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Assisting patients experiencing family violence: A survey of training levels, perceived knowledge, and confidence of clinical staff in a large metropolitan hospital

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Abstract

Objectives: Family violence is a public health issue. It occurs in many forms, is most commonly directed at woman and children, and contributes significantly to death, disability, and illness. This study was conducted in the clinical staff in a large metropolitan hospital and aimed to determine levels of family violence training, self-perceived knowledge and confidence, specific clinical skills, and barriers to working effectively in the area.

Methods: A short, targeted online survey was designed to capture the required information. Descriptive statistics were calculated, and free-text responses were analyzed using qualitative content analysis.

Results: Survey responses were received from 534 staff (242 nurses, 225 allied health, 67 medical). Sixty-five percent had received some form of family violence training, mostly of short duration (1–3 h); 72% reported having little or no confidence working in the area, while 76% indicated that they had little or no knowledge in the area. Longer duration training was associated with an increase in knowledge and confidence ratings. Family violence screening rates and knowledge of several specific family violence clinical skills (how to appropriately ask clients about family violence and family violence risk factors) were also low. Thirty-four percent indicated that they did not know what to do, when a patient disclosed experiencing family violence. The most commonly indicated barriers to working effectively in this area were suspected perpetrators being present, perceived reluctance of patients/clients to disclose when asked, and time limitations.

Conclusion: This research provides a useful snapshot of clinical staff perceptions of their family violence skill levels in a large metropolitan Australian tertiary hospital. It highlights the need for further in-depth training in clinical health professionals in family violence. The research will allow for family violence training to be tailored to the needs of the professional discipline and clinical area.

Keywords

allied health, domestic violence, family violence, health service, hospital, medical, nursing

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Introduction

Family and domestic violence is a significant public health issue for many countries and communities around the world.[1] Family violence occurs in multiple forms, including physical, emotional, psychological, sexual, and financial abuse. Women and children are most prominently the recipients of family violence directed abuse; however, family violence can be perpetrated against a person of any gender and sexual orientation, and occurs across the life span.[2,3] In Australia, rates of family violence are high. One-quarter of Australian women have experienced physical or sexual violence perpetrated by an intimate partner.[4] One-quarter have also experienced emotional abuse by an intimate partner.[5] Neck and head injuries accounted for almost two-thirds of hospitalizations of women due to partner or spousal assault, with 7% resulting in brain injuries.[6] This conveys a significant public health problem. In the 15- to 44-year-age group for females, intimate partner violence contributes more strongly to death, disability, and illness, than any other preventable risk factor.[7] It has been estimated that the health, administration, and social welfare costs of violence against women in Australia, when combined, total $21.7 billion AUD a year.[8]

Two recent state government–based investigations have focused on the issue of family violence in Australia. A *Special Taskforce on Domestic and Family Violence in Queensland* was convened and in February 2015 released the report *Not Now, Not Ever: Putting an End to Domestic and Family Violence in Queensland*.[9] This report provided 140 recommendations aimed at ending domestic and family violence and enabling access to safety and support. A *Royal Commission into Family Violence* was also convened in the state of Victoria, and in March 2016, the *Summary and Recommendations* report from the commission was released.[10] The 227 recommendations in this report were directed at organizational change within current systems and opportunities to reform all aspects of dealing with family violence. Recommendation 95 advised the Victorian Government to resource public hospitals to implement a whole-of-hospital model for responding to family violence, drawing on evaluated approaches in Victoria and elsewhere, within 3 to 5 years.[10]

The appropriate identification of, and response to, family violence is an important skill set for all hospital clinicians and not just the responsibility of a single discipline or profession (e.g. social work, nursing, or medical staff).[11,12] Patients with family violence experiences can present to any part of the hospital, including to the emergency department, for a scheduled inpatient admission, or to an outpatient clinic. While there has previously been some debate about the utility of widespread screening for family violence, the general consensus is that routine inquiring should be occurring in healthcare settings, where appropriate training and procedures have been implemented.[11,13–15] Targeted screening is the most widely recommended frontline approach.[16] However, it is also noted that the first contact with a service may not be the most effective screening point, as it can take time for patients to develop trust in the service.[17–19] Furthermore, information provided by women who have experienced abuse indicates that they recommend continuing to ask patients when family violence is suspected, even if initial screening does not result in a disclosure.[17] As such, all hospital clinicians should be trained in family violence inquiry and response skills as these may be required at any time point during a patient's involvement with the health service.[11,15]

Studies in specific groups of healthcare professionals, including psychologists, mental health professionals, social workers, general practitioners (GPs), and nurses, generally indicate reduced family violence knowledge and screening confidence.[20–23] British research in a sample of predominantly GP and nurse respondents indicated that most of these healthcare workers felt uncomfortable talking about domestic violence, had received little training in the area, but would welcome further training.[24] A recent multi-disciplinary survey of healthcare professionals, with half employed in public hospital positions, indicated suboptimal rates of confidence in screening, supporting, and referring patients experiencing family violence.[25] While this survey yielded a low response rate (6.7%) and a relatively small sample size ($N = 114$), it provided a useful first step in identifying knowledge and training gaps in a cohort of healthcare professionals practicing in a similar environment to the present study.

The current research project was developed as part of the Strengthening Hospitals Response to Family Violence (SHRFV) initiative, established by Victorian State Government to implement Recommendation 95 from the Royal Commission.[26] The key tenets of this initiative are to train frontline health workers to identify the signs of family violence in patients, to respond appropriately, and for health workers to receive support to do this work effectively, consistent with recent practice recommendations informed by research in the sector.[27] There are a number of factors that can affect the capacity of people experiencing family violence to access appropriate support through health services and to feel comfortable disclosing family violence.[28] These include privacy in consulting spaces; time constraints on, and attitudes of, service providers; lack of continuity with services; the quality of the support provided—including promotion of appropriate services; and fear of the potential of involvement of child protective services agencies resulting in the removal of children.[28] The SHRFV initiative aims to address a number of these issues through a transformative change process within key health services.

The Royal Melbourne Hospital (RMH), in conjunction with partner service NorthWestern Mental Health, and

independent health organizations Tweddle Child and Family Health Service, and Dental Health Services Victoria received state government funding as part of the SHRFV initiative. The five key implementation elements outlined within the SHRFV framework were engaging leadership and building momentum, laying a foundation for success, building capacity and capability, building partnerships, and creating an evidence base.[29] This final implementation element was the catalyst for the current study. Reduced levels of self-rated knowledge, confidence, and specific family violence skills were anticipated in the current survey, akin to the research outlined above. Although, it was unclear how directly the results would translate to the Australian setting, with acute hospital healthcare clinicians and a wide cross-section of professional disciplines.

The SHRFV RMH Family Safety Team sought baseline data about the hospital's family violence response from the staff (reported in this article) and patients (in a subsequent survey). The aim of this study was to determine the levels of training, knowledge, and confidence working in the area of family violence in clinical staff across Royal Melbourne Hospital, current family violence clinical skills, as well as staff perceived barriers to working effectively in this area. To the knowledge of the study team, no standardized, formalized family violence training at a service-wide level had been previously run at the health service. However, a Grand Round (1-h open access lunchtime seminar) had been presented on the topic within the preceding 18 months. The collected data will serve as a baseline measure prior to the implementation of a hospital-wide transformation change project aimed at improving the hospital's response to clients experiencing family violence. The baseline data will assist in tailoring appropriate training to staff according to discipline, level, and clinical area, and can be used as a comparison to evaluate the impact of the initiative when paired with similar research surveys once the initiative is embedded and ongoing.

Methods

Study design, study tool, and data collection

Approval for this study was granted by the Melbourne Health Research and Ethics Committee. Data for the study were collected using an online survey, via the SurveyMonkey platform. Existing clinician questionnaires within the literature were considered, but found to be too lengthy for the purposes of a large hospital-wide survey,[30,31] or to contain too many questions related to personal attitudes about domestic violence.[32] Two other more recently published tools were not available at the time the study was conducted.[25,33] A short, targeted survey was considered more likely to attract respondents and lead to full completion of the questions. Several available resources were consulted including a recent survey conducted at RMH in Social Work and with emergency department doctors,[23] and the Royal Women's Hospital Strengthening Hospitals Response to Family Violence Project Tool 6D Pre and Post Training Survey.[29] Feedback on the draft survey was sought from the RMH Allied Health Management and Senior Clinician team ($N=40$), executive nursing staff and nurse unit managers ($N=39$), and the SHRFV Steering Committee, which includes medical staff, partner site representatives, and health consumers ($N=16$). The survey was edited in response to feedback received as part of this consultation process.

The survey was designed to collect the professional demographic information of respondents (discipline, hospital area, years of experience in profession), elicit data regarding prior family violence training and their perceived knowledge and confidence working in this area, gauge the current estimated rates of screening clients for family violence experiences, and identify barriers that staff perceive within the setting to working effectively in this area. The survey utilized a Likert-type scale to obtain quantitative ordinal data, forced choice responses (i.e. Yes, No, Somewhat), as well as free-text sections (Questions 8–11) inviting respondents to provide further information if particular selections were made to the forced choice responses. The survey questions are provided in Supplemental Appendix 1.

Setting and participants

The RMH is part of the Melbourne Health healthcare network. It is a large tertiary metropolitan hospital for adults with multiple divisions, including emergency medicine, trauma (Level 1 Trauma Service), and rehabilitation. All available email addresses of nursing ($N=1541$), medical ($N=1067$), and allied health ($N=422$) staff were sent an email by their professional lead providing information about the study and inviting them to participate via a webpage link. [Health Service 1] employs staff from a wide range of cultural and ethnic backgrounds, religions, gender identities, sexual orientations, and ages, across the adult life span. No restrictions to participation were placed on participants on the basis of these diversity factors. Details about these factors were not collected as part of the survey. However, it is likely that staff from a broad range of backgrounds participated in the research.

Analysis

Descriptive statistics were calculated for all categorical and Likert-type response questions. Secondary group comparison statistics were conducted in specific areas to determine whether years of experience affected prior training rates and whether rates of prior training affected

knowledge and confidence ratings. Free-text responses to Questions 8 to 11 were analyzed using qualitative content analysis,[34] with codes developed inductively. For each free-text question, all answers were extracted and compiled into one text. The text was read for familiarity with the content, and meaning units (words/phrases) were identified and then condensed. Codes were developed to label meaning units, and a coding scheme was discussed and agreed upon by two researchers. Two researchers (N.R. and T.D.W.) independently coded 20% of the free-text responses, and codes were compared for agreement. The remaining 80% of the sample was then coded by a single researcher. Themes were identified to describe the content of the categories.

Table 1. Sample demographics ($N = 534$).

Profession/Subgroup	N	%
Nursing	**242**	**45.32**
City Campus (Acute)	141	26.40
Emergency Department	64	11.99
Royal Park Campus (Subacute)	30	5.62
Rehabilitation	7	1.31
Allied Health	**225**	**42.14**
Physiotherapy	52	9.74
Social Work	42	7.87
Occupational Therapy	37	6.93
Clinical Nutrition/Dietetics	18	3.37
Speech Pathology/Audiology	18	3.37
Psychology	17	3.18
Other	41	7.68
Medical	**67**	**12.55**
Acute	24	4.49
Emergency Department	18	3.37
Rehabilitation	11	2.06
Subacute	1	0.19
Outpatients	4	0.75
Other	9	1.69
Years of Experience in Profession		
<1 year	21	3.93
1–5 years	136	25.47
6–10 years	121	22.66
>10 years	256	47.94

Results

Characteristics of the participants

Of the 3030 invited staff, 534 participated in the online survey. There was a large degree of variation in response rates across professional groupings. The allied health response rate was the highest at 53.32%, the nursing response rate was 15.70%, and medical staff response rate was 6.28%. Professional demographic information about the participants is shown in Table 1, including professional discipline and area, percentage of sample, and years of experience within their profession.

Prior training

Responses indicated that 64.99% of respondents had received some prior family violence training, with 27.72% indicating that they had received training in the last 2 years. Table 2 shows the number of hours of family violence training received and the location/provider of the training. Self-taught learning was the most commonly endorsed area of previous training, followed by teaching during the clinician's professional training course, and in service teaching at Royal Melbourne Hospital (the participants' current place of employment).

The amount of family violence training received as part of clinical professional training courses was analyzed according to clinicians' years of experience in their profession. An independent-sample Kruskal–Wallis test indicated no significant differences in the number of hours of family violence training provided as part of clinical professional training courses by years of experience ($H = 3.525$, $p = .318$). A similar rate of respondents indicated that they had received no family violence training as part of their clinical professional training, across years of experience brackets (61.90%, <1 year; 56.89%, 1–5 years; 61.16%, 6–10 years; 58.20%, 10+ years).

Table 2. Respondents' hours of family violence training and location/provider of the training.

Training type	None	1–3 h	4–6 h	7–9 h	10–15 h	16+ h
Self-taught	54.66%	29.55%	7.29%	1.01%	1.82%	5.67%
In-service session/s at RMH	76.19%	19.88%	2.28%	0.62%	0.21%	0.83%
In-service session/s at another hospital	81.68%	13.15%	2.80%	0.43%	1.72%	0.22%
One-off workshop, external training	87.47%	6.05%	1.94%	2.38%	1.08%	1.08%
External short course	94.48%	1.99%	0.88%	0.66%	0.88%	1.10%
During your professional training	65.48%	22.59%	5.44%	1.67%	1.67%	3.14%
Other	87.74%	7.42%	1.61%	0.32%	0.97%	1.94%

RMH: Royal Melbourne Hospital.

Table 3. Respondents' self-ratings of skills and experience in the area of family violence by survey question.

Question	Respondent Ratings by Percentage of Sample					
Staff FV knowledge rating	No Knowledge	Little Knowledge	Moderate Knowledge	Strong Knowledge	Very Knowledgeable	
	17.79	58.24	18.16	4.68	1.12	
Staff FV confidence rating	Not at all confident	A little amount confident	Moderately confident	Confident	Very confident	
	37.27	35.02	19.85	6.55	1.31	
Staff FV screening rate of patients	Never	Rarely	Sometimes	Often	Always	
	37.64	31.27	20.0	9.18	1.87	
Frequency working with patients with FV experiences	Never	Very seldom	Sometimes	Often	Most of the time	Always
	17.19	58.24	18.16	4.68	1.12	0.19

FV: family violence.

Knowledge and confidence ratings

Respondents' ratings of their knowledge and confidence levels working clinically in the area of family violence were generally low, as were screening rates, and the frequency with which staff work with clients with known family violence experiences (Table 3). Both the knowledge and confidence ratings were analyzed according to cumulative hours of previous family violence training (across all training types). This indicated that 7 to 9 h of training was required for a minimum of 50% of respondents to rate their knowledge level at moderate or above, while 16+ h of training was required for 75% of respondents to rate their knowledge level at moderate or above. For confidence ratings, 10 to 15 h of training was required for a minimum of 50% of respondents to rate their confidence level at moderate or above, while 16+ h of training was required for a minimum of 75% of respondents to rate their confidence level at moderate or above.

Specific family violence clinical skills

Of the questions that related to specific clinical skills, the majority of respondents (59.55%) indicated they do not know how to appropriately ask patients about family violence. Just under a third (29.04%) indicated they know somewhat, while only 11.05% indicated they believed they did know how to ask appropriately. Respondents indicating *Yes* or *Somewhat* to this question were requested to describe how they would ask clients about family violence, and 132 out of 216 respondents in these categories provided free-text responses. Content analysis of these responses suggested that there was a range of "safety-related" questions that could be asked to elicit responses from patients. Staff also indicated that they would employ open-ended questioning in a discrete manner when asking about family violence, with a small number indicating that they would directly inquire about violence. Examples of text responses to this question are as follows:

> You need to ask in a non-threatening, non accusing way. Often asking about home life, children, any issues with family, do you feel safe at home.

> Ask open ended questions, develop a rapport, don't push.

> In a non-judgmental manner, working to enhance the patient's sense of safety and trust in order to facilitate them disclosing family violence issues.

When asked about key indicators of family violence, just over half of the respondents (51.50%) reported that they were not aware of factors that may indicate a patient/client is at risk. Just over a third (36.52%) indicated that they were somewhat aware, while only 11.99% indicated that they were aware of key risk factors. Respondents indicating *Yes* or *Somewhat* to this question were requested to describe what the key indicators are, with 144 out of the 259 respondents from these categories providing a free-text response. Respondents identified physical signs (e.g. bruising, fractures, urinary tract infections) as key indicators of family violence. Also nominated were observed patient behavior and family interactions (i.e. patient demeanor changing when perpetrator present, patient fear about returning home). Finally, social factors including alcohol and other drug abuse and social isolation were identified. Examples of responses include the following:

> Physical injuries, scared demeanour. Quiet in front of family members. Pt [patient] tells me.

> Physical signs of physical abuse. Secretive/protective behaviour. Highly concerned about making decisions without the input of another (the potential abuser).

> Low income, IVDU [intravenous drug use] or alcohol misuse, frequent presentations, injuries that do not match stories/history . . .

Respondents were also asked whether they knew what to do if/when a patient/client disclosed experiencing family

Table 4. Challenges in addressing family violence endorsed by respondents.

The patient/client's partner/child/parent (i.e. suspected perpetrator) is present	58.41%
Patient/client's reluctance to disclose when asked	54.16%
Time limitations when seeing a patient/client	51.54%
I don't know what to do or say	48.74%
Language barriers	46.81%
Concern about offending the patient/client or affecting rapport	44.29%
Lack of supporting policies and procedures	35.59%
Privacy issues in the clinical area in which I work	35.20%
Another vulnerable person is present (i.e. children)	34.62%
The topic of family violence is uncomfortable	25.53%
Concerns about staff safety in asking questions about family violence and initiating action	25.34%
Little or no access to supervision that supports safe and reflective practice in this area	23.79%
Other (please specify)	6.19%

violence. One-third of respondents (33.71%) indicated they did not know what to do when disclosures occurred, half (50.75%) indicated that they knew somewhat, while 15.54% indicated that they did know. Those providing *Yes* or *Somewhat* responses were requested to describe what they would do, when a disclosure occurred, with 241 out of 354 respondents in these categories providing a free-text response. Content analysis from these responses indicated that many staff would refer to social work or a treating physician if family violence was disclosed. Many staff also identified that they would gain consent and discuss confidentiality with patients before acting on disclosures. Finally, staff identified formally documenting the disclosure in medical records. Examples of responses include the following:

> Inform team looking after client and ask for proper channelling in the hospital.

> Escalate to person in charge.

> Be supportive and open. Refer to social work.

> Engage in further discussion to determine what type of family violence, if client wishes to address violence and discuss options. Provide support, actively listen and offer assistance.

> Discuss with social work with pt's [patient's] consent. Escalate to law enforcement if pt [patient] consents. Consider whether pt [patient] can be discharged safely. Screen for mental health consequences and manage accordingly—psychology, psychiatry, pharmacological.

Barriers

The final question of the survey related to clinician perceived challenges in addressing family violence. Participant responses to this question are shown in Table 4. The most commonly indicated challenge by respondents was a suspected perpetrator being present. The two other challenges indicated by more than half of the respondents were clinician perceived reluctance in patients/clients to disclose when asked, and time limitations when seeing a patient/client. Additional challenges that were indicated by over 40% of respondents included not knowing what to do or say, language barriers, and concerns about affecting rapport or offending the patient/client. Respondents indicating "Other" challenges, that were not listed on the survey, were asked to specify what these challenges were. Thirty-two "Other" responses were indicated, and 80 free-text responses provided. Content analysis indicated that staff perceived a lack of training and education as a significant barrier in addressing family violence. Other barriers included pragmatic limitations such as managing access to sensitive patient information. Also indicated was the perception that family violence was out of the scope of their professional role. In addition, a lack of community supports and services to help woman disclosing violence was identified as a barrier.

Discussion

Training

While over half of the hospital respondents had received some form of family violence training, self-taught learning was the most common type, and only a third had received some form of family violence education during their professional training course. When family violence training did occur as part of professional training, it was usually of 3 h duration or less. Interestingly, no differences were seen in rates of training within professional training course, by years of experience within the profession. This appears to indicate that rates of training in family violence have not increased in healthcare training courses, at least over the last 10 to 15 years, despite there being an increasing recognition of family violence as a significant health and social problem.

Self-ratings of knowledge and confidence levels were low, along with estimated patient/client screening rates for family violence. Analysis indicated fewer hours of training in family violence were associated with lower ratings of

knowledge and confidence. Thus, brief 1- to 3-h training sessions in family violence appear to be ineffective at improving self-rated knowledge and confidence in healthcare workers. The data suggest that a minimum of 7- to 9-h training is required for at least 50% of staff to rate their knowledge as moderate, while 10- to 15-h training is required for the same proportion to rate themselves as confident working in the area. The training space in many healthcare services is already saturated, with regular mandatory training in topics such as hand hygiene, fire safety, basic life support and managing patient aggression, taking clinicians off clinical duties for a number of hours each year. Thus, gaining access to staff for family safety training, and for enough time for the training to be effective (i.e. 7–9 h), may be difficult. The findings of the current study were integrated into the [Health Service 1]'s design of their family violence training. Focus was put into training a Family Safety Advocate Network of clinical champions throughout the hospital, who had received at least 9 h of training in family violence clinical response, prior to rolling out the shorter duration training modules recommended by the SHRFV initiative. Family Safety Advocates were also provided with regular top-up training, and were encouraged to keep family violence on the agenda in their clinical areas and act as a support for other staff who had less knowledge about family violence.

Screening

Very few respondents indicated that they screen every patient/client for family violence, with the majority never or seldom screen patients/clients. A high proportion also indicated that they never, or very seldom, work with patients/clients who have disclosed family violence, to the clinician's knowledge. This is likely to be at least partially related to the low screening rates. If clinicians are generally not screening clients for family violence, they are less likely to be aware of this as an issue in their patient/client population. Existing research indicates that, statistically, one in four Australians will experience family violence across their lifetime.[4,5,7,35] And thus, it is likely that most health professionals will have a proportion of clients with family violence experiences in their caseload, at all times.

Confidence, knowledge of skills, and barriers

Given the low self-ratings of knowledge and confidence levels provided by clinicians, it is not surprising that knowledge of specific family violence clinical skills including how to ask clients, identifying risk factors, and responding to disclosures was sub-optimal. The data on barriers to working effectively in the area of family violence indicated that staff perceive there are a high number of challenges within the hospital setting with six different challenges being endorsed by more than 40% of staff. The most commonly indicated barrier, a suspected perpetrator being present, conveys a high level of clinical risk, when situations are not managed effectively. The number of staff endorsing this barrier suggests that this is a relatively well-known risk among the hospital's clinical staff, and also that suspected perpetrators may commonly attend hospital appointments, visits, and admissions with suspected/known victims. The next most commonly endorsed challenge was respondents' perceptions that the patient/client may be reluctant to disclose when asked. This information is useful as it indicates staff training and education focused on the method of sensitive inquiry and how to increase the likelihood of clients feeling comfortable to disclose may be useful. Time limitations when seeing patients/clients being the third most commonly endorsed challenge suggest that staff perceive there may not currently be enough scope within their clinical role to allocate the time required to appropriately address this issue with clients. Thus, other potential avenues for working in this space more effectively, such as an increase in social work staffing on wards and units (who could conduct family violence screening, risk assessment, and safety planning as needed), could be useful. An additional barrier identified through free-text responses was a lack of education and training, which adds support to the need for a hospital-wide training program.

Response rate

The overall response rate to the survey of 17.62% is a limitation but is comparable to other surveys of large cohorts of health professionals (e.g. contacted pool of ⩾2000) that have used exclusively online/email administration, without the option of paper administration. Hassenbusch and Portenoy[36] obtained a response rate 18.70% from a contacted pool of 2209, and Hollowell et al.[37] obtained a response rate of 13.96% from an invited pool of 3065. The sample size and response rate are both considerably larger than another recent family violence clinical knowledge survey in hospital and community healthcare workers in a similar geographical area ($N = 114$, response rate 6.7%).[25] Another limitation of the current survey is the lack of collection of the following demographic data of participants: gender, age, and ethnicity. In order to keep the survey short and targeted, the study team determined that professional discipline, clinical area, and years of experience were the more relevant demographic data to obtain. Responding appropriately to patients' family violence issues is important for all clinical staff, and thus, the gender, age, and ethnicity of staff should not affect how, or whether, they assist patients with family violence issues.

There was also a large degree of variation in the survey response rate, across discipline, with the strongest participation rate shown by the allied health professions. At Royal Melbourne Hospital, allied health staff deomonstrate high rates of participation in staff surveys generally, consistently responding at a higher rate the hospital-wide average. The survey was also designed and led predominantly from

within Allied Health, specifically the Psychology and Social Work departments, and managers provided multiple reminders to encourage participation in team meetings and forum presentations. The nature of the clinical work conducted by a number of the allied health professions, and the ability to identify the topic as an important area for their practice and the health service, may also have been another driving factor to the higher response rate. Furthermore, it is likely that nursing staff, in particular, had less time and access to computer workstations and checking their work emails during shifts, relative to allied health staff, and this is likely to have affected their capacity to fill in the survey. The variations in response rate are a limitation of the study as the proportion of respondents by profession does not correspond to the same proportions as those invited to participate, or the proportions that make up the clinical workforce within the hospital. Thus, the responses from allied health clinicians overrepresent this professional group within the invited sample, relative to the actual professional demographics of [Health Service 1] clinical staff.

There are studies with larger sample sizes of medical professionals, when they have been the sole study group in family violence knowledge studies.[30,33] However, these studies have been in GPs and psychiatrists, and not doctors from a range of specialities in a general medical hospital. A similar multi-disciplinary Australian study did not report on response rates of individual professions, but yielded an overall low response rate, and relatively low medical participant numbers ($N=32$, overall response rate of 6.7%). Another Australian study obtained a moderate sample size ($N=216$) of psychiatrists, although this still only represented a 4.6% response rate from invited participants. As such, engaging medical staff in surveys on the topic of family violence may be a wider problem in the Australian research field and may have implications for the capacity of trainers to generate interest in this professional group for future training.

Comparison to the literature

The results of this survey are similar in a number of areas to a survey of general practice clinicians (GPs, $N=183$; nurses, $N=89$) in the United Kingdom that utilized the Physician Readiness to Manage Intimate Partner Violence Survey (PREMIS).[24] In this study, the median response for duration of previous domestic violence training was 1 h, with clinicians generally providing low ratings about their preparedness to perform most domestic violence assessment and response procedures (including asking appropriate questions about domestic violence, identifying symptoms, and responding to disclosures).

In contrast, the current results differ from a recent survey of both hospital and community healthcare workers in Australia, which reported higher levels of confidence (59% of respondents indicating they *agree* or *strongly agree* with the statement, "I am confident in screening patients for family violence experiences").[25] In this study, information about previous family violence training rates was not provided. Thus, it is unclear whether respondents had received higher levels of prior training. Of note, however, the majority of respondents in this study indicated that would benefit from further training (60.8%).

Informing future training

In addition to existing resources that have discussed the implementation of Recommendation 95 from the Victorian Royal Commission,[38] this study provides valuable information that the RMH SHRFV initiative team will use to tailor family violence training to the needs of hospital clinical staff. Particular areas of focus for education training identified by the research include information about prevalence rates and how common family violence experiences are likely to be in the patient cohort, information about risk factors and how this can assist with targeting screening, using the method of sensitive inquiry to ask about family violence when screening a client, and how to appropriately manage disclosures that are received by training staff in the hospital's family violence procedure and guideline. The data set will also allow for the family training program to be tailored according to professional discipline and/or clinical area, by undertaking further subgroup analysis of the responses. Some of the family violence training will be discipline specific (e.g. groups of nurses or physiotherapists trained together), while other sessions will be multi-disciplinary and involve cross-disciplinary professionals who work in specific clinical areas (e.g. the Emergency Department, including doctors, nurses, and allied health staff).

Staff-identified barriers will also be addressed in the training. This includes encouraging clinicians to work with their services to make time to address family violence issues appropriately with their patients and formulating strategies that can be used to move patients into a confidential area, when a suspected perpetrator attends the consultation. Similarly, educating clinicians that victim survivors are more likely to disclose if asked directly, in a safe confidential environment, by a trusted person, in a supportive manner that emphasizes they have the right to choose, is required to address clinicians' perception that clients will be reluctant to disclose, when asked.[17,18]

The survey utilized for this research has also been administered at the independent partner organization [Health Service 3]. The results of the [Health Service 3] staff survey will be presented in a subsequent study and will allow for the comparison of data between the two services. A patient study has also been carried out to investigate the health services screening rates and practices, from the perspective of patients, prior to the implementation of the training initiation.

Conclusion

Family violence is a social and health problem that predominantly affects women and children. Clinical staff respondents (nursing, allied health, medical) to an online survey at RMH indicated low levels of knowledge and confidence when working clinically in the area of family violence. Most indicated that they had received some degree of family violence training; however, this was generally of short duration (1–3 h). Longer duration training was associated with an increase in family violence knowledge and confidence ratings. Respondents' family violence screening rates and their endorsement of knowledge of several specific family violence clinical skills (how to appropriately ask clients and family violence risk factors) were also low. The most commonly indicated barriers to working effectively in this area were suspected perpetrators being present during consultations, perceived reluctance of patients/clients to disclose when asked, and time limitations. This research provides a useful snapshot of clinical staff perceptions of their family violence skill levels in a large metropolitan Australian tertiary hospital. It highlights the need for further in-depth training in this area in clinical health professionals.

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Ethical approval to participate

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Supplemental material

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