

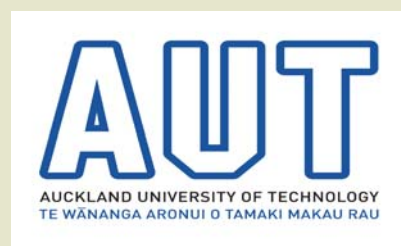
**Interdisciplinary Trauma Research Unit**

**Plunket Family Violence  
Evaluation Project**



**I**nterdisciplinary  
**T**rauma  
**R**esearch  
**U**nit

*Te wairere au noa*



## **Plunket Family Violence Evaluation Project**

Sharon Vallant, MA, RGON  
Senior Lecturer

Jane Koziol-McLain, PhD, RN  
Associate Professor

Brenda Hynes, MBA, RGON, RSCN, PG Diploma (Public Health)  
National Clinical Advisor (Nursing), Royal New Zealand Plunket Society

### **Acknowledgements**

The Research Team would like to thank the Plunket staff and clients who took part in the interviews and focus groups. We also thank Plunket clinical nurse advisors who assisted in record review and to Pritika Sharma of the ITRU and Denise Wilson from Massey University who supported focus group processes.

### **Contracted Organisation**

This report was commissioned by the New Zealand Ministry of Health to Auckland University of Technology. The views expressed in this report are those of the authors and do not necessarily represent the views of the Ministry of Health.

June 2007  
Interdisciplinary Trauma Research Unit  
Auckland University of Technology  
Private Bag 92006  
Auckland, New Zealand 1142

ITRU Report No 6  
ISSN 1177-4347

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## Executive Summary

In March 2003 The Royal New Zealand Plunket Society instituted a *Family Violence Policy and Protocol* calling for a screening question about partner violence to be included in the initial history for all new baby cases. Four activities were carried out to gather information about the processes and outcomes of the Plunket response to Family Violence. These included Plunket staff focus groups (4 focus groups involving 20 Plunket staff members), review of Plunket Health Records and national database information (reviewing records for 133 clients), and several client interviews (n=4). The evaluation activities focused on four Plunket locations. Selected findings are summarised below.

- Plunket staff participants in this evaluation project were aware of the *Family Violence Policy and Protocol*. Their descriptions generally detailed the screening process, with little reference to interventions such as safety plans or referrals and recommendations.
- Staff talked about their initial anxiety and apprehension in asking women about violence in their relationships, which dissipated once they gained experience and confidence.
- Ongoing screening was recommended because of the changing nature of relationships between women and their partners over time. Staff also felt some women needed to build a relationship with them (the Plunket nurse) before they would disclose violence.
- Plunket staff were adamant that the *Family Violence Policy and Protocol* had influenced their practice in a positive manner. The introduction of the policy had made them engage with family violence in a way they hadn't previously.
- Two of the four Plunket clients interviewed didn't realise that they had been asked about violence in their relationships after having been screened, indicating that some staff may not be asking the screening question in an effective, direct manner.
- Among the 133 new baby case records reviewed, 64% had documentation of family violence screening and 6% (n=8) had evidence of a positive screen response. There was significant variation in the screening rate across locations (30% to 80%).
- Both Plunket staff participants and Plunket client participants spoke about the importance of having a relationship, as this enhanced the ability to have family violence discussions.

The unique service that Plunket offers to women and the ability of Plunket staff to build relationships with their clients were identified as enablers to implementing the *Family Violence Policy and Procedures*. Activities are currently underway to revise the *Family Violence Policy and Protocol*, to further support Plunket staff in implementing the policy and in facilitating documentation of screening and intervention.

## Background

Family violence is a reality for many in Aotearoa New Zealand. Children are often caught in what Hughes et al. call a “double whammy” - the phenomenon of being both a victim and a witness of abuse.<sup>1</sup> The overlap between domestic violence and child abuse is believed to be between 30% and 75% depending on the methodology and definition used.<sup>2-4</sup> Men who batter their wives are more likely to physically abuse their children<sup>5</sup>; at the same time, battered women may use more punitive child-rearing strategies.<sup>6</sup> Children may also be neglected because their mothers are preoccupied with the violence they experience from their partner or because they suffer from depression.<sup>7</sup>

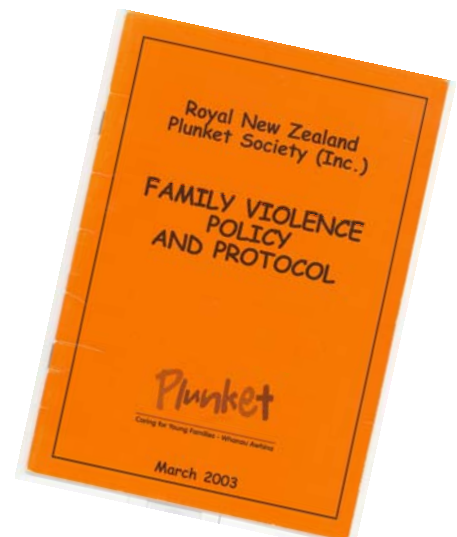
The last decade has produced evidence that witnessing the battering of their mothers may be as traumatic for children as being a direct victim of abuse; both have similar psychological and developmental effects.<sup>8-10</sup> There is increasing agreement that “family violence is a contagion that is seriously threatening the health and emotional well-being of many young children.”<sup>11</sup> Far too many children are living in “dangerous, chaotic, and highly dysfunctional families”.<sup>9</sup> Perry refers to children growing up in unstable, violent homes as “incubated in terror”.<sup>12</sup> Children caught in the crossfire of domestic violence are exposed to repeated incidents of violence between individuals with whom they have strong personal and loving relationships.

Internationally and in New Zealand, health care has responded to the high prevalence of family violence and its significant impact on women’s and children’s health by calling for routine family violence screening. While there is evidence that women feel comfortable in disclosing partner violence to health professionals, it has been found that women are unlikely to disclose information unless asked directly.<sup>13-17</sup> Bateman and Whitehead found that the majority of postnatal health care clients did not disclose relationship problems until asked directly, thus supporting the need for routine questioning.<sup>17</sup> Studies have found that health professionals working in the community, including in the context of early childhood health care, are in a good position to provide ongoing support to women who disclose abuse.<sup>15, 17, 18</sup> Women feel comfortable and able to trust the health visitor; and the inclusion of home visiting means health professionals are more likely to assess potential social problems.<sup>15, 17, 18</sup> Gewirtz and Edleson<sup>19</sup> recommend that early intervention focus on promoting healthy attachment relationships between the infant and non-abusive caregivers, combined with concrete support to access services and develop social support networks.

A family violence policy was introduced to the Royal New Zealand Plunket Society in March 2003. Given the high prevalence of family violence among young women in Aotearoa, and the supportive relationship between a new mother and her Plunket nurse that spans several visits, there is an opportunity for effective screening and intervention. Since the implementation of the policy in 2003, however, little is known about “how things are going”. Therefore, this research project was designed to evaluate aspects of the Plunket Family Violence Policy.

### ***Screening Question Example (Plunket Policy)***

*Have there ever been any times when you have been hurt by, or felt afraid of, your partner or someone important to you?*



## Methods

### *Evaluation Aims*

1. Identify patterns of family violence screening (“discussions” and “referrals”).
  - a. Extract key variables from the national database (PCIS) since database inception (2003) to present and analyse family violence screening by location, ethnicity and deprivation level (included in an earlier report by Brenda Hynes).
  - b. Abstract information from a selection of *Plunket Health Records* (up to 50) in 4 locations to document family violence screening practices across new baby cases.
2. Conduct a focus group with Plunket staff in each of 4 locations (same locations as 1.b) to identify partner violence screening enablers and barriers.
3. Conduct approximately 24 semi-structured interviews with clients who respond to an invitation to share their experience of being asked about violence in the context of Plunket nurse services in 4 locations (same locations as above; 6 women in each location).

### *Data Collection*

This mixed-method study was conducted in four purposefully selected Plunket locations in Aotearoa New Zealand. The four locations were chosen to include rural and urban populations, representation of Maori, Pakeha and Pacific Island populations, high and low deprivation areas and high and low family violence screening rates (confirmed in findings). Three locations were in the North Island and one in the South Island.

Ethics approval was gained from the Multi-Region Ethics Committee and the Plunket Ethics Committee.

### **Focus Groups**

Four Plunket Family Violence Evaluation Project focus groups were held between August and October 2006. The purpose of the focus groups was to gather information about Plunket staff experiences and opinions of implementing the Plunket Family Violence Policy, to identify the enablers and barriers to routine screening, and measures taken to overcome these barriers. A semi-structured focus group format was used as described by Sandelowski.<sup>20</sup> Selected questions used to guide the discussion are listed below (see also Appendix A).

### ***Selected Interview Guideline Questions***

#### **Screening Process**

- Can you tell me how you came to know about the family violence policy?
- Can you describe the policy/programme?
- Thinking about your experiences working for Plunket, has the Policy influenced your practice?

#### **Barriers**

- Are there things that get in the way of asking about family violence in practice?

#### **Overcoming Barriers**

- You have talked about some things that get in the way of talking about family violence, have any of you found ways to overcome any of these barriers?

Plunket staff from each of the four study locations were invited to participate in the focus groups. Three of the four study locations were small, with only one or two staff members, so Plunket staff from surrounding areas were invited to join these focus groups. Participation was voluntary and potential participants were informed about the study in an information sheet and verbally by the researcher (Sharon Vallant). Plunket managers were not asked to participate in focus groups.

Focus groups lasted approximately one and a half hours and were attended by local Plunket staff and facilitated by two persons from the Interdisciplinary Trauma Research Unit (ITRU). There were a total of twenty participants (17 Plunket nurses, 2 Plunket Karitane and 1 Maori Community Health Worker), with each group having between 3 and 7 participants. Each focus group was tape recorded and the discussion transcribed verbatim. A summary of the focus group was returned to each participant for their comments. No feedback was received from any participant.

### **Client Interviews**

Individual interviews with Plunket clients were held in September and October 2006. The purpose of the client interviews was to discuss with women the experience of being asked about violence in their relationships.

Initially a random sample of up to twenty Plunket clients [one location had less than 20 potential participants] from each of the study locations with new babies born between August 2005 and October 2005 were invited to join the study by letter from the Royal New Zealand Plunket Society (see Appendix B). When there was limited response to this invitation, a further [up to] 20 letters were sent to potential participants. Plunket staff in the four locations were also asked to inform eligible women of the study and give them the researchers contact details if they were interested.

These recruitment efforts resulted in only four women agreeing to participate. These four women were informed about the study by written information sheet and verbally by the researcher (Sharon Vallant). All four interviews were held in the women's homes. Interviews were tape recorded and transcribed verbatim. Selected questions used to guide the semi-structured interview are listed below (see also Appendix C). In gathering information about perception of screening, it is likely that women with an abuse history (current or past) may react to screening differently compared to women without an abuse history. Therefore participants in this study were screened as part of the interview.

### ***Selected Interview Guideline Questions***

#### **Screening Process**

- Have you been asked about violence in your relationship by a Plunket nurse?
- What was it like to be asked questions about violence in your relationship?

#### **Intervention**

- Would you describe the process as supportive? (of being asked questions and provided with resources)
- Tell me how you felt supported? / Tell me why you didn't feel supported?

#### **Usefulness**

- Has being asked the questions and being provided information and referrals changed anything for you? Can you tell me how?

## **Record Review**

The Plunket electronic database does not allow for tracking of screening across visits, nor does it include screening "results". Therefore, a review of the *Plunket Health Record* was conducted to examine screening practice. A maximum of 50 new baby cases with dates of birth between August 2005 and October 2005 in the four selected Plunket locations were reviewed. In the one location with more than 50 new baby cases, records were randomly selected. Records were reviewed for the first eight months of life so as to include the first four core visits.

Record review was standardised using a data abstraction sheet (see Appendix D). The sheet was developed in consultation with Plunket staff to clarify the way the *Plunket Health Record* is used in practice. The data abstraction sheet was pilot tested on a small sample of records in a location not included in the study and modifications made as needed.

The researcher (Sharon Vallant) participated in the record review in all four locations, assisted by the Plunket Clinical Advisor for the area. In order to ensure consistency and accuracy in using the data abstraction sheet, both the researcher and Clinical Advisor initially reviewed the same four client records. The data abstraction sheets were moderated by the researcher and discussed before further records were reviewed.

## **Electronic Data Base**

Family violence screening variables were extracted from the national Plunket electronic database (PCIS) 2003 to 2005 in order to report the number of Plunket cases, the number of "Family Violence discussions", "FV health promotion recommendations" and "FV health promotion referrals" for the period 2003-2005. These variables were analysed by location, ethnicity and deprivation level over time and presented in an earlier report by Brenda Haynes. In the current evaluation project, family violence information in the PCIS was downloaded and matched to the new baby cases selected for record review.

## ***Data Analysis***

### **Qualitative Data Analysis**

Qualitative data gathered through focus groups and individual interviews were analysed using qualitative descriptive analysis. Descriptive analysis is used to describe, compare and classify a phenomenon<sup>21-24</sup>. It is expected that descriptions are an accurate account of the meanings participants attribute to the event.<sup>20</sup>

All transcripts were reviewed to check for accuracy prior to beginning analysis. Then, data gathered from the focus groups and individual interviews were read and re-read to gain an overall picture of the content. From this categories were identified. These categories were reviewed by the investigators in order to validate the findings; only minor changes were made at this stage.

### **Quantitative Data Analysis**

Data abstracted from the *Plunket Health Record* were entered into SPSS and merged with electronic PCIS data. The frequency of partner violence screening was calculated for each core visits and total.



## Findings

### ***Plunket Staff Focus Groups***

*"After the couple of results I've had it was like, I think we need to keep asking that". (Participant B, FG 3)*

#### **Family Violence Policy and Protocol Awareness**

Most participants were aware of the Plunket Family Violence Policy. Participants said they had been introduced to the policy at professional development days, variously referred to as *study days*, *education days*, and *workshops*. The opportunity to work in groups and practice asking the family violence screening questions during the professional training was a valuable experience, with one participant describing the day as *"enlightening"*.

Several participants also spoke of being introduced to the policy during their orientation. Participants of one group felt that awareness had also been raised by the research officer's presence and discussions over the weeks preceding the focus group meeting.

Participants were able to articulate their understanding of the Family Violence Policy, such as:

*"One is asking the question and how you ask it and why you're asking it. Two is if you see something or you're told something, the policy has a list of working out problem solving things to recognise. What it is and what action we should take. And then it also gives you ideas of where you can go for advice and the documentation of it". (Participant C, FG 2)*

Generally, participants felt implementing the Plunket Family Violence Policy was hard for them initially. They said that at first they did not have *"enough knowledge"* and had little understanding of the policy. One participant stated feeling *"overwhelmed at first with the policy"* having found it *"really hard"*.

The effectiveness of the Plunket Family Violence Policy was questioned by one participant. She asked:

*"What is Plunket achieving by asking all these questions? ... Is it a numbers game? So you ask these questions and improve family health?" (Participant F, FG 4)*

Other participants felt they were making a difference, reporting that they did follow up with clients who screened positive and that they were making referrals to other agencies as needed.

One participant acknowledged that despite being introduced to the Family Violence Policy during orientation and being aware of the need to incorporate the Policy into practice, she did not make herself familiar with it until she felt forced to:

*"I have to say that when I first came across the family violence part, I knew that I would face it and I always knew that I had a clinical leader to support me and also I could have asked anybody in the room here, but so that didn't mean that I went and looked at that policy straight away cause I didn't. And even in my orientation it was given to me and it was tucked in a corner and I sort of looked at it, too much to learn at that time. But when it happened to me, I went to my clinical leader who straight away said what does the policy say ... so she left it to me to find out and that's when I started reading it and I had to get back to her. So that was a good learning curve and also it made me look at the policy. It made me realise that if I don't have someone around on the day then I've got to know where to find that help or access that information". (Participant C, FG 2)*

## **The Process of Screening**

### ◆ When and how to screen

Participants had differing views on how and when to screen for family violence. While most participants were aware that The Policy requires them to ask the screening question in the initial history taking, one participant questioned whether the first visit was the appropriate time to ask. She felt the screening questions were intrusive:

*"First clinic contact might be a more neutral place to ask it...when you're going into a home to do a home visit they're asking you into their area and I just sort of think to go in and ask a question like that is quite an intrusive sort of thing". (Participant A, FG 3)*

Another was sure that the first visit was the right time to screen.

*"I only choose to do it on the second [visit] if I can't ask it on the first, like I want to ask that right at the beginning because they don't know me, I'm a stranger and they might open up and that's what I've been led to believe has helped". (Participant C, FG 2)*

Many participants spoke of the need to ask the screening questions on an ongoing basis as sometimes the women's relationship(s) changed over time. One participant said she screens the woman again when her baby reaches toddlerhood for this reason.

Another reason for screening on an ongoing basis was that the relationship between themselves [Plunket staff] and the client changed over time. In all four focus groups participants voiced the need to build a relationship with the client before screening or expecting a woman to disclose violence in her relationship.

*"You have to have a good relationship first, you know, to get the clients to know you and feel comfortable sharing things with you first. There will be a second and third time visit you know". (Participant A, FG 1)*

*"Do it [screen] once you've built up a bit of a rapport with them so that they sort of know you". (Participant A, FG 3)*

Participants felt the way questions were asked as well as the words themselves were important.

*"We have to find a way to ask the question". (Participant A, FG 1)*

*"I don't say 'family violence', it's the way we say it, the right words".  
(Participant B, FG 1)*

Some participant had clear strategies for the way they approached asking the screening question.

*"Because I do not want to break the relationship between me and my client. I want to let her know that I care for her, and I value her and I want her to trust me as I trust her. And I want her to know that I am there for her and I want her to feel safe with me. So to ask that question, I say to the mother, 'I have a question here that I do not really want to ask you, but because there are a lot of women out there that have been abused and murdered, and mistreated and every women, especially as a mother, you have your value...I have to ask you this question, maybe you are okay, maybe there is no violence here, but there are some mothers out there that are living in agony and all sorts of violence, and they have no chance to talk to anybody. So we start asking this question to every house we are going to, to try and see if we can help them to make a little difference, or to save them'. And I find it very successful". (Participant C, FG 1)*

*"For myself I've found that it hitches on quite nicely to the statement that I make about... what we've collected the information for and what we do with it..." (Participant A, FG 2)*

*"I suppose the standard way that I would probably approach it is to use the resource 'thriving under five book' and to me that's probably the easiest way because its sort of saying, hey its normal, its written in a book, and its covered in there...So I use that as the tool to ask the parents". (Participant C, FG 3)*

#### ◆ Assessing for family violence

It seems from the discussion that participants use assessment skills as well as screening questions to identify women and children at risk of violence. Most participants were able to describe instances of using observational skills to assess a client's situation.

*"Its an observation thing as well as asking a question thing". (Participant C, FG 3)*

*"You don't even get told, you get that pause which might cause you to ask more questions or discuss family violence in a general way really, rather than specific because maybe specific is too close". (Participant B, FG 2)*

*"Little clues, little signs, little bits of body language". (Participant B, FG 3)*

*"Some of them, you can tell by the way they look, and they look down and things like that, and we've got to catch their expressions. And when you look around the family, you've got to look at the children as well. You know, you've got to look at her", (Participant G, FG 1)*

*"They're crying there. That's the sign, they are not talking or anything, but, that's the sign that tells you there's something going on inside the family".  
(Participant A, FG 1)*

### **Influence on Practice**

When asked if the Family Violence Policy had influenced their practice as Plunket nurses, most participants felt that it had. Some felt the policy had significantly heightened their assessment skills, for others there was an increased awareness of the issue of family violence, and for some it provided guidelines that hadn't previously been in place.

*"I think sometimes you can go into a house with the father and the mother sitting there, and I can think of a scenario that I've got at the moment, where he's always there. And before I wouldn't have thought anything of it, but now every time she comes into the Clinic he's there and he's talking and I'm sort of watching now to see that she's got some interaction going too, because I sort of feel like you've got this control stuff here...I don't know whether there's any family violence or anything like that going on, but its just me being more aware I think, looking at those sort of scenarios".  
(Participant A, FG 3)*

*"And the tones of voices, sometimes if you go out of the room for something it makes you aware to listen to the tones of the voices as you've left the room. Sometimes I say I'm just going to go and wash my hands, which you do, and I listen to the tones as I'm out of the room. And I wasn't doing that before but my ears are just clicked all the time". (Participant B, FG 3)*

*"I don't want to say that we didn't bother with family violence because that's not true. We did bother with family violence of course, but it had to be more in your face before you did. And sometimes just occasionally you might see something or hear something and you had to remind yourself that you were there for the baby 'let's not get too involved in this, we're here for the baby', you know. Then the family violence policy stopped all that because it's, we suddenly had an obligation to do something about it".  
(Participant A, FG 2)*

*"Asking the questions and following the guidelines, talking to the moms and talking back to the clinical leader, maybe going back to the mum again to say that we are going to do this and actually it improves the way we practice maybe for the next client, for the next family violence case. Or maybe I should have done it this way or should have done it better next time, handle it in a better way...It actually improves the way we go and ask the same question or handle the next family violence case". (Participant B, FG 1)*

### **Implementing the Policy**

Most participants could recall encountering family violence in their practice. However, those who worked predominantly in low deprivation areas felt they were less likely to have a positive response to the family violence screening questions. In fact one participant reported

she had never had a positive response, another said that she “very rarely” got a positive response.

The Family Violence Policy involves possible Child Youth and Family referral and safety planning for women who are experiencing abuse. Discussions about intervention evidenced that there was some variation in how The Policy was being applied.

#### ◆ Safety Plans

While participants discussed the value of safety planning, no formal or uniform process was evident. The development of a safety plan between the Plunket nurse and Plunket client was generally described as a verbal act. Some nurses reported that they would document when they had discussed a safety plan with a client.

*“This is an ongoing thing of safety for her and her children...I’m making sure she’s got a plan. I’m making sure that if he turns up on the doorstep again and what ever, that this is what she would do”. (Participant E ,FG 4)*

*“It’s really a spoken thing as opposed to a written thing. Well, I mean I might document it but you know, it’s not something that you write for them. I think it’s easier to ask ‘So what do you do to keep yourself safe’...each person has their own coping mechanism and for some people having the neighbours know about it would be the last thing on earth they would want. As opposed to the other person who would jump the fences, rush over and bang on the neighbours door. So there’s a whole range of possibilities I guess...Yeah really just talking through the safety plans really. Just talking about what’s available, how they may contact somebody”. (Participant B, FG 2)*

#### ◆ Child Youth and Family Referrals

Participants recognised the importance of referring to Child Youth and Family (CYFS) and other agencies when family violence is disclosed, whether by spontaneous disclosure or in response to screening. However, for some there was a dilemma of knowing what to do. One participant talked of the process of taking action as being “huge”. She used the policy as a guideline and described the outcome as “amazing”. Again there appears to be no consistent approach by the participants as to when and how they make referrals when they encounter Family Violence

*“You say to them, ‘what do you want me to do with the information you’ve given me’, you know. They’ve unloaded it, they’ve given it to you. You have then really got to say back to them, ‘what do you want me to do?’ And I think that’s the hardest part is going from there as to what you do. And so this woman asked me to go to the police, so I went to the police straight after that, after I’d finished the visit and notified the police. And then the next day I heard that the police had been called to the home and they uplifted the mother and the children and she’d gone to Women’s Refuge from there. So I mean it’s difficult, very very difficult. And I didn’t even ask the question really. It was her disclosing to me at the time”. (Participant C, FG 3)*

*"We just talked through what she would like me to do with the information, what she wanted from all of it, how I could best help her. And we talked about services that could, would be becoming involved and the reasons why I would have to notify Child, Youth and Family and the services and what benefit it would be for her personally. We talked about her safety plan at that stage as well and I used the resources that I've got with Women's Refuge and everything.... The Mother, before I left the home, had assured me of her safety and that of the children's safety, we went through all of that. I then notified my Clinical Leader. We got Child, Youth and Family on board and I also got support through my Karitane nurse to go in. I notified the people that were involved as well." (Participant B, FG 3)*

*"Mostly what I deal with is the safety of the mother and the child. First we find out straight up whether the babies in danger and actually usually that's not the case. It's usually directed at her. It's a case of keeping her safe and the child safe. Now if there was any danger for the baby absolutely, I would refer it to CYFS. But we talking about two different things here aren't we really.... And that policy is really clear you know if you've got the guidelines and the child is in danger you refer. But in many cases the woman, the last thing in the world that she would want is for CYFS, it could actually make the situation worse I would have thought". (Participant A, FG 2)*

*"I found that if the family violence has escalated over a period of time, and it started off as something that was an indicator, then you have to look at writing notes, a CYFS referral. But it's actually for your information. Just letting them know the picture that there's been a bit of family violence in the last few weeks and you list what's happening. And then you look at the protective factors that are happening in that family, whether the mother has removed herself from the partner or the partners not there at the moment. She's got an order out to keep him away...CYFS might see that and think that's good, we'll leave that for the moment unless we get something else from the neighbour". (Participant C, FG 2)*

## **Documentation**

Participants described how they use the *Plunket Health Record* to document family violence screening and discussions. The Family Violence screening space under *Family Health Determinants* was used to note the date of screening and some reported using the space to note the response to screening. Descriptions of observations and discussions were reported to be documented in the *Process Recording* sections of the *Plunket Health Record*.

*"But what I normally do is, if it's a Yes, I write a 'yes' but I go back to the page with the lines and I'll write the story there". (Participant B, FG 1)*

*"I just ask the question and put the dates down there, but if there's any family violence then we write it on the other side". (Participant D, FG 1)*

*"I write 'positive' sometimes because it might come out half way through my talk and I've written it down. I don't write things down in words in front of them, I might add it to... there's quite a picture showing, they're telling me a little bit more about what happened in their family, and why it happened. So I just listen and write it down later and put 'positive' at the front". (Participant C, FG 2)*

*"Sometimes I put feeling safe or whatever, depending on what the answer was". (Participant B, FG 3)*

No standardized approach to documenting family violence discussions emerged across the focus groups. Of significance was the reference by some participants to the use of separate documentation. Some participants spoke of using separate documentation and withholding information because they felt not to do so made it unsafe for the client. One participant felt seeing documentation of violence might prompt the partner to give the woman or the Plunket staff member "a hiding". (Participant F, FG 4)

Only one participant talked about documenting family violence screening and discussions in POND [electronic database]. This participant was clear that she documented in POND every time she screened or had a discussion about family violence.

*"If I've asked a [family violence] question that would be signed and dotted [in POND<sup>a</sup>] that I asked the family violence question. Anything to do with family violence I dot it [in POND], put it there and then if they were telling me about it I'd write it and still put a dot [in POND]". (Participant C, FG 2)*

## **Barriers to Screening**

Discussion in the focus groups indicated that most participants were putting the Family Violence Policy into practice however participants identified several barriers to implementing The Policy, in particular barriers to asking the screening questions.

### **◆ Lack of Privacy**

Lack of privacy to ask screening questions or to have discussions about violence was the predominant barrier to implementing the Family Violence Policy raised by the participants. While lack of privacy was identified as a problem during home visiting as well as on clinic visits. Participants working in both urban and rural communities felt that the presence of others at the time of a home visit was a major barrier for them.

*"I find that a lot of rural families, Dad's always there when you visit, cause they're farmers, they're in a large part of the day or they come in because you're coming as well and they're sort of part of the family thing so I find that you can't approach it then and so its quite difficult". (Participant C, FG 3)*

*"Some people are never, ever on their own, so you can't ever have family violence discussions" (Participant E, FG 4)*

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<sup>a</sup> POND is the Plunket On-Line National Database. The data is then reported through the Plunket electronic database (PCIS)

*"But if they come to the clinic, and there are a lot of people waiting outside, then you can't. We need a safe gap of time for each one".  
(Participant D, FG 1)*

#### ◆ Fear

Fear of repercussions from questioning women about violence in their relationships appears to be a prominent barrier to screening. Participants from the three locations that had predominantly higher deprivation scores reported feeling scared for their own safety and for the safety of their clients.

*"And sometimes it's, it's immediately after you've asked it, maybe the woman's busy talking to her baby or holding her baby or something and you're talking, then she goes rock still. Ooh! It's a bit scary and then she might just carry on talking again but that might be an indication that you know, things aren't right". (Participant A, FG 2)*

*"It's also scary too, because The Policy said that you have to tell them first that you are going to talk to someone about it and that is the hardest part I realise. But that is the policy and you know that is what I said earlier. It's like a demand for you. Even though you're scared to tell them, because that is the end of your relationship with them. And I find it very very hard and scary. Luckily you get out of the house before something happens to you".  
(Participant C, FG 1)*

Going into situations [home visiting] without enough information leaves Plunket staff not knowing what to expect. Participants felt that this is a particular problem when clients 'transfer in' to the area, as staff have no access to documentation until they find the family and request the Plunket Health Record (PHR). Going to visit families without enough information was identified as an increasingly frequent problem with referrals from midwives and other health professionals.

*"It's also the communication between the people, the health professionals and the agencies. If they're not letting you know that these things are happening, you are walking in very vulnerable at times". (Participant A, FG 3)*

Fear of asking women the screening questions because of a lack of confidence and inexperience (ie. when the policy was first introduced or when they first practiced as Plunket nurses) was expressed by many of the participants.

*"And I think probably 90% of us were saying I can't ask that question. I just can't do that. And I was certainly one of them, I thought I can't ask, I cannot walk into somebody's house and ask them that question".  
(Participant A FG 2)*

*"I found it very difficult to ask the questions with enough confidence and for me I had to actually go out and practice it and ask people, other staff, how they did it. I think it was because I wanted to get it right and get it so that it was effective and would work. You know I didn't want to actually pussyfoot around it. I wanted to actually have the right tools for it. And it*



*has become easier as I do it. But I mean the first few times when I was asking it on my own, I felt very uncomfortable". (Participant C, FG 2)*

*"I feel very uncomfortable asking it and always have". (Participant A, FG 3)*

One participant disclosed that when the policy was first introduced, a group of staff members devised ways to ask the question that prevented the possibility of getting an answer.

*"And I think also at first several of us worked out some rather interesting ways of asking it but not asking it [laughter] or asking it without being in the position where you might get an answer". (Participant A, FG 2)*

#### ◆ Lack of Time

Lack of time was identified as a barrier to screening. Participants felt that the number of questions they need to ask along with the limited time they have with each family means they need to prioritise their care and this sometimes results in not screening. Others felt that *"it was not worth asking"* the screening questions because then the woman may disclose and that requires time and attention.

*"Time that I don't have. All this stuff comes out" (Participant D, FG 4)*

*"When you're really busy with your work you just go through all these questions and then suddenly you just have to weigh the baby and do other stuff and then you forget that you haven't finished doing the whole book, documentation .... and 'oh my gosh, I haven't done this thing". (Participant D, FG 1)*

*"Time, nursing time. You know if you've gone to a case where there's an issue with the family. There's a problem with the baby or Mum's got something that's a higher priority, that [screening] sometimes just doesn't get done on a first visit and then I think that the question can be overlooked quite easily because of that, because you're dealing with other things at the time that are probably more a priority for the family". (Participant C, FG 3)*

#### ◆ Challenging Family Violence as a 'Norm'

Another barrier to screening for family violence was the clients' understanding or perception of violence. Some participants feel that a number of clients living in violent relationships consider their situations as 'normal'.

*"You know, what you decide is family violence and what the people that are living in the situation might think it is, are two different things too". (Participant A, FG 2)*

*"I don't think that many women know that emotional abuse is another form of family violence". (Participant G, FG 1)*

Participants of one focus group, who were themselves from a variety of different ethnic groups, agreed that culture played a part in clients' understanding of what constitutes family violence.

*"Hitting is a part of their culture and that is what they believe in. No one can tell them 'No!'" (Participant C, FG 1)*

*"Or to talk with them if they are yelling at the kids .... If the kid is doing something and she said you wait until the nurse has gone you're going to get it. You're going to get it. And you can't talk to her Tongan mother because that is what they believe. They have to punish them so that they can be good when they grow older". (Participant C, FG 1)*

*"I think that's the same as in the Samoan culture too. Disagreeing like that is the same. And not only that but a husband and a wife, they always see that the man is the head of the family and everybody should respect him and obey, whatever he says goes". (Participant D, FG 1)*

For some participants it was their own cultural beliefs that created a barrier to understanding what constitutes Family Violence.

*"Its not easy because of the different culture...I didn't know the difference between family violence and like a broken relationship. And I do not know whether to classify this as a family violence or this is a conflict in the family". (Participant C, FG 1)*

*"Because we are in a different culture and if I saw an Indian family or Samoan family because I didn't know much about their culture, so I have to make sure that I understand what I'm going to say by following the policy. Because there are some families, living together like brothers and sisters. In our custom it's no good talking about something while the brothers and sisters are together, but I don't know about the other cultures". (Participant E, FG 1)*

#### ◆ **Client Demeanour**

The attitude or demeanour of the woman can influence Plunket staff decisions about whether to screen or raise discussion about Family Violence. Participants identified both verbal and non verbal cues that indicated the woman's receptiveness to discussing violence in her relationship.

*"...the demeanour of the women herself. Perhaps it just isn't appropriate and you kind of know it. You think ahhh. She might be answering other questions very defensively say, and doesn't really want to divulge a lot about anything even a phone number or her address. And you kind of get the impression that that's probably not a particularly good question to chuck in there right now. So you might leave it till the next time". (Participant A, FG 2)*

*"Because they feel uncomfortable talking about it, so when they're confronted with that question, they'll either tell you truthfully or it's not the right time for them". (Participant F, FG 1)*

In addition some participants noted that the woman's' shame was a barrier to women disclosing violence.

*"Shame is a big thing". (Participant C, FG 4)*

*"It's a biggie...". (Participant E, FG 4)*

#### ◆ Client Fear of Reporting

In one location (but not the other three) participants reported that the clients' perception of Plunket as a government agency with a duty to report was a barrier to effective screening.

*"Most families too, they're not really receptive to Plunket, they see Plunket as more to do with CYFS and the Police" (Participant F, FG 1)*

*"They're scared. They are scared that we will report, that we will refer them to somewhere. And sometimes they don't talk, just yes, no. They don't explain things to you". (Participant C, FG 1)*

#### ◆ Media

Of note was the impact that the recent Kahui twin murders and subsequent media exposure had on the way Plunket staff were received when screening. In most of the locations, participants discussed the positive aspects of the high profile of family violence in the media in response to the Kahui twin murders. They felt that this enhanced their ability to have discussions about family violence with clients.

*"When it's just happened in the media, that high profile is a good opportunity to re visit it again with your client because they are thinking about it. They have seen it on the news and it's another chance for them to talk about it if they want to. And you've brought it up because of the news, because of the high public [profile]". (Participant C, FG 2)*

*"After the Kahui twins it became a lot easier to talk about what it means to be advocate for children... After the Kahui twins,[it] was real easy to talk to people". (Participant A, FG 2)*

However in one study location the media interest in the Kahui twin murders was seen as having a negative impact on implementing the family violence policy.

*"I have been noticing after the Kahui twins, it's a little bit hard. They look at us as pokey noses [laughing]". (Participant B, FG 1)*

### **Enablers to Screening**

#### ◆ Gaining Privacy

Strategies for overcoming barriers to screening and discussing violence with clients usually involved manoeuvring the situation to gain privacy or to get information to the woman without others seeing. One participant spoke of taking the mother out to the car under the

guise of offering her a choice of booties for the baby; another used the strategy of taking the woman off to the garden to ask gardening questions.

*"And if you're really concerned, you know that there's something going on, and the mother is giving you gestures and you can't ask that question, you can help her. You can say if you could help me with my bag outside, I have got this pamphlet I have to give you, its in the car, can you come with me. My preceptor told me that and it works". (Participant B, FG 1)*

*"But if I know that the timing's not right, I usually invite them to clinic or meet with them at another place where its comfortable for them, or leave like, I'll write little notes and sort of turn around if we can't speak while there's family members present and there's quite a few times when I've done that". (Participant F, FG 1)*

*"You're carrying those family violence cards. Little cards with all the refuge numbers and other numbers, you just sneak it in the book, just open the book and she can have a look and slide it there, close the book and give to her". (Participant C, FG 1)*

#### ◆ **Building a relationship/ trust**

Participants recognised that for some clients there is a need to allow time to build a relationship and gain trust before they will disclose violence in their relationships. Having the opportunity to develop a relationship with the client over time was seen as an enabler to implementing the family violence policy.

*"It can take a long time and the worse one that I came across, it took a whole year for a Mum to actually disclose it to me. You know and then ... yeah and then she really did disclose it to me". (Participant B, FG 2)*

*"I don't know but with the ones that I've had ... they've reported it in a fairly low key way. They're happy for me to know about it but they don't want me to be jumping up and down and doing anything about it just yet. They don't really know me yet. I think they've got to get to know me". (Participant A, FG 2)*

*"They don't usually come straight out and say 'No, there's family violence going on'. It's once the rapport gets going with the Mum that more is revealed in your assessment I think". (Participant B, FG 3)*

#### ◆ **Unique Plunket Role**

Some participants felt that Plunket had a number of unique and positive qualities that not only enabled the implementation of the Plunket Family Violence Policy but ensured that staff were in a good position to support women and children. Home visiting as a unique service that the Plunket nurse can offer was identified specifically as an enabler.

*"But the uniqueness of being in somebody's home gives you the courage to help". (Participant B, FG 2)*

*"Well I see the Plunket Nurse as the coal face. We are the few professional people who actually go into peoples houses we may only ever be given the opportunity to go in once ...we're in their home, we're sitting at their dining table, we're in a much more personal situation than the nurse at the doctors...we've broken down a few barriers by just being there". (Participant B, FG 2)*

The implementation of the Plunket family violence policy was challenging for many of the participants in this study when they were first introduced to it, but they had all incorporated it into their practice in individual ways. Most participants demonstrated confidence in their understanding of The Policy and many were able to share sentinel experiences where women had freely disclosed abuse and appropriate action had been taken.

The multiple barriers to screening and intervening means that Plunket staff have to come up with creative ways to screen and support women and their families. Their individual approaches to practice reflected the nature of community nursing. Most importantly the participants of this study appeared to be committed to promoting and protecting the safety of their clients.

## ***Plunket Client interviews***

### **The Process of Screening**

Plunket clients who volunteered to participate in this study were asked if they had ever been questioned about violence in their relationships by a Plunket nurse. Three of the four participants initially said 'no', they had not been. However, when it was explained that phrases such as "emotionally unsafe" and "physically unsafe" may have been used, two of the participants felt sure that they had been screened for family violence by their Plunket nurse.

*"Yes, now that you've said unsafe, I do vaguely remember a question something about unsafe". (Participant Z)*

One of the participants that had been unaware of being screened for family violence stated that she didn't understand what was being asked of her when she was questioned. She described feeling "*confused about what it meant*" (Participant Z).

*"For me personally if they'd explained to me that it's part of what their job is, and then asked me, then I would have understood it instead of having to ask what do you mean". (Participant Z)*

The three women that had been screened said that it felt okay to be asked about violence in their relationships. Two were clear that they had not been "offended" by being asked the screening questions.

*"I wasn't offended by it. It was ok". (Participant W)*

*"I wasn't offended. Yeah I certainly wasn't offended". (Participant X)*

For one participant "*feeling comfortable*" (Participant X) with the Plunket nurse was an important factor that impacted positively on how she felt about being asked the family violence screening questions.

When asked if screening for family violence was something that Plunket nurses should do, the women said they felt it was.

*"I do because it's one of the things that affect the mother and the children". (Participant X)*

*"I can understand the logic behind why it would be asked and ultimately they're here to protect help protect the child. I'm assuming that helping protect the mother helps the child". (Participant Z)*

While one participant agreed that screening for family violence was something that Plunket nurses should do, she questioned whether women would answer truthfully.

*"But then I'm not quite sure whether a mother would answer truthfully anyway". (Participant X)*

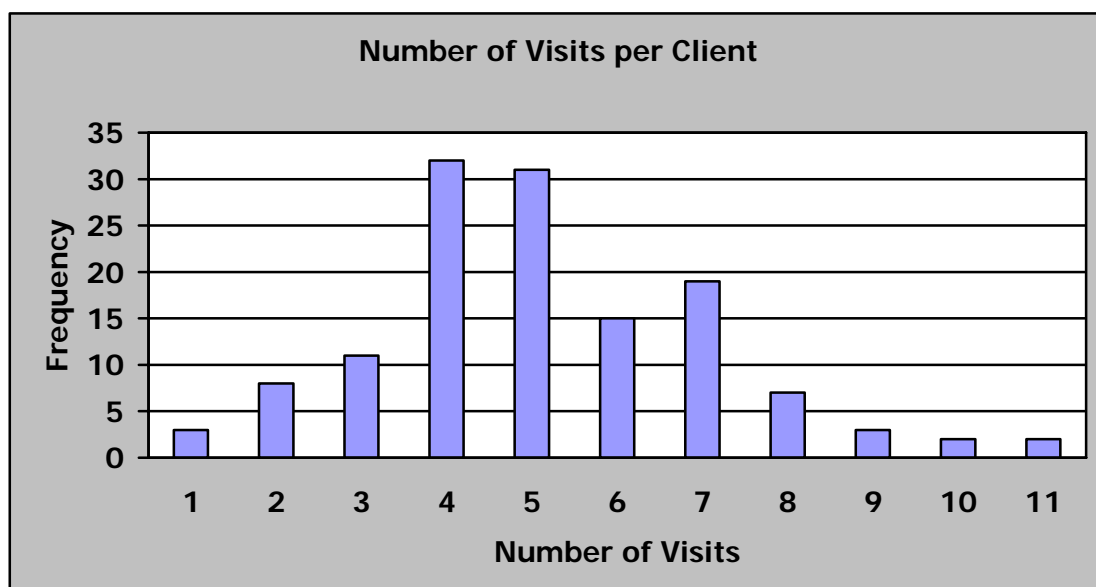
Interestingly one client who chose not to disclose violence in her relationship when screened by the Plunket nurse, but disclosed to the researcher, still believed that Plunket nurses should screen for family violence. She felt a woman should be given the opportunity to *"talk to the Plunket nurse"* if she needed to (Participant W).

The women interviewed felt it was important that Plunket nurses screen for family violence. They found it acceptable to be asked the questions about violence in their relationships. There was evidence however that the way the women are asked the screening questions is important for clarity and understanding on their part.

## **Record Review**

### **Total Visits**

A total of 133 Plunket Health Records (PHRs) were reviewed; 16, 27, 40 and 50 per location. Six hundred eighty-three visits were recorded for the 133 clients in the 8 month period of the study. The minimum number of visits per client was one and the maximum was 11 (mean = 5 visits per client; see figure below).



For the 133 clients, many (35%) did not have a first core visit (see table below).

	Number of clients	%
First core visit (2-5 weeks)	87	65.4%
Second core visit (6-9 weeks)	120	90.2%
Third core visit (10-15 weeks)	117	88%
Fourth core visit (4-7 months)	119	89.5%

### Screening Rates

There was evidence of being screened for family violence in 85 (63.9%) of the 133 records reviewed. This includes those with either a date (n=63) or comment (n=22) indicative of family violence screening recorded in the Plunket Health Record (PHR). No documentation evidenced screening on more than one occasion. Plunket location was the sole client demographic/history variable statistically associated with screening rate. Screening rate by location varied from a low of 30% to a high of 80% (p<.001).

Among those with first core visits, there was evidence of family violence screening in 64% (see table below). The rate of screening decreased with subsequent visits. The occurrence of screening at the second core visit was 18% among all clients, and 30% among clients who had not been screening previously (during the first core visit). No family violence screening was documented beyond the second additional visit.

### Frequency and Method of Screening Documentation

Visit (N)	Core visit 1 (87)	Core visit 2 (120)	Core visit 3 (117)	Core visit 4 (119)	Additional visit 1 (105)	Additional visit 2 (58)
Date	33	19	3	1	5	2
Comment	23	2	0	1	0	0
Total	56	21	3	2	5	2
Screened	64%	18%	3%	2%	5%	3%

Twenty seven comments were found in the family violence section of the PHR. The most frequently recorded comments included "nil" (n=23), "others present" (friend/partner/family; n=11), "not appropriate" (n=11) and "nil of note" (n=4). Other comments noted in one or two charts included: "no", "no concerns", "safe", "no opportunity", among others. While some of the comments can be interpreted as providing a rationale for why screening was not done ("others present"), in other instances such as "nil", it is not clear whether the screen was done or whether the screen was done and no family violence was disclosed.

### Family Violence Discussions

Discussions (indicating a positive screen) about family violence were infrequently recorded in the *process recording* section of the Plunket Health Record. Only 8 of the 133 PHRs reviewed

had documented evidence (a written comment) of a discussion on family violence. These family violence discussions were with 8 different clients.

**Safety Plans**

There was documented evidence of a safety plan having been discussed with the client in one of the 133 PHRs reviewed.

**Referrals and Recommendations**

Referrals and recommendations made by Plunket staff are recorded in the PHR in a manner that made it difficult to ascertain whether the referral/ recommendation was related to family violence. Therefore these have not been included in the report.

**PCIS Data**

Plunket staff record contact data on the Plunket electronic data base (PCIS), this includes data that relates to 'Family Violence Discussions' and 'Child Abuse'. This data is recorded as 'Care Delivery', 'Referral' and 'Health Promotion'.

'Care Delivery' documented as a Family Violence Discussion include screening and interventions. The following table shows the 'Care Delivery', Referral' and Health Promotion' contacts that relate to Family Violence (code 39) and/or Child Abuse (code 34) for the 133 clients included in the record review.

	Care Delivery Family Violence Discussions	Referral	Health Promotion
Core Visit 1	39	1	
Core Visit 2	24		
Core Visit 3	5	1	1
Core Visit 4	7	1	1
Additional Visit 1	15		2
Additional Visit 2	2		
Additional Visit 3	2		
Total number of women	70	3	4

Seventeen clients had more than one Family Violence and/or Child Abuse Care Delivery contact recorded during the 8 months of the study. A total of 70 clients had one or more Family Violence and/or Child abuse Care Delivery contacts recorded.



## DISCUSSION

### *The Process of Screening*

The Plunket staff participants in this study were aware of the Plunket Family Violence Policy/Protocol, and most were able to describe it. Generally these descriptions included detail of the screening process, with no specific reference given to 'safety plans' or 'referrals and recommendations'. There was initial anxiety and apprehension at the introduction of The Policy. Plunket staff were especially anxious about asking clients the screening questions until they had gained experience at it and gained confidence in their ability to ask women about violence in their relationships.

Plunket staff were aware that The Policy required them to screen for family violence during the initial history taking at the first core visit (2-5 weeks). Generally the staff thought this was the right time to screen. At the same time however, record review indicated that 36% of women were not screened for family violence at the first core visit. It would seem that if women were not screened at the first core visit the likelihood of them being screened decreased with subsequent visits. Variation in screening rate by location demonstrates the need for a systems approach to policy implementation.

Many of the Plunket staff interviewed discussed the need for ongoing screening because of the changing nature of relationships between women and their partners over time, they also felt some women needed to build a relationship with them (the Plunket nurse) before they would disclose violence. Nevertheless there was no documented evidence that Plunket nurses are screening for family violence in an ongoing manner. The lack of documentation of subsequent screens may. However, reflect the nature of The Policy and the format of the Plunket Health Record which has space for only one date.

Some Plunket staff participants raised the fear that the act of intervening, and to a lesser extent screening, put the relationship between Plunket nurse and Plunket client at risk. Both Plunket staff participants and Plunket client participants spoke about the importance of their relationship in enhancing family violence discussions.

Plunket staff were aware that the way they asked the family violence screening questions was important. They were able to describe different approaches to asking the screening questions that ensured using the 'right words' or the 'right timing'. Their discussion about approaching women and asking about violence in their relationships indicated that many still felt ill at ease using the screening question. The fact that two of the four Plunket clients interviewed didn't realise that they had been asked about violence in their relationships after being screened by a Plunket nurse indicated that some staff may not be asking the screening questions in an effective manner. Added to this is the fact that only eight of the 133 charts reviewed indicated that there had been a positive response to family violence screening, indicating a lower than expected incidence rate.

Plunket staff were themselves adamant that the Family Violence Screening Policy had influenced their practice in a positive manner. The introduction of The Policy had made them engage with family violence in a way that they hadn't previously. They were also aware that their assessment skills with regard to identifying risk factors for violence in relationships and families had been enhanced. Plunket staff put a strong emphasis on using assessment skills

as well as asking the screening question to identify women and children at risk of violence. This emphasis on 'assessing' for indicators of violence may be a reason for the gaps seen in the documentation of screening for family violence.

The focus group discussions highlighted the barriers to implementing the family violence screening. These included a lack of privacy, lack of time, fear and perceptions of violence. These barriers were not unexpected as they reflect findings of previous research. What the Plunket staff were clear about was that they had developed strategies to overcome some of the barriers. Plunket staff described numerous tactics they had developed in order to be able to speak with a woman privately in order to ascertain her safety. The unique service that Plunket offers to women and the ability of Plunket staff to build relationships with their clients were identified as enablers to implementing the Plunket Family Violence Policy.

### ***Strengths and Limitations***

A strength of this study was the range of data sources. These included Plunket staff, written and electronic data and several Plunket clients. This range of data provided insight into how the Plunket Family violence Policy and Protocol was implemented.

There were several limitations to the study. First and foremost, only four Plunket clients came forward to share their perspectives about family violence screening. This data should not be considered representative of other clients. The social stigma associated with family violence may have led to the poor response to the letter of invitation (see Appendix B).

A limitation to the focus group related to the risk that participants may have reported what 'should' be done rather than what was actually done. Additionally, while it was important that Plunket managers were not involved in the focus groups, the consequence of this was that their experiences and opinions about implementing the Family Violence Policy and Protocol were not heard.

### ***Implications***

It was evident from both record review and focus group discussions that there was not a consistent approach to conducting and documenting family violence discussions. What was apparent was that many of the Plunket staff interviewed had stories to tell that demonstrated their awareness of family violence and in their practice they had developed strategies for supporting women and children.

*"We just talked through what she would like me to do with the information. What she wanted...how I could best help her. And we talked about services that would become involved and the reasons why... and what benefit it would be for her personally. We talked about her safety plan at that stage as well and I used the resources that I've got from Women's Refuge and everything...the Mother, before I left the home, had assured me of her safety and that of the children's safety, we went through all of that. I then notified my Clinical Leader. We got Child, Youth and Family on board and I also got support through my Karitane nurse to go in." (Participant B, FG 3)*

Significant challenges lie ahead in continuing to build the capacity and quality of the Plunket response to family violence. Actions have already begun as a result of this collaborative evaluation project. For example, a new policy has been drafted that advocates partner violence screening at each core contact visit, states that all Plunket staff have a responsibility in pursuing safety and well being of children and families, and integrates partner abuse and child protection. New client education materials and investigating documentation improvements are also on the agenda. To consider the policy 'done' would be a mistake, but ongoing efforts in training, policy development, collaboration and staff support bode well for the future.



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## **APPENDIX A. Focus Group Guide**

### **Plunket Family Violence Evaluation Project-** **Focus Group guide**

#### Screening Programme:

- Can you tell me how you came to know about the family violence policy?
- What is your understanding of the policy?
  - Can you describe the policy/programme?
  - Have you discussed the policy as a team?
- Can you tell me how the policy is or is not implemented in this area?
- Thinking about your experiences working for Plunket, has the Policy influenced your practice?
  - Can you tell me about your experiences (of screening for family violence)?
  - Has the Policy influenced the way you respond to women and children?
  - In what ways?
  - Have you asked clients about violence in their relationship as a Plunket nurse?
  - What was it like to ask the questions?
  - Did asking the questions feel safe to you?
  - Were clients offended by you asking the questions?
  - How did you feel after the interaction?
- As you know, we looked at a random sample of PHR. Can you tell me about the process of documenting screening and actions taken.
  - Often times we would see 'nil' on the screening line. Can you tell me what that means?
  - Out of 50 PHRs, there was one that indicated a positive family violence screen. How would you interpret this? A reflection of practice?

#### Barriers

- Are there things that get in the way of asking about family violence in practice?
  - Are there particular issues when home visiting?
  - We know from research that one in three women have experienced partner abuse, this would hold true for Plunket staff as well. How might this impact implementation of the policy in practice?
  - Are there any cultural issues?

#### Overcoming barriers (enablers):

- You have talked about some things that get in the way of talking about family violence, have any of you found ways to overcome any of these barriers ?

- What might be some things to overcome these barriers?
- What needs to be in place to overcome these barriers?
- What would it (does) it take for a family violence programme to be successful?

### Closing

- Have you got any other suggestions for how family violence intervention could be more effective?
- In getting back to the MOH, what would you want to say?
- What haven't we talked about that you think is important?
- Any questions?

### THANK YOU

- Review resources, make referrals.
  - Domestic Violence Centre 24/7 crisis line 303 3939
  - South Auckland Family Violence Prevention Network (M-F 8.30–4) 263 6841

We would also like to talk with a sample of plunket clients about this issue of addressing family violence in their care. We posted letters of invitation as a first step. Would you be willing to talk with any of your clients and ask if they would be willing to have a chat with us about their opinions and experiences about incorporating family violence assessment in well child care?



## APPENDIX B. Client Letter of Invitation

Dear

The Royal New Zealand Plunket Society has joined with AUT University to conduct an evaluation to gather information about recent changes in Plunket family assessment procedures. These procedures address the safety and well being of children and families. All mothers of babies born between August 2005 and October 2005 in four selected locations in Aotearoa/New Zealand have been selected to participate in this evaluation. You have received this letter because your baby was born between April and June and you live in one of the selected locations.

We are inviting women to share with us their perception of Plunket family assessment promoting child safety and well being during an individual interview. We expect interviews to last 20 to 30 minutes. It is your choice whether to participate or not, however we do want to hear from as many women as possible. Whatever choice you make about joining the study, the service you receive from Plunket will not be affected. If you would be willing to hear more about the study, please contact Sharon Vallant the Research officer, within 10 days. Sharon can be contacted by telephone toll free 0508 AUT WISE (0508 288 9473) or email ([sharon.vallant@aut.ac.nz](mailto:sharon.vallant@aut.ac.nz)). She can discuss with you what is involved, as well as post a participant information sheet to you.

Yours sincerely,

Brenda Hynes  
National Clinical Advisor (Nursing)  
Royal New Zealand Plunket Society

**APPENDIX C. Client Interview Guide**  
**Plunket Family Violence Evaluation Project-**  
**Client Interview guide**

**SECTION I – SCREENING PROCESS**

- Have you been asked about violence in your relationship by a Plunket nurse?
- What was it like to be asked questions about violence in your relationship?
- How did you *feel* when you were asked the questions?
- Did being asked the questions feel safe to you?
- Asking the questions might be offensive to some. Was that the case for you?
- How did you feel after the interview?
- Because we know that women will feel differently about being asked these questions depending on whether they have experienced violence in their relationships or not, I would like to you if there have been any times when you have been hurt by or felt afraid of your partner or someone close to you?

**NOT SCREENED / NEGATIVE SCREEN**

- Do you think that screening for family violence (asking questions about violence in womens relationships) is something that Plunket nurses should be doing?
- If so, when would be a good time to have this discussion?
- Are there any questions you think I should have asked that I didn't?
- Do you have any questions you would like to ask me?

Koha \$20  
Petrol Voucher

Address for posting:

**SECTION 2 - INTERVENTION**

- Would you describe the *process* as supportive? (of being asked questions and provided with resources )
  - Tell me how you felt supported / Tell me why you didn't feel supported
- What information did the nurse provide you with?

- What information was most meaningful to you?
- Were there any questions that the nurse should have asked you that she did not?

**SECTION 3 - USEFULLNESS**

- Has being asked the questions and being provided information and referrals changed anything for you? Can you tell me how?
- Has it changed anything for your children?
  - Can you tell me how?
- Has the process improved your safety?
  - Can you tell me how?

**SECTION 4 – CLOSING**

- For some women , the process could result in increased danger from their partner. Did this happen for you?
  - What made it unsafe?
- Are there any questions you think I should have asked that I didn't?
- Do you have any questions you would like to ask me?

**THANK YOU**

- Review resources, make referrals.  
 Domestic Violence Centre 24/7 crisis line 303 3939  
 South Auckland Family Violence Prevention Network (M-F 8.30–4) 263 6841
- Koha\$20 Petrol Voucher  Address for posting:

THAT'S ALL, THANK YOU AGAIN.

Label tape with date, study id code number, interviewer name.

Interviewer comments/thoughts/concerns (use back page as needed):

## APPENDIX D. Record Review Form



***STUDY ID*** \_\_\_\_\_

Location:	NG	ME	HW	CC
Date of Audit:	Auditor: SV BH AJ			

0

Audit stop date (baby DOB + 8 months): \_\_\_\_\_

### ***CORE CONTACT DATA***

### **CORE VISITS**

	Age	Date	Place 1 = Home 2 = Clinic 3 = Phone	Designation 1=RN 2=PN	Screening 0 = NO 1 = YES	Recommendation 0 = NO 1 = YES	Referral 0 = NO 1 = YES	Health need 0 = Unknown 1 = Low 2 = Medium 3 = High
	2-5 wks							
	6-9 wks							
	10-15 wks							
	4-7 months							

***ADDITIONAL CONTACT SUMMARY***

**ADDITIONAL VISITS**

Date	Age	Place 1 = Home 2 = Clinic 3 = Phone 4 = Group 5 = Family centre	Screening 0 = NO 1 = YES	Recommendation made 0 = NO 1 = YES	Referral made 0 = NO 1 = YES	Health need 0 = Unknown 1 = Low 2 = Medium 3 = High

1.1 Deprivation Level (at current address) \_\_\_\_\_

1.2 Ethnicity of child: 1 \_\_\_\_\_ 2 \_\_\_\_\_ 3 \_\_\_\_\_

- |                     |                         |                                |
|---------------------|-------------------------|--------------------------------|
| 1 European          | 9 Niuean                | 17 Other Asian                 |
| 2 European/Pakeha   | 10 Tokelauan            | 18 Middle Eastern              |
| 3 Other European    | 11 Fijian               | 19 Latin American/<br>Hispanic |
| 4 NZ Maori          | 12 Other Pacific Island | 20 African                     |
| 5 Pacific Island    | 13 Asian                | 21 Other                       |
| 6 Samoan            | 14 South East Asian     |                                |
| 7 Cook Island Maori | 15 Chinese              |                                |
| 8 Tongan            | 16 Indian               |                                |

## 2.0 HEALTH HISTORY: Child Health Determinants

2.1. Gestational Age at birth

- 0 < 32 weeks  
1 32-37 weeks  
2 38-42 weeks  
9 Not stated

2.2. Discharge (from LMC) Feeding status

- 0 Breast Exclusive  
1 Breast Fully  
2 Breast Partial  
3 Artificial  
9 Not stated

## 3.0 HEALTH HISTORY: Maternal Health Determinants

3.1 Birth

- 0 Normal  
1 C-Section  
9 Not stated

3.2 Antenatal and parenting education

- 0 No  
1 Yes  
9 Not stated

3.3 Previous postnatal depression

- 0 No  
1 Yes  
9 Not stated

3.4 Pre birth problems during this pregnancy

- 0 No 9 Not stated  
1 Yes Describe \_\_\_\_\_

## 4.0 HEALTH HISTORY: Family Health Determinants

4.1 Mothers DOB \_\_\_\_\_ (or age \_\_\_\_\_)

4.2 Mother requires interpreter

- 0 NO  
1 YES  
9 Not stated

4.3 Mother in paid employment

- 0 NO  
1 YES  
9 Not stated

4.4 Father in paid employment

- 0 NO  
1 YES

- 9 Not stated
- 4.5 Living arrangement
  - 0 Lives with partner/spouse
  - 1 Lives with family/friends
  - 2 Lives alone with children
  - 9 Not stated
- 4.6 Number of siblings \_\_\_\_\_
- 4.7 FV Screen Date 1\_\_\_\_\_ Date 2\_\_\_\_\_
- 4.8 Change of address since first visit
  - 0 none
  - 1 one
  - 2 two
  - 3 three or more

***PROCESS RECORDING***  
**CORE VISITS**

			ACTION TAKEN:				
	Date	Screening 0 = NO 1 = YES	Safety Plan 0 = No 1 = Yes	Recommen dation 0 = NO 1 = YES	Recommendation made	Referral 0 = NO 1 = YES	Referral made
2-5 wks							
6-9 wks							
10-15 wks							
4-7 months							



***PROCESS RECORDING***

**ADDITIONAL VISITS**

		ACTION TAKEN:				
Date	Age	Screening 0 = NO 1 = YES	Recommendatio n 0 = NO 1 = YES	Recommendation made	Referral 0 = NO 1 = YES	Referral made

