropriate methods to derive statistical estimates of prevalence Improvements were made to sampling and screening procedures A probability sampling scheme was used based on random selection of eight hour nursing shifts (7 a m –3 p m 3 p m –11 p m 11 p m –7 a m) enabling representation of those who attended at all hours People attending the emergency department can enter either through acute (including overnight stay) or non acute entry points The acute section of the department caters for more severe illness and operates 24 hours while the non acute section offers ambulatory care services between 9 a m and 5 p m Both sections were staffed by researchers to screen all attendees

The screening questionnaire contained the definition of domestic violence and six questions including whether the patient had ever experienced domestic violence the type of violence relationship to the abuser and whether the person had experienced abuse as a child (physical and/or sexual) Six of the measures of the types of violence were taken from the Conflict Tactics Scale[34] (pushing shoving and grabbing slapping kicking biting or hitting with a fist throwing objects beating up and using a knife gun or other weapon) To be congruent with the chosen definition these items were augmented with other measures which included serious threats to a person s life and/or children sexual abuse and emotional abuse including verbal abuse social isolation and economic deprivation

Between 29 April and 9 June 1991 there were 156 nursing shifts of which we selected 51 at random Staff shortages resulted in two shifts being excluded but the remaining 49 were staffed by researchers who covered all points of entry The hospital attendance records showed that 1996 people attended during the selected shifts Researchers approached people for participation when they were alone so that the confidential screening questionnaire could be completed in privacy Patients who were too ill (n = 101) unrouseable (n = 21) or who were accompanied by another person who did not leave their side (n = 23) were not approached for inclusion in the study

Since violence before the age of 16 is usually termed child abuse and is subject to mandatory reporting in Australia a lower age limit of 16 was set for participation Of the 1851 who were approached 40 were found to be under 16 years of age and were excluded while 62 had attended during a previous selected time period and had already completed the questionnaire Of the 1749 who were eligible for selection 23 were found to be mentally retarded 21 were in a confused state at the time of presentation two were illiterate 34 spoke little or no English and 55 were found to be senile This left a potential study population of 1614 The ward attendance book showed that there were 313 who were otherwise missed mostly those who had attended at busy times or who attended about the time of the nursing shift change Of the 1301 who were approached 68 (5 2%) refused and 22 (1 7%) gave incomplete responses leaving 1211 from whom complete responses were received (93 1% of those approached or 75% of those not excluded)

The sample of 1211 comprised 654 men and 557 women with mean ages of 41 2 (standard deviation [SD] 19 4) and 41 8 (SD 20 9) years respectively Sixty seven per cent entered the acute section of the department and 33% came through the non acute section Most (78%) were Australian born There was a very low representation of Aboriginal and Torres Strait Islander people in this study (1 5%)

Results

Among the responders 171 (14 1%) disclosed a history of domestic violence 130 women (23 3%) and 41 men (6 3%) Table 1 shows the risk of each type of abuse among men and women and the relative risk (female male) with 95% confidence intervals for each type While men and women were equally likely to report abuse during childhood women were much more likely to report abuse as an adult or as both child and adult Table 2 shows the age specific prevalence among men and women and the separate age specific relative risks for women compared with men The age distribution was not uniform among men with those aged between 30 and 50 years more likely to report being a victim of domestic violence The distribution among women was also not uniform but while women aged between 40 and 50 years had the highest prevalence of reported domestic violence even at older ages the prevalence approached 10% The relative risks for women compared with men were significantly greater than 1 0 for all age groups except 60–69 years which had a 95% confidence interval that included 1 0

Table 1 Prevalence of disclosure of domestic violence and relative risk for women compared with men

History	Men (n = 654)	Women (n = 557)	Total (n = 1211)	Relative risk (95% CI)
Not abused	86 9%	69 7%	78 9%	
Any abuse	13 1%	30 3%	21 1%	2 31 (1 83–2 91)
as an adult	4 6%	15 1%	9 4%	3 35 (2 24–5 00)
as a child	6 9%	7 0%	6 9%	1 02 (0 67–1 54)
as child and adult	1 7%	8 3%	4 7%	4 91 (2 57–9 39)

When the point of entry to the hospital was examined for victims and non victims the three groups reporting abuse were all over represented in the acute section of the emergency department compared with the non acute section Of those who were surveyed in the overnight stay accommodation of the emergency department those abused as both child and adult were the only group overrepresented numbering three times as many as the non abused group

Table 3 shows the recency of the abuse separately for men and women Most of the disclosures concerned episodes that had occurred more than a year previously although in 8 3% of cases it was within the past 24 hours In the total sample the prevalence of recently experienced domestic violence was 1 1% (95% CI 0 5–1 7) It is possible that their attendance at the emergency department was a direct result of their recent experience which would suggest that one in 100 emergency department attendances is as a result of domestic violence This has obvious implications for emergency department management Of these victims 69% presented to the emergency department between 5 p m and 8 a m typically when staff who were trained to deal with domestic violence (principally social workers) were not rostered on Twenty one per cent of those abused both as child and adult had experienced abuse within one week compared with 6% of the adult abuse only group

Respondents were asked the identity of their abuser Women were more likely to suffer violence at the hands of a spouse boyfriend or de facto while men were more likely to be abused by spouse, de facto father or brother While the relative risks of abuse by each type of person were similar for women and men (all confidence intervals straddle 1 0) women were much more likely to report violence perpetrated by boyfriend abusers than men were by girlfriend and boyfriend abusers (relative risk 10 09 95% CI 1 42–71 6) Twenty eight per cent of the doubly victimised group were abused as adults by a father compared with 4% of the adult abuse only group

Those who disclosed domestic violence were asked to identify the type of violence which they had suffered Table 4 shows the proportion of men and women disclosing a history of domestic violence who reported experiencing each type of abusive act and the relative incidence (with 95% CI) None of the experiences was significantly more reported by women than by men (all of the confidence intervals include 1 0) except for

Table 2 Age-specific prevalence of disclosure of domestic violence and relative risk for women compared with men

Age group of victims	Men (n = 654)	Women (n = 557)	Total (n = 1211)	Relative risk (95% CI)
Less than 20	4 4%	26 5%	15 4%	6 00 (1 85–19 43)
20 29 years	5 0%	27 3%	15 1%	5 50 (2 76 10 94)
30 39 years	14 2%	27 8%	19 9%	1 94 (1 08–3 50)
40–49 years	9 1%	34 8%	21 2%	3 83 (1 76 8 32)
50–59 years	4 0%	22 0%	11 2%	5 50 (1 61–18 73)
60–69 years	6 0%	9 8%	6 8%	1 64 (0 46–5 81)
Over 70 years	0	9 4%	5 1%	(not calculable)

Table 3: Recency of experienced domestic violence

	Men (n = 41)	Women (n = 130)	Total (n = 171)
Within 24 hours	7 3%	8 6%	8 3%
Within 1 week	4 9%	3 1%	3 6%
Within 1 month	7 3%	7 8%	7 6%
Within 6 months	7 3%	14 8%	13 0%
Within last year	12 2%	5 5%	7 1%
Longer than 1 year	61 0%	60 2%	60 4%

sexual abuse, which was significantly more prevalent among female than male victims of abuse (χ^2 = 36 54, P < 0 00001) When the severity of abuse was examined for the adult abuse only group, and the adult and child abuse group, there was little difference in the milder forms of abuse such as pushing, kicking and throwing objects, but there was an increase in the more severe forms of violence for the doubly victimised group Nineteen per cent of the adult abuse only group reported sexual abuse compared with 35% of the doubly victimised group There was a statistically significant difference between the two groups (χ^2 = 4 36, df = 1, P = 0 037)

Respondents who disclosed domestic violence were asked further questions about their use of health services Sixty victims (35 1%) reported injuries or health problems related to domestic violence during the last year Forty-seven of this group had received treatment by health professionals for injuries or health problems during the last year Most (52 1%) had attended a general practitioner, 40 4% had attended the emergency department at Royal Brisbane Hospital, 10 6% had attended other hospitals, 6 1% had been treated by a psychiatrist and 2 1% had seen a counsellor

The probability of disclosing domestic violence was modelled using logistic regression The "demographic" variables of age, sex, and country of birth (Australia v elsewhere) were included together with the variable (disclosure of) child abuse This technique models the risk of disclosure of domestic violence as a function of each of the variables, and gives relative risks for disclosure adjusted for the effects of the other variables Because there was a mild "inverted U" shaped age distribution (see Table 2), models were fitted that included a quadratic as well as a linear trend component to age groupings This makes parameter interpretation less straightforward, but provides a better fit of the model to the data Interaction terms were also fitted in modelling, but none was significant

The regression results appear in Table 5, which shows parameter estimates (+ standard errors) and the relative risks (95% CI) for people differing by one unit of each variable Exponentiating the parameter estimates for the variables (i e , calculating e^x, where x is the parameter estimate) gives the relative risks for each of these after accounting for each of the other variables Thus, for example, men had only 0 22 times the risk of women after accounting for all other variables (95% CI, 0 15–0 33), while those born in Australia had the same risk as those born overseas Victims of child abuse had 4 33 times the risk of disclosing domestic violence as those without such a history (95% CI, 2 80–6 69), after accounting for the other variables Note that, from Table 1, the "raw" relative risk for women compared to men was 2 31 (95% CI, 1 83–2 91), while the "adjusted" relative risk for women (calculated as the inverse of that for men) was 4 50 (95% CI, 3 02–6 71)

Discussion

To our knowledge this study is the first of its kind to be conducted in an emergency department in Australia The adult domestic violence prevalence in this sample of emergency department patients is comparable with the findings of Stark et al [18] and Goldberg and Tomlanovich[19] in emergency departments of general hospitals in the United States While the hospital records system was unable to give summary demographic data to enable assessment of sample bias, the random sampling time frame procedure used in this study makes the findings more likely to be generalisable to emergency departments of major public hospitals in Australia

There is, of course, the risk that the study encountered a significant number or proportion of domestically abused people who either denied their experiences or failed to disclose them at screening This would indicate that our prevalence estimates are underestimates The extent of this is unknown It was noted that 19% (n = 313) of the potential study population (n = 1614) were otherwise missed and perhaps, more importantly, 1% (n = 23) of potential respondents were unable to be approached to fill in the questionnaire because the accompanying person would not leave their side If all of the latter were victims of domestic violence, the prevalence estimates would change from 14 1% (95% CI, 12 1%–16 1%) to 16 1% (95% CI, 14 1%–18 1%)

The risk of adult victimisation for women compared with men confirms that women are at much greater risk than men of being victims of domestic violence The implications of these findings are that assessment of women for a history of domestic violence should be routinely incorporated into history-taking on admission to emergency departments The results show not only the risk for women of being abused by husbands and de facto partners, but the high risks for young women of "dating violence" Young men were also at risk for abuse by fathers and brothers

The risk of being abused as an adult was significantly increased if there had been a history of child abuse This may also be useful information to be ascertained from the history of those with suspected abuse who attend the emergency department It was noted that more of those who were doubly victimised as children and adults than those who had only been abused as adults were interviewed in the emergency department overnight stay accommodation, suggesting that the reasons for their attendance were perhaps more serious than other victims, or that they had to be retained for social or safety reasons Also, a greater number of the doubly victimised group were abused in their adulthood by their fathers, which suggests that abuse by fathers continues into adult life

The study has raised the awareness of health professionals about the large numbers of people, particularly women attending the emergency department, who have a history of domestic violence However, the study

Table 4: Proportion of men and women disclosing a history of domestic violence who reported experiencing each type of abusive act, and the relative incidence

Reported experience	Men (= 41)	Women (n = 130)	Total (n = 171)	Relative risk (95% CI)
Pushing	61 0%	76 9%	73 1%	1 26 (0 87–1 64)
Kicking	58 5%	67 7%	65 5%	1 16 (0 87–1 54)
Throwing objects	53 7%	46 2%	48 0%	0 86 (0 61–1 21)
Choking	26 8%	30 0%	29 2%	1 12 (0 63–1 98)
Beating	36 6%	51 5%	48 0%	1 41 (0 91–2 18)
Weapon used	26 8%	15 4%	18 1%	0 57 (0 30–1 09)
Serious threat	17 0%	30 8%	27 5%	1 80 (0 88–3 71)
Sexual abuse	7 3%	30 0%	24 6%	4 10 (1 34–12 57)
Emotional abuse	63 4%	72 3%	76 0%	1 14 (0 88–1 47)

also raises the issue of resources to match the increased awareness and identification of victims of domestic violence in the emergency department. It was shown that most victims who had reported experiencing violence in the past 24 hours presented to the hospital between the hours of 5 p.m. and 8 a.m., when no social work staff was available. During the course of this study, patients attended the emergency department who were at high risk of further abuse should they return home from hospital, and who required emergency community accommodation in the middle of the night. Several incidents observed by research staff during data collection revealed that medical and nursing staff did not have knowledge of referral sources other than social work staff.

One of the limitations of this study is that measurement of the types of violence is inconclusive. It does not take into account the intensity, frequency, meaning and impact on the victims of the various types of violence, the context in which the violence takes place, and the injuries suffered by the victims. This has been noted by other investigators [35-37]. Even though this study shows that there were no significant differences for types of violence experienced by women and men (except sexual abuse), the potential consequences of violent acts which are described by the same labels, such as "beating", may be different. A study by Berk et al [38] showed that the violence of men against women is more severe and results in greater physical injury than the violence of women towards men. To obtain an accurate picture of the difference between male and female victims of domestic violence, reliable measures need to be developed to incorporate these factors.

Overseas studies have indicated the frequent use of psychiatric services by victims of domestic violence and the adverse psychological effects of the abuse [1 15 18 20 21]. This study points to the need for further longitudinal and in depth research to establish a firmer scientific basis for the recognition and treatment of post-traumatic psychiatric morbidity associated with domestic violence.

Table 5 Results of logistic regression modelling of age, sex, country of birth and history of child abuse as predictors of disclosure of domestic violence*

Variable	Values or range	Estimate (SE)	Relative risk (95% CI)
(Constant)	—	1 717 (0 588)	—
Sex			
Male	1	-1 505 (0 203)	0 22 (0 15–0 33)
Female	0		
Age	16 90		
Linear trend		1 034 (0 326)	2 81 (1 48–5 33)
Quadratic trend		0 988 (0 301)	2 69 (1 49–4 85)
Birthplace			
Australia	1	-0 004 (0 233)	1 00 (0 63–1 57)
Elsewhere	0		
Child abuse			
Yes	1	1 466 (0 222)	4 33 (2 80–6 69)
No	0		

*The table shows the range or value of each variable together with its parameter estimate and its associated standard error. The relative risk for people differing by one unit of each variable and the 95% confidence limits for each odds ratio.

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MEDICAL RECORD EXAMINATION

SUMMARY SHEET

ID NO.: (1-4)

UR OR MASTER PT.NO: (5-12)

SEX: (13) M_1 F_2

D.O.B.: (14-19)

MARITAL STATUS: (20)

OCCUPATION: (21-24)

RELIGION: (25-26)

SUBURB/TOWN: (27-30)

Has the patient identified as a victim of domestic violence on the questionnaire? YES(1) NO(2) (31)

EXAMINER'S JUDGEMENT: POSITIVE $_1$ PROBABLE $_2$ SUGGESTIVE$_3$ NEGATIVE$_4$ PERPETRATOR$_5$ (32)

EMERGENCY/OPD/IN PATIENT PRESENTATION NO:_____ (35-37) ADMISSION/PRESENTATION DATE:_____(38-43)

PRESENTING COMPLAINT to EMERGENCY DEPARTMENT - TRAUMA

PHYSICAL INJURIES	Bruising/ Abrasions	Minor Lacerations	Stab Wounds	Gunshot Wounds	Human bites	Animal bites	Other
1 Head	44	52	60	68	76	4	12
2 Face	45	53	61	69	77	5	13
3 Upper limbs	46	54	62	70	78	6	14
4 Upper trunk	47	55	63	71	79	7	15
5 Breasts/Chest	48	56	64	72	80	8	16
6 Lower trunk	49	57	65	73	1	9	17
7 Genitalia	50	58	66	74	2	10	18
8 Lower limbs	51	59	67	75	3	11	19
Recorded as caused by d.v.?	21	22	23	24	25	26	27

PHYSICAL INJURIES	Sprains/ Strains	Fracture	Dislocation	Burns	Painful areas	Strangulation marks	Other
1 Head	30	38	46	54	62	70	78
2 Face	31	39	47	55	63	71	79
3 Upper limbs	32	40	48	56	64	72	80
4 Upper trunk	33	41	49	57	65	73	1
5 Breasts/Chest	34	42	50	58	66	74	2
6 Lower trunk	35	43	51	59	67	75	3
7 Genitalia	36	44	52	60	68	76	4
8 Lower limbs	37	45	53	61	69	77	5
Recorded as caused by DV?	6	7	8	9	10	11	12

PRESENTING COMPLAINT to EMERGENCY DEPARTMENT

MEDICAL	15			
Recorded as caused by d.v.?	16			
PSYCHIATRIC	Alcohol/ Drug abuse	Suicide attempt (incl. overdose)	Other psychiatric problems	
17	18	19	20	
Recorded as caused by d.v.?	21	22	23	
OBSTETRICS & GYNAECOLOGY	Pelvic pain/ Dyspareunia	Miscarriage	Sexual assault/Rape	OTHER
24	25	26	27	28
Recorded as caused by d.v.?	29	30	31	32
SURGICAL	33			
Recorded as caused by d.v.?	34			

REFERRALS	YES	TYPE
REFERRAL TO SOCIAL WORKER	38	39
PSYCHIATRIC ASSESSMENT	40	41
REPORTED TO POLICE - Type of assault	42	43
INPATIENT ADMISSION	44	45-46
VISIT TO OPD	47	48
OTHER	49	50

Date of first attendance at hospital? _____ (52-57)

8 December, 1993

DEPARTMENT OF SOCIAL WORK - AFTER HOURS ON CALL SERVICE GUIDELINES

THE AFTER HOURS ON CALL SERVICE TO THE DEPARTMENT OF EMERGENCY MEDICINE IS PRIMARILY DIRECTED TOWARDS THREE SPECIFIC TYPES OF PRESENTATION:

1. Domestic Violence
2. Child Abuse
3. Rape/Sexual Assault

1. Domestic Violence

People who present with an episode of Domestic Violence which falls within the jurisdiction of the Domestic Violence (Family Protection) Act 1989

The people who fall within the ambit of this legislation and for whom a protection order may be sought are:

1. A man and woman who are or have been married to each other;
2. A man and woman who are or have been living in a defacto relationship.
3. A man and woman who are the biological parents of a child whether or not they have lived together

Boyfriend/Girlfriend relationships do not fall under the provisions of this legislation and are still seen in the context of the after hours service because of referral complexities

Page Social Worker as soon as abuse identified.

Inform patient after phone discussion with Social Worker

2. Child Abuse

Age Group 14 Years to under 17 years

Relationship of child to perpetrator irrelevant.

If Abuse is reported at Triage

- Page Social Worker as soon as possible to assist with referral to RCH

If Abuse is suspected during DEM examination.

- Page Social Worker as soon as possible to discuss attendance

3. Rape/Sexual Assault

↓

Presentation to DEM

↓ Medical

↓ possibly police involvement

↓ If person wants to lay charges

↓ examination by GMO at hospital or at GMO offices (depending on persons condition)

Page Social Worker as soon as possible

SITUATIONS WHICH ARE OUTSIDE THE BOUNDARIES OF THE SERVICE.

1. Other Types of Violence
2. Social Crises
3. Referrals to see RWH Inpatients

1. OTHER TYPES OF VIOLENCE

THAT IS

- parent/adult child violence,
- sibling violence,
- violence in the context of a homosexual relationship,
- stranger assault (excluding sexual assault, rape and child abuse)

Page Social Worker if unsure whether case falls within the guidelines

2 SOCIAL CRISES

THAT IS

presentations that are primarily,

- sudden death
- homelessness
- alcohol & drug overdoses
- problems related to intellectual disability
- attempted suicide or psychiatric problems

Page Social Worker if unsure whether case falls within the guidelines

3 REFERRALS TO SEE RWH INPATIENTS

The RBH Social Workers do not provide a "call in" service to RWH