Domestic Violence (DV) is a public health problem with far-reaching effects for society. Local public health departments typically serve high-risk populations and have a unique opportunity to provide routine DV screening to all clients receiving services.

This project piloted a DV screening program in the family planning clinic of a local public health department. Two interventions were required; the first was a 2-hr inservice program for family planning clinic staff. The second intervention consisted of development and implementation of the screening program. A comprehensive DV curriculum was developed and carried out at an inservice prior to the implementation of the screening program. Screening was evaluated over a 4-week period in the health department. Of the 182 women who were screened for DV, 21 (11.5%) screened positive for DV.

Domestic Violence (DV) is a pervasive public health problem with far-reaching consequences for society. An examination of recent statistics reveals that DV is on the rise nationally and locally. DV screening was not routinely performed at the local public health department. The nursing director of the health department believed that DV was a significant problem in the county and had the desire to develop and implement a DV screening program with a focus on identification and vention of DV.

SUMMARY OF TARGET GROUP AND CONTEXT ASSESSMENT

A collaborative effort of the Centers For Disease Control and Prevention, the National Institute of Justice, and the National Violence Against Women Survey (Tjaden & Thoennes, 1998) sampled men and women in the United States regarding their experi-
ences with violent victimization. Findings from this survey showed that 25% of the surveyed women experienced partner violence in their lifetime; 76% of women who were raped or physically assaulted were attacked by a male intimate (Tjaden & Thoennes, 1998). One in three women who were injured during the assault required medical care (Tjaden & Thoennes, 1998).

Women ages 19 to 29 are more likely than other women to be victimized (U.S. Department of Justice, 1995). Women living at or below poverty level are also more likely to be victims of DV (U.S. Department of Justice, 1995). Goals of Healthy People 2010 (U.S. Department of Health & Human Services, 2000) are to reduce the rate of physical assault by current or former intimate partners from 4.5 physical assaults per 1,000 to 3.6 per 1,000 in persons age 12 and over, representing a 20% improvement.

Economic costs of DV are considerable, both in the health care system and the legal systems of the U.S. Estimated medical expenses for one DV victim per year are $1,633 (Alexander & Elliott, 2000). The effects of DV in the home are also associated with indirect costs in the workplace, such as decreased productivity, absenteeism, errors, and employee turnover (Alexander & Elliott, 2000).

Noneconomic costs of DV are also significant. Twenty-six percent of all suicide attempts in women are related to DV (Alexander & Elliott, 2000). Additionally, DV is known to cause low birth weight in pregnant women and often leads to alcohol abuse (Alexander & Elliott, 2000). Seventy percent of children living in homes where women are abused are also abused, and boys who witness abuse in the home are much more likely to become abusive to their partners, develop drug and alcohol problems, and become delinquents (Alexander & Elliott, 2000). Therefore, early detection and prevention of DV through a screening program is a very important public health issue.

In Michigan, over half (58%) of the women experienced male perpetrated violence in 1996 (Michigan Department of Community Health [MDCH], 1996). Additionally, one in five women with current partners reported sustaining some type of violence in that relationship (MDCH, 1996). Locally, DV arrests rose 7% in 2000, and the women’s advocacy agency in the county assisted 261 victims of DV the same year.

COMMUNITY ASSESSMENT

There are two levels of assessment for this project. First, the assessment of specific family planning (FP) clinic services (the pilot group); second is a provider assessment of the FP clinic.

The FP clinic provided services to 4,406 female clients in 2000. Of these, 13% were Hispanic. Seventy-four percent of the clients were ages 18 to 29. The demographic profile shows that typical clients in the FP clinic are young White women, who may or may not be in low socioeconomic conditions. These women come to the FP clinic seeking contraceptives: 61% select oral contraceptives, 16% choose injection, 10% select con-
doms, and the remainder (13%) select other methods such as sterilization, intrauterine device, hormone implant, diaphragm, and natural methods.

The provider assessment yielded the following results: The FP clinic is operated in four sites of the local public health department. Clients pay a sliding scale fee for clinic services. Each client completes an initial history form on her first visit, where three questions pertaining to DV are asked. These questions are answered using self report; the client checks “yes” or “no” regarding date rape, sexual abuse, and physical abuse. A pap smear is performed on each client on the initial visit and annually for renewal of contraceptive prescription. Similarly, each client completes the same three self-report questions on subsequent visits to the FP clinic.

There are eight registered nurses who work in the FP clinic. All are women. Their ages range from 26 to 61, with an average of 49 years. Seven out of the eight nurses (87.5%) hold a baccalaureate degree in nursing.

A countywide multiagency survey was conducted in April of 2000 regarding DV issues in the county. Thirty-two public health nurses responded, 6 of whom identified themselves as FP clinic nurses. The nurses identified their DV learning needs as follows (in descending order of priority): services for victims, identification of injuries, use of personal protection orders, identification of families at risk, prosecution of perpetrator, reasons why victims stay in abusive relationships, and how to perform a danger assessment.

THE DV SCREENING PROGRAM

Two interventions were selected. The two interventions were selected based on the following criteria: feasibility, cost, empirical support, theoretical framework, and agency support of the intervention. The DV screening program was piloted in the FP clinic of a local public health department. The first intervention consisted of a 2-hr inservice for nursing staff. The second intervention was the actual development and implementation of the DV Screening Protocol (Appendix A) using the Abuse Assessment Screen Tool (Appendix B).

Intervention 1: Inservice Program

The first hour of the inservice was open to all interested health department nurses. Many nurses from other health department programs (such as maternal and infant support, immunizations, etc.) expressed a desire to learn more about DV and its effects on clients. The second hour of the inservice was specifically for nurses practicing in the FP clinic. Continuing education units were available for both programs.

Curriculum for the inservice was developed by combining several approaches to DV screening. Portions of the curriculum were tailored to address the learning needs identi-
fied by the health department nurses in the DV survey. The Health Belief Model (Strecher & Rosenstock, 1997) provided a theoretical framework for curriculum development. Table 1 illustrates linkages between the constructs of the Health Belief Model and the DV screening curriculum. In addition, the first in-service focused on information related to the self-identified learning needs found in the DV survey. The use of a theoretical framework and addressing the self identified learning need of in-service attendees is supported in the literature (Glanz, Lewis, & Rimer, 1997; McKenzie & Smeltzer, 2001).

Goals of the program were:

1. To screen and identify victims of DV in the county by FP clinic staff only.
2. To prevent DV among women in the county.

Goals were developed through collaborative efforts of the FP clinic coordinator, nursing director, the program planner, and personnel from a local women’s agency not affiliated with the health department. The local women’s agency is a nonprofit organization that offers services to victims of DV. The program planner and a social worker from the women’s agency conducted the in-service. Collaboration with key stakeholders strengthened agency support of the program.

Other strategies utilized in the in-service were the distribution of buttons that read, “Is someone hurting you? I can help,” as well as laminated pocket cards for health care professionals that contained the following information: framing statements, screening questions, appropriate responses, and the 24-hr crisis line number. These pocket cards were given to FP clinic nurses to reduce anxiety about screening and to provide a handy reference for a nurse who might be uncomfortable screening for DV and were briefly explained in the in-service. A Spanish interpreter employed by the health department also attended the in-service.

**TABLE 1**

<table>
<thead>
<tr>
<th>Perceived Susceptibility</th>
<th>Presented national, state, and local data.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Perceived Severity</td>
<td>Presented relevant data, effects of DV, injuries associated with DV.</td>
</tr>
<tr>
<td>Perceived Benefits</td>
<td>Nurse can be an advocate for women, and DV is preventable.</td>
</tr>
<tr>
<td>Perceived Barriers</td>
<td>Relevant barriers were discussed. Pocket reference card given to each family planning nurse.</td>
</tr>
<tr>
<td>Cues to Action</td>
<td>Discussed how to screen for DV, appropriate setting, privacy, timing, use of interpreters, and confidentiality. Posters will be placed in each clinic room. Buttons were distributed to each family planning nurse.</td>
</tr>
<tr>
<td>Self-Efficacy</td>
<td>Competence and expertise of family planning nurses were stressed. Each nurse participated in role-play exercise.</td>
</tr>
</tbody>
</table>
Twenty-two nurses attended the first hour of the inservice. The program planner was primarily interested in the evaluation of the full 2-hr inservice that was attended by FP clinic staff. Therefore, evaluation focuses on the 8 nurses in the FP clinic staff.

Twelve nurses attended the full 2-hr inservice. Eight of these were nurses in the FP clinic, and 4 were nursing managers. One hundred percent of the FP clinic nurses attended both hours. At the conclusion of the inservice, attendees completed an evaluation form (Appendix C). Each participant \( n = 12 \) scored 100% on questions 1 through 6, which evaluated cognitive learning. Questions evaluating perceived self-efficacy both pre- and postinservice demonstrated a 26% improvement following the inservice. Obtaining continuing education units and holding the inservice on the morning off from clinic duties was useful in that 100% of FP clinic staff attended.

Inviting all staff to the first hour of the inservice was not optimal because the room was crowded and there was not enough time for questions. High attendance and numerous questions demonstrated interest and need for all health department nurses to increase their knowledge and skills related to DV. First hour attendees learned basic information about DV but did not learn about appropriate screening methods and questions. In the future, it is recommended that both hours be limited to staff who will be implementing DV screening.

Intervention 2: Implementation of Screening

The second intervention consisted of implementation of DV screening. The health department Screening Protocol (Appendix A) and Abuse Assessment Screen (Appendix B) were developed in collaboration with the FP clinic coordinator, the nursing director, the program planner, and a representative of a local women’s advocacy agency. Collaboration was crucial in establishing agency support of the screening policy and tool. In addition, the Abuse Assessment Screen (Appendix B) was translated into Spanish by a professional translator employed by the health department. The Abuse Assessment Screen (framing statement and screening questions, Appendix B) was adapted from the American College of Gynecology (2001). The U.S. Preventive Services Task Force (1996) stated that “there is insufficient evidence for or against the use of specific screening instruments … but including a few direct questions about abuse … may be recommended” (p. 562).

Additional items were added to the Abuse Assessment Screen (Appendix B) for evaluation and tracking purposes. The nurse completing the form was asked to document whether (a) the client was referred to the women’s advocacy agency and (b) the referral was completed on-site or at the referral agency. Other items that were tracked were (a) whether the client was reminded of the police emergency number and (b) which specific brochure(s) were given to the client.
An additional strategy was the placement of posters in each clinic examination room. The FP clinic coordinator selected three posters. A wide variety of patient brochures were available from the women’s agency for use at the health department. The FP clinic coordinator and the program planner discussed the importance of primary, secondary, and tertiary prevention information in the brochures. Two brochures were selected, and one was available in Spanish. Clinic nurses familiarized themselves with each brochure to give each client the brochure(s) they identified as most appropriate.

Actual screening was implemented in all four sites of the health department. A written evaluation was completed after 4 weeks of implementation of the program. During the initial 4-week period, 6 FP clinic nurses participated in the actual screening process and were asked to complete an evaluation. The 2 other FP clinic nurses were reassigned to other health department clinics during the 4-week period and did not participate in the screening program. Six nurses (100% of participants) completed and returned the evaluation. Overall, nurses felt that the program was going well. Four out of the 6 respondents (67%) reported that the screening questions were “easily understood” by clients. Four out of the 6 respondents (67%) reported no problems screening for DV; two respondents stated that DV screening “is just one more thing to do” in an already busy clinic. Four out of 6 respondents (67%) did not know what the laminated pocket cards were; perhaps the explanation was too brief or they were not attentive at that time. One respondent (16%) found the pocket card very helpful. Estimated time taken to conduct screening ranged from 1 to 2 min (M = 1.5 min). Estimated time taken to counsel someone who answered “yes” to any of the screening questions was 3 to 20 min (M = 11 min).

During the 4-week evaluation period, 182 screening forms were completed. Of the 182 completed forms, 21 (11.5%) screened positive for abuse. Total number of clients seen in the FP clinic during that time period was not available, but the clinic averages 300 eligible clients per month, which indicates that approximately 61% of all clients were screened. Table 2 summarizes findings. Of the women who answered “yes” to Question 1 (n = 10), 1 woman indicated that the abusive relationship had ended. Only 2 women indicated a positive response to Question 2, which might indicate that the abusive relationship may not be with an intimate partner. In fact, 3 women who responded “yes” to Question 1 indicated that a sibling was the abuser; this was hand written in the margin of the assessment form. Eleven (52.3%) of 21 women indicated that they had experienced

<table>
<thead>
<tr>
<th>English</th>
<th>Spanish</th>
<th>Positive for Abuse</th>
<th>Positive Responses (by Question)</th>
</tr>
</thead>
<tbody>
<tr>
<td>%</td>
<td>%</td>
<td>%</td>
<td>Q1</td>
</tr>
<tr>
<td>97</td>
<td>177</td>
<td>3</td>
<td>11.5</td>
</tr>
</tbody>
</table>

Note. N = 182.
sexual abuse by responding positively to Question 3; 4 of these women indicated that this abuse had occurred “long ago.”

The questions on the Abuse Assessment Screen (Appendix B) regarding referral, emergency numbers, and brochure(s) selected were not answered on the vast majority of completed forms in which women screened negative for DV. For women who screened positive for DV \( n = 21 \), 10 of the forms (47.6%) were at least partially completed. Only three forms (14.2%) were fully completed by the nurse, which raises serious issues for institutionalization of DV screening in the health department. In future inservices, it is recommended that the importance of completing forms is stressed, and incorporation of a random chart review should be implemented to address adherence issues. In addition, more time needs to be taken to explain the function of laminated pocket cards so that their use can be evaluated more effectively.

**EVALUATION**

Since the implementation of the DV screening program in the FP clinic of a local public health department was implemented, screening increased from 0 women screened for DV to 182 women (representing approximately 61% of clients seen in FP clinic) screened in a 4-week period; detection of abuse increased from 0% to 11.5% in the same 4-week period. In other studies in which DV screening was implemented in the health department setting, detection of abuse ranged from 7% to 9% of all women screened (Quillian, 1996; Shepard, Elliott, Falk, & Regal, 1999; Wiist & McFarlane, 1999). These studies analyzed DV screening protocols in a prenatal and maternal–child clinic, which may account for some of the difference in abuse detection. In addition, the specific screening tool was not explained in theses studies and may account for some differences in results.

Overall, implementation of screening was positive. FP nurses were able to ask the screening questions to a large number of clients. Women who screened negative for DV received information that they could use to help a friend who might be a DV victim. Over 11% of women screened were identified as victims of DV; these women were counseled regarding help that is available to them in the community. Even though some of the women were abused as children, information regarding community resources may be useful.

Changes are recommended as the screening program continues. It is essential that tools be utilized (laminated cards) and forms be fully completed, particularly for women who screened positive for DV. It would also be useful to incorporate the screening questions and follow-up information into a patient database (if available) to facilitate analysis. In addition, it is recommended that the program receive an evaluation after 6 months of implementation. This evaluation should include random chart review to assure nurse knowledge and adherence to the screening protocol. An evaluation of the total number of clients seen in the family planning clinics and comparing that to the number of women
screened for DV should also be performed. It is also recommended that the evaluation include items that can be used to explain why all clients were not screened. Possible reasons may include having a family member present, lack of time, and so forth. Those involved in the intervention should be asked for their input regarding the screening process. It may also be helpful to develop a brief questionnaire that asks clients to respond to how they felt about being screened for DV or their input into improvement of the questionnaire design.

The development of the screening program required time and effort. It is estimated that the development and implementation of this DV screening program required 150 hr of staff time. The brochures were provided at no cost. The cost of the nine posters, 10 buttons, and 10 laminated pocket cards was $55.00. Average time spent screening for DV by FP health department nurses was 1.5 min. For women who responded “yes” to any of the questions, the screening was estimated to take 11 min. The amount of time required for screening is relatively short; considering the potential benefits of early detection and prevention, DV screening is feasible and cost effective.

**CONCLUSIONS**

Public health departments routinely provide services to women who are in high-risk categories for DV. Routine screening for DV is recommended by the U.S. Preventive Services Task Force (1996) and reduction of intimate partner violence is a goal of *Healthy People 2010* (U.S. Department of Health and Human Services, 2000). Local public health departments can play an important role in detection of DV and improve their responses to DV victims. Implications for decreased economic costs and improved health in the lives of women are great. This project demonstrated the efficacy of screening in detection of DV victims by FP nurses and is an important first step in addressing the problem of DV in communities.

**REFERENCES**


**APPENDIX A**

**Domestic Violence Screening Protocol: Family Planning Clinic**

**Goals:**

1. To screen and identify victims of domestic violence in the County.
2. To prevent domestic violence among women in the County.

**Objectives:**

1. To provide domestic violence screening for all women who seek clinic services.
2. To provide safe and appropriate referrals/resources for all women seeking clinic services who are domestic violence victims.
3. To provide domestic violence prevention education/materials to all women seeking clinic services.

**Plan:**

1. Nurses screening for domestic violence must complete domestic violence screening inservice (2 hr).
2. Screen all women for domestic violence using the Abuse Assessment Screen. It is recommended that this be done verbally and in private.
3. For clients who report abuse:
   a. Provide referral to the women’s agency verbally and with brochure.
   b. Offer immediate on-site women’s agency referral by calling: 1-800-***-****.
   c. Indicate what was done on the Abuse Assessment Screen.
   d. Offer information about police 911 emergency number.
4. For clients who do not report abuse:
   a. Offer brochure available in English and Spanish, and discuss as needed.

**APPENDIX B**

**Abuse Assessment Screen**

Because violence is so common in many women’s lives and because there is help available for women being abused, I now ask every patient about domestic violence.

1. Within the past year, have you been hit, slapped, kicked, or otherwise physically hurt by someone?
   Yes  No
2. Are you in a relationship with a person who threatens or physically hurts you?
   Yes  No
3. Has anyone forced you to have sexual activities that made you feel uncomfortable?
   Yes  No
Referral to women’s agency? Yes  No
Women’s agency: On Site  Referral out
Reminded of police emergency number 911? Yes  No
Brochure given (circle): Name of brochure #1  Name of brochure #2

**APPENDIX C**

**Screening for Domestic Violence Evaluation**

Instructions: Please answer the questions below. Please circle the **best** answer.

1. Domestic violence occurs in:
   a. Women living in poverty
b. Professional women  
c. Health care professionals  
d. All of the above  

2. Which of the following are consequences of domestic violence?  
a. Drug and alcohol abuse  
b. Motor vehicle accidents  
c. Poor nutrition  
d. Weight loss  

3. When is a woman at greatest risk for abuse?  
a. When she disagrees with her partner  
b. When she leaves or divorces the abuser  
c. When she burns the pot roast  
d. When the children are at school  

4. Which of the following are risk factors for domestic violence?  
a. Financial stress  
b. Pregnancy  
c. History of violence in the family  
d. All of the above  

Please fill in:  

5. Please list 3 physical findings commonly seen in abused women.  
a. ___________________________________________________________  
b. ___________________________________________________________  
c. ___________________________________________________________  

6. Please list the name of the agency to which you would refer a domestic violence victim:__________________________________________  

Please circle the answer that best describes your feelings:  

7. Before this inservice, I felt comfortable screening women for domestic violence  

Strongly agree  agree  neutral  disagree  strongly disagree
8. Now that I have completed this inservice, I feel comfortable screening women for domestic violence

Strongly agree  agree  neutral  disagree  strongly disagree

9. The Abuse Assessment Screen is simple and quick to perform

Strongly agree  agree  neutral  disagree  strongly disagree

10. Please list any additional learning needs that you may have related to domestic violence screening: