RESPONSES TO QUESTIONS TAKEN ON NOTICE

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Ms CLAREMONT: Family and Community Services established a working group and I attended the first meeting of the working group. Since that time-
The Hon. GREG DONNELLY: When was that?
Ms CLAREMONT: I would have to check the date. I think it was February. At that meeting a presentation was given around the approach to the development of the framework and the elements that would be included, the time frames for its development over this year and a proposal around the oversight that that group would have over the development of the framework. Following that first meeting we were contacted by the consultants as part of their first stage of preliminary consultations to talk about the work that NSW Health has been doing in domestic violence policy under the previous frameworks and the projects that we have led. The date of that I would have to confirm.
The Hon. GREG DONNELLY: If you could do that, please.
Ms CLAREMONT: Certainly.

ANSWER:

The NSW Department of Family and Community Services convene the Domestic, Family and Sexual Violence Framework Steering Committee. The NSW Ministry of Health has been represented by Meredith Claremont at the meeting on 14 February 2012, and Cathrine Lynch at the meeting on 3 April 2012.

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The Hon. CATHERINE CUSACK: The screening material that you have just tabled asks one question: "Within the last year, have you been hit, slapped or hurt in other ways by your partner or ex-partner?" That is really the extent of the screening. Is that correct?

ANSWER:

All women attending antenatal and early childhood health services, and women aged 16 years and over who attend mental health and alcohol and other drugs services, are screened as part of the Routine Domestic Violence Program.

The prevalence of domestic violence and associated risks is high for female patients and clients in these clinical groups. NSW Health defines domestic violence as:

> *"Violent, abusive or intimidating behaviour carried out by an adult against a partner or former partner to control and dominate that person. Domestic violence causes fear, physical and/or psychological harm. It is most often violent, abusive or intimidating behaviour by a man against a woman. Living with domestic violence has a profound effect upon children and young people and constitutes a form of child abuse."*

The screening tool is based on this definition.

During screening, NSW Health workers provide patients and clients with key information to assist them to make an informed decision about participating in the screening. This includes information on the health impacts of domestic violence, assurances relating to the standard questions asked of all women and the limits of confidentiality. Women are then asked the following two questions.

1. Within the last year have you been hit, kicked, slapped or hurt in other ways by your partner or ex-partner?
2. Are you frightened of your partner or ex-partner?

If the response is "no" to both questions the women is given an information card and told this is a card we give all women about domestic violence.

If the woman answers "yes" to either or both of the questions, two further questions are asked.

1. Are you safe to go home when you leave here?
2. Would you like some assistance with this?

Health workers then ask patients and clients to consider the safety concerns raised in the answers and if they want to take steps to act on those concerns.

The questions devised for routine screening are based on evidence and form part of other initial screening in four key services: Antenatal, Early Childhood, Mental Health, and Drug and Alcohol services. The questions are proven to be effective and annual data since 2003 indicates that 5.6 – 7 per cent of all women screened report abuse on initial screening.

Since 2006, NSW Health workers have been directed through the *Domestic Violence - Identifying and Responding (PD2006_084)* Policy Directive to ask the following additional questions during a screening.

1. Do you have children? (If so) have they been hurt or witnessed violence?
2. Who is/are your child/ren with now? Where are they?
3. Are you worried about your child/ren's safety?

Health workers must make a report to the Department of Community Services' Helpline on 133 627 where he or she has reasonable grounds to suspect a child is at risk of significant harm.

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The Hon. CATHERINE CUSACK: I hear the point you are making about it being informative, but this is supposed to be a screening tool, and is being presented to the Committee as a screening tool. The information here gives five different examples of domestic violence, but the single question that is asked appears to me to be inadequate. Where did the question come from and what is the evidence supporting that, given that is really the entirety of the screening?
Ms SUCHTING: At the time the routine screening was implemented across NSW Health 10 years ago, the evidence base for a broad-ranging intervention like this across a range of services like this was to create an environment for disclosure, a safe environment, to ask a limited number of questions and then to provide a pathway for referral if required and also critical information.
The Hon. CATHERINE CUSACK: But how was it arrived at just a single question? What is the evidence supporting that and has it been evaluated whether a single question is adequate?
Dr CHANT: I think the research done by Anthony Zwi and Spangaro, we can provide a copy of that paper, but that was very supportive of the role screening had played. I can go back and see. From my recollection it did not particularly comment negatively.
The Hon. CATHERINE CUSACK: I understand. I am trying to establish whether this has been evaluated.
Dr CHANT: The process has been evaluated. Anthony Zwi did a process of looking at the screening and some further work being commissioned looking at the screening in the Aboriginal and maternal infant's strategy program, again by Anthony Zwi's group. I can provide that paper to you. Interestingly, 23 per cent of people coming out of that paper disclosed their first episode in consequence of this one single question. I would have to have a direct discussion with Anthony about whether it prosecuted the question.
The Hon. CATHERINE CUSACK: What I am trying to establish is whether this has been evaluated, because often things can be improved. Is there some process you have in place for saying this is what has been happening? What is the feedback from the workers? The Audit Office is very clear that you should be setting in place a means for people to give you that sort of feedback and that there be some process in place to improve it in a practical way.
Dr CHANT: This is academically reviewed. I can give you the paper which was published in a proper public health journal. I will go back and reread that to see whether the specific issue about the question could be enhanced or is covered by any of the work published or unpublished, to address that issue.

ANSWER:

A pilot of Routine Screening for Domestic Violence was conducted in two health areas in 2000, South Eastern Sydney and Macquarie Area Health Services. The Pilot was evaluated in J Irwin and F Waugh (2001) *Unless they are asked – Routine Screening for domestic violence in NSW*

Health, Department of Social Work, Social Policy and Sociology, University of Sydney. This initial pilot found the questions were valid.

A decade later the screening tool was evaluated and documented by J Spangaro, A Zwi, R Poulos (2010) *After the Questions: Impact of Routine Screening for Domestic Violence in NSW Health Services,* School of Public Health and Community Medicine, University of New South Wales.

The evaluation confirmed that the screening tool is well accepted by women screened and by the workforce implementing screening. The process increases responsiveness to domestic violence through: heightened alertness to domestic violence; enhanced understanding of the links between domestic violence and specific health problems; and a greater sense of providing comprehensive care when domestic violence is addressed.

In the Zwi/Spangaro evaluation, the nature of the questions was further analysed through interviews with workers using the screening tool. A number of key enablers were identified. Workers identified one of the enablers of screening as the scripted nature of the questions: specifically, that there are only two of them and they are brief and concrete. In each service the screening is undertaken as part of a larger assessment for treatment and workers indicated that acceptability of the domestic violence screening questions hinged on not adding too much time and complexity to the process. To this end, the direct and closed-ended questions were also seen as easier for women to facilitate disclosures. Moreover, having scripted questions served the dual function of relieving workers from framing the questions, as well as providing a visual prompt within the assessment schedule.

A critical aspect of the scripted screening questions for both patients and workers, that facilitated their use, was that all women are asked the same initial question. Demonstrating to patients that the questions were standard, added to their legitimacy. To be *standard practice* from the perspective of patients requires that screening is *prescribed practice* from the perspective of workers. This simplified the task, as it became routine and extinguished dilemmas about whether to ask.

A conclusion from the evaluation was that repeat questioning/screening is desirable and increases the likelihood of disclosure.

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The Hon. CATHERINE CUSACK: I have just been in [location] and had a complaint that on 22 February this year a woman presented with the police. There was nobody trained at the hospital. There was no advice all day until the afternoon that there was nobody trained. When she went to the next day the kit was out of date. I realise this is a specific example, but it was a frustrating case both to the police and to the woman. What I am trying to find out is do you have a system of ensuring that these kits are-not out of date and are available in a timely way and in a community the size of [location], which is a regional centre, that the on-call system is working and if there are not enough people trained for that, someone else has to be trained so that work can be undertaken?
Dr CHANT: I certainly agree with you and we will look into the [location] case and get back to the Committee. The issue of sexual assault services particularly in rural and regional-and I note we are talking about not remote services when we are talking about centres you are referring to-is a challenge in getting appropriately qualified and trained practitioners. The centre has done a number of pieces of work to try to develop capacity and training, and I am happy to provide a report to the Committee about those initiatives, but there are significant challenges.

ANSWER:

A response was sought from the Sexual Assault Service of the relevant Local Health District.

To protect reference to individuals in this case, the location of relevant sites are not named.

A Sexual Assault Forensic Service for post pubertal children and adults who have been sexually assaulted is available at the location, if required and consented to by the victim, as there is a Medical Officer in the location who has had experience in the provision of forensic procedures.

There has been some interest shown by local General Practitioners (GPs) in the location which may result in greater availability of Sexual Assault Forensic Examinations. The recent temporary employment of a female GP as the Sexual Assault Medical Project Officer, through funding from the Ministry of Health until the end of June 2012, is one strategy currently in place by the Local Health District to increase the number of GPs available to provide Sexual Assault Forensic Examinations.

There is no paid on-call Sexual Assault Service available at the location or named Hospitals (Counsellor and/or General Practitioner). Clinicians trained to respond to Sexual Assault Crisis presentations at these sites may be contacted, if available, at the respective sites as part of a voluntary after hours Sexual Assault roster. In the event that there is no available Sexual Assault Crisis Counsellor at the location then the paid on-call Sexual Assault Service at the next closest location is contacted.

If a person requires a forensic medical examination, access will be coordinated by the Sexual Assault Crisis Counsellor. If a doctor is available then the forensic medical examination will occur at this site, with support from the Sexual Assault Crisis Counsellor. If a doctor is not available, or the doctor is not appropriate (in terms of gender or appropriate training), then the Sexual Assault Service will be contacted to coordinate a forensic medical response at a nearby hospital (where they are more likely to access an appropriate clinician). In extreme circumstances where there is no available doctor at either site, then arrangements may be made to transport the person to an alternative site. Transport will then be negotiated with the person, hospital and/or police as appropriate. There are no current resources allocated specifically for assisting with the transport of sexual assault victims, and only one Sexual Assault Counsellor within the Local Health District to oversee the Sexual Assault Service.

In most instances, sexual assault forensic medical examinations are able to be provided within the required timeframe as per the *NSW Health Sexual Assault Policy and Procedures (Adult) (2005)*[1]; however, at times there may be a delay between presentation and the conducting of the forensic medical examination.

The Sexual Assault Counsellor who coordinates counselling/medical-forensic services at the location is responsible for maintaining the Sexual Assault Investigation Kits (SAIK) at the relevant Hospitals. Since the discovery of the out of date SAIK in 2011 the kits are reviewed on an annual basis and replenished, as required, according to number of kits available and expiry dates. Additionally, the Sexual Assault Counsellor at the location is aware of all kits used at the relevant Hospitals and is able to maintain adequate supplies as they are used.

The Division of Analytical Laboratories (DAL) has indicated that elements of the kit are marked with an expiry date by the manufacturer, notably sterile swabs. DAL advises that these expiry dates are not relevant for the purposes of a sexual assault investigation. This is due to the fact that these swabs are modified by DAL prior to dispatch, which renders the expiry irrelevant. DAL advises that the modification prevents mould growth and the degradation of DNA. The Sexual Assault Working Group of the Forensic Interagency Meeting resolved in February 2012 to conduct a review of the Interagency *Guidelines for Responding to Adult Victims of Sexual Assault* and the Sexual Assault Investigation Kit (SAIK). The NSW Ministry of Health, DAL and the NSW Police Force are represented on this Working Group. The evidence collection kit will be considered in the review.

[1] http://www.health.nsw.gov.au/policies/pd/2005/PD2005_607.html.