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We’ve Had Training, Now What?

Qualitative Analysis of Barriers to Domestic Violence Screening and Referral in a Health Care Setting

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The present study assesses barriers to identification and referral of domestic violence (DV) victims by staff at a health care institution following a 3-hr DV training program in which 752 health care providers participated. Focus groups are conducted with staff in hospital departments that serve a high volume of women. Responses to focus group questions identify system-wide and individual hospital department barriers. These barriers have implications for health care organizations trying to implement DV screening protocols through training alone to change staff behavior in diverse clinical settings. Limitations of this study and future research recommendations are also discussed.

Keywords: domestic violence training; healthcare and domestic violence; healthcare barriers

Many studies indicate that domestic violence (DV) victims are a high-risk, high-volume group that is treated by the health care system. In primary medical settings, 17% to 25% of female patients reported DV in the past year, and 35% to 44% reported DV during their lifetime (Gin, Rucker, Frayne, Cygan, & Hubbell, 1991; Hamberger, Saunders, & Hovey, 1992; Johnson & Elliott, 1997). In obstetrical settings, prevalent estimates of DV among patients...
range from 5% to 29% (Gazmararian et al., 1996; Hamberger & Ambuel, 2001). Battered victims are at risk for a variety of medical problems, including pregnancy and childbirth complications (Hamberger & Ambuel, 2001). They are also at risk for other gynecological problems, HIV infection and other sexually transmitted diseases, chronic somatic disorders, and exacerbation of existing medical conditions (Eisenstat & Bancroft, 1999). Battered women also suffer a variety of mental health disorders, including depression, anxiety, posttraumatic stress disorder, and substance abuse (Gleason, 1993; Golding, 1999; Saunders, 1994). Therefore, because battered victims are frequent consumers of health care services and because DV has a distinct, negative impact on the health status of such victims, health care professionals are in a prime position to both identify and help them (Ambuel, Hamberger, & Lahti, 1997).

Efforts to improve identification and referral for battered victims in health care settings have resulted in an increasing number of programs within hospitals that provide both direct service to victims and training to clinicians (Hamberger & Phelan, 2004). Some hospital-based training programs have been evaluated, showing wide variations in effectiveness. For example, Mandel and Marcotte (1983) found that brief training reduced the number of inappropriate prescriptions written by physicians but not the rate at which providers detected victims. Saunders and Kindy (1993) noted a positive association between prior training or personal acquaintance of a victim and detection of DV by clinicians. Research has also shown improved self-efficacy or confidence to identify and help victims as a result of participation in DV training programs (Hamberger et al., 2004). In addition, Campbell et al. (2001) demonstrated, through implementation of a system change model, significant improvements in staff knowledge of DV, more positive professional attitudes toward DV as a medical problem, and increased patient satisfaction with health care providers and organizations following the system change intervention. However, no differences were observed between the intervention settings and the control settings on measures of DV victim identification.

The literature on self-efficacy and change in provider knowledge and attitudes toward DV as a medical problem clearly justify the need for training programs to help health care providers learn needed knowledge, skills, and confidence to identify and help partner violence victims. The present authors previously found that a 3-hr didactic training program, provided to 752 clinicians in a health care setting, improved self-efficacy of participants, with lasting effects noted at a 6-month follow-up (Hamberger et al., 2004). Elements of this training program, based on the Family Peace Project curriculum
(Ambuel et al., 1997), included providing clinicians with a common knowledge base of definitions, dynamics, incidence, and prevalence of DV; the importance of viewing DV as a medical issue; didactic discussion about common presentations of DV victims in medical settings; videotaped interviews of battered women discussing their experiences with the medical system; and discussion of legal and ethical issues in dealing with DV cases. Training also focused on enhancement of specific skills needed to screen and respond effectively to patients who are potential victims.

The question that remained was whether training alone resulted in implementation of consistent DV screening and referral procedures throughout the health care system. A number of studies have provided evidence that education alone is not associated with increased screening and identification of partner violence victims (Waalen, Goodwin, Spitz, Petersen, & Saltzman, 2000). Furthermore, Campbell et al. (2001) concluded that education alone is insufficient to alter actual practice behavior following successful training and that institutional policies may constitute important barriers that must be addressed to affect actual practice behavior. Consistent with those previous findings, a systematic review of charts in various hospital departments in the present study revealed inconsistent screening practices after training occurred. For example, providers in Behavioral Health (BH) showed a 95% screening rate following training, whereas obstetrics and Emergency Department B (EDB) showed screening rates near 0. Other departments, Labor and Delivery (LD) and Emergency Department A (EDA), showed screening rates between 40% and 45%. These findings justified further investigation of facilitating or inhibiting environmental factors that could affect task performance. For example, clinicians highly motivated to identify and help partner violence victims may encounter organizational factors that inhibit such behaviors. McLeer, Anwar, Herman, and Maquiling (1989) identified one example of this barrier. They observed that following the removal of a written DV screening protocol, observed screening rates dropped from 30% to nearly 5%. However, except for the report of McLeer et al. (1989), little attention has been directed toward identifying systemic barriers to screen and help partner violence victims in health care settings. The purpose of the present study was to identify such organizational barriers. Because this is an exploratory study, no specific hypotheses are proposed about the types of barriers that would be identified. However, the variation observed in screening compliance across several departments (described above) indicated that we would identify barriers that typified the overall health care organization (systemic barriers) and those that would be specific to certain clinical departments.
METHOD

Health Care Setting

The health care setting in which the study took place is an integrated health care system consisting of two hospitals and a large multispecialty practice located in a medium-sized, midwestern community serving a population of more than 150,000.

Research Design

Departments that served a high volume of women patients were studied. These departments included BH, two emergency departments (EDA and EDB), endoscopy (END), LD, obstetrics and gynecology (OB), and women and infants (WI). BH provides services to patients with mental health and/or substance abuse issues through a continuum of care ranging from outpatient to inpatient services. EDA is located in a lower socioeconomic area, serving an underserved population in a hospital that is known to be a major provider of mental health and substance abuse treatment. Therefore, many psychiatric emergencies are handled in EDA. EDB is considerably larger than EDA, serves a greater cross-section of the community, and tends to treat more typical medical crises. END provides services to patients with various gastrointestinal complaints and provides a variety of diagnostic and treatment procedures. OB comprises various independent outpatient primary care providers who provide reproductive health care services to women. LD is an inpatient setting for women giving birth. Once the birth is complete, patients are transferred to the WI unit for postpartum and infant care. A single medical record follows patients from LD to WI.

Participants

Managers from each of the above departments were asked to identify three to five staff members to participate in focus group interviews. Managers were asked to recruit a broad range of stakeholders who reported both positive and negative experiences with DV screening following training. Participants were 80% registered nurses and 20% mental health service providers. Participant gender was 85% female and 15% male. Average time in their respective profession was 16 years, and average duration of employment within the health care system was 14 years. Average participant age was 42. Total number of participants for the 7 focus groups was 39, for an average of 5 to 6 participants per group.
Procedure

Focus group questions were developed to answer practical questions about how the training that had taken place 6 months earlier was being implemented. In particular, given that prior research has shown that education alone is insufficient to demonstrate screening behavior change and that a prior study on the current health system (Hamberger et al., 2004) showed that individual learners reported increased self-efficacy and knowledge to screen and help DV victims, we were interested in determining whether and what types of barriers to implementation were being encountered. Each focus group was asked nine questions related to its experience with implementing the screening and intervention skills it had previously learned. Although some of the questions queried positive experiences and other aspects of training, the present study reports only themes related to barriers. Following each question, the ensuing group discussion was open ended and facilitated only for purposes of clarification and to ensure that all participants were able to present their views. Each focus group lasted for about 90 min.

Because it was felt that some participants might not feel comfortable expressing their opinions if the sessions were tape recorded, in an attempt to facilitate candid responses, the decision was made to not tape record the focus groups. Three members of the hospital’s DV task force conducted the focus groups. The facilitators served as note takers and documented participants’ verbatim responses to questions. The facilitators’ notes were immediately transcribed into a written format to reflect verbatim responses. The focus group participants were guaranteed anonymity and were assured that no names would be disclosed and only aggregate responses would be reported.

Data Analysis—Coding Categories of Responses

Coding categories were developed from the data through a consensus process whereby the investigators reviewed the transcripts and identified themes until an exhaustive list was developed that captured the range of responses. Each rater individually coded statements in the notes according to the established coding guidelines. The raters then reviewed their results together to ensure that there was full agreement about appropriate coding categories for each response. Coding categories were later combined into more general themes in an effort to make the qualitative analysis more meaningful.

The themes that emerged from the data analysis were related to barriers to screening for DV in the health care setting. These themes can be looked at in a variety of ways toward the goal of suggesting organizational change. By
looking at a general overview of the themes, an understanding of hospital-wide barriers can be better understood. On the other hand, looking at themes specific to targeted departments illuminates department-specific obstacles. These are important distinctions to recognize in designing process improvement initiatives within an organization.

RESULTS

The present study found that barriers to implementation of DV screening and referral protocols generally fell into five themes for the health care system studied: (a) questions about the appropriateness and value of screening given patient presentation and clinical setting, (b) inadequate provider expertise resulting in feelings of frustration, (c) concerns about time and workload priorities, (d) concerns about the process of screening, and (e) concerns about the outcome and efficacy of screening.

In looking at the various categories of responses to focus group interviews, it is also interesting to compare responses by staff in different departments. Perhaps certain clinical settings present specific barriers needing targeted process improvement efforts by program administrators. There may be valuable lessons to be learned from settings in which staff identify fewer screening barriers.

Questions About the Appropriateness and Value of Screening Given Patient Presentation and Clinical Setting

A significant number of questions were raised as to the appropriateness of DV screening to specific clinical presentations by patients. Concerns were raised as to specific patient populations that might be unable to respond appropriately to screening or that have more acute issues to deal with during their medical examination. Some of the patient groups specifically identified as less appropriate for screening included intoxicated patients (BH, EDA), psychotic patients (BH, EDA), women in active labor (LD, WI), and patients presenting with stroke, heart attack, or other acute medical crisis (EDA, END). For example, one participant stated that the "main objective in this department is to make sure labor (is) going OK" (LD). Another respondent stated that he "did not want to assess for a problem they did not come in for." Another issue that was evident in this theme was the belief that the screening could be handled more appropriately by somebody else in a different department. Nurses asked why physicians do not screen, LD nurses suggested that the question be asked once a patient is transferred to the Women & Infants
unit, and the emergency department staff questioned the practice of screening patients who are in a medical crisis.

Some of the concerns raised were generally related to a feeling that the questions get too involved in patients’ personal lives rather than focusing on traditional medical issues. One participant suggested that “screening could be relevant if put in with a lot of other screening questions, (for example) gun ownership, alcohol and drug abuse, etcetera” (EDB). Staff expressed frustration over being forced to screen all patients, feeling that “no one across the country . . . is doing this” (EDB). They further questioned, “How much responsibility do I own to save the world?” (EDB).

Questions of appropriateness and value were identified 20 times by staff in EDB and 7 times in EDA. Staff in END identified these concerns twice, whereas staff in Women & Infants and Labor & Delivery each identified these concerns once. Staff in BH and OB did not identify any barriers in this coding category.

**Inadequate Provider Expertise Resulting in Feelings of Frustrations**

The main issue identified in this theme was a sense of discomfort and/or lack of expertise in dealing with the subject of DV. Staff expressed the belief that DV is a personal matter (EDA), and some feel “afraid of abuse” (OB) based on their discomfort and anxiety about dealing with the topic. One respondent stated that the “staff should not be put in the position of having to ask the question” (EDB). Other staff identified ongoing fears of being ill prepared for responding to a “yes” answer in a helpful manner (EDA, END). Some participants admitted to feeling that DV is an uncomfortable issue and therefore “avoid it until it stares you in the face” (OB). Some focus group participants hypothesized that colleagues might have “personal experience with abuse and that makes it difficult to address the issue” (OB).

This category of responses also included some feelings of anger and frustration communicated by staff during focus groups about screening. Staff also commented on the importance of organizations to provide adequate facilities and support for screening and intervention. For example, one participant noted the need for a financial commitment to this process, for “a patient advocate, (adequate) space, et cetera” (EDB).

Each participating department identified this barrier of inadequate expertise at least once. Frustration stemming from being ill prepared to deal with abuse was most frequently noted by staff in the two emergency departments, with nine statements coming from EDB and three from EDA. BH staff identified this barrier three times, whereas OB and END staff each identified this
twice. Finally, staff in Women & Infants and Labor & Delivery each expressed their general frustration with DV screening procedures once.

**Concerns About Time and Workload Priorities**

Health care providers interviewed in this study seemed to believe that asking patients about DV has the potential to create a significant increase in work responsibilities or require use of resources other patients might need. This included concerns such as “do we have time to address the patient’s needs properly?” (EDA) as well as concerns that these situations could potentially “tie up an exam room” (OB). Some of the statements in this category reflect an ongoing need in health care to juggle multiple responsibilities and to prioritize areas where one should focus energies. For example, one participant questioned, “How can I teach someone about domestic violence when I’ve got someone in a neighboring bed who needs me more?” (EDA). Another respondent commented that “there is no time to establish the rapport necessary to ask the question” (EDB).

Workload or time issues were identified most frequently by staff in the two emergency departments studied, with four statements in this category by EDA and two statements by EDB. Staff in Labor & Delivery, OB, BH, and END each made one statement regarding workload or time constraints being a screening barrier. Women & Infants staff did not identify this issue as a DV screening barrier.

**Concerns About Process and Procedures of Screening**

The issues identified in this theme demonstrate that staff did develop an understanding of DV screening issues through training or other experiences. Concerns about privacy, confidentiality, and the referral procedures reflect a level of sensitivity to the unique dynamics of screening for DV as opposed to screening for other medical problems. Staff identified concerns such as “only curtained areas” separating patients (EDA), making it difficult to achieve privacy for screening. “Family members being around” (LD, OB) was another challenge noted by providers, with one participant questioning, “What if her partner comes in the room and sees the pamphlets and information?” (WI).

Responses in this coding category were found nine times in each of the emergency departments studied. Staff in both Women & Infants and OB expressed process and outcome concerns three times. BH and Labor & Delivery staff each identified these barriers once. Staff in END did not identify any concerns in this coding category.
Concerns About Efficacy and Outcome of Screening

Respondents recognized the complexity of DV and that screening alone may have limited the benefit to victims. This concern led to statements such as “frustration is when people don’t follow through, even when the referral has been made” (BH). A participant reported “frustration that patients won’t seek help” (EDA) and the “cycle of violence.” Staff requested greater feedback on whether screening provided any real benefit to patients (i.e., “Is there positive feedback on anyone we have helped or from referral sources?” [EDB]). Two other respondents noted “there is no data on how effective asking is” (EDB). These comments indicate that many staff are not convinced of the effectiveness of inquiring about DV. This skepticism toward the outcome of screening is not likely to facilitate the inclusion of routine screening questions in health care.

Department-Specific Responses

Each department that participated in a focus group for this study expressed unique concerns and issues related to DV screening and referral procedures. A close examination of specific departmental responses provided a clearer idea of the true flavor of each clinical setting studied and potential issues that influence compliance with screening.

BH. Staff in BH indicated that their normal procedure is to ask patients several questions related to DV in addition to the standard screening questions. Because BH also screens patients younger than 18 for abuse, anxiety was expressed about mandatory reporting issues and related concerns for patient confidentiality when screening and identifying adult DV victims.

BH staff identified other screening barriers in their setting. The population of severely mentally ill or intoxicated patients presented one challenge, as professionals “don’t know if their responses are valid.” Privacy concerns were raised for inpatients with a roommate who might be present during an inpatient admission. In addition, time constraints were seen as a problem given the “number of questions that have to be asked” at the time of admission. Staff also wondered if there is adequate time to establish trust with patients to enable them to discuss these sensitive issues at the beginning of treatment.

EDA. Responses from staff in this department generally reflected significant barriers to DV screening and referral procedures. One major issue raised was the fact that the DV question was not a standard part of the medical
record. Instead, a sticker with the question was being added to charts; how-
however, staff admitted that “sometimes charts slip by without the sticker.” Pri-
vacy was another significant concern identified. Staff indicated that the “sig-
ificant other is there all the time” and that there is only a “curtain between
patients.” Participants also commented that they felt this type of question is
too personal to be properly addressed in their clinical setting. In addition,
time constraints were identified as a problem in EDA, as patients are there
“20 minutes to 2 hours and they’re gone.” Although EDA staff admitted to
“discomfort in asking the question” and a “low positive identification rate,”
they questioned “why not use assessment skills” rather than universal
screening to identify victims.

The multiple challenges presented by the patient population served in
EDA were also reflected in some focus group responses. This included diffi-
culties with patients who are intoxicated, actively psychotic, non-Eng lish-
speaking, or illiterate. Additional questions were raised about the level of
follow-through by patients who received referrals. The staff requested ongo-
ing feedback on patients who were helped by their intervention. Social work
presence in EDA was also identified as a need, reflecting a sense that staff do
not feel equipped to deal with patients’ multiple problems in an emergency
care setting.

EDB. Staff in EDB expressed multiple concerns about DV screening and
other job stressors during focus group interviews. Although staff admitt ed
that they “don’t ask (the DV question) as much as we should,” they pointed
out multiple frustrations with screening. Frustrations identified include “the
question is badly worded,” “people make a joke of it,” “no time to establish
rapport,” “it’s stressful to ask,” “lack of relevance,” “lack of privacy,” and
“huge volume of patients.” Some comments made by EDB focus group par-
ticipants reflected a level of antagonism toward mandatory screening. Some
staff questioned, “How far do we go into people’s lives?” Others wondered,
“Why are we put in the uncomfortable position of having to verbally ask the
question?” Participants commented that they resented the fact that they are
forced to screen all patients. Finally, the general sense of frustration in this
department was reflected by one staff member’s comment: “How much cyni-
cism do we have when we deal with patients who use their money to buy ciga-
rettes and alcohol rather than medicine?” Although many important screen-
ing barriers were identified in EDB (e.g., lack of privacy, time constraints),
general staff frustration and questions about the relevance of screening were
important to this group, as evidenced by the large number of comments
offered.
Despite many positive responses to screening expectations, END staff identified important barriers. Focus group participants admitted to “initial discomfort with (the) question,” specifically feeling uncertain of “what to do with a yes answer.” Staff reported that the “biggest objection was from doctors when they heard us” screen patients. In addition, concerns were raised that patients come in more focused on the procedure they need, so at this time, “why ask something offensive?” Staff also felt that some patients have been “in (the) system for a while . . . and should have been asked elsewhere . . . why ask the same question multiple times?” Time constraints and a high volume of patients were also seen as important screening barriers in this department. In addition, staff noted that having the question printed on assessment forms is critical to success because “the sticker does not work well.” Finally, staff in this department expressed frustration with their perception that other hospital departments were not screening for DV consistently.

OB. OB staff expressed a general commitment to helping DV victims they might identify through screening procedures. Staff, furthermore, commented that training and new screening procedures “brought more awareness” and “stimulated greater uniform use of (the) question.” OB staff also indicated that they were taking some proactive steps to ensure patient privacy for screening by “hav(ing) him [the partner] come in near (the) end” of the appointment and “assur(ing) him he will be able to be present for the major parts of the experience.”

Aside from the general acceptance of screening expectations, staff in this area identified some important screening barriers. Time constraints were one identified concern, as the “doctor likes to be on track with seeing patients, and asking the question can take you off track.” Other concerns related to the physical layout of the clinic, as there is “no place to take patient to collect themselves” and “no space for counselor” to meet with patients. In addition, staff pointed out that no accommodation was currently available to allow patients in crisis to exit the clinic via a private route. This issue leads to “tying up a room if (patient needs) to stay . . . to talk to a counselor.” Some issues of provider discomfort were identified (e.g., “It is painful personally for some staff to ask the question because of personal experience”). Frustration was also noted “with the patient who stated the problem and still goes back to her abuser.”

Labor & Delivery. Many of the questions raised by LD staff related to the appropriateness of screening women who are in labor. Patients are “uncom-
fortable because of labor,” and staff expressed their primary emphasis on ensuring that “discomfort is controlled.” Staff felt this information could be more readily obtained in outpatient OB departments before delivery or by WI after delivery. This department indicated that its “focus is on family involvement,” making it difficult to achieve privacy for screening. Some frustration was noted over the competing desire for family involvement in their department and the privacy that the system requires for DV screening. Efforts have been made by staff to be creative by trying to screen patients privately when they go to the bathroom, but “[patient’s] husband sometimes even goes into the bathroom.” Concerns were also raised as to the brief length of stay in this department, as they “haven’t established rapport” with patients prior to screening for such a personal issue. Finally, LD staff admitted that some judgments may be made about who to screen based on whether “she . . . look(s) like she is abused.”

Women & Infants. Privacy issues were a major concern identified in this department. WI staff noted that they historically “tried not to dictate to patient’s family that (they) need to leave the room (because of) family centered philosophy.” Staff have tried to creatively address this issue by following patients to the bathroom and so forth, similar to the LD department strategy stated above. Despite such creative attempts, concerns continued to be noted, such as, “What if partner comes in the room and sees the pamphlets and information?” These concerns were further reflected in staff questioning whether “Women and Infants is the proper point of entry” for DV screening. Despite those questions, WI staff stated that their “unit does value the importance of safety in the home environment.”

WI staff also admitted that screening does not occur consistently in their department, estimating that “it is asked about 60% of the time.” Furthermore, the WI group noted that “some staff are so task oriented” that they begin to “view it just as a sticker or a task.” Some problems were noted regarding the use of a screening sticker rather than having the screening question printed on assessment forms. For example, staff stated that the “sticker is often in different places on the chart” and separating the question from other parts of the admission leads to the view that it is “just a sticker or a task” and not as important as other assessment questions. Finally, staff in this department felt that more feedback on their efforts would be helpful in answering the question, “Did I really make a difference?”
DISCUSSION

The present study sought to identify barriers to screening and identifying partner violence victims throughout a health care system that developed and implemented a system-wide initiative to do so. The goal of the study was to identify barriers to screening that were part of the very system that implemented a universal DV screening and intervention program as well as to identify barriers that are specific to individual departments throughout the broader system. This is the first study that we are aware of that has attempted to identify barriers to implementing skills learned from a documented successful health care provider training initiative (Hamberger et al., 2004). Overall, the present findings support the conclusions of Campbell et al. (2001) that achievement of changes in actual clinical practice requires the modification of institutional policies and procedures that may inhibit implementation of such practices. Findings from the present study represent an initial effort to identify the types of institutional and systemic barriers and department-specific barriers that may frustrate such efforts.

Implications of System-Wide Barriers Identified

Focus group participants identified important factors that a health care organization must address as part of effective implementation of a DV screening program. Quality training must be provided to staff. But it must be recognized that education alone is insufficient to significantly alter the behavior of health care providers to screen, identify, and help partner violence victims in health care settings (Olson et al., 1996; Patel, Hamberger, & Griffin, 2001; Waalen et al., 2000). One repeated theme in the focus groups was the need for printed forms with a DV screening question to be present. The presence of the question on assessment forms serves as an important reminder from providers to screen patients. In support of this call from the focus groups, Patel et al. (2001) found that adding the screening question to the history and physical form in a family practice clinic increased documented screening from 2% to 92% but found no independent effect of a 3-hr education program.

Adding other intervention components to staff education was found by Waalen et al. (2000) to be related to increased screening and identification rates. Likewise, in the present study, providers in the focus groups expressed a need for ongoing feedback that screening procedures help patients. This type of outcome data could serve as an important reinforcement of screening efforts. Pape, Minsky, and Hamberger (2000) found that following implementation of department-specific continuous quality improvement methods,
screening rates increased significantly across a number of health care system departments. In addition, referrals of patients for assistance, either to the local women’s resource center or to the health system–based family violence coordinator, also increased significantly.

Another set of systemic barriers centered on the general theme of inadequate expertise resulting in frustration with the system. Focus group participants reported personal discomfort with the issue of abuse. This discomfort can be addressed with adequate training that addresses skills and attitudes. Several studies have demonstrated that training that targets provider attitudes and skills can significantly increase the provider’s sense of self-efficacy and comfort to address DV among patients (Hamberger et al., 2004; Harwell et al., 1998; Thompson et al., 2000). All of these training programs were comprehensive, skills oriented, and longer than 1 hr. It may be that effective training will have its most important effect on the comfort and self-efficacy of health care providers to screen and help partner violence victims. It may also be that staff members who have received training will benefit from periodic in-service training to bolster skills and enhance comfort in addressing DV.

The other aspect of staff frustration identified, the lack of in-house resources or referral networks with DV advocates, is also important. Health care providers frequently feel overwhelmed at the prospect of screening for DV because of the fear of neglecting their basic clinical mission or not having adequate resources to which the patient can be referred (Brown, Lent, & Sas, 1993; Sugg & Inui, 1992; Waalen et al., 2000). Hence, leaders of health care system initiatives to screen and help partner violence victims must develop such resources. This can be accomplished by a combination of hiring staff to function as in-house DV advocates and developing collaborative working relationships with local domestic abuse advocacy programs to whom patients desiring referral can be sent. In addition, training of health care providers should include discussion of the appropriate role of the health care provider in screening, identifying, and helping partner violence victims. Gerbert, Caspers, Bronstone, Moe, and Abercrombie (1999), for example, found that health care providers reported lowered frustrations after adjusting their goals to consist of asking the screening question, providing compassionate supportive care, and dispensing information about community resources while respecting and accepting their patients’ rights to determine their own course of action.

Although certain protocols encourage health care providers to employ universal screening methods (i.e., screen every patient; Ambuel et al., 1997), some respondents in our study questioned this wisdom, particularly for those patients who might be too ill or impaired to respond or provide a valid response. Although universal screening might be ideal, it may not always be
practical or even desirable. McNutt, Carlson, Gagen, and Winterbauer (1999) surveyed abused and nonabused women in both health care and social service settings about their preferences and experiences with DV screening. Fewer than half of abused women from health care settings and DV outreach programs agreed that physicians should ask all women about DV. In addition, whereas the vast majority agreed that women should be screened if they presented for injuries, only 20% agreed that women presenting with illness, such as the flu, should be screened. Although in need of more research, health care systems may need to develop guidelines and policies for determining the relevance of screening for patients with particular levels of impairment or illness.

Although not identified universally as a systemic barrier, the issue of privacy mentioned by many respondents is, in fact, a systemic one. Only the system can ensure that patients have a sufficiently private setting in which to receive health care services. Patients must be cared for in settings that afford adequate privacy for dealing with sensitive medical and psychosocial issues; otherwise, providers may fear that screening could compromise a victim’s safety and avoid it. Conversely, victims that sense danger to their privacy and confidentiality will also likely deny abuse (Gerbert et al., 1996). Hence, as health care systems implement system-wide programs to screen for DV, it will be necessary to provide adequate physical space resources. Indeed, one can appreciate the concern and frustration of a health care provider who sees a patient in a clinical space, separated only with a cloth barrier, attempting to screen and subsequently provide support for a patient once DV has been identified.

Finally, program developers and health system administrators must recognize some of the conflicts between various system values and goals. In particular, many hospitals value and actively advocate for family-centered care, whereas DV screening requires patients to be separated from family members. These conflicts must be recognized and discussed openly with staff for them to be addressed. Strategies for reconciling these two seemingly disparate core values would have to be developed to overcome this particular barrier.

Implications for Individual Departments

In addition to overall systemic barriers discussed above, identification of barriers specific to individual departments suggests that health care systems are not monolithic institutions. Instead, individual departments appear to confront unique barriers that require specific interventions at the departmental level. Addressing barriers that are present throughout a hospital is not real-
istic in every setting. However, working to reduce department-specific barriers may require fewer resources while significantly affecting screening compliance.

**BH.** Specific interventions by DV program professionals to address the screening barriers identified by BH staff include further training on mandatory reporting. Some flexibility might need to be given to BH staff in terms of when patients must be screened. For example, the expectation that all patients be screened at admission may be unrealistic when dealing with patients presenting with psychosis, dementia, or intoxication. Policies in BH settings may need to make allowances for patients to have time to stabilize prior to DV screening. Finally, as in all settings, privacy concerns must be addressed to ensure that family members and other patients are not present when DV screening occurs.

**END.** Concerns raised by END staff provide practical leads for process improvement efforts. Objections to screening from physicians need to be further explored. Perhaps focus groups with physicians would highlight additional barriers or training needs. Physician objections also point to the importance of including the entire health care team in decision making and changes in policies and procedures. Also, staff concerns about how to respond to a positive screen can be addressed through further focused training.

**Women’s health.** In the hospital studied, pregnant women receive prenatal care in OB, go through labor in LD, and get postpartum care in WI. The responses from focus group participants in these departments revealed opportunities for greater collaboration among women’s health practitioners in addressing DV. Perhaps joint focus groups with representatives from each department would help clarify and coordinate the various roles and responsibilities for DV screening and intervention. A common theme emerged in these areas regarding the conflict between a philosophy of family-centered care and privacy required for DV screening. This can be addressed as part of training on multiple sensitive questions that need to be asked of patients to ensure appropriate medical care and a safe childbirth experience (e.g., questions of sexually transmitted disease, substance abuse, and previous pregnancies). Screening for DV can be viewed as one of these subjects, in which all patients have a right to discuss issues privately with a health care provider. Because of the challenge of establishing privacy during childbirth, greater collaboration is needed between these departments, which may treat a large number of the same women. Use of a single medical record in women’s health would allow all providers to be aware of past responses to screening,
reducing the need for repetitive questioning. Finally, concerns about time constraints can be addressed with the availability of advocates to provide direct crisis intervention to victims, which can greatly reduce this burden on busy providers.

Emergency. Significant barriers to DV screening, as well as important opportunities for reducing them in the emergency departments, were reflected in focus group responses. For example, updating assessment forms to include the DV screening question was seen as a more effective way to ensure the presence of the question than use of a screening sticker, which was initially used in the present situation. In departments that treat a large population of non-English-speaking patients, translation services should be available, along with language and culturally appropriate screening tools and resource materials. In addition, assisting staff and management in dealing with privacy issues is an important challenge. The ideal change would be for private triage or exam areas to be available; however, it may be more feasible to help staff identify private opportunities for screening, such as going for x-rays or urine specimens. Emergency department staff, as well as most staff in other departments, may benefit from periodic feedback on patient outcomes as a result of DV screening. Program administrators need to explore ways to respond to this request while protecting patient confidentiality. In departments where vocalized, strong attitudinal issues are present, as in EDA and EDB, these attitudes need to be addressed directly.

Should Health Care Screening for DV Focus on the Emergency Department?

The present study raises important questions as to whether emergency departments are adequately equipped to handle the demands of routine DV screening and referral. Is privacy routinely established for patients in these settings? Does the emergency room have sufficient staff to respond appropriately to the large volume of victims that might be identified through screening? In a busy emergency department, screening may not consistently occur without the backup of onsite advocates to provide support, information, and referral (Brown et al., 1993; Sugg & Inui, 1992). Great care must be taken to ensure adequate privacy. Even the perception that their privacy is in jeopardy could lead patients to withdraw from the screening and identification process (Gerbert et al., 1996).

The above observations lead to important questions about the focus of many initiatives on responding to victims present in emergency departments. This focus on the emergency department is based on the idea that victims
may be more likely to present in an urgent care setting or may lack a primary care provider. However, research on prevalence of abuse victims in clinical practice shows that emergency departments are far from the exclusive source of help seeking for abuse victims. In addition to family practice settings (e.g., Hamberger et al., 1992), battered victims are found in large percentages in internal medicine clinics (Gin et al., 1991), obstetrics and gynecology clinics (Hamberger & Ambuel, 2001), and gastrointestinal medical clinics (Drossman, Leserman, Nachman, Gluck, & Toomey, 1990). Our findings suggest that other departments and points of entry into the health care system are suitable for asking patients about DV as long as relevant barriers are identified and appropriate training and solutions to cope with barriers are developed.

Study Limitations

Identifying barriers through focus groups with selected staff members from identified acute care, hospital-based departments was a limitation of this study. This method could have produced skewed results by including those with the strongest feelings on the subject. The perspectives of the managers who recommended the focus group participants may have introduced some bias into the results. However, we requested that managers recommend participants with a wide range of opinions and experiences with implementing the training they had received. In addition, data from the focus groups suggested that participant responses varied considerably, reflecting the diversity of opinions and experiences sought. Interviewing large groups of staff from multiple hospital-based settings or including feedback from patients about their experiences with screening could further expand our knowledge of existing barriers to identifying and helping battered women throughout the health care system.

Because the focus groups included participants from two hospitals belonging to a single health care system, the results may be less generalizable to other hospitals in different settings with different organizational structures. Still, several of the system-wide barriers and department-specific barriers identified in the present study were consistent with barriers identified in a number of other studies that used either focus group methodology in other geographical areas (Brown et al., 1993; Sugg & Inui, 1992) or survey methodology with national samples (Love et al., 2001).

Another study limitation is that rather than audiotape the focus group sessions, we used note takers. This could have resulted in biased reporting, as the note takers could have filtered information from the respondents. The decision to use note takers was intentional and based on our experience that in
such a setting where departmental managers knew the participants, we would get more candid responses if participants felt their anonymity was being maximized. In addition, multiple note takers were used for each focus group to maximize accuracy and amount of information gleaned. The data indicated considerable consistency of recorded information among the separate note takers.

Summary

This study contributes to the existing DV literature in that it explores both systemic and department-specific barriers to implementation of a DV screening program in a health care setting. Issues of time constraints, staff frustration, process and outcome concerns with DV screening, and relevance of DV screening to patient population or department are likely to exist in many settings. Department-specific screening barriers may also exist, which can and must be targeted in a cost-effective manner. For example, the simple task of updating forms to include a DV screening question may be the most powerful intervention in achieving improved compliance (Patel et al., 2001). Other important recommendations include ongoing staff training, feedback to staff on patients who are helped, problem-solving privacy concerns with staff, and flexibility with when patients are screened to facilitate rapport with patients.

This research also points to the potential for success in expanding screening procedures into outpatient settings rather than focusing largely on emergency departments. Outpatient providers may be better equipped to deal with DV cases because of more long-standing relationships with patients. In addition, these providers may be able to provide more effective follow-ups than is feasible in acute care settings. Future research can lead to a greater understanding of which medical settings most effectively address DV issues with patients. It is clear from this study that structured focus groups with staff highlight opportunities to improve the effectiveness of DV screening initiatives in health care settings.

REFERENCES


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Marie Wolff, Ph.D., has an extensive background in community-academic partnership building, medical and urban sociology, and curriculum development. She was the coproject director on a Health Resources and Services Administration Residency Training Grant in Primary Care that implemented a community health and family violence curriculum in four family medicine residency programs. She currently has a grant to develop and pilot test an objective structured clinical exam for the assessment of primary care residency competency in primary and secondary prevention of intimate partner violence. She also has conducted, analyzed, and published numerous qualitative research studies.