

**Domestic Violence Against Women
and the Impact of Routine Screening in a Hospital Emergency Department**

By

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**DOMESTIC VIOLENCE AGAINST WOMEN AND THE IMPACT OF
ROUTINE SCREENING IN A HOSPITAL EMERGENCY DEPARTMENT**

by

JANICE DEFEHR

**A Thesis/Practicum submitted to the Faculty of Graduate Studies of The University
of Manitoba in partial fulfillment of the requirements of the degree
MASTER of SOCIAL WORK**

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ABSTRACT

Although domestic violence against women is a leading cause of injury in our society, resulting in repeated use of hospital emergency services, the literature suggests that domestic violence is difficult to detect without universal screening practises.

This research project aimed to determine the impact of routine screening on the frequency of domestic violence detection in a hospital adult emergency department. The research was guided by a Single System A B research design and Quasi-Experimental Non-Equivalent Comparison Group design. Evaluative criteria developed by researchers Stark, Flitcraft and Frazier (1979), was used to identify patterns in domestic violence documentation from both periods of this study, in order to determine if detection of domestic violence had increased with the introduction of routine screening in the second period. Tick sheets completed by emergency staff in the B, or screening phase, documented patient responses to screening, as well as barriers perceived to prohibit screening. Requests for referral from the Emergency department to the hospital Social Work department were totalled in a period preceeding routine screening, and during the screening period. As well, findings from this study were compared with findings from a similar study of routine screening conducted out of a Vancouver hospital emergency department (Grunfeld, Ritmiller, Mackay, Cowan & Hotch, 1994). A total of 991 emergency records were analyzed in this study, with 506 records in the pre-screening period, and 485 records from the screening period.

The findings indicate that detection of domestic violence could be improved in the emergency department, and the routine screening protocol introduced may be a valuable

tool towards this goal. A small but statistically significant trend towards positive and adequate documentation of domestic violence was evident in General Emergency Documentation in the routine screening period. Staff participation in the routine screening protocol was not "routine", as only 24.5 % of the women were screened in the B phase. One referral to the Department of Social Work occurred in the second phase of the Winnipeg project.

Approximately 1% of female patients' records in both phases of this study contained documentation of domestic violence, however, an additional 22.9% of forms contained documentation that reflected the possibility of domestic violence, according to rating criteria used for analysis (Stark et al, 1979). A substantial level of domestic violence was detected (13.4% of women screened) when 119 women were screened for domestic violence. The screening mechanism tested in this study clearly was useful in detecting domestic violence, however, its documentation was generally limited to the data sheets used in the B phase of this study, and was not evident in the General Emergency Documentation analyzed in both periods of this research.

Staff at Vancouver's Hospital and Health Sciences Centre emergency department detected domestic violence in 6.4% of the women they screened, and screened 59.4% of the female patients in their screening period. Nurses in Winnipeg identified their own discomfort with the screening protocol as the most frequent barrier to screening, while language barriers and the presence of relatives were the most common identified barriers preventing domestic violence screening by Vancouver nurses.

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INTRODUCTION

Domestic violence against women is a pervasive problem in our society and a major public health concern, resulting in repeated use of hospital emergency rooms, personal physicians and clinics (Turner & Cheaper, MacLeod, 1987; Loring & Smith, 1994). Social science research shows that systems failures play a role in maintaining the problem (Harris & Dewdney, 1994, p. 58; Johnson, 1985, pp. 112-114; Hatty, 1987). Along with social service and police systems, hospital emergency department policies and protocols have come under the scrutiny of social science research (Stark, Flitcraft & Frazier, 1979; Stewart, 1993; Bowker & Maurer, 1987). Findings generally point to an inadequate emergency department response that typically begins with staff failure to identify battered women (Tilden, 1989; Loring & Smith, 1994; Issac & Sanchez, 1994). Emergency department personnel frequently "treat" and "release" women without detecting or addressing the cycle of violence that causes their injuries and threatens their health. When the actual cause of battered women's injuries is unidentified, care given by the emergency department is limited and often inappropriate. Low rates of detection seem to persist unless hospital emergency departments screen women routinely for domestic violence (Stewart, 1993; Bowker & Maurer, 1987; Loring & Smith, 1994; Stark, Flitcraft & Frazier, 1979). Appropriate, efficient and empowering care of battered women in emergency departments is dependent on accurate identification of battered women.

This report presents a research project aimed at determining the impact of routine screening for domestic violence against women, on rates of domestic violence detection in

a hospital emergency department. Chapter one will explore the empirical and theoretical context underpinning this research, giving particular attention to literature related to the role of hospital emergency departments in addressing domestic violence against women. Methodology used in this project will be described in Chapter two. Chapter three presents the study's findings. The final chapter in this report offers a discussion of the findings.

CHAPTER 1

LITERATURE REVIEW

Incidence Rate of Battering

Radical feminists in the mid-seventies were the first to draw attention to the problem of domestic violence against women in the mid-seventies. Now the battering of women is recognized as a serious and widespread problem in our society (MacLeod, 1987; Turner & Shapiro, 1986; Herman, 1992, p. 2). According to the records of shelters and other helping agencies in Canada, approximately one million women, (one in seven or eight) are battered each year (MacLeod, 1987, pp.6-7). In a recent survey of Canadian women who had ever married or had common-law relationships with men, 29% had experienced physical or sexual violence from their male partners (Rogers, 1994). The study, reported by Statistics Canada, used a sample consisting of 12, 300 randomly chosen women, a sample representative of the population of Canadian women who had been in eligible relationships. The study limited its definition of violence to behaviour considered an offense under the Canadian Criminal Code. A total of 45% of battering cases in this study resulted in physical injury to the woman.

Battering is a leading cause of injury to women (Chez, 1988) with physical effects ranging from minor bruises to death. Stark, Flitcraft and Frazier (1992) assert that battering accounts for approximately 22 to 35 percent of women who seek treatment in hospital emergency rooms, while others have found that approximately 40% of all injuries

to women presenting at emergency departments are caused by battering (Kurz & Stark, 1988). More injuries to North American women result from battering than from rape, mugging and automobile accidents combined (Stark and Flitcraft, 1988, pp. 293-318). Battering, rape and other forms of domestic violence are so integrated with women's lives that they can hardly be described as outside the range of usual experience (Herman, 1992, p. 33; Pressman, 1989, p. 21).

Definition of Battering

Wife abuse, woman abuse, spouse abuse, domestic violence, or conjugal violence are all terms used interchangeably with the term battering. Differences in these labels emphasize or de-emphasize the marital nature of the violence, the gender issues associated with it, and attribution of responsibility for the violence. The term battering refers almost exclusively to violence perpetrated by men against women with whom they are in intimate relationships (Geffner & Pagelow, 1990, p. 113.) The term battering is uniquely defined by the context in which it occurs, the behaviour that comprises it, and the gender-specific nature of this phenomenon (Ganley, 1989, pp. 200-203; Kaufman, 1992).

Behaviour that comprises battering differs from stranger-to-stranger violence because the domestic and relatively private context of battering allows ongoing contact between offender and victim (Ganley, 1989, pp. 200-201). Battering differs from forms of family violence such as child abuse or abuse of the elderly since battering occurs between two adults who are thought to be in a peer relationship with one another (Bograd, 1984).

Battering is typically not an individual incident, but rather refers to a pattern of

behaviour that, over time, and without intervention, increases in frequency and severity (Ganley, 1989, p. 202-203; Geffner & Pagelow, 1990, p. 119; Burge, 1989). Incidents of physical and sexual violence may not appear to increase over time in some cases, however, an overall increase in battering will typically be apparent if the entire pattern of psychological and physical control is observed and assessed. Lenore Walker was the first to articulate the cyclical nature of battering (1979, pp. 55-70). Rather than viewing violent episodes as isolated and random, Walker theorized that they are part of a chronological series of stages that repeat in relationships where men behave abusively. In this view, violence is typically preceded by a period of tension building, and is immediately followed by a period of calm. The calm is called a "honeymoon period". Apologies to the victimised woman, and promises of change are typically offered during this phase. Eventually this stage passes, tension begins to build again, violence erupts, and the cycle repeats.

In the view of the author, theory concerning the cyclical nature of battering comprises an important part of the overall theory underpinning clinical interventions with women victimized by battering. When an existing cycle of violence is mistakenly identified as isolated violent episodes, the problem of battering is not understood. Professionals, victims, and perpetrators may be lead to believe that the battering has ceased if a period of time has passed since the last violence outburst. However, if an existing cycle of violence is identified, it may be apparent that individuals are simply moving through a phase of the pattern that either precedes or follows acts of violence.

Types of Battering

Battering behaviour has been categorized into two general groupings called "hands on" and "hands off" battering (Ganley, 1989, pp. 200-203; Geffner & Pagelow, 1990, p. 113). Although these two terms are not widely used, the author finds them helpful in depicting two main dimensions of the phenomenon of battering. "Hands on" battering consists of physical or sexual assaults which are repeated against the same woman by the same man. Physical assault can include shoving, pushing, scratching, biting, slapping, burning, beating, or strangling, with or without the result of physical injury. Physical assault often is accompanied by sexual assault that can include coerced or pressured sex, forcing the victim to have sex with third parties, in the presence of children, or in other circumstances when the victimised woman does not give consent (Avis, 1992). Sexual assault is often perpetrated with severe brutality resulting in emotional damage, physical injury, and sometimes loss of life (Ganley, 1989, p. 200). While it is easy to distinguish between physical and sexual assault in theory, actual incidents of battering violence can be difficult to categorise. Sexual assaults are always both physically and emotionally violating. Physical assaults may include sexual dimensions simply because they are carried out by a man against a woman. The sex-specific nature of battering is reflected in the prominence of injuries to chest, breast, and abdomen, as well as the high rate of violence during pregnancy (Stark, Flitcraft & Frazier, 1979).

"Hands off" battering differs in that the man does not currently initiate direct contact with the woman's body. Even so, the spoken or unspoken threat of actual physical violence remains, since the man perpetrating hands off battering has carried out sexual or

physical violence against his partner in the past. Assaults are now delivered through psychological battering that typically includes activities associated with brainwashing, often not unlike the techniques of terrorization used to control prisoners of war (Herman, 1992, pp. 76-86; Geffner & Pagelow, 1990, p. 116). The physical or sexual violence that has occurred in the past gives the psychological battering its power. These "hands off" behaviours may include threats of violence, coercing the woman to participate in degrading activities, mind games, economic controls, the misuse of logic, repeated attacks on the victim's self-esteem, torturing or killing of pets, destruction of property, and excessive controlling and monitoring of the victim's activities and relationships (Ganley, 1990, p. 201; Kaufman, 1992). Even though the woman may not have recently been physically attacked in this kind of battering, she knows the assaults she observes are meant for her. It is her belongings that are typically destroyed, and even when the perpetrator harms himself, others, or his own possessions, he is likely to blame her for making him do it. "Hands off" battering should not be confused with "emotional abuse" which is an appropriate label for behaviour that is psychologically abusive, but occurs without a credible threat of violence in relationships where the male partner has not been physically or sexually violent in the past (Ganley, 1989, p. 201).

Social and Psychological Effect of Battering on Women

It is the character of traumatic events, rather than individual personality characteristics, that are the most powerful determinants of psychological harm (Herman, 1992, p. 57). The social and psychological effect of battering on women is similar to the

psychological experience of prisoners of war (Burge, 1989). During episodes of violence or crisis, the individual's immediate focus is on survival and self-protection. Shock, disbelief, withdrawal, fear, disorientation and denial are common early reactions to incidents of battering violence. Other early responses may include extreme dependence, suggestibility, or minimization of injuries sustained (Burge, 1989).

While trauma has immediate effects on individuals, life-threatening experiences also cause psychological effects beyond the initial incidents (Smith and Gittelman, 1994). This is especially true for survivors of battering. Women victimized by battering often report feelings of helplessness, isolation, confusion, entrapment, abandonment, humiliation, anxiety, mistrust, and feelings of failure (Geffner & Pagelow, 1990, p. 117; Smith & Gittelman, 1994). Feelings of guilt can be especially intense when women have witnessed the violation of children or others as part of their experience of battering (Herman, 1992, p. 54). Women who are battered often hold negative views of themselves, often perceiving themselves as deviant. They commonly experience confusion about their identity (Geffner & Pagelow, 1990, p. 114; Smith & Gittelman, 1994). Women who are battered tend to have stronger suicidal tendencies than non-abused women, and many survivors of battering have histories of actual suicide attempts (Geffner & Pagelow, 1990). In fact, battering accounts for one in four suicide attempts by all women (Stark, Flitcraft, Zuckermann, Grey, & Robison, 1981, p. 7).

"Hyperarousal", "intrusion", and "constriction" are three main signs of psychological distress, according to the diagnostic criteria of the Post-Traumatic Stress Disorder (American Psychiatric Association, 1994, pp. 209-211; Herman, 1992, p. 35).

Although the author is generally not supportive of battered women receiving this formal diagnosis, she finds the American Psychiatric Association (1994, pp. 209-211) description of trauma-related distress to be helpful in portraying the psychological effects of trauma on individuals. Hyperarousal refers to conditioning of the autonomic nervous system produced by the experience of trauma, and is an important sign of post traumatic distress (Herman, 1992, pp. 35-36). Women suffering from hyperarousal are always vigilant, suffering from both generalized anxiety and specific fears. Their elevated state of arousal causes many types of sleep disturbances, and makes concentration difficult (American Psychiatric Association, 1994, p. 210). They startle easily and react with irritation to seemingly small provocations (Herman, 1992, pp.35-36).

Intrusion refers to the victim's reliving of past traumatic events through flashbacks and nightmares, thoughts, perceptions and images, as though they are still occurring in the present (Herman, 1992, p. 37-42; American Psychiatric Association, 1994, p. 209).

Traumatized people also relive moments of trauma in their actions. Reenactments can be dangerous, or conversely, adaptive and integrative. Regardless of the purpose they may serve, the reliving of traumatic events brings back to the survivor the dreaded emotional intensity of the original traumatizing event. In its intensity, this overwhelming experience of emotion is qualitatively unlike an untraumatized person's experience of negative emotions. The survivor's wish to avoid intrusive experiences often leads to a withdrawal from activities and relationships that may trigger terrifying flashbacks. Intrusive facets of post traumatic distress may therefore interfere with an individual's efforts to re-establish a normal life.

Constriction, or numbing is a third indication of post-traumatic distress. A paradoxical state of detached calm and disconnection, constriction can occur when a victim is rendered completely powerless. The victim's perceptions are often distorted or numbed, so that she may feel like she is dreaming or leaving her body (Herman, 1992, p. 43). Sometimes alcohol or narcotics are used to achieve a numbing effect (Herman, 1992, p. 44; Stark, Flitcraft, Zuckerman, Grey, & Robison, et al, 1981). Constriction ceases to be an adaptive response after the danger has passed, as it prevents the integration needed for healing to occur (Herman, 1992, p. 45). Constrictive processes that suppress conscious thought about the trauma restrict the survivor's life, so that situations that are reminiscent of the trauma are avoided, and initiatives involving future risk and planning are bypassed (p. 47). The protection against overwhelming emotions offered by constriction is costly, perpetuating the effects of the trauma and reducing the victim's quality of life.

The ongoing violation and trauma implicit in women's experiences of battering produces profound change in survivors. "Traumatized people feel utterly abandoned, utterly alone, cast out of the human and divine systems of care and protection that sustain life ... a sense of alienation, of disconnection, pervades every relationship..." (Herman, 1992, p. 52).

Physical Consequences of Battering

Victims of domestic violence typically present at emergency departments after 1700 hours with bilateral and multiple injuries to the head, neck, breasts, chest, abdomen, and back (Morrison, 1988). Injuries associated with battered women are neck bruising

from choking; whip or cordlike injuries across the back; ruptured eardrums caused by severe slapping; bite or punch injuries to the breasts and nipples; kick and punch bruising to the lateral thighs; facial bruising, lacerations and abrasions (Sheridan, 1993). Battered women frequently present with multiple contusions, lacerations, burns, fractures particularly in the nose, jaw, ribs and arms (Appleton, 1980; Rounsaville, 1978; Gayford, 1975). Fractures, lacerations and dislocations occur equally with battered and non-battered women, however, abrasions and contusions occur more frequently with battered women than other populations (Morrison, 1988). Women who are raped may have injuries to the vulva and vaginal tearing. They may have contracted infections, an unwanted pregnancy, or sexually transmitted disease as a result of rape (Burge, 1988). Generally, intentional injuries tend to be located in the centre of the body which is easily covered with clothing, while injuries caused accidentally tend to be located towards the body's extremities. "Defensive posturing" injuries to the mid-ulnar areas of the arms are also common (Sheridan, 1993).

Among battered women, battering during pregnancy is a frequent occurrence and pregnant battered women constitute a frequently undetected high-risk group (Parker & McFarlane, 1991; Stewart & Cecutti, 1993). Breasts and abdomen are common targets of assault in pregnant women who are battered (Stewart, 1993; Chez, 1988; Sheridan, 1993). Battering can contribute to miscarriage (Loring & Smith, 1994) and low birth weight infants (Bullock & McFarlane, 1989). The term "pattern of injuries" refers to injuries inflicted over a period of time, while the term "patterned injuries" refers to those whereby one can identify the object or objects used in the assault (Sheridan, 1993). Often objects

used are those that are readily accessible in homes, such as extension cords, irons, coat hangers and belts. Bite injuries are patterned, as are punch injuries to soft tissue, which result in circular bruising (Sheridan, 1993). Battered women will commonly have bruises with injuries at several sites that are at various phases of healing, and it is not uncommon for old and new injuries to exist in the same locations (Burge, 1989).

Battering also contributes to the development of long term physiological problems. Battered women experience significantly more somatic symptoms than non-battered women (Jaffe, Wolfe, Wilson, & Zak, 1986; Kernouac, Taggart, Lescop & Fortin, 1986; Smith, 1994). Complaints of abdominal, back, and headache pain, insomnia, fatigue, anemia and disturbing physical sensations are frequently reported by battered women (Kernouac et al, 1986). Irritable bowel syndrome and gynecological disorders are associated with battered women more than with women in other populations (Council on Scientific Affairs, American Medical Association, 1992). In addition, pregnant and non-pregnant women who are battered are more likely to develop chemical dependencies compared to women who are not battered (Amaro, Fried, Cabral & Zuckerman, 1990; Stark, Flitcraft & Frazier, 1979).

Women's Dynamic Struggle Against Victimization

Much research has attempted to isolate single factors that might explain many women's decisions to remain with violent men (Johnson, 1992; Gelles, 1976; Dutton & Painter, 1981). The theory of learned helplessness has been applied to battered women, in an attempt to explain why they appear resigned to stay with men who victimize them

(Blair, 1986; Walker, 1979, p. 47). In her ground breaking book, The Battered Woman, author Lenore Walker likens women's decisions to stay with violent men to the behaviour of dogs, rats, and other people whose behaviour is determined by a negative cognitive set rather than by limitations that actually exist (1979, pp. 47-51). Battered women "...who do not attempt to free themselves from a battering relationship..." operate from a belief in helplessness that brings their perceptions into reality" (p. 47), she argues. Consequently, she claims, the women become passive, submissive and helpless (p. 48) and their feelings of powerlessness contribute to the cause and maintenance of violent behaviour (p. 51).

Other research clearly and convincingly discounts the belief that battered women are passive helpless victims. According to qualitative research conducted through the Battered Women's Advocacy Clinic in London, Ontario, no single factor consistently determines when a woman will take action in response to battering. The decision to leave is not a function of some absolute level of violent, economic, or psychological deprivation, but rather the decision to leave depends on an on-going, careful weighing of psychological, economic, social and physical risks. Each woman's decision making is highly individual, reflecting an interactive process that cannot easily be captured by quantitative methods of inquiry with large numbers of women (Greaves, Heapy & Wylie, 1988).

The view that battered women passively commiserate in their victimization fails to recognize the dynamic help-seeking process that typically characterises battered women's responses to battering. Evidence seems to suggest that help-seeking patterns in battered women, are actually no different than the help-seeking strategies employed by the rest of

the population facing personal problems of some type. Research into help-seeking patterns in the general population reveals that the presence of objective symptom-problem characteristics are not the primary determinants of help-seeking behaviour (Gross & McMullen, 1983, p. 51). Many community health surveys and epidemiological studies have shown that high percentages of generally healthy populations evidence some physical or psychological aberration amenable to treatment, yet do not seek professional help. Therefore, merely recognising some difficulty or unusual symptom is evidently not sufficient in motivating an individual to decide to take action. Rather, a dynamic process influenced by many factors such as age, social network, and education, affects when an individual will view a "symptom" as a problem, and one that is amenable to aid (Gross & McMullen, 1983, p. 49 & 51). Often the social context surrounding the problem, and its messages defining health, sickness and normality, rather than the problem itself, are most significant in determining whether help will be sought (Gross & McMullen, 1983, p. 53). Help-seeking behaviours which appear dysfunctional when considered in isolation from the perspective of the help-seeker, often emerge as logical and realistic when interpreted within the life or cultural context of the individual (Gross & McMullen, 1983, p. 53).

Once the difficulty is identified as a problem, and is further viewed as a problem that could be relieved with help, more than half of adults in the general population begin seeking help (Gourash, 1978). Initially, help is sought from informal sources, such as friends, relatives, or neighbours, before help is requested from professional service organizations (Gourash, 1978). Before individuals approach professional helpers, much activity in the help-seeking process has likely already occurred. The assumption that

people's help-seeking begins at the level of professional help, leads to the belief that certain individuals are passive in response to domestic violence, and possibly partly to blame for their problem.

Research specific to battered women's help-seeking shows them to be active strategists in their survival. A study conducted by Harris (1988) reveals eight general categories of questions that women who leave their battering partners commonly address, giving evidence of cognitive processes reflecting initiative and agency. Johnson (1985, p. 110) found that battered women resemble other help-seekers in the general population in their inclination to first access informal sources of help before resorting to professional help. Gondolf and Fisher (1988, pp. 2-18) found women made an average of six different types of efforts to stop the battering before they came to a shelter. They found the battered women in their study to be logical and assertive in response to the abuse they were experiencing. Bowker's (1983) studies of battered women's help-seeking found that women received on average six to eight instances of help from informal sources for every instance of abuse (cited in Gondolf and Fisher, 1988, p. 31). Similarly, Dobash and Dobash (1982) reported that battered women actively struggled to get help. All of these studies show battered women as resourceful, active help-seekers, contradicting the common belief that with repeated abuse, women typically become immobilised, increasingly terrorized into submission and passivity (Harris and Dewdney, 1994, p. 55). To advance the erroneous belief that battered women are passively resigned to their victimization, is to ignore the extent and ingenuity of women's resistance to battering, in spite of tremendous forces working against them.

Theoretical Reconstructions of Battering in the Literature

Academic literature explores the causes and nature of domestic violence against women within the parameters of various ideological paradigms. Suzanne Hatty (1987) identifies five prominent theoretical reconstructions of battering in the domestic violence literature, outside the feminist framework she endorses. One paradigm focusses upon privatization, locating the root causes of violence within specific marriage relationships. A second paradigm identified portrays the violence as a manifestation of either male or female pathology. Within this paradigm, violent men may be typified as deviant, abnormal, social isolates, or mentally unwell. A third position interprets violence against women within the context of aggressive acts occurring between two individuals, with the direction of the violence obscured. Within this framework, both genders are viewed equally as potential victims. A fourth ideological position emphasises victim precipitation, focussing on provocation on the part of the woman, while de-emphasising structural causes of violent crime. Finally, a fifth paradigm focusses on the family as an interactive system wherein each family member has an affect on the behavioral or emotional responses of other members. Each family member is seen to contribute to the problem in some ways, even if the perpetrator is ultimately viewed as responsible for the battering (Hatty, 1987). Hatty argues that within these ideological perspectives the nature of female victimisation is renamed, redefined, and legitimated through incorporation into social science theory. She asserts that these five ideological positions invalidate women's accounts of the violence on ideological as well as personal levels, in their exclusion of feminist interpretations and their re-affirmation of the status quo (1987).

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In the opinion of the author, Hatty's identification and criticism of domestic violence frameworks are valid, as she points to the inadequacy of "single factor" research in explaining the existence of domestic violence. Her argument against domestic violence frameworks that "psychologise" and "depoliticise" battering is compelling. While the author finds her description of identified frameworks to be scant and somewhat redundant, she shares her wariness of research that proposes explanations for battering in the abnormality and peculiarities of women victims. The personal experiences and traits of oppressed peoples may or may not make a major difference in the face of enormous negative socio-political forces. Research that fails to situate individual factors related to domestic violence within a macro ecological context perpetuates erroneous beliefs about victimised people.

Others have summarized social science frameworks or explanations for battering. Reviewing 15 social science theories about battering, Straus and Gelles found only three major levels of analysis (1979, pp. 550-577). Intra-individual theories form one identified level. Within these perspectives, qualities of abusive men and abused women, such as alcoholism or psychopathology are used to explain the problem of domestic violence. This level seems to correspond with Hatty's categories of privatization and pathology. Social psychological theories form a second theoretical level. Within these perspectives, interactions between individuals and their environments are used to explain the existence of battering. Social learning theory is an example from this theoretical grouping (Rotter, 1954; Bandura, 1977; Mischel, 1979). Its articulation of the role of modelling and experience in learned behaviours has been used to explain violent behaviour such as

battering (Straus & Gelles, 1979, pp. 550-577). Finally, a third level identified by Straus and Gelles consists of sociocultural theories that examine social norms, institutional organization and values. With a focus primarily on macro social forces, sociocultural theories examine the privilege created for men as a class as a result of men's battering of women. Both second and third levels appear to encompass feminist domestic violence paradigms.

Feminist Understanding of Battering

An adequate feminist definition of battering is elusive. There is no unified feminist perspective on male violence against female partners (Bograd, 1984; Taylor, 1993, p. 205). Feminist perspectives which have been shown to be empirically valid are compelling to the author because they recognize explanatory value in a wide spectrum of theories, and acknowledge that no single framework offers a complete explanation for the existence of battering. Individually based theories ignore the macro context of violence against women, while sociological theories often can not account for the existence of non-violent relationships in patriarchal culture (Burge, 1989).

Feminist theories explaining the existence and nature of battering encompass a combination of theories about individuals, families and society. However, feminist theory gives particular weight to social factors external to the individual (Stark, Flitcraft & Frazier, 1979). Taking a broad, macro-social view, feminist theory postulates that forces external to couples, create a macrostructure that sanctions the abuse of women (Harris & Dewdney, 1994, pp. 57-58; Tilden, 1989). Gender and power are two such forces that are

regarded as important in feminist understandings of battering (Taylor, 1993, pp. 205-206). Marriage and family are examples of social structures that have been shaped by gender and power (Bograd, 1992). Feminist perspectives focus on the effect of gender and power on marriage and family, observing how all these factors combine to create conditions where abuses of men's power and restricted options for women are frequent occurrences (Tilden, 1989). Feminist perspectives assert that male violence reinforces men's dominant position in society, relative to women. Male violence against women is perceived as a function of women's secondary status in society relative to men (Schechter & Gary, 1992, p. 244). Feminist frameworks view the phenomenon of battering as the most overt form of control used by men as a class, over women (MacLeod, 1987, p. 3).

Feminists view the social construction of gender as a powerful reinforcer of male violence against women. Men are generally conditioned to be aggressive, independent, and achievement oriented while women are primarily socialized to be relational, nurturing and well connected with others (Bem, 1974; Gilligan, 1982, p.17). Women learn to evaluate their worth primarily on the basis of their relational abilities, while men are taught to evaluate their worth according to their individual accomplishments. Women are socialized to prioritize the well-being of others, assume responsibility for the behaviour of a partner, and care for others (Gilligan, 1982, p. 17). They are taught to find their own identity through the relationships they have with others (Bem, 1974). Reitsma-Street identifies three common lessons about caring that are shared by girls in our society: First, girls learn that women are primary providers of physical and emotional care. Second, adolescent females hold to very restricted meanings of self-care. Third, boyfriends are

adolescent girls' primary recipients of care (1993, p.108). Feminist frameworks assert that the social construction of gender in society creates expectations of male and female behaviour that are exploitive and dangerous to women (Brown & Dickey, 1992; Shepard, 1992).

The basis of much feminist research on the social construction of femininity and masculinity is social-learning theory, a product of the behaviourist school of psychology (Rotter, 1954; Bandura, 1977; Mischel, 1979.) One main principle of social learning theory is that behaviour is controlled by its consequences. Acts that are regularly followed by rewards tend to reoccur, while those that are not positively reinforced, tend to become less frequent. Men perpetuate certain expectations of masculinity because such behaviour is usually rewarded with economic, political and social power in our society. Male associated traits such as aggression or agency tend to increase status more so then relational female associated traits, such as nurturing. Feminists use the social learning principle of reward to explain male violence against women, explaining that violence is a means towards a rewarding end consisting of male control, domination and power (Burge, 1989; Kaufman, 1992; Kuypers, 1992, p. 111).

A second principle of social learning theory which holds that the factors of observation and imitation help explain behaviour, is used in feminist perspectives to explain men's continuing aggression against women (Phares, 1991, pp. 342-399). Parents, sports heros, teachers, movie stars and other potent models, display gender-typed behaviour which men and women learn to imitate from early childhood through their adult years. The more powerful, nurturant, and accessible the model is, the more likely it is that

the model's beliefs will be emulated. Also, the more the model is seen to have traits like the observer, the more probable it is that his or her behaviours and beliefs will be adopted. Boys who observe their fathers battering their mothers may be more likely to batter women than the sons of non-violent fathers (Geffner & Pagelow, p. 115; Ammerman & Hersen, 1990, pp. 5&6; Hotaling & Sugarman, 1986). However, even children whose fathers are not violent are inundated with violent gender stereotypes through the media. With prolonged exposure, this modelling contributes to the normalization and acceptance of violence.

Consistent with its recognition of macro forces that perpetuate male privilege and female subordination in domestic spheres, feminist theory rejects frameworks that locate the root cause of battering solely within family or dyadic interactional processes, within individual internal psychology or personal history. Research has not been successful in isolating single individual traits, or individual developmental history that could be used to separate people in marriages plagued with battering, from those in non-violent marriages (Geffner & Pagelow, 1990, p. 125; Bograd, 1992). Similarly, no simple, strong, empirical correlation exists between women's experience of battering and their family of origin patterns (Bograd, 1992). While women who were abused as girls will have suffered damage to their self-esteem, many other messages embedded in societal and cultural beliefs and practises devalue women's experiences and emotional well-being (Pence, 1985). Women's sense of worth is certainly shaped by circumstances in childhood, but self-esteem is also shaped by current situations, and other devaluating messages culture sends, and continues to send, about their worth. The pervasive social, economic, symbolic

and political inequality between men and women in our society forms the context for marriages and common-law partnerships, and although the individual family may be the scene for violent behaviour, feminist perspectives do not view it, or the pathology of individuals within it, as the primary source of the violence (Bograd, 1984).

Just as individual, couple and familial traits have not been established as single factors predisposing women to male victimization or predisposing men to be violent, race, occupation, religion, level of education, and class are also not viewed as simple determining factors for battering within feminist perspectives (Hotaling and Sugarman, 1990; Geffner & Pagelow, 1990, p. 122; Goldner et al, 1990; Kaufman, 1992; Hansen & Goldenberg, 1993, p. 84). Women's income, employment status and education cannot be used to discriminate victims of battering from non-victims (Hotaling & Sugarman, 1986). Similarly, demographic variables have not been shown to accurately distinguish women who have been abused from women who have never been battered (Saunders, Hamberger & Hovey, 1993). Men who behave abusively and women who are abused are well represented in every segment of society (Geffner & Pagelow, 1990, p. 122; Goldner et al, 1990). For these reasons, feminist domestic violence frameworks do not view intrapsychic characteristics of perpetrators and victims as root causes of domestic violence, but rather focus on the inequality between men and women in their broader social, economic, and political environment.

Feminist frameworks conclude that neither battered women nor violent men constitute a homogeneous group that can be characterised as unique and easily recognised in comparison with the rest of the population. While men who behave abusively are

typically authoritarian, often paranoid, secretive and grandiose, they are also typically sensitive to social norms and the realities of power (Herman, 1992, p. 75). Men who batter their female partners, do so where society condones and tolerates their tyrannical behaviour. Far from the common misperception, abusive men show skill in managing their anger, allowing themselves to batter in privacy where they are least likely to come into conflict with negative public consequences. The conventional and well-socialized appearance of both men who batter and women who are abused, testifies to the claim that battering is essentially normative in our society, as disturbing as this norm is (Herman, 1992, p. 33; Gelles & Straus, 1979, p. 549).

The Role of Systems Failure

In keeping with feminist sociological explanations for the existence of battering, and consistent with feminist's commitment to avoid blaming women victims, feminist theories often offer evaluation of various systems' contributions to the problem of battering. Examination of the inadequacies of medical, police, and social work responses to battering reveals that system failures play a role in maintaining the problem of battering in society (Harris & Dewdney, 1994, p. 58; Taylor, 1991, pp. 223-227). Research indicates that the police are the most accessible service to battered women, because they are the most known of the service providers, and they are available 24 hours of the day (Johnson, 1985, p. 111). Of all the service providers for battered women, the police have undoubtedly sustained the most criticism (Bowker, 1983). Common complaints cited in the literature are related to police reluctance to deal with domestic disputes, which are

generally not perceived as authentic police work within the profession (Johnson, 1985, pp. 112-114). Police tend to conceptualize their work in two different categories: law enforcement, including the prevention and detection of crime, and keeping the peace. Keeping the peace is not seen to be as important as law enforcement within police circles. Intervening in cases involving battering is perceived to fall into the category of peace keeping, and lacks status for this reason.

A second criticism frequently appearing in the literature focusses on police reluctance to charge, possibly because the connection between domestic violence and peacekeeping leads to attempts to encourage reconciliation, rather than arrest. Failure to charge may also be due to police failure to recognize or take seriously the danger present in many battering situations (Harris, 1988). In defence, police claim many women do not want to pursue legal action against their own spouses, and appear to fear that pressing charges will provoke further violence. Police reluctance to charge is affected by police awareness that many women will withdraw complaints before their cases ever reach court (Johnson, 1985, p. 114). Manitoba's zero tolerance legislation may have led to improvements in police and prosecutorial discretion in the province.

The literature indicates that the problem of battering does not fit easily into medical mandates either. In her study of staff responses to battering in three emergency rooms, Kurz found that even the minority of "positive" helper responses to battered women presenting in the emergency room were contingent on several factors (1987). Staff responded with more time and empathy when battered women appeared to be "true victims" in immediate danger, when they indicated they were taking action to leave their

relationships, and when they had "pleasant personalities". Women who were chemically dependent, "evasive", and women who were perceived as irresponsible for leaving the hospital with their abusive partner, led to staff perceptions that the women were responsible for violent incidents. Staff tended to view such women as wilful deviants. Emergency department personnel in her study also indicated that they felt powerless to respond to the women, and believed that the battering was not a legitimate medical problem.

Further research concerning medical responses to battered women has uncovered similar findings (Hatty, 1987). In their study of general and family medical practitioners in the Province of Manitoba, Trute, Sarsfield and Mackenzie (1988) found that Manitoba family physicians tended to underestimate the occurrence of battering across the patient populations of women they serve. Although they found that younger physicians with more recent training tended to inquire about and respond to issues of battering more often than older colleagues, overall evidence suggests that Manitoba family physicians' response to battering was limited, and was not extended to many battered women in search of help.

A third system often turned to for help by battered women is the social services. Inadequacy of the response of this system also plays a role in the problem of battering (Shepard, 1991). The plight of battered women can be relegated to the margins of social workers' concerns in several ways. First, social workers demonstrate a marked inclination to redefine the problem of battering as a situation of potential child abuse, subordinating the welfare of women to the welfare of their children (Johnson, 1985, p. 115; Hatty, 1987). When public resources are restricted, political pressure to prioritize child welfare

over the well-being of battered women only increases (Johnson, 1985, p. 117). Social work involvement with battered women is usually the result of contacts established with the family for issues pertaining to the children in the family, and cases tend to be filed according to the initial reason for contact (Hatty, 1985). Women are usually the social worker's primary contact regarding the welfare of the family, while men responsible for the violence are often seen much less frequently by workers. Traditional, patriarchal beliefs that hold women responsible for family matters are often inadvertently reinforced in the social services due to this pattern (Johnson, 1985, p. 117). These factors increase the likelihood that battering will be viewed as tangential to the central issue receiving attention.

It has been further argued that social work education does not adequately prepare workers to prioritize women's needs in cases of battering (Shepard, 1991). Despite the fact that women are by far the most frequent users of social services, the educational process in most schools of social work does not reflect this reality by prioritizing the needs and perspectives of women in course work. Priority is given to the family context of battering which includes a wide complex of material and emotional problems, many of which are associated with children (Johnson, 1985, p. 117; Turner & Shapiro, 1986). Social work training emphasises healing, reconciliation and maintenance of the nuclear family, and social workers tend to feel more equipped to help support the family system than to support women, regardless of whether they choose to remain in or leave an abusive relationship (Johnson, 1985; Shepard, 1991).

Finally, social services support offered to battered women tends to be on a

concrete level, and is often given prematurely, without balanced consideration of the painful mourning process and feelings of profound loss that often accompany women's response to battering (Turner & Shapiro, 1986). Help offered at concrete levels only is inadequate in addressing the powerful emotional ties that keep many women from carrying through on intentions to separate from violent men. In addition to concerns about police, medical, and social services' responses to battered women's help-seeking, many have observed that service delivery between these systems is generally uncoordinated, making it necessary for help-seeking women to link services together themselves, starting afresh with each system they approach (Hatty, 1987; Johnson, 1985, p. 111). Like other help-seeking people in the general population, obstacles encountered by battered women attempting to get formal assistance are frequently derived more from deficiencies in system response, then from flaws in help-seeking behaviour (Harris & Dewdney, 1994, pp. 57-58). As the problem of battering is increasingly recognised, bureaucratized, and professionalised, maintaining a woman and victim-centred focus becomes an even greater challenge for help-givers in police, medical and social work services (Hatty, 1987).

Emergency health care professionals are in a unique position to detect battering and offer help since most victims of violence eventually come to a hospital emergency room for treatment, particularly those who have been severely abused and might be at greatest risk for physical injury and or death (McLeer, 1987). Many times medical personnel in emergency rooms are the first non-offender witnesses to injuries sustained as a result of battering (Bowker & Maurer, 1987).

The inadequacy of hospital emergency room response to battered women has been

well documented in the literature. One common criticism identifies emergency medical professionals' poor record of identifying battered women who present for treatment (Stark, Flitcraft & Frazier, 1979; Issac & Sanchez, 1994; Stewart, 1993; Bowker & Maurer, 1987; Loring & Smith, 1994; Morrison, 1988; Bell, Jenkins, Kpo & Rhodes, 1994; McLeer, 1987; Tilden, 1989). Abused pregnant women represent a specific high-risk group that is frequently not identified as battered by emergency caregivers (Stewart, 1993). Medical staff tend to restrict their treatment of women's injuries to medical aspects only, failing to inquire specifically about the cause of injuries. Failure to ask specific, validating abuse-related interview questions in private precludes the possibility of making a contextual diagnosis, and creates the first barrier to adequate emergency care (Loring & Smith, 1994).

An additional criticism of emergency department responses to battered women is that time spent with them is often brief, routine, insensitive and impersonal (Tilden, 1989). The literature indicates that battered women are more frequently medicated or referred to psychiatric treatment in comparison with women presenting with accidental injuries. While this finding may be evidence of staff sensitivity and desire to help, treating battered women as sick can undermine confidence, creates dependencies on medication, and strengthen battered women's dependence on abusive male partners (Stark, Flitcraft & Frazier, 1979; Dobash & Dobash, 1978; Jobling, 1974). Reluctance to mount a serious effort in providing necessary emergency services for battered women continues to impede care for victimized women in many hospital emergency departments, despite the fact that over 15 years have now passed since the first reports on battered women appeared in the

literature (Issac & Sanchez, 1994).

Barriers to Emergency Department Care

One deterrent to the identification of battered women is the difficulty emergency room staff often experience in recognising trauma symptomatology (Loring & Smith, 1994). Battered women's presentations are similar to other hostages of violent crimes (Fauman, 1982). They often appear depressed, evasive, may have difficulty concentrating, and may have psychogenic amnesia (Stark, Flitcraft & Frazier, 1979). Victims of battering often present with symptoms that appear to have no clear organic basis. Staff unfamiliar with trauma symptomatology may view battered women's visits as abuse of the system, overlooking the possibility that women's complaints are due to trauma (Morrison, 1988).

A second explanation for inadequate emergency care of battered women concerns staff attitudes and beliefs about battering (Loring & Smith, 1994). The belief persists that battered women choose their victimization in some ways, by marrying or remaining with abusive partners (Tilden, 1989; Bendtro & Bowker, 1992). This belief deters medical staff from addressing women's experiences of abuse, and the fear of being blamed for attacks deters some battered women from seeking health care (Tilden, 1989).

Staff response can be further impeded by the common belief that asking about abuse directly is not respectful of women's privacy, and is not appropriate questioning for emergency medical staff (Tilden, 1989; Kurz & Stark, 1988; Warshaw, 1989). Emergency room personnel often experience denial in an attempt to distance themselves from the

injuries inflicted on battered women, particularly when staff are overloaded with work and the pace is rushed (Roberts & Roberts, 1990, p. 106; Tilden, 1989; Dobash & Dobash, 1978). Physicians attempt to protect themselves from the non-physical problems of battered women since they are not trained to deal with problems that are social and political in nature (Dobash and Dobash, 1978; Stark, Flitcraft & Frazier, 1979). Emergency room personnel often perceive that a successful outcome is unlikely in their work with battered women (Stark, Flitcraft & Frazier, 1979). The medical paradigm defines disease as something that develops in the body, merely influenced by outside factors. Diagnoses that exclude physiological abnormality are often not well understood. Hence, they often lead to psychiatric referrals, prescriptions for sedation and analgesics (Morrison, 1988). Overcrowding, lack of resources, staff shortages, equipment failures and patient load also contribute further to a work mind-set where readiness to ask about abuse is minimal (Morrison, 1988).

Emergency departments have emphasized highly technological intervention in the last decade. Definitions of "emergency" have changed with technological advances, and often what is emergent to the people presenting is not seen to be critical by the specialists providing care. Victims of violence often view their social situations as emergencies regardless of the physical evidence they show (Morrison, 1988). The response of emergency department caregivers does not have a neutral effect on the problem of battering in our society. Like other helping professionals, emergency department staff may reinforce economic, racial and sexual injustices through their individual attitudes and practices (Stark, Flitcraft, Zuckermann, Grey & Robison, 1981).

Some barriers to appropriate care are "victim-related". Women who have been battered tend to avoid identifying themselves as victims of domestic violence for various reasons. They fear retaliation, and have learned that exercising their own initiative could be perceived as insubordination by their abusive partners, an offense for which they may have to pay dearly (Bowker & Mauer, 1987; Foster, Veale & Fogel, 1989; Bohn, 1990; Herman, 1992, p. 91). Battered women know that they can never be certain they have escaped the surveillance of their abusive partners, even when they are not physically present with them (Herman, 1992, p. 91).

Feelings of shame and the belief that they bear some responsibility for the battering deters some abused women from identifying themselves (Bohn, 1990). Battered women are often unaware that large numbers of women are victimized by intimate partners, and they perceive their situations to be unique (Bowker, 1987). Since traumatised individuals oscillate between anxious clinging to others and isolation, battered women may not cooperate with emergency staff, but instead align themselves with their abusive partners for comfort, with some hope that they may change as they promise (Herman, 1992, p. 56; Loring & Smith, 1994). Initial reactions to trauma, such as numbness and a shock-like state, rationalization or denial may also deter battered women from volunteering disclosures of abuse (Bohn, 1990).

Appropriate Emergency Department Care

A substantial body of research indicates that detection of battered women presenting at emergency departments and opportunity to respond therapeutically is

dependent on the use of routine questioning of all female patients about abuse or violence in their lives (Smith & Gittelman, 1994; McLeer & Anwar, 1989; Stewart, 1993; Campbell & Sheridan, 1989; Tilden, 1987; Grunfeld, Ritmiller, Mackay, Cowan & Hotch, 1994; Smith & Gittelman, 1994; Ratner, 1992; Saunders, Hamberger & Hovey, 1993). Those who have studied battered women emphatically state that the single most important service professionals can offer women victims is to ask directly about abuse (Burge, 1989). Spontaneous disclosures from battered women are rare, and screening that is based on the judgement of health care providers is insufficient since emergency department staff seriously underestimate the numbers of victimized women in their care (Tilden, 1994; Campbell & Sheridan, 1989; Isaac & Sanchez, 1994). Conversely, 16% - 30% of female trauma patients will report that they have been battered when they have been asked directly how their injuries occurred (Kurz, 1987). When healthcare providers initiate routine discussions of abuse, they communicate that the problem is not too insignificant, shameful or deviant to talk about, they validate women's feelings and communicate hope for change (Burge, 1989). Rather than inviting fabrications of abuse, direct questioning reflects the frequent occurrence of battering in society, reduces women's shame and discomfort, and invites open discussion (Campbell & Sheridan, 1989). Direct questioning about abuse early in assessment allows for more efficient planning of hospital care (Campbell & Sheridan, 1989).

Screening protocols usually recommend several questions that staff can use to facilitate disclosures of battering (Tilden, 1989). Vancouver Hospital and Health Sciences Centre Emergency Department uses the following opening statement, or a paraphrase of

it: "We know that violence is a problem for many women, so we routinely screen all women for abuse or violence in their lives. Is this a problem for you in any way?" If women say "yes", they are asked whether they want help from the hospital's domestic violence program. Help is offered if it is requested (Grunfeld et al, 1994). Staff are welcome to use a close paraphrase of the suggested screening question, however, it is important that they ask directly about abuse or violence in the life of the presenting woman. Campbell and Sheridan (1989) recommend the following question when injuries more clearly suggest abuse: "It seems that the injuries you have could have been caused by someone hurting or abusing you. Did someone hurt you?" The screening question can also be shortened when injuries suggest abuse: "Who hit you (Sheridan, Belknap, Engle, Katz & Kellcher, 1989)?"

Of more importance than the words used to screen for abuse is the manner of the person conducting the screening. A supportive, non-judgemental and non-assuming tone is necessary for screening efforts to be successful in creating conditions where battered women can disclose experiences of violation (Tilden, 1989). Maintaining an empathetic approach to battered women can be challenging in situations where the women are hostile, apathetic, or "non-compliant". It may be helpful for staff to consider the adaptive purposes these behaviours serve. Emergency department nurses, social workers and physicians will need to develop a collaborative and supportive alliance with victimized women, remembering that the process of leaving a violent partner is dangerous and complex, and usually takes time, safety, resources and psychological readiness (Smith & Gittelman, 1994).

Finally, privacy is critical to effective screening (Smith & Gittelman, 1994).

Triage is usually the location where screening for abuse is conducted, however, privacy and time at triage are often limited. Screening should never be conducted when patients are accompanied by friends or relatives who decline staff invitations to remain in the waiting room. To help compensate for the disadvantageous rushed pace and relatively exposed location of screening at triage, additional subsequent questioning during history-taking, or in other treatment areas, may help improve overall conditions so that disclosures of abuse can occur (Grunfeld et al, 1994). Screening questions must always be asked outside of the presence of any persons who have accompanied battered women to the emergency department, particularly male partners of presenting women. Hospital translators can be used to help screen women in situations where the triage nurse does not understand the language of the presenting women.

Although responsibility for screening for battering is generally assigned to triage nurses at the emergency department triage (McLeer & Anwar, 1987), questions about abuse can be asked by any nurse, social worker or physician during the course of history taking, assessment or treatment. Since their first attempts at routine screening for domestic violence against women, the Vancouver Hospital and Health Sciences Emergency Department has widened their initial screening model, which was very dependent on triage nursing staff. They have found that routine screening protocols are carried out much more effectively when all nurses and physicians share ownership of a screening protocol (Kathleen Mackay, personal communication, summer 1996). While staff should ensure that unnecessary duplication of screening is avoided by checking

patient documentation, it is important for each professional staff person in the emergency department to be prepared to screen women in a direct and compassionate manner about battering. The recommended screening question is appropriate for routine screening at triage or in treatment areas. It can be used at any point during a woman's visit to the emergency department, in cases where female patients display obvious injuries, and in cases where domestic violence is not suspected (Grinfeld, et al, 1994).

Having detected domestic violence, health care givers are faced with the challenge of intervening. One proposed model for intervention suggests that emergency physicians bear ultimate responsibility for quality of medical care to people presenting at emergency, and must ensure that an adequate trauma history is obtained and documented, a thorough assessment of battered women's functional and emotional status is made, assessment regarding women's needs for safety and legal information is conducted, and a follow-up plan referring them to community supports is in place (Morrison, 1988; McLeer & Anwar, 1987). Affective assessment must include assessment of abused women's suicidality or homicidal potential. Assessment of women's safety must include assessment of risk to their children. Any staff person who has reason to believe that children are in danger, or that an adult is likely to harm another person or themselves, is obligated to inform appropriate authorities, according to the law in their region. While physicians may only provide direct care in the areas of documentation, diagnosis, treatment of medical and surgical problems, they must ensure that the other aspects of care are delegated and adequately supervised (McLeer & Anwar, 1987).

Feminist principles for therapy with battered women provide further guidelines for

care. Just as an empathic, supportive manner is critical to effective screening practices, women who are being battered need to experience sincere support from all emergency staff they encounter. Women need to hear that they are not responsible for their partner's choice to use violence. While they may or may not share responsibility for conflict in their relationship, men who choose violent behaviour and abuse are fully responsible for such behaviour (Pressman, 1989, p. 23). Assault is a crime, and no person deserves to be abused.

Second, battered women benefit from care that is focussed on their strengths (Harris & Dewdney, 1994, p. 55-58). Battered women are survivors of violent and controlling environments, and have resilience, coping skills, strength, and specialised knowledge about violence within their own lives. When their expertise is recognised by staff, women experiencing violence can be invited to work collaboratively with staff to address safety concerns and problem solve. Staff who acknowledge battered women's expertise about their own circumstances will avoid giving advice. The temptation may be to advise women to disclose abuse, leave abusive partners, press charges, or arrange for counselling. However, major change may be dangerous or non-advantageous for women with abusive partners. It is more effective to share information about resources available to battered women and express concern, then to advise women to make choices. If women choose not to process or discuss an abusive situation, their wishes must be respected (Hotch, Grunfeld, Mackay & Cowan, 1995).

Finally, battered women presenting at emergency departments need to hear that they are not alone in their circumstances (Shepard, 1991; Brown & Dickey, 1992;

MacLeod, 1987, p. 3). Many women experience violence from their husbands or partners, and many of these women meet together in support groups (Pressman, 1989; Brown & Dickey, 1992). The solidarity of an affirming group remains the most powerful avenue of healing for the isolation, shame and despair that comes with battering (Herman, 1992, p. 214). More than offering support and advocacy, feminist group work helps survivors gain awareness of the connection between their individual experience, and the larger reality experienced by many women. It equips women to challenge messages that blame them, strengthens their views about themselves as survivors, and energises them to continue to work towards health and wholeness.

Conclusion

Domestic violence literature clearly describes the enormous impact of battering on the psychological, physiological and social well-being of women. Emergency departments can play a vital role in addressing the chronic victimization experienced by many women seeking emergency care. By screening women routinely for domestic violence, the hospital system increases the visibility of this major health problem, and increases detection of domestic violence. When domestic violence is detected, the emergency department can proceed to offer appropriate help.

METHODOLOGY

Rationale for This Study

A Corporate Policy on Domestic Abuse (partner/elder) has been in place at the Health Sciences Centre (HSC) since January 20, 1993 (see Appendix A), the result of several years of interdisciplinary collaboration and consultation (MacKay, 1995). This policy was accompanied by a training program orienting employees to it and attempting to help staff improve in their ability to identify and intervene where incidents of partner or elder abuse were suspected (see Appendix B). More than 2,000 of 5,000 (40%) employees received this training. The statistical measure used to evaluate the program was any change in the total number of referrals made to the Social Work Department. In the three months following the training, the average number of referrals to Social Work increased from an average of 13 referrals per month, to 23 per month. For the quarter following this three month period, however, the number of referrals soon fell to the before-training average (Mackay, 1995).

It is suspected that a partial explanation for low rates of domestic violence referral can be found in current policy which requires emergency department physicians, social workers and nurses to screen for domestic violence only when staff suspect it is a problem for the patient (Corporate Policy and Procedure Manual, 1993, section 30; see Appendix A). As the following literature review suggests, the use of professional discretion in domestic violence screening tends to mislead emergency department staff from positive identification of battered women. Medical professionals inadvertently under-estimate the

number of battered women in their practices, and tend to maintain a low index of suspicion when battered women present with injuries (Stark, Flitcraft & Frazier, 1979). Without policy that requires emergency department staff to ask all women about abuse, large numbers of battered women remain unidentified throughout their hospital visit, and emergency staff forfeit the opportunity to address this enormous threat to women's health. Adequate emergency department response to domestic violence against women begins with staff detection of domestic violence (Issac & Sanchez, 1994; Morrison, 1988; Tilden, 1989).

Research Objectives and Hypotheses

1. This study aimed to determine the effect of routinely screening female patients for domestic violence, on the frequency of domestic violence detection at Winnipeg's HSC adult emergency department. The practise of routine screening required, with a few specific exceptions, that every female patient presenting in the adult emergency department be asked a brief question about domestic violence (see Appendix C). It was hypothesized that routine screening for domestic violence of all women presenting would increase the number of abuse disclosures made by women, thereby increasing the rate of domestic violence detection in the department.
2. Using the General Emergency Documentation (GED) Form for analysis, this research aimed to identify current patterns of emergency staff documentation of domestic violence, both during the period preceding routine screening, and during the routine screening period. Several questions were posed: Are explicit terms such as battering, wife abuse, or

domestic violence used in the GED forms? Are there cases where the researcher might suspect domestic violence as a cause of injury, where source of injury is vaguely documented, or not documented at all? Does staff documentation of domestic violence change with the practise of routine screening? It was hypothesized that when staff would screen women routinely for domestic violence, documentation of battering would become more specific in chart records. The Chi Square test for independence and the Mann-Whittney U test were used to evaluate the significance of qualitative and quantitative differences in domestic violence documentation between the pre-screening period and screening period of the study. In addition, the Proportion Frequency Approach was utilized to assess the significance of differences between daily patterns of domestic violence documentation throughout both periods of this study. Data was tested for autocorrelation prior to the Proportion Frequency analysis and appropriate modifications were made as required.

3. This project aimed to identify barriers to the implementation of routine screening at the HSC emergency department. Although nurses and physicians were asked to screen all women for domestic violence, it was acknowledged that there would be times when this expectation would not be met. In some cases described later in this report, screening would be inappropriate. It was hoped that this research project would identify significant factors which staff view as impediments to routine screening in the emergency department. Staff were asked to record barriers to screening on "tick sheets", and the total number of ticks in each identified category was calculated by the researcher.

4. This research determined to note any increases or decreases in the number of

emergency department referrals to the hospital department of Social Work during the period of routine screening. It was hypothesised that referrals to Social Work from the emergency department would increase with the practise of routine screening. The number of requests for referral to Social Work due to domestic violence were totalled by the emergency department social worker, and reported to the researcher.

5. This study attempted to replicate the research on routine screening conducted in the Vancouver Hospital and Health Sciences emergency department in 1993 (Grunfeld, Ritmiller, Mackay, Cowan & Hotch, 1994). With the practise of routine screening, this emergency department was able to identify 6.3% of the women they screened, as battered. Compared to identification rates before routine screening, this figure represented an increase of about 5% (Grunfeld et al, 1994). The research at the HSC aimed to compare rates of detection during a routine screening period, with the rate of detection documented in the Vancouver study of routine screening. The Chi Square test for independence was used to evaluate the significance of differences between the Vancouver and Winnipeg rates of domestic violence detection, as well as differences between numbers of patients screened in each study.

Research Design

To evaluate and monitor the effect of routine screening on the nature and frequency of domestic violence detection, this research project utilized a Quasi-Experimental Group design. Using the group as the unit of analysis, this design facilitates an overall comparison of the nature and frequency of domestic violence documentation

between the pre-screening and screening periods comprising the study.

To further evaluate the impact of routine screening on the frequency and nature of domestic violence documentation, data were analyzed using a Single System, A B design. Using this design, the unit of analysis was each day in the study, and the emergency department was viewed as a single system. The design allowed comparison of the domestic violence documentation for each of the 20 days in the study. The "A", or "baseline" phase measured the daily proportion of domestic violence detection in the HSC adult emergency department as it existed prior to the introduction of a routine screening protocol. In the "B" period of this design, the daily proportion of domestic violence detection was measured while routine screening was occurring.

The design was chosen for several reasons. Single-subject research designs are helpful in studies where data is being collected about either a single client system, or specific social program (Grinnell & Williams, 1990, p. 232). In this research project, data was collected to help evaluate the effectiveness of a routine screening program. Single case designs are advantageous in that they do not limit the B phase intervention to any particular theory, technique or practise. This flexibility allows the researcher to determine the intervention that is best for the client (Grinnell & Williams, 1990, p. 235). The A B design, with its baseline phase, is desirable in comparison with a B design, since the A B design has the potential to be descriptive, as well as exploratory (Grinnell & Williams, 1990, p. 258). It establishes information about the target "problem" before and during an intervention, providing a higher level of knowledge than a research design whose purpose is simply to gather facts (Grinnell & Williams, 1990, p. 304). This study endeavoured to

provide exploratory information about the daily percentage of domestic violence detection in a hospital emergency department, however, it also aimed to measure any change in the detection rate that might emerge with the introduction of a routine screening protocol.

The single case, A B design also poses limitations. Fluctuations in the baseline data may make execution of an A B study difficult (Grinnell & Williams, 1990, p. 250). Data sources may not be accurate and instruments for measuring may prove themselves to be invalid. As with other research designs, knowledge that measurement is being taken may cause changes in subjects' behaviour that do not result from the intervention (Grinnell & Williams, 1990, p. 248-249). Other uncontrolled intervening variables might also explain changes in the target problem, therefore, the AB design only allows tentative conclusions to be drawn about the effectiveness of a particular intervention. The design is not explanatory. Finally, an A B design is limited in comparison with an A B A B design, which produces stronger evidence that changes observed during the B phases are related to the intervention introduced during those periods (Grinnell & Williams, 1990, p. 243-244). Since this study was non-funded, and the researcher's access to hospital data was limited, the A B design was chosen as the best design possible within these limitations.

Outline of Data Collection

Data collection began in the A phase, otherwise referred to as the pre-screening period. All women's General Emergency Documentation Forms (GED forms; see Appendix D) dated within ten 24 hour periods were analyzed to determine the number of charts documenting domestic violence against women before routine screening was

introduced, as well as to determine general patterns of domestic violence documentation in the emergency department before routine screening was introduced. Specified criteria were used to rate each document.

Similarly, in the B phase, otherwise referred to as the screening period, all women's charts dated within ten 24 hour periods were analyzed to determine the number of charts documenting domestic violence against women in this period, as well as to determine patterns of domestic violence documentation in this period. The same criteria used to rate charts in the pre-screening period was also used in the screening period.

Additional data was collected by staff, from all women patients presenting to the department during the ten designated screening shifts. The data indicated women's responses to nurses and physicians' screening for domestic violence, as well as any barriers that might have made screening of some patients impossible. This data was recorded by nurses and physicians on tick sheets, which were later retrieved and analyzed (see Appendix E). Since the tick sheets were only used in the screening period, no comparison of tick sheet data could be made across the two periods in this study.

The ten 24 hour periods comprising the pre-screening period were as follows: September 7, 8, 14, 17, 18, 23, 24, 26, 29, and October 4, all in 1996. The ten 24 hour periods comprising the screening period were as follows: February 1, 2, 8, 11, 12, 17, 18, 20, 23, and 28, all in 1997. The 24 hour segments in each period were spread across a month's time, rather than condensed into ten consecutive days to reduce the potential impact of certain monthly occurrences on the data, such as the arrival of welfare cheques. Spreading the 24 hour segments throughout the month also exposed the data to a greater

number of staff persons' influence, since many of the emergency nurses and physicians work several consecutive shifts, and then have several consecutive days off. The ten 24 hour periods in both phases of this study were chosen, using a random numbers table. Week days and weekends were chosen separately using this method, to ensure that at least a minimal number of weekends would be represented in the study.

The period of months separating the pre-screening and screening phases of data collection was caused by several factors. To obtain as accurate a baseline as possible, the researcher wanted to assign the pre-screening period to a time before some staff in the emergency department were made aware of the study. In the month of October, 1996, this study was considered for implementation through a process entitled the Health Sciences Impact of Research review. This review of the proposed research project involved the Director of the emergency department, Dr. Louis Ludwig. The researcher decided to use the month of September, 1996, with one date in early October, to comprise the pre-screening period to minimize the reactive effect that staff knowledge of the study might have on the baseline data. The month of February was chosen to form the parameters for the screening period because ethics approval for the project was only granted in the month of December, 1996, and several training sessions in preparation for the research were scheduled in the month of January, 1997. If the HSC Impact of Review process would have coincided with the Social Work and Nursing ethical reviews, the time separating both pre-screening and screening periods could have been reduced.

The Routine Screening Protocol

The routine screening protocol was designed to include participation from triage nurses, admitting nurses and physicians, reflecting the belief that it is advantageous to screen patients as early in their emergency visit as possible. If triage nurses failed to ask the screening question, the admitting nurse who would see the patient after triage, had opportunity to do so. As the last professional to see the patient, the emergency physician was to be responsible for asking the screening question if neither of the triage or admitting nurses had already done so.

A tick sheet (see Appendix E) with accompanying instructions accompanied every female patient's chart during the routine screening period. It allowed nurses and physicians to determine at a glance whether the patient had been screened, and record positive and negative responses to the screening question at any time throughout the emergency care process. The tick sheet was also used to measure the screening efforts and barriers to screening for the three medical professional groupings involved in this study: triage nurses, admitting nurses and physicians. All information provided by staff on tick sheets was completely anonymous, and the researcher was not able to identify any names of patients or staff through information recorded on the tick sheets. The accompanying instructions explained how the tick sheet should be used, and defined the barrier categories on it. These barrier categories were borrowed from the tick sheet used in the Vancouver Hospital and Health Sciences emergency department research into routine screening (Grunfeld, Ritmiller, Mackay & Cowan, 1994). When all the tick sheets were collected, the total "ticks" for each barrier category were calculated. Barriers were

totalled according to professional role in the emergency department, since impediments to screening identified by one professional grouping were expected to vary from those identified by another.

Training of Emergency Physicians and Nurses

In keeping with the inservice and training structure already in place in the HSC emergency department, nurses and physicians were trained separately for participation in this research project. Four 45 minute inservices were held for nurses, with approximately 3-5 nurses in attendance at each inservice. The researcher was informed that this level of attendance was usual for inservices, and that nurses who had been at the inservice typically informed other nurses as needed. Only one 45 minute inservice was held with physicians. With approximately ten physicians in attendance, including the Head of the Emergency Department, a greater proportion of physicians were introduced to this research, compared to the nurses. The number of training sessions for both nurses and physicians comprised the maximum amount of inservice time available for a research project conducted in the department.

The sessions preparing nurses were the same as the session preparing physicians. Staff were informed that this research project was to replicate a similar study of routine screening conducted at the Vancouver Hospital and Health Sciences Centre (Grunfeld, et al, 1994). They were informed that the staff training sessions were based on the handbook entitled, Domestic Violence Intervention by Emergency Department Staff (Hotch, Grunfeld, Mackay & Cowan, 1995) which is an excellent resource for introducing staff to

the practise and principles of universal screening of all presenting women, for domestic violence. Staff were presented with a verbal disclaimer (see Appendix F) which offered a general overview of the focus and nature of the research, indicated what would be expected of emergency nurses and physicians, and specified ways that staff and patient interests would be protected. Using an overhead transparency copy of the tick sheet, staff were oriented to the tick sheet and accompanying instruction sheet. While screening was to generally occur routinely with female patients, staff were reminded that legitimate barriers like the acuity of a patient's condition, might make screening inappropriate or impossible. The researcher asked staff to refrain from "second guessing" women's responses to the screening question. For example, if they indicated "no", staff were to tick the "no" box, regardless of whether the patient was believed. The researcher informed staff that she would also be accepting patient responses recorded on the tick sheet at face value. Staff were encouraged to use the screening question empathetically, and respond to positive disclosures according to the expectations of the HSC domestic violence policy (Corporate Policy & Procedure Manual, Domestic Violence Protocol, section 30. Patient Care). Copies of the policy were provided for staff at every training session, for perusal outside of the session, if staff wished. At each session, the majority of staff left with a copy of the policy.

Staff were reminded of resources to help them respond to positive disclosures of domestic violence, such as the plasticised domestic violence cards (see Appendix G), brochures available in the department indicating community resources, and referral to the HSC department of social work. In addition, they were informed of the option of inviting

women to phone the Osborne House 24 Hour Crisis Line. HSC staff were informed that shelter staff were aware of the research project, and had arranged for additional staffing for the crisis line during every 24 hour screening period at the emergency department, in case demand for the line would be increased with this research project. This was presented as an excellent option for women disclosing after 1700 hours, when social workers are not available in the HSC department of social work. Staff were reminded that counsellors on the line could help women patients assess their safety, the safety of their children, inform them of crisis and non-crisis help available in their organization and in the community. Emergency staff were informed that their unit manager had given permission for telephones to be brought to patients who wished to avail themselves of a private conversation with an Osborne House counsellor.

While the HSC emergency department response to battered women could have been further developed, a range of basic services could have been offered to female patients victimised by abuse. Women who disclosed experience of domestic violence could receive the opportunity to make arrangements for counselling with an HSC social worker in a location of their choice. They could be offered brochures that discuss safety planning and community resources. They could have their risk assessed and immediate needs discussed, according to the "medical response to abuse cases" plasticised card. They could have domestic violence documented in their emergency documentation. It was hoped that these services would send an empathetic message that would name and recognize women's experiences of violation, signalling that counselling, police or legal, shelter, and community-based help is available.

After time was given for questions, staff were given a few brief examples to consider, and were asked how they would respond, and record responses on the tick sheet. The researcher felt satisfied at the end of each session that the staff were well informed of their role in the research, and their right to refrain from participating, if they chose.

Staff in attendance at training sessions typically asked questions, and often generated discussion relevant to the research. Responses to the proposed research varied, with some staff expressing hostility and strong opposition to the task of routine screening, and other staff expressing willingness to participate and personal interest in the research. A total of 5 nurses expressed their opinion that routine screening was "an abuse of their authority as nurses", and was disrespectful of female patients' privacy. Three nurses expressed the view that persons from other professions would be better situated to screen for domestic violence. They suggested that social workers, or family physicians who have ongoing relationships with patients should screen patients for domestic violence. Physicians did not voice opinions of this nature at their training session. Two physicians questioned the validity of the study, and asked for more information about the research objectives and hypotheses then the researcher was prepared to give. She explained that all the goals of the study had been approved by the Health Sciences Impact of Research Review, as well as the Nursing and Social Work Ethics Reviews, but that some information would be withheld at staff training sessions to preserve the construct validity of the study. Even so, training participants were given a significant amount of information about the study, and the construct validity of the study may have been threatened due to

hypothesis-guessing on the part of nurses and physicians. Their agreement or disagreement with what they felt to be the hypothesis may have affected their screening behaviour in fundamental ways.

Some aspects of training occurred at the shift changes within routine screening periods. It was not possible for the researcher to be physically present at every shift change within a 24 hour period, since each period contains many shift changes, and shift changes are frequently not simultaneously occurring across triage nursing, admitting nursing and physicians. However, the researcher was typically present at shift changes before midnight, at 7:30 a.m., and 8:00 p.m., immediately before and during designated screening shifts. At those times, the researcher attempted to speak to registration clerks, charge nurses, and the triage nurses, to remind them that they were on a "screening shift" and answer any questions.

The emergency department Unit Manager helped to prepare staff for participation in the research project in several ways. Notices were posted concerning the study at the triage desk and main nursing station in the emergency department. Charge nurses received specific notice of the study as well as the screening dates prior to the first three 24 hour screening shifts. In addition, a large highlighted notice was posted on the outside of the box containing tick sheets and instruction sheets. It read as follows: "Triage nurses, please complete/initiate these sheets on ALL females. Sheets already attached to triage note. Sheets to be used on the following dates: Feb. 1, 2, 8,11,12,17,18, 20, 23, 28. Thank you!!" The researcher also informed early in the study that the routine screening question was written out and posted at the triage desk, to make it more

accessible for triage staff to use. While triage nurses were asked by the Unit Manager to ensure that tick sheets attached to triage notes accompanied female patients' GED forms on screening shifts, registration clerks were given the responsibility of detaching tick sheets from GED forms before GED forms were sent to Medical Information to be filed. The researcher picked up tick sheets regularly during the course of the routine screening period, to decrease staff access to completed tick sheets, and reduce the likelihood of loss.

Implementation of the Screening Protocol

Some problems with the method surfaced early in the screening period, but seemed to improve as the study progressed. Although it appeared that everything possible had been done to inform staff of expectations for participation, some staff, including some charge nurses, on some of the first screening shifts indicated that they were not aware of the study, and had no knowledge about expectations of staff choosing to participate. Some staff did not know where tick sheets were located, were not aware that triage nurses were expected to attach them to triage notes, and had no familiarity with the instruction sheet accompanying every tick sheet. Some staff misunderstood the directive to screen every female patient, thinking rather that they were to screen females suspected as having difficulty with domestic violence.

The researcher's attempts to offer brief explanations at shift changes were welcomed by some staff, while other staff either avoided the researcher or expressed strong objection that the study was being conducted in their department. Time was not taken on these occasions to discuss the nature of the objections, although one nurse stated

that screening was rarely conducted on one shift because the staff were "way behind" and the patient load was excessive. On at least one occasion, completed tick sheets were accidentally sent to Medical Information. They were never retrieved, as the researcher was informed that obtaining them would be difficult. Similarly, tick sheets were, on at least one occasion, retrieved from other hospital wards, and brought back to the appropriate file folder in the registration area of the emergency department.

As the study progressed, staff indicated their familiarity with it much more frequently. Several individual staff persons told the researcher of their personal support for the research, and some expressed concern about their perception that large numbers of staff chose not to participate.

Analysis of the GED Forms

Triage, diagnosis and history/physical information on the blue physician's copy of the GED form (see Appendix D) was used to determine the rate of domestic violence detection in the pre-screening and screening period. The blue physician's copy is part of this triplicate form produced in the HSC emergency department. An identical copy of the physician's copy remains in patients' charts, and a second identical copy is filed for auditing purposes. The blue physician's copies are filed according to month in Medical Information for a maximum of six months. They were accessed by the researcher, with permission, at no cost. The GED form was the only hospital documentation accessed in this research. This research did not require access to patient's charts.

The task of analyzing emergency documentation presented a challenge, since

documentation of domestic violence against women can be vague and inconsistent. To provide consistent criterion for evaluating emergency documentation, four categories developed by Stark, Flitcraft and Frazier (1979) were used, with some additional clarification for the purposes of this study.

The first category was called "positive". Women patients in this study were considered "positive" for domestic violence when information on their General Emergency Documentation (GED) form specified that at least one injury was inflicted by a boyfriend, husband, or other male intimate. "Male intimate" included an uncle, partner, or brother. For the purposes of this study, the criteria for the "positive" rating was further expanded to include any note specifying domestic violence recorded in the GED form, even if such documentation excluded mention of specific injury or the relationship of the perpetrator to the patient. This criterion for the "positive" rating is similar to HSC's Corporate Policy definition of domestic violence, which is as follows: "Partner/elder abuse is defined as physical injury, sexual assault, emotional harassment, financial exploitation, and threats of bodily harm to any adult from a significant other, regardless of relationship" (Corporate Policy and Procedure Manual, 1993, section 30; See Appendix A).

The second category, called "probable", included all women whose emergency documentation indicated that at least one injury resulted from a kick, punch, hit or shot, or similar and intentional assault by another person. The relationship of assailant to the female victim was not noted in documentation. Further, to be rated as "probable", the documentation must have provided evidence of an assailant's intentional aggression. Documentation of injuries that excluded any evidence of assault were not included in this

category. For example, injuries caused by kicking suggest assault by an assailant, however, injuries such as burns, lacerations, or fractures, may have occurred accidentally. Only injuries that implicitly or overtly suggested assault were included in the "probable" category.

A third category, "suggestive", was assigned to GED forms where "...at least one injury was inadequately explained by the recorded medical history " (Stark, Flitcraft and Frazier, 1979). In the opinion of the researcher, the phrase, "inadequate explanation of injuries" lacked objective definition in Stark, Flitcraft and Frazier's (1979) published findings, and so criteria defining it further were developed. Injuries documented as resulting from "intoxication", and "falls" which were not otherwise explained, were included in the "suggestive" category, in both periods of this research. Although it was recognised that consumption of alcohol does place people at risk of incurring injury, it was decided that, by itself, intoxication was not an adequate explanation for injury. Consumption of alcohol is often a factor in domestic violence episodes, and alcohol and narcotics are sometimes used by victims to achieve a numbing effect (Herman, 1992, p. 44; Stark, Flitcraft, Zuckerman, Grey, & Robison, et al. 1981). Similarly, GED forms with explanations of injuries that only included "slipped and fell", or "fell down stairs", were rated as "suggestive". Pushing, shoving, kicking and punching are common occurrences in domestic violence episodes, and could easily cause falls that result in injury (Ganley, 1989, pp. 200-203; Geffner & Pagelow, 1990, p. 113; Sheridan, 1993). GED forms which used "fell" to explain injuries of patients aged 65 and older were not included in the suggestive category, since falling is a major cause of injury in elderly populations.

Documentation of "falls" that included additional information, such as "fell on ice", "tripped on curb", or "fell on slippery floor", were not included in the suggestive category. Rather, they were rated as "reasonable negative", if they did not meet the criteria of any other rating.

The fourth category called "reasonable negative" included all documentation of injuries explained by an etiology that did not include domestic violence. According to Stark, Flitcraft and Frazier (1979) this category was to include those records specifying muggings, and all other assaults specified as anonymous. This category was also expanded for the purpose of this study, to include women's presentations that concern other physiological problems unrelated to injury. For example, documentation indicating a female patient was treated for pneumonia, was classified as "reasonable negative" if it did not contain additional information that would qualify it for a different rating. No judgement about whether the injury matched the recorded etiology was made in the rating process.

The categories "probable" and "suggestive" reflect ambiguous documentation of injuries, wherein domestic violence had not been ruled out as a cause of injury. It was suspected that the practise of routine screening would help improve emergency department detection of domestic violence against women, thereby increasing "positive" documentation, and decreasing the number of documents with "probable" and "suggestive" ratings.

Reliability of Criteria Used for Analysis of GED Forms

In the absence of information indicating the reliability of the four categories, the researcher arranged for the testing of the four categories, and the inter-rater reliability of these categories proved to be satisfactory. As part of the process, three social workers from the HSC social work department, along with the researcher, were asked to categorise the documentation from 15 specified GED forms as either "positive", "probable" and "reasonable negative" categories. At the time of this testing, the researcher was not planning to use the category of "suggestive" because she believed it to be unnecessary to the research. This opinion changed after she began to rate documentation, as she was surprised to see a significant number of charts documenting injury that did not meet the criteria for "positive" or "probable" ratings. At the same time, the category of "reasonable negative" seemed inappropriate documentation where explanations of injury appeared incomplete. Therefore, the category of "suggestive" was introduced.

Because the category of "suggestive" was not included in the first round of reliability testing involving HSC social workers, a set of twelve new GED forms were rated by the researcher and another individual, on March 19, 1997, wherein the use of each category was required. Ambiguity evident in the criteria of the categories used by the social workers was clarified before this second round of reliability testing. Ratings from the first round of testing involving three social workers varied somewhat from the researcher's rating, with one rating 67% identical to the researcher's rating. The two other ratings were 93% identical to the researcher's ratings. Ratings with the second round of

testing involving all four categories were completed between the researcher and another individual. This rating was 100% identical to the researcher's rating. Confident that the reliability of the categories had been established, the researcher began rating pre-screening documents again, from the first 24 hour period of the pre-screening period, using all four of Stark, Flitcraft and Frazier's rating categories (1979). To monitor and further ensure consistency in the researcher's use of categories, every rating other than "reasonable negative" was accompanied by a brief note, explaining why the form was assigned a "positive", "probable" or "suggestive" rating.

Assistance With Interpretation of GED Forms

In preparation for this research the investigator reviewed all GED forms of female patients presenting in a one month period (May, 1996). Almost every piece of documentation reviewed contained medical language and shorthand that could not be understood by a non-medical person. Deciphering medical records was problematic, not only the diagnosis and treatment sections of the form, but also the history and physical sections. Often the researcher could not even be certain how to transcribe problematic sections of the emergency record. Concerned that her interpretations of records would not be adequate, the possibility of obtaining assistance was considered. The option of asking an HSC physician from a non-emergency department was ruled out since this thesis does not have a budget whereby a staffperson can be reimbursed for interpreting the approximately 1,000 pieces of documentation. As a last resort, Dr. David Willems, a family physician, agreed to help "translate" documentation for each patient record that was

to be analyzed in this study, without reimbursement. Dr. Willems is not a hospital employee, and was required to familiarize himself with HSC policy concerning confidentiality, and sign an oath of confidentiality, which was submitted to the HSC corporate office.

Impact of Routine Screening on Social Work Services

To meet the fourth research objective, Ms. Kathy Blythe, an emergency department social worker, was asked to note the number of domestic violence consults requested by the emergency department during a period before and during routine screening (January, 1997). Referrals to Social Work were monitored for the purpose of determining the demand that a routine screening protocol might place on Social Work resources.

Comparison of Vancouver and Winnipeg Findings

Finally, a simple comparison was made between the percentage of women disclosing experience with domestic violence at Winnipeg's Health Sciences Adult Emergency Department and the emergency department of the Vancouver Hospital and Health Sciences Centre. A comparison of findings between the Winnipeg and Vancouver studies must recognize differences in design and methodology between the two research projects. The routine screening study done at Vancouver General Hospital and Health Sciences Centre adult emergency department used only triage nurses to screen female patients for domestic violence (Grunfeld et al, 1994). In contrast, the study of routine

screening conducted out of Winnipeg's Health Sciences Centre involved triage nurses, admitting nurses and physicians.

Because the Winnipeg study was structured to include nurses and physicians beyond triage in the screening practise, the tick sheets and related methodology used in Winnipeg differed from the Vancouver study. In Vancouver, tick sheets recording patient response to screening and barriers to screening remained at the triage desk. Each tick sheet contained space for ten patient entries, and similar to the tick sheet used in Winnipeg, each entry allowed space for staff to tick patient responses to the screening question, or to tick reason(s) why the screening was not conducted. Tick sheets circulated with patient charts throughout the emergency department in Winnipeg, giving admitting nurses and physicians opportunity to screen and record on tick sheets.

It may also be important to note that the screening question recommended for use differed slightly from the question recommended in Vancouver. In Vancouver, staff were asked to use the following question or paraphrase of the question: "We know that violence is a problem for many women, so we routinely screen all women for abuse or violence in their lives. Is this a problem for you in any way?" (Grunfeld et al, 1994). In Winnipeg, the following question or paraphrase of the question was recommended: "We know that violence at home is a problem affecting the health of many women, so we routinely screen all women for abuse or violence in their lives. Is this a problem for you in any way?" It was hoped that the word "health", which was intended to be understood in the broadest sense possible, would help frame the screening question in the context of health care, making it easier for patients to understand why health care professionals were addressing

the issue. Perhaps patients held to a more narrow definition of health, and the use of the word in the screening question may have inhibited some women from disclosing.

Other differences between the studies concern the pre-screening period of ten 24 hour periods in the Winnipeg study, and the absence of a comparison or pre-screening period in the Vancouver study (Grunfeld et al, 1994). Staff from the hospital's domestic violence program in Vancouver estimated that the identification rate for domestic violence was about 1% or less before routine screening was introduced (Anton Grunfeld, M. D., Department of Emergency Medicine, Vancouver Hospital and Health Sciences Centre, personal communication, summer 1996), however, this estimate was not verified by any controlled comparison or pre-screening period data. In addition, Vancouver staff screened patients within 7 non-random consecutive days (Grunfeld et al, 1994), while Winnipeg staff screened patients during 10 specified days, randomly spread through the month.

Design and Methodological Limitations

The amount of time between the pre-screening and screening periods of analysis posed limitations that may have threatened the internal validity of this study. First, seasonal differences may have accounted for differences in disclosure rates between the periods. One HSC staff person has casually observed that domestic violence presentations at the HSC emergency department tend to increase with warm summer weather, and decrease during cold winter months. The researcher did not find evidence of this in the literature. Auditing documentation during the month of February might have

yielded depressed rates of disclosure compared with "baseline" data collected from late summer or early fall documentation.

Second, separating the pre-screening and screening audits by a period of months may have made the study vulnerable to a greater number of historical events than would be the case if the pre-screening and screening periods were close together. The researcher was concerned that domestic violence cases appearing in the media might sway public opinion against female victims, making staff less likely to screen empathetically during the screening phase. From September 1996 through February 1997, the researcher attempted to monitor media coverage of domestic violence and other abuse stories. Two stories received considerable coverage during this time. One focussed on the public disclosure of a hockey player's experiences of professional sexual abuse from a coach, and another story focussed the battering and murder of a local woman, who died shortly after her presentation at the adult HSC emergency department. This occurred only hours before one of the sessions preparing nurses for their role in this research project. It was not possible to determine the effect that these events, highly visible in the media, might have had on staff behaviour related to domestic violence. No similar events were reported during the screening period, to the researcher's knowledge.

The validity of this study may have also been undermined by changes in staffing, which would be more likely to occur over a period of months, than a period of weeks. If an influential and empathetic staffperson works during one period and not in the other, this intervening variable could introduce error. While the decision to conduct the first ten audits considerably earlier than the last ten makes the research vulnerable to seasonal and

historical intervening variables, concern that staff knowledge of the study might artificially boost the rate of domestic violence documentation in the pre-screening period outweighed concerns about limitations associated with a time lapse between pre-screening and screening periods.

The research design and methodology was further limited by the study's disproportionate reliance on physician documentation on the GED form, compared to nursing documentation. The routine screening protocol introduced by this research required participation from both nursing and physicians, however, physician documentation dominates the GED form analyzed in both periods of this study.

The decision to use physician documentation was made for several reasons. The GED form is the most comprehensive record of patients' visits to the HSC emergency department. Information on this document reflects nurses' triage and admitting work with patients, and sums up all information uncovered by emergency nurses and physicians that is deemed relevant to patients' immediate health. Physicians typically see patients only after triage and admitting nurses have seen them. Documentation produced by nurses is reviewed by physicians before they see patients. As such, physicians are typically in the most informed position to detect domestic violence, before patients are treated and released. As physicians also bear ultimate responsibility for patient diagnosis and treatment in the emergency department, it could be argued that the obligation to detect domestic violence rests most heavily with them.

This project also relied heavily on physician documentation for practical reasons. The physician's copy of the GED form was accessible and free of charge, whereas access

to any additional nursing documentation was complicated and expensive (see Appendix D).

CHAPTER 3

FINDINGS

Out of 485 women who presented in the screening period, 119, 24.5% of the total number of women seen in emergency during the screening period, were screened for domestic violence. Since 75.5% of the women presenting were not asked the routine screening question, it must be concluded that screening did not occur "routinely", and any impact of a routine screening protocol on rates of domestic violence detection in the HSC emergency department remains undetermined.

Screening Conducted by Emergency Professionals

Data from the tick sheets indicates the proportion of screening conducted by each professional grouping in the department: triage nurses, admitting nurses and physicians. As Table 1 indicates, more than half of patients who were screened (54.6%), were screened by triage nurses. Admitting nurses screened 28.6%, and physicians screened 16.8% of the total number of female patients screened in the department. A certain amount of screening had already occurred before admitting nurses and physicians addressed female patients since triage nurses address patients first, admitting nurses second, and physicians are the last professional group to see each patient. Each patient was to be screened only once. Considering the numbers of women who were screened at triage (13.4%), admitting nurses screened 8.1% of the number they could have screened (see Table 2). Similarly, acknowledging the fact that a total of 21.5% of the sample had already been screened by either triage or admitting nurses before physicians had the

opportunity to screen, physicians screened 5.2% of the number they could have screened.

Table 1
Distribution of Screening by Discipline
N = 119

	Number Screened	Percentage of Total Screened
Triage	65	54.6 %
Admitting	34	28.6 %
Physician	20	16.8 %

Table 2
Proportion of Available Cases Screened by Discipline
N=485

	Available	Percentage Screened
Triage	485	13.4 %
Admitting	420	8.1 %
Physicians	386	5.2 %

Domestic Violence Detection Evident in GED Forms

The first objective of this research was to measure the effect of routine screening on the rate of domestic violence detection evident in the GED forms. The Chi square test for independence was used to evaluate differences between ratings, in the pre-screening and screening periods (see Table 3). Overall differences in ratings between periods was not shown to be statistically significant ($\chi^2 = .77771$, d. f. =3, $p = .85479$). This test does not provide statistical evidence to refute the null hypothesis that no relationship exists

between routine screening and increased detection of domestic violence.

The Mann-Whitney U Test provided an alternate way of testing the hypothesis that routine screening is associated with increased detection of domestic violence. The mean ranking was lower in the screening period (492.04) compared to the pre-screening period where the mean ranking was 499.79. The median rating was 4 for each period. Given the ordinal rating system used in this analysis, a lower mean ranking in the screening period indicates that the trend towards positive documentation of domestic violence existed in the screening period. However, the observed significance level (corrected for ties) was large ($z = -.7397$, $n = 991$, one-tailed $p = .22975$), too large to allow rejection of the null hypothesis that the pre-screening and screening groups come from the same distribution. The significance level indicates that there was no significant overall difference in pattern of ranks in screening or pre-screening period. There is a good chance that the difference in mean rankings was due only to chance, rather than the screening practised in the second period of this study. This test indicates that there is no statistically significant evidence to suggest that routine screening is associated with an increase in domestic violence detection.

Table 3
Classification of Cases by Screening Period
N = 119

Rating	Pre-Screening No. & Percentage of Total		Screening No. & Percentage of Total	
Positive	5	1.0 %	7	1.4%
Probable	15	3.0 %	15	3.1%
Suggestive	40	7.9 %	43	8.9%
Reasonable Negative	446	88.1 %	420	86.6%
Column Total	506	100%	485	100%

While the Chi Square test for independence, and the Mann-Whitney U test did not yield significant findings, longitudinal analysis of the day by day percentages of "positive" ratings across both periods through the use of the Proportion Frequency Approach, indicated a statistically significant trend toward increased "positive" documentation of domestic violence in the screening period ($p < 0.05$). This approach analyzes the difference in rating trends between pre-screening and screening periods using a single system design. This process requires the establishment of a zone of "no change", for "positive", "probable" and "suggestive" ratings, during the pre-screening period. Each zone contained 7 typical cases. To achieve a significance level of 0.05 or less, 6 or more cases in the screening period had to fall above the zone established for each of the three baseline ratings. Analysis of the daily percentage of forms rated "positive" (see Figure 1) using this approach indicated that 6 cases in the screening period were found to be above the typical zone established in the pre-screening period. The trend is not major, and does not exceed the minimal requirement of 6 cases (see Figures 1, 2 & 3).

This trend may be influenced by the fact that 60.0% of the days in the pre-screening period had zero documentation of domestic violence that met the criterion of the "positive" rating in this study. The screening period had fewer days with zero "positive" documentation of domestic violence (40.0% in total). Days with zero documentation of domestic violence were all week days in the pre-screening period. The first, second and second last days in this period which had positive documentation of domestic violence, were weekend days. No pattern indicating an effect from the time of the month could be identified. In the screening period, half of the days with zero "positive" documentation of domestic violence were week days, and the other half were weekend days. The weekend days with zero "positive" documentation of domestic violence occurred very early in the month, while the other two days with no documentation of domestic violence occurred in the second and third weeks of the month.

It is important to note that pre-screening and screening days with no "positive" domestic violence documentation (see Figure 1) were infrequently mirrored with corresponding zeros in the "probable" and "suggestive" data (see Figures 2 and 3). For example, although no domestic violence was documented throughout days four through eight of the pre-screening period, a significant amount of documentation from the exact same days was "suggestive" of domestic violence, according to the criterion explained in the previous chapter. Similarly, the first two days of the screening period containing no positive documentation of domestic violence (see Figure 1) had comparatively large percentages of "probable" ratings, indicating evidence of intentional injury without ruling out domestic violence as a cause. The seventh day of the screening period showed no

documentation of domestic violence, however 18.18% of the documents on the same day had to be rated as "suggestive" of domestic violence. Percentages in the screening period found to be above the typical zone for positive cases were evenly spread throughout the period, and more variation in daily percentages is evident in the screening period than the pre-screening period. The percentages of daily ratings in the pre-screening and screening periods. As indicated in the methodology chapter, percentages of daily "probable" ratings in both periods were "transformed" after the "probable" ratings in the screening period were found to be autocorrelated. Retesting indicated that the "probable" ratings were no longer autocorrelated. Data comprising the other classifications was shown to be independent (Bloom, Fischer & Orme, 1995).

Figure 1
Daily Percentage of Pre-Screening and Screening Documents Rated "Positive"

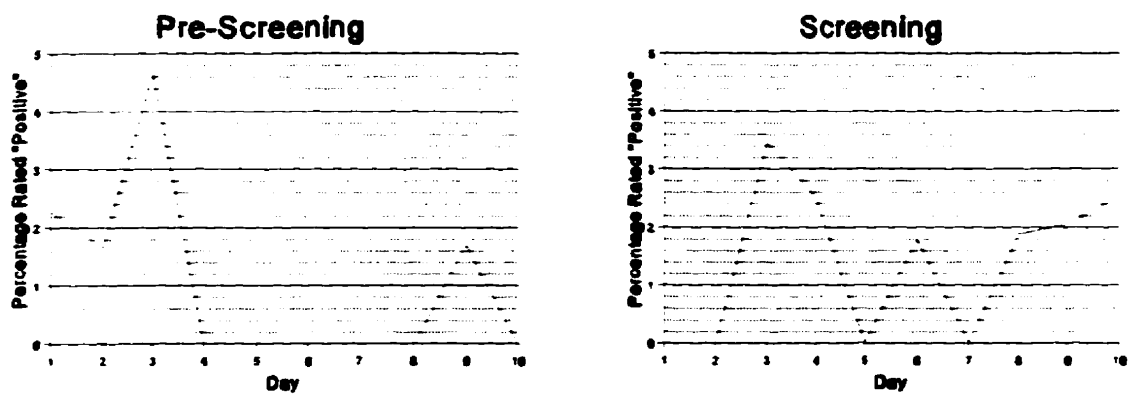


Figure 2
Daily Percentage of Pre-Screening and Screening Documents Rated "Probable"

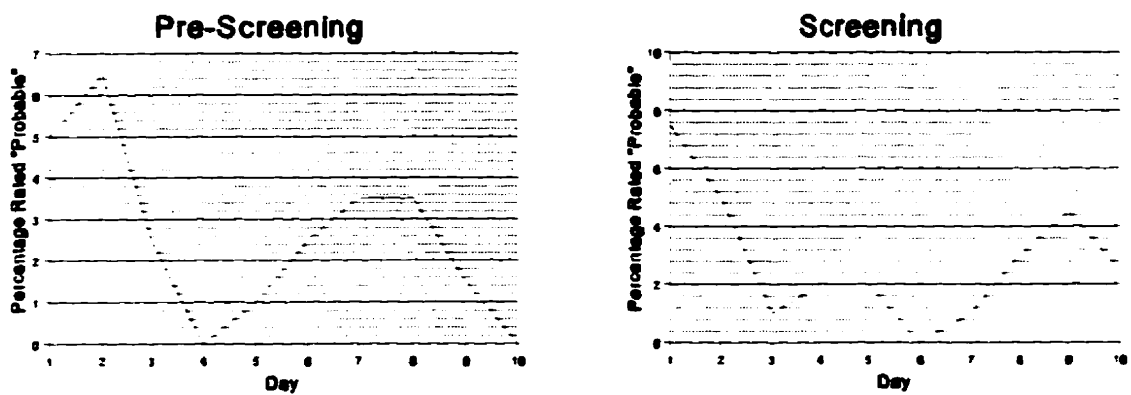
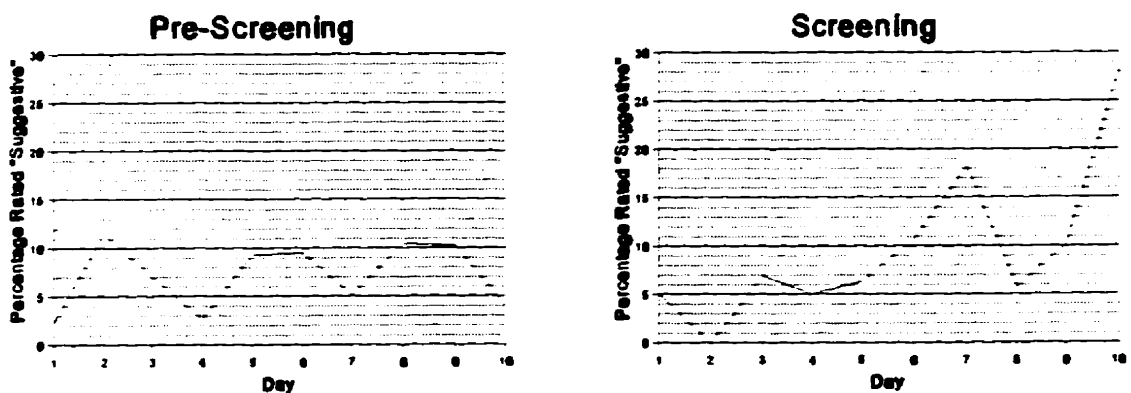


Figure 3
Daily Percentage of Pre-Screening and Screening Documents Rated "Suggestive"



Domestic Violence Detection Evident in Tick Sheet Data

Data from the tick sheets indicates that a total of 16 out of 119 women (13.4 %) screened in the screening period, answered "yes" to the domestic violence question, thereby disclosing that domestic violence is a problem for them in some way. Positive responses to screening were generally evenly represented across professional groupings in the emergency department (see Table 4). Out of the total number of women screened by triage nurses, 12.3% answered the screening question positively. For both admitting nurses, 14.7% of the women screened answered the domestic violence question positively. In response to physician screening, 15.0 % of women screened answered positively. The Chi Square statistical test was used to evaluate the differences between observed frequencies reported in Table 4, and expected frequencies ($\chi^2 = 0.17$, d. f. = 2, $p > 0.05$). Due to low numbers in the expected frequencies cells, significant findings are more likely to occur than the alpha level indicates. The test indicates that the relationships between professional role and patient response to screening reported in this table are not significant at the 0.05 level, and are likely to be the result of sampling error alone (Babbie, 1975, p. 427).

Table 4
Percentage Positive by Discipline
N = 119

	"Yes" Responses No. & Percentage of Total		"No" Responses No. & Percentage of Total	
Triage	8	12.3 %	57	87.7 %
Admitting	5	14.7 %	29	85.3 %
Physician	3	0.15 %	17	85.0 %

Patterns in Documentation of Domestic Violence

The second objective of this research project was to identify current patterns of domestic violence documentation in the GED forms, in both pre-screening and screening periods. As the graphs (see Figures 1, 2 & 3) and frequencies in Table 3 indicate, "positive", or adequate documentation of domestic violence is scant in both screening and pre-screening periods. In the pre-screening period, only 5 forms in 506 total (1.1 %), documented domestic violence according to the "positive" classification. Similarly, in the screening period, a total of 7 GED forms out of 485 in total (1.4%), contained documentation of domestic violence, although tick sheets from the same period indicate that 16 women disclosed that domestic violence was a problem for them in response to the screening question. Out of 991 GED forms analyzed in total, only 12 GED forms documented domestic violence, 1.2% of the total sample.

While it was predicted that categories indicating vague and inadequate documentation suggestive of domestic violence would decrease in the routine screening period, an increase in documents rated "probable" and "suggestive" can be seen in the

screening period. The proportion of "probable" ratings in the pre-screening period rose from 3.0% to 3.1% in the screening period. The proportion of "suggestive" ratings in the pre-screening period rose from 7.9% to 8.9% in the screening period. No statistically significant increase between pre-screening and screening "probable" or "suggestive" categories was found using the Proportion Frequency Approach. As well, the Chi Square test for independence and the Mann-Whitney U test did not yield significant findings at the 0.05 level.

Barriers to Routine Screening

The goal of identifying barriers to the implementation of routine screening was a third objective of this study. It was not uncommon for an individual staff person to identify more than one barrier prohibiting the screening of a single patient. According to the data on the tick sheets, the barrier preventing screening by far most frequently identified by triage and admitting nurses, was "not comfortable" (see Table 5). Triage nurses checked this barrier 66 times during the screening period, and admitting nurses checked it 15 times. The physicians checked the category of "not comfortable" one time in total. The definition of "not comfortable" appearing on the instruction sheet that accompanied every tick sheet states "the patient was not screened because the staff person was too uncomfortable with the task of asking the screening question" (see Appendix E).

Table 5
Barriers to Screening -Total Ticks in Each Category
(Number and Percentage of Total Barriers Identified by Profession)

	Acuity	Language Barrier	Relative Present	Not Comfortable	Too Busy	Other/ Comments	Row Total by Profession
Triage	4 2.8%	8 5.7%	30 21.3%	66 46.8%	11 7.8%	22 15.6%	141 100%
Admitting	3 7.3%	4 9.8%	5 12.2%	15 36.6%	2 4.9%	12 29.3%	41 100%
Physicians	1 14.3%	2 28.6%	2 28.6%	1 14.3%	0 0%	1 14.3%	7 100%

"Disagreement with the study process" represented the third most commonly identified barrier to screening by triage nurses and the second most frequently identified barrier for admitting nurses after "not comfortable" (see Table 6). The "comments" section contained the exact phrase "do not agree with study process" 14 times in the Triage nurse section, and 7 times in the Admitting nurse section of the tick sheet. Physicians did not record this phrase, or any comment expressing disapproval of the "study process".

Categories of "acuity" "language barrier" and "too busy" were infrequently checked by triage nurses, admitting nurses and physicians. In fact, physicians rarely identified barriers preventing them from screening patients. "Too busy" was never checked, "language barrier" and "relative present" were each checked a total of two times, and "acuity" was checked only once by a physician. The only comment written by a physician indicating reasons why screening was not done were "patient gravely ill; also patient and family mentally challenged".

Table 6
Written Comments Indicating Barrier to Screening
(Number and Percentage of Total Screened by Profession)

	"Do not agree with study process"		"Not appropriate"		Other	
Triage	14	21.5%	6	9.2%	2	3.1%
Admitting	8	23.5%	2	5.9%	2	5.9%
Physician	0	0%	0	0%	1	100%

Referrals to the HSC Department of Social Work

The fourth objective of this research was to note any increases or decreases in the number of domestic violence requests for referral to Social Work from the emergency department during the practise of routine screening. HSC domestic violence policy requires staff to refer patients identified as victimized by domestic violence, to the hospital department of social work. The tick sheets indicate that 16 women in the month of February indicated that domestic violence is a problem for them in some way. Retrospective data indicating total numbers of domestic violence referrals for female patients from the emergency department to the hospital department of social work, during the pre-screening period (September, 1996) was unavailable. As a second choice, the total number of referrals in the month preceding the routine screening period (January, 1997), as well as during the month of routine screening (February, 1997) were made available.

In the month of January, only one referral indicating domestic violence was made to the HSC department of Social Work from the HSC adult Emergency department.

During the month of February, in which ten 14 hour periods of "routine" screening took place, no domestic violence referrals were made to the HSC department of Social Work from the Emergency department. Only one referral to the Social Work department was made in the month of February, however, the reason for referral was not specified as domestic violence. (It is interesting to note that domestic violence was detected by the social worker, after the referral had been made).

This finding corresponded with feedback from Osborne House. Approximately half way through the routine screening period, the Executive Director from Osborne House contacted the HSC Department of Social Work and was referred to myself (Bonnie Bryant, personal communication, February, 1997). She indicated that Osborne House had not noted any increase in calls, and was not hearing from female patients at the HSC Emergency department.

Comparison of Winnipeg and Vancouver Findings

The fifth and final objective of this study was to compare the HSC findings with the findings from the routine screening study conducted out of the Vancouver Hospital and Health Sciences Centre adult emergency department. Having recognised differences in research design and methodology in the previous chapter, comparisons can be made between the findings from both studies. A total of 424 women presented during the Vancouver study period of 7 days, compared with 485 women who presented during the Winnipeg study period of 10 days (see Table 7). Of the Vancouver total of 424 women, 252, or 59.4% of the women, were screened for domestic violence. In Winnipeg, 119

women were screened out of 485, resulting in a total of 24.5% of women screened. It is interesting to note that although the Winnipeg study utilized emergency nurses and physicians beyond triage to implement the routine screening directive, staff in Winnipeg screened 34% fewer female patients than the triage nurses screened in Vancouver. The Chi Square test for independence confirmed the significance of the differences reported in Table 7 ($\chi^2 = 208.55$, d. f. = 1, $p < 0.05$).

Table 7
Percentage Screened in Vancouver and Winnipeg
(Number and Percentage of Total Women in Screening Period)

	No. Screened		No. Not Screened		Screening Period Total	
Winnipeg	119	24.5%	366	75.5%	485	100%
Vancouver	252	59.4%	172	40.6%	424	100%

In Vancouver, 6.3% (16 women) of women screened disclosed that domestic violence was a problem for them, while in Winnipeg, 13.4% (16 women) of women answered "yes" to the domestic violence screening question (see Table 8). The Chi Square test for independence confirms the significance of these differences ($\chi^2 = 6.05$, d. f. = 1, $p < 0.05$).

Table 8
Positive Responses in Winnipeg and Vancouver
(Number and Percentage of Total Women Screened)

	No. of Women Disclosing		No. of Women Not Disclosing		Total Women Screened	
Winnipeg	16	13.4%	103	86.6%	119	100%
Vancouver	16	6.3%	236	93.7%	252	100%

It is not possible to compare barriers to admitting nurses' and physicians' screening practises across the studies, since Vancouver's routine screening relied on triage nurses only. Comparison between Winnipeg triage nurses and Vancouver triage nurses should note that triage nurses in Winnipeg had the knowledge that admitting nurses and physicians would have opportunity to screen patients who were not screened at triage. Triage nurses in Vancouver screened 59.4 % (252 women) of the total number of women who presented in their screening period (see Table 9). Winnipeg's triage nurses screened 13.4 % (65 women) of the total number of women who presented in their screening period. Vancouver triage nurses identified "language barrier" and "relatives present" as the most frequently presenting barrier to screening, whereas, "not comfortable" was by far the most frequently identified barrier to screening reported by Winnipeg triage and admitting nurses. The Chi Square test for independence indicated that the difference reported in Table 9 was significant at the 0.05 level ($\chi^2 = 211.08$, d. f. = 1, $p < 0.05$).

Table 9
Number and Percentage of Winnipeg and Vancouver Women Screened by Triage Nurses

	No. Screened		No. Not Screened		Total Women in Screening Period	
Winnipeg	65	13.4%	420	86.6%	485	100%
Vancouver	252	59.4%	172	40.6%	424	100%

Proportion of Sample Not Seen Beyond Triage

A sample total of 60 (6.1%) women left without being seen beyond triage, either because they were admitted to other hospital departments, or because they decided not to wait to be seen by an admitting nurse or physician (see Table 10). This is significant because staff will not have had the opportunity to screen these women beyond triage, as they did with all the rest of the screening sub-sample. As well, staff in the pre-screening period would have had less opportunity to detect domestic violence with women not seen beyond triage. As Table 9 indicates, a total of 34 women (6.7%) left without being seen beyond triage out of 509 women in the pre-screening period, and a total of 24 women (4.9%) left without being seen beyond triage out of the 485 women presenting in the screening period. The Chi Square test for independence does not confirm the significance of the differences reported in Table 10 ($\chi^2 = 1.41$, d. f. = 1, $p > 0.05$).

Table 10
Number and Percentage of Women "Left Not Seen" (LNS) vs. Women Seen Beyond Triage

	No. of Women LNS		No. of Women Seen Beyond Triage		Total Women in Both Periods	
Pre-Screening	34	6.7 %	472	93.3 %	506	100%
Screening	24	4.9 %	461	95.1 %	485	100%
Study Total	58	5.8 %	933	94.1 %	991	100%

The vast majority of these GED forms were rated as reasonable negative, based on the entrance complaint and any other information on the GED form (see Table 11).

Table 11
Ratings for Forms Designated "Left Not Seen" (LNS)
(Number and Percentage of Total Women LNS)

	Reasonable Negative		Suggestive		Probable		Positive		Total Women LNS	
Pre-Screening	30	88.2 %	3	8.8 %	1	2.9 %	0	0%	34	100%
Screening	21	87.5 %	2	8.3 %	1	4.2 %	0	0%	24	100%

No rating was assigned to three GED forms in the pre-screening period, because the copies were too faded to be legible. The missing ratings comprise approximately 1% of the total number of pre-screening period ratings, and less than 1% of the total ratings assigned in this study. No missing values occurred in the study beyond this. The Chi Square test for independence does not confirm the significance of the differences reported in Table 11 ($\chi^2 = 0$, d. f. = 3, $p > 0.05$). The small numbers in the expected frequencies

cells suggest that significant findings would be more likely to occur than the alpha level indicates.

Proportion of Sample With "Sexual Assault" Entrance Complaint

GED forms which had entrance complaints of "sexual assault" automatically met the rating criterion of "probable" for domestic violence, and were therefore rated as such. Sexual assault documentation is limited to the entrance complaint on GED forms, and a separate and more thorough documentation form is completed for sexual assault patients. In both periods of this study, however, only the GED forms were analyzed for domestic violence. This is significant because these forms, rated as "probable" might have received a "positive" rating, if the documentation specific to sexual assault patients had been analyzed.

A total of 7 sexual assault patient GED forms were rated as "probable" for domestic violence in this study, with 4 sexual assault patients presenting in the pre-screening period, and 3 sexual assault cases presenting in the screening period (see Table 12). In each period, the number of GED forms specifying sexual assault comprise less than 1% of the total number of women presenting in each period.

Table 12
Number and Percentage of Sexual Assault Patients

	No. of Sexual Assault Patients		Total Women
Pre-Screening	4	0.79 %	506
Screening	3	0.62 %	485
Study Total	7	0.71 %	991

CHAPTER 4

DISCUSSION

Staff Participation in Routine Screening Protocol

A complete explanation for the low level of staff participation in the routine screening protocol is not known. Several factors could be considered. Some staff may have refrained from screening because they felt unprepared to respond to positive disclosures. Staff may have refrained from screening because the issue of domestic violence raised personal issues for them. They may have feared liability in cases where patients made disclosures. Physicians and admitting nurses may not have remembered that they were on screening shifts if tick sheets were not consistently attached to patient GED forms. Conditions in the emergency department concerning workload and scheduling may have dampened staff willingness to participate.

As the tick sheets indicated, the most frequent barrier to screening for triage and admitting nurses was staff discomfort with the task of screening. Reasons for staff discomfort will have varied. The triage location might have produced a significant level of discomfort. Compared to the work space typically allocated to physicians or admitting nurses, the triage area is exposed to the waiting area. A line up of prospective patients immediately behind the patient speaking to the triage nurse is not an uncommon occurrence, making privacy difficult to ensure. Correspondingly, the presence of relatives or friends at triage represented the second most significant barrier to screening by triage nurses. If the location of triage screening was a significant source of discomfort to triage

nurses, it seems ironic that this group of professionals screened more patients than both admitting nurses and physicians in the study. Considering this, it seems unlikely that their location was the main source of discomfort with the routine screening protocol.

Staff participation may have been impeded by the barriers already described in the literature review of this report. The view that routine screening for domestic violence is disrespectful of women's privacy and inappropriate questioning for emergency medical staff was expressed by several emergency nurses, and is a view that has surfaced in other emergency department studies (Tilden, 1989; Kurz & Stark, 1988; Warshaw, 1989). It also appears likely that on some occasions, patient load and an extremely rushed pace of work reduced the priority of domestic violence in the HSC emergency department, a second barrier to screening addressed in the literature (Morrison, 1988).

Finally, staff may have refrained from participating in the study if they perceived it to lack authority and face validity. At the physicians' training session, and at two nurses' training sessions, some staff-persons voiced concern that the study did not seem to be an effective way of establishing the prevalence of battered women presenting to the emergency department. They had wrongly assumed that this was an objective of this research. When the researcher informed them that this study was not aiming to establish the rate of domestic violence presentations to the department, and indicated that she would not be disclosing the specific objectives of the study, some staff-persons seemed dissatisfied with the quantity of information they were being given. If this was the case, they may not have felt "safe" participating. Their own hypothesis-guessing may have led them to suspect that they would be in disagreement with the study's hypotheses. In

addition, since the researcher, with student status, introduced the research as a non-employee of the hospital, the research may have appeared to be incidental and unimportant to staff.

Domestic Violence Detection Evident in GED Forms

Given the rate of staff participation in the routine screening effort, it is not surprising to find that differences in "positive" ratings are minimal between pre-screening and screening periods. As previously stated, physicians only screened 5.2% of the total number of women they could have screened, and analysis of the GED forms relied most heavily on physicians' "history and physical" notes, which comprised the majority of information on the GED forms. While this percentage may represent an increase over the level of screening typically carried out by HSC emergency physicians, it indicates that their screening practise for domestic violence was not "routine", and probably not significant enough to cause a large increase in domestic violence documentation on the GED forms.

The small trend towards an increase in adequate, "positive" documentation of domestic violence in the screening period appears to be consistent with the literature review earlier in this report, which concludes that routine screening is essential for adequate detection of domestic violence. The issue of domestic violence was given increased visibility throughout January and February, 1997, as domestic violence training sessions for staff, staff memos, and signs posted drew attention to the study and the problem. Tick sheets circulating with female patients charts on designated screening days indicated that 16 women disclosed domestic violence. The researcher responsible for the

study was physically present in the emergency department for brief periods, several times throughout the screening period. One might speculate that increasing the visibility of the issue of domestic violence might lead to a marked increase in domestic violence detection in the GED forms; but this was not what occurred. Consistent with the views expressed in the literature, detection of domestic violence as evidenced in the GED forms, remained low in the absence of a legitimate routine screening practise. Further research is necessary, however, to confirm any causal relationship routine screening and increased domestic violence detection in the HSC adult emergency department.

Apart from the fact that the trend towards increased documentation of domestic violence was minimal, the low rate of domestic violence documentation evidenced in both periods merits consideration in and of itself. Does the lack of domestic violence documentation in both periods reflect a low prevalence of domestic violence in the female adult population presenting at the HSC adult emergency department? A rate even close to 1% contradicts a substantial body of research which suggests that battering is a leading cause of injury to women (Chez, 1988; Stark, Flitcraft and Frazier, 1992; Pressman, 1989; Kurz & Stark, 1988; MacLeod, 1987, pp. 6-7). One would also suspect that the prevalence of domestic violence is higher than the 1% currently documented, since data from the tick sheets indicated that 13.4% of women screened for domestic violence indicated it was a problem for them. In addition, the substantial level of pre-screening and screening GED forms rated "probable" and "suggestive" seems to support the view that low levels of detection are unlikely to reflect a low prevalence of domestic violence among female patients in the department.

A second question arises from these findings. Is the lack of domestic violence documentation a reflection of inadequate recording on the part of physicians and other staff who make entries on the GED forms? Perhaps domestic violence is being detected at an appropriate rate although it is not being documented in the GED forms adequately. HSC corporate domestic violence policy requires staff to "...document on the Medical Record the details of the (domestic violence) assessment and interventions..." (see Appendix A). In addition, the policy requires staff to record a "...diagnostic statement indicating partner/elder abuse when supported by the explanation given by the patient, or (record) suspected abuse by partner/family when explanation given by patient is inconsistent with injuries" (see Appendix A).

A third question arises concerning the rate of domestic violence documentation. Does the low rate of domestic violence documentation reflect a correspondingly low rate of domestic violence detection in the emergency department? Is it possible that even though tick sheets accompanying patient documentation indicated 16 women were coping with domestic violence in some way, staff responsible for documenting domestic violence on GED forms failed to detect it as a problem for their patients? Perhaps the study's reliance on the GED forms to the exclusion of nurses' documentation was partly responsible for the low rate of detection uncovered in the study. A higher rate of disclosure may have been found if nurses notes had been included in the analysis. It is possible that disclosures reported to nurses, were not documented by physicians on the GED form.

Additional questions remain in view of the low rate of domestic violence recorded

in GED forms. How effective is the current HSC corporate domestic violence policy in the adult emergency department? To what extent is the policy shaping domestic violence identification and "treatment"? What process is in place to monitor the effect of the policy on practise? What indicators currently provide some basis for evaluation of the domestic violence policy? Has the current policy been implemented to its fullest potential? Has any sustained difference in detection and "treatment" of domestic violence resulted from the introduction of the HSC corporate domestic violence policy in the emergency department? If the current policy fails to translate into appropriate staff detection of domestic violence, then policy concerning staff response to domestic violence (ie. documentation, referral, risk assessment) will be equally impotent.

Rate of Referral to Department of Social Work

The finding that no domestic violence referrals were made to the Department of Social Work during the screening period does not necessarily indicate that referrals to patients were not offered. It is possible that patients declined referral offers made by emergency staff. However, the rate of referral reported in this study raises questions about the working relationship between the social work and the emergency department. Are emergency staff familiar with the hospital social work resources available to them? Are social workers accessible to assist emergency staff in responding to domestic violence? Does the absence of social work staff after 1700 hours play a role in the low rate of emergency referrals to Social Work? The rate of screening in the screening period was infrequent, and it is not possible to identify even preliminary associations between a

routine screening protocol and impact on the Department of Social Work resources.

Comparison of Winnipeg and Vancouver Findings

Three possible explanations for the difference in rates of domestic violence detection between Vancouver (6.4% of its screened sub-sample) and Winnipeg (13.4% of its screened sub-sample) could be advanced. First, perhaps Winnipeg staff, who did not screen as a matter of routine practise, were more likely to screen those female patients that raised their suspicion of domestic violence. Second, there may have been a greater number of women experiencing domestic violence presenting to the Winnipeg HSC emergency department, than to Vancouver General Hospital's emergency department. Third, the increase in positive responses to screening compared to Vancouver might be caused by the most significant methodological difference between the two studies. Perhaps the team effort involving HSC triage nurses, admitting nurses and physicians who participated in the screening was more effective in increasing domestic violence detection, than the Vancouver screening protocol which relied on triage nurses alone. It is interesting to note that even with fewer women screened in Winnipeg (24.5% compared to 59.4 % in Vancouver), a higher rate of domestic violence experienced by women was detected in Winnipeg, compared with Vancouver.

Differences in staff participation between Winnipeg and Vancouver may have been due to differences in the financial and human resources underpinning the studies. While Winnipeg staff received the maximum number of inservices to prepare them for participation in the research, it is possible that more training, information or resources

were needed for staff to feel comfortable participating. The research into routine screening in Vancouver was funded by Health Canada (Project # 4887-10-91/117) as a demonstration project for other hospital emergency departments across Canada. The routine screening protocol in Vancouver was launched by employees of the hospital's Domestic Violence Program. Dr. Anton F. Grunfeld (MD, FRCPC), the principal investigator in the research, is Assistant Professor, Division of Emergency Medicine, Department of Surgery. Kathleen Mackay (MSW), a staff social worker, was an integral part of the routine screening research, along with psychologist Deborah Hotch (Ph.D). Their study of routine screening was part of a larger study conducted by the hospital's Domestic Violence Program, entitled, Identification, Assessment, Care, Referral and Follow-up of Women Experiencing Domestic Violence Who Come to the Emergency Department for Treatment (Grunfeld, Hotch & Mackay, 1995). In contrast, the Winnipeg study of routine screening was largely initiated by the researcher, in affiliation with the Social Work Department and under the direction of the Department Director. As student and non-employee of the Health Sciences Centre, the non-funded research project may have appeared unimportant to HSC staff. While the Winnipeg research relied on a smaller number of people to launch the project, considerably more physicians and nurses were invited to participate in screening, in comparison with the Vancouver study, which only used triage nurses.

Conclusion and Recommendations for Further Research

Data from the tick sheets seems to point to the value of a routine screening (and

documentation) protocol for detecting domestic violence. A substantial level of domestic violence (13.4% of women screened) was detected when 119 women were screened for domestic violence, and their responses were immediately documented by the staff person who asked. Conversely, documentation from the 991 GED forms analyzed produced very little evidence of domestic violence detection in the HSC adult emergency department. Documentation of domestic violence on the screening period tick sheets did not translate into documentation of domestic violence on the GED forms, analyzed in both periods of this study. While a statistically significant trend towards positive documentation of domestic violence was evident in the screening period, the fact remains that only approximately 1% of forms documented domestic violence in both periods of this study. When evidence of domestic violence was represented in the GED form documentation, it was typically vague and limited (6.1% of GED forms met the criterion for "probable" and 16.8% met the criterion for "suggestive").

Nursing staff identified "not comfortable" as the greatest barrier to routine screening, and physicians generally ignored this aspect of the study, identifying no barriers preventing screening. No domestic violence referrals were made to Social Work during the routine screening period. Similarly, the extra support for emergency staff arranged through Osborne House was reduced half way through the screening period due to a lack of use. A total of 59.4% of women were screened in the Vancouver study of routine screening, and 6.3% of this total reported that domestic violence was a problem for them. In Winnipeg, only 24.5% of the women were screened, however, 13.4% of those screened indicated that domestic violence was a problem for them.

Several questions remain which might be addressed through qualitative research at some future time. What factors cause the level of domestic violence documentation in the GED forms to remain low? Do those study days containing no "positive" documentation of domestic violence have anything in common that might explain the lack of documentation, or were there coincidentally no female patients coping with domestic violence presenting during those times? Would supportive services from the social work department or other women's groups in the community, be helpful in increasing detection and treatment of domestic violence in the department? What kind of back-up assistance would be most helpful? Is there evidence of domestic violence detection and treatment that has not been acknowledged by this study? What could be done to strengthen emergency services to female patients who are threatened by domestic violence? Finally, how do nurses and physicians see the problem of domestic violence fitting into their health care delivery? Do they see a role for themselves in this area? Would nurses and physicians be open to a routine screening protocol limited to female patients presenting with unexplained injuries? How comfortable are they in carrying out the HSC's corporate policy on domestic violence? Do the same barriers that prohibit routine screening impede the implementation of the domestic violence policy in the department? Qualitative analysis focussed on staff responses to these questions might be useful in the creation of conditions that encourage and support staff in their work with domestic violence.

Without investing a large amount of time, emergency triage nurses, admitting nurses and physicians can offer women who struggle with domestic violence appropriate care when they present in the department. Asking directly and routinely about domestic

violence helps to penetrate the isolation frequently experienced with abuse, and communicates that other women also experience the problem of domestic violence. Documentation of domestic violence provides legal evidence that may prove invaluable. Safety assessment for victimized women and their children communicates concern and provides tangible assistance. Information sharing about one or two potentially helpful resources allows women to access a more comprehensive level of assistance at a future time. These services help to ensure that women who live with domestic violence will not experience emergency health care as indifferent and irrelevant to their health.

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APPENDIX A
HEALTH SCIENCES CENTRE (HSC) CORPORATE DOMESTIC VIOLENCE
POLICY

 CORPORATE POLICY & PROCEDURE MANUAL	SECTION	POLICY NUMBER
	30. PATIENT CARE	30.20.70
POLICY TITLE DOMESTIC VIOLENCE (PARTNER/ELDER ABUSE) PROTOCOL	APPROVED BY EXECUTIVE STAFF	DATE
	<i>Rohaf</i>	93/01/20
		PAGE OF 3

- 1.0 PURPOSE:**
- 1.1 To ensure that identification of abuse and appropriate intervention is provided to patients where partner/elder abuse is suspected.
 - 1.2 To ensure that victims of partner/elder abuse receive optimal health care in a consistent and comprehensive manner, through an interdisciplinary approach.

2.0 DEFINITION:

- 2.1 Partner/elder abuse is defined as physical injury, sexual assault, emotional harassment, financial exploitation, and threats of bodily harm to any adult from a significant other regardless of relationship.

3.0 POLICY:

- 3.1 The health care professional, as identified in Policy 30.30.30, who suspects partner/elder abuse will:
 - 3.1.1 identify and assess the degree of abuse.
 - 3.1.2 provide immediate care as required.
 - 3.1.3 name the abuse and verify the abuse with the patient.
 - 3.1.4 provide information about partner/elder abuse and review options of follow-up according to the following procedure.
 - 3.1.5 consult the Department of Social Work.
 - 3.1.6 respect the patient's decision regarding follow-up.
- 3.2 If a staff member, who suspects abuse of a patient, is unable to follow the protocol the staff member will refer the patient to a Head Nurse/Department Head who will complete the protocol.
- 3.3 All health care professionals will document on the Medical Record the details of the assessment and interventions (Policy 30.30.30).

4.0 PROCEDURE:

- 4.1 The health care professional's responsibility is to:
 - 4.1.1 Interview the patient alone, note the behaviours of the abused person and document the entrance complaint, all interventions and outcomes of the interventions.
 - 4.1.2 Document the behaviour of the partner or adult relative in case of elder abuse.



- 4.2 Review with the patient his/her:
 - 4.2.1 Past social and medical history.
 - 4.2.2 Past incidents of family violence.
- 4.3 The physical examination will include:
 - 4.3.1 Documented signs and symptoms of physical injury.
 - 4.3.2 Complete Body Diagram (form #85545). Forms are available in the Domestic Violence Resource Information on each unit.
 - 4.3.3 Completed requisition for a Medical Photograph (Policy 30.40.30) if deemed appropriate.
- 4.4 There shall be a diagnostic statement indicating:
 - 4.4.1 Partner/elder abuse when supported by explanation given by the patient.
 - OK 4.4.2 Suspected abuse by partner/family when explanation given by patient is inconsistent with injuries.
- 4.5 Health care professionals will be responsible for:
 - 4.5.1 Calling Security if the presence of the "significant other" places the patient/staff at risk.
 - 4.5.2 Treating the injuries as appropriate according to professional practice.
 - 4.5.3 Providing resource information, legal information, safe shelter information and counselling services to the patient.
 - 4.5.4 Requesting assistance from Security to help the patient to call the police if the patient wants charges to be laid.
 - 4.5.5 Assisting the patient to access resources to provide protection for children (Child and Family Services - 944-4050).



- 4.5.6 Informing partner/significant others/family, if requested, that patient will make direct/indirect contact with them regarding the decision to return/not to return home. If there is a risk of harm to patient/staff, call for assistance from Security.
- 4.5.7 Completing a Social Work consult.
- 4.5.8 Completing a Post-Partum Inter-Agency referral form for patients who are antepartum or postpartum patients.
- 4.6 If the patient plans to return to the abusive situation, staff will be responsible for:
- 4.6.1 Completing a Risk Assessment with the patient.
- 4.6.2 Negotiating a protection plan for the patient and dependent family members that includes:
- telephone numbers for safe shelters
 - plan of escape
 - location of transportation money (ie. taxi, bus, etc.)

APPENDIX B

OUTLINE OF PREVIOUS HSC DOMESTIC VIOLENCE TRAINING SESSIONS

FRAMEWORK FOR PRESENTATION DOMESTIC VIOLENCE PROTOCOL

- 1. Definition**
- 2. Information about abuse**
 - issue of power
 - cycle of violence
 - myths
 - why women remain
- 3. H.S.C. Corporate policy**
- 4. Identification**
 - psychological features
 - abuse injuries
 - batterers characteristics
 - questions to aid in identifying
- 5. Assessment**
 - assessment questions
 - common statements
- 6. Intervention**
 - intervention questions
 - community links
- 7. Documentation**
 - list of expectations
- 8. Review of procedures**

APPENDIX C

ROUTINE SCREENING QUESTION

Domestic Violence Screening Question

There are several ways to ask patients whether they are experiencing abuse or violence. The Vancouver study required use of the following question: "We know that violence is a problem for many women, so we routinely screen all women for abuse or violence in their lives. Is this a problem for you in any way (Grunfeld et al, 1994)?" I recommend the following question for use in this study: "We know that violence at home is a problem affecting the health of many women, so we routinely screen all women for abuse or violence in their lives. Is this a problem for you in any way?"

Additional Questioning

Additional questions may be deemed appropriate in situations where abuse is suspected. "The injuries you have suggest to me that someone hit you. Is that possible (Hotch, Grunfeld, Mackay, & Cowan, 1995, p. 11)?" "Has anyone hurt you (Hotch et al, 1995, p. 11)?" While these questions may be appropriate in some cases, it is recommended that they do not substitute for the routine screening question recommended, for the purposes of this study.

APPENDIX D

GENERAL EMERGENCY DOCUMENTATION FORM

APPENDIX E

DOMESTIC VIOLENCE TICK SHEET AND INSTRUCTION SHEET

Instructions for Use of Tick Sheet

1. Routine Screening Question for All Female Patients

"We know that violence at home is a problem affecting the health of many women, so we routinely screen all women for abuse or violence in their lives. Is this a problem for you in any way?"

How to Record Responses on the Tick-Sheet

If women respond with "no", please check the box under "DV=NO". If women respond with "yes", please check the box under "DV=YES". **Please refrain from filling out tick sheets while patients are present.**

Record Responses According to Professional Role

If you are a triage nurse, please record responses to screening (or your reason for not asking the screening question) in the section under "Triage Nurse". Similarly, if you are an admitting nurse or physician, please record responses or reasons for not screening, in the appropriate section.

How to Determine Whether Patient Has Been Screened

Simply glance at tick-sheet. If either the triage, admitting nurse, or physician has checked off a response to the "DV Question", no further screening is required. Conversely, if the tick-sheet indicates your patient has not yet been asked the screening question, please do so, recording the response on the tick-sheet.

If the Screening Question Was Not Asked

The expectation is that every woman will be screened for domestic violence once in their visit to the emergency department, preferably as early in their visit as possible. If it was not possible for you to screen a female patient for domestic violence, please check one of the boxes in the section marked "If DV Question Not Asked", indicating the reason screening could not take place. Ignore this section if the tick-sheet indicates screening has been completed.

Definitions of Reasons DV Question Could Not Be Asked

Acuity -- the patient was not screened because her life was in immediate danger

Language Barrier -- the patient was not screened due to difficulty communicating in the patient's language

Relative Present -- the patient was not screened because a relative or friend insisted on remaining with the patient

Not Comfortable -- the patient was not screened because the staff person was too uncomfortable with the task of asking the screening question

Too Busy -- the patient was not screened because other demands on the staff person had to take priority so that screening was not possible

Your cooperation in this research is sincerely appreciated. Please forward any questions or concerns to Janice DeFehr, ph. 783-0275

APPENDIX F

DISCLAIMER PRESENTED AT STAFF TRAINING SESSIONS

The purpose of this research project is to measure the effect of a routine screening program for domestic violence, for female patients presenting at the Health Sciences Centre (HSC) adult emergency department.

Routine screening will require minimal staff time. The screening question is brief: "We know that violence at home is a problem affecting the health of many women, so we routinely screen all women for abuse or violence in their lives. Is this a problem for you in any way?"

It is best to screen as early in a patient's emergency visit as possible, so that care can be efficient and appropriate throughout the patient's stay. However, in a case where it is not possible for a triage nurse to screen, the admitting nurse will be responsible for screening the female patient. Similarly, when neither triage or admitting nurses have screened a patient, the physician will be responsible for screening the female patient. A glance at the tick sheet accompanying each woman's chart will indicate if the patient has been screened on this visit to the emergency department. If it was not possible to screen the patient, staff will be asked to indicate the barrier to screening with a tick or comment, on the tick sheet. Staff may respond to women's positive disclosures as they have in the past, however, additional resources will be available to assist staff in assessing risk and offering supportive counselling.

Staff participation in this study is totally voluntary, and staff participating in routine screening of patients may withdraw from this responsibility at any time, without penalty. As usual, staff may access the Employee Assistance Program if participation in this study raises personal issues.

Only myself, and an assistant, Dr. David Willems, M. D., will be accessing data from general emergency documentation, and only I will access data on the tick sheets. Tick sheets are entirely anonymous, and any patient or staff names appearing on other emergency documentation will not appear in notes or in any other place in this research. Data will appear in aggregate form only, and reporting will be strictly statistical. Analysis will be based strictly on quantitative methods. It will be impossible to identify any patient or staff persons in the research report. Expectations for confidentiality outlined by HSC policy will be observed at all times. Findings from this research may be published. Again, if this should occur, it will be impossible to identify patients or staff in any published report of the research findings. Data will appear in aggregate form only and reporting will be strictly statistical.

This study has been approved by both the Ethics Review Committee of the University of Manitoba Faculty of Social Work, the Ethical Review Committee of the Faculty of Nursing, as well as the HSC Impact of Research Review. This research comprises the thesis requirements of my Master of Social Work degree. A summary of the findings will be available on request.

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APPENDIX G

MEDICAL RESPONSE TO ABUSE: TWO-SIDED CARD

MEDICAL RESPONSE TO ABUSE CASES

IDENTIFICATION:

1. Were you hit? (shoved, pushed, threatened, sexually abused)
2. Who did this?
3. Do you see yourself in danger? (immediate/ leaving the HSC)

RISK ASSESSMENT:

1. Are you living with this person?
2. Does he know where you are now?
3. Where is he?
4. Has he done this before? When? How often?
5. Are there weapons?
6. Are there children and where are they?
... With whom?
... Has he hit (ever abused) the children?
7. Do you feel safe going home?
8. Where are you going when you leave here (HSC)?

INTERVENTION:

1. Do you have someone you can talk to? (... family, friend, counsellor)
2. Can you trust them?
3. Would you stay somewhere other than home? (... family, friend)
4. Are the police involved?
5. Have you seen a lawyer before?
6. What do you feel you can do now? (... testing for cognitive awareness and motivation skills)
7. Would you like us to contact ... for you?

DOCUMENTATION:

1. Diagram
2. Summary of answers.

RESOURCES

COUNSELLING:

- | | |
|--|----------|
| 1. Child Protection Centre | 787-2811 |
| 2. HSC Social Worker | 787-1287 |
| 3. Klinik 24-Hour Crisis Line | 786-8686 |
| 4. Evolve: Men's Treatment Groups,
Women's Support Groups | 788-4402 |
| 5. Elder Abuse Resource Centre | 942-6235 |

POLICE & LEGAL:

- | | |
|---|----------|
| 1. Police - Emergency | 911 |
| - Non-Emergency (but require car to attend) | 986-6222 |
| 2. Victim Services | 986-6350 |
| 3. Women's Advocacy Program | 945-6851 |
| 4. Court Victim/Witness Asst. Program | 945-3594 |
| 5. Lawyer (Legal Aid) | 985-8500 |

SHELTER:

- | | |
|--|----------------|
| 1. Family, friends. | |
| 2. Osborne House | 942-3052 |
| 3. Salvation Army (24 hours) | |
| Women's Services | 946-9461 |
| 4. KWEE - WIDJUTWIN Inc. | 772-0303 |
| Crisis Line - 24 hours | 1-800-362-3344 |
| 5. City/Provincial Emergency Social Allowance (after business hours) | 945-0183 |

COMMUNITY-BASED:

- | | |
|---|----------|
| 1. Child & Family Services | |
| Main Office | 942-7987 |
| After hours | 944-4050 |
| 2. North End Women's Resource Centre | 589-7347 |
| 3. Ft. Garry Women's Resource Centre | 269-6836 |
| 4. Native Women's Transitional Centre | 989-8240 |
| 5. Pluri-Elles Manitoba Inc. Centre de Femmes | 233-1735 |