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Domestic violence screening in a public mental health service: A qualitative examination of mental health clinician responses to DFV

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Accessible Summary

What is known on the subject?

- Mental health clients experience higher estimated rates of domestic violence, yet mental health services are less likely to screen for domestic violence.

What the paper adds to existing knowledge?

- This paper qualitatively explores the perspectives and experiences of mental health practitioners in inpatient and community teams in a publicly funded hospital and health service (i.e. public mental health service).
- Mental health practitioners described a lack of domestic violence training, as well as a lack of knowledge of domestic violence and support mechanisms for victims, when domestic violence is disclosed by clients.
- The paper highlights the unique difficulties and barriers experienced by clinicians in screening for domestic violence while also dealing with clients suffering a mental health crisis.

What are the implications for practice?

- The paper sheds more light on the issue of domestic violence in mental health in terms of screening, and identifies avenues for improvement in mental health services; particularly the need for staff training and education.

Abstract

Introduction: Domestic violence is particularly prevalent within mental health client groups, though screening for domestic violence within mental health services is often overlooked.

Aim: To investigate the experiences and opinions of domestic violence screening by mental health clinicians in a publicly funded hospital and health service.

Methods: Semi-structured interviews were conducted with twelve clinicians working in publicly funded mental health services in Queensland, Australia. Transcripts were thematically analysed.

Results: Four main themes emerged from the data: staff training and experience; prioritizing domestic violence screening; attitudes to domestic violence; and victim support. Participants discussed a lack of training for, or expectations of, domestic violence screening in mental health services. They also highlighted a lack of resources enabling them to appropriately respond when domestic violence was identified.

Discussion: Education, attitudes and resources relating to domestic violence are major factors that should be addressed for the successful screening and treatment of clients in mental health.

Implications for Practice: This paper informs services of the gaps in knowledge and care around domestic violence and mental health. A less medicalized approach to the treatment of mental health should be adopted, and domestic violence training introduced for all healthcare practitioners, to improve client outcomes.

KEYWORDS
domestic violence, mental Health, screening, social work

1 | INTRODUCTION

Gender-based domestic violence is a pervasive condition that affects between 17% and 23% of women in Australia, and one in three women worldwide (Australian Institute of Health and Welfare [AIHW], 2019; World Health Organization [WHO], 2021). Domestic violence is generally described as behaviour by a partner or family member that causes physical, sexual or psychological harm, and includes (but is not limited to) aggression, coercion and/or control. It is a major cause of physical and mental health issues such as chronic disease, depression, suicide and substance abuse (WHO, 2021). The adverse impact of domestic violence on victims is acknowledged by key health organizations worldwide and was declared a global public health issue at the World Health Assembly in 1996 (WHO, 2002). Despite long-term international recognition of domestic violence as a major health concern, rates of partner violence have remained relatively unchanged in Australia since 2005. However, increased awareness has led to a higher proportion of these people accessing services related to domestic violence; including hospitalizations, police and homelessness services (AIHW, 2019).

Women experiencing domestic violence in Australia have a reported 30–50% higher emergency department usage than women not affected (Baird et al., 2019). An American study found that women experiencing domestic violence were over four times more likely to present to the emergency department, which may indicate an underestimation of actual presentations (Kothari et al., 2015). Given the high rates of health care usage by this group, there is substantial opportunity for domestic violence identification through screening in public healthcare settings.

Although screening for domestic violence is becoming more accepted within acute health care settings, the precise benefits, and how screening should occur remains open to debate, with some contending that screening must wait until after a trusting relationship has been built, to reduce client apprehension and re-traumatization (Anyikwa, 2016). In Australia, routine screening in many healthcare settings is currently only conducted for maternity patients (Soh et al., 2021). Other healthcare services have inconsistent rates of screening, and public mental health services in particular report low rates of inquiry (Coyle et al., 2019; Cunningham et al., 2016; Fisher et al., 2020). The exact rates of screening being undertaken in Australian hospitals are unclear, as there are no legislated guidelines or mandates to collect such data, and each state differs on domestic violence recommendations (Fisher et al., 2020).

Screening for domestic violence in mental health settings is particularly important given the high estimated rates of domestic violence that have been reported within the population, and the intersectionality of domestic violence and mental health (Khalifeh et al., 2016; Trevillion et al., 2012). Women who experience domestic violence have an increased risk of experiencing mental health conditions such as anxiety and depression, post-traumatic stress disorder (PTSD), self-harm and substance abuse (Kumar et al., 2013; Sutton et al., 2020). These findings are further supported by the high rates of sexual trauma and domestic violence seen in women admitted to an inpatient psychiatry unit in Australia (Niven et al., 2022). Mental health concerns are high in both victims and perpetrators of violence. Understanding the trauma history of clients is essential in the mental health environment for providing adequate treatment. Trauma-informed care is an approach that focuses on the impact of early life and ongoing trauma on a person's physical, psychological and behavioural health. This model of care seeks to interpret the clinical presentation in light of the individual's background, acknowledging the long-term consequences and impacts of trauma, particularly in the development of mental health issues (Wilson et al., 2017). Trauma-informed care requires empathy, relationship-building, consistency and stability, and focuses on reducing the risk of re-traumatization. Adequate and early screening of trauma and domestic violence can assist with appropriate interventions and health risks. Experiencing repeated forms of interpersonal violence

and abuse can lead to complex trauma, which involves a range of traumatic health problems and psychosocial challenges (Salter et al., 2020).

Failing to recognize domestic violence and trauma in mental health can lead to misdiagnosis and inadequate or inappropriate treatment. For improved delivery of care in mental health services, it is essential to further investigate how domestic violence and trauma-informed care are understood and practised in public health settings. Mental health services have traditionally focussed on clinical risk assessment and safety planning of immediate physical and mental health concerns (e.g., suicidality, self-harm), and mental health symptomology (e.g., psychosis, mania) (Arkins et al., 2016; Soh, 2021; Xiao et al., 2016). This is often termed medicalization of care, or the biomedical model (Salter et al., 2020). Clinicians tend to focus on physical safety, with an emphasis on physical violence over other forms of control and abuse (Sutton et al., 2020). There also remains a documented lack of general knowledge about domestic violence by mental health practitioners, impeding appropriate intervention, as clinicians focus on mental health symptoms of violence, and fail to address the underlying interpersonal, social and systemic causes of domestic violence (Arkins et al., 2016; Trevillion et al., 2014).

A recent American study found that over 50% of mental health practitioners dealt with clients who have experienced domestic violence, although they were unlikely to have received any domestic violence training or education (Sutton et al., 2020). Previous studies of psychology and social work clinicians found that only around one-third of clinicians had undergone any type of family violence training and that this was often short in duration averaging from one to three hours (Fisher et al., 2020). Self-report studies have also shown low self-ratings on knowledge and confidence in dealing with family violence disclosures (Soh et al., 2021). Domestic violence is well-known to co-occur with mental health issues, making the lack of domestic violence screening and identification in mental health departments even more problematic (Trevillion et al., 2014). Domestic violence has a strong and well-documented contributing factor and impact on mental health, and therefore, it is unlikely that the mental health concern will be resolved while domestic violence remains present (Humphreys et al., 2021). While several studies have found inadequate, inappropriate or an absence of screening for domestic violence in mental health departments, little is known about mental health clinicians' opinions on screening, or the barriers and enablers to screening that exist within publicly funded mental health services.

2 | AIMS

This study aimed to explore mental health clinicians' experiences and opinions of domestic violence screening within a public mental health service (including barriers and enablers to screening, identification and response), and to identify areas for improvement or further study.

3 | METHODS

A qualitative descriptive design, using semi-structured interviews, was used to explore the experiences and opinions of mental health staff relating to domestic violence screening. The study was undertaken using a Grounded Theory approach, whereby the theory is based or "grounded" in the data and emerges from within (Creswell, 1998; Creswell et al., 2007; Krysik & Finn, 2010). This approach was chosen due to the dearth of knowledge and literature surrounding the conceptualization of the issue of domestic violence screening in mental health. Using a Grounded Theory approach means that there is no theoretical expectation, and allows interview participants to revisit, review and decipher their retrospective experiences of clinical practice with people experiencing domestic violence through open-ended discussion and insightful inquiry with the researcher using probes that are relevant to the inquiry and that could elucidate valuable information at a deeper level.

3.1 | Sample size

Determination of a sample size within qualitative research is based upon establishing information power rather than statistical power (Malterud et al., 2016; Sandelowski, 2001). The number of participants required is guided by the scope of the phenomena, the experiential characteristics of the participants, and the findings from continual and reiterative data analysis undertaken in Grounded Theory research (Tie et al., 2019). The scope of the study was relatively specific, and participants were purposively sampled for their exposure to clients experiencing domestic violence. Based on these parameters, and the expertise of experienced clinician-researchers, it was determined that the study would recruit a minimum of ten participants across specializations. Constant comparative analysis undertaken from the commencement of the study, using both inductive and deductive reasoning, was used to determine the final sample size.

3.2 | Participants and recruitment

Multidisciplinary clinicians (e.g., nursing staff, social workers, psychologists, psychiatry registrars and psychiatrists) from the mental health department of a large, public, hospital and health service in metropolitan Australia, were invited to participate in the study via purposive sampling. Advertisements on staff noticeboards and in staff email broadcasts were used to advertise the study to those working as healthcare clinicians in mental health services. Responding clinicians had a key role in conducting comprehensive mental health assessments and determining ongoing support for the clients. Potential participants were experienced, senior clinicians with an extensive background in mental health. Clinicians were invited by a research team member, independent

of clinical care, via email. Clinicians came from mental health teams across the continuum of care (e.g., Mental Health Acute Care Team, Drug and Alcohol Specialist Services, Adult Mental Health Inpatient Units, Psychiatric Mother and Baby Inpatient Unit, and Community Mental Health), all of whom worked in a capacity which often involved working with women who may experience domestic violence.

3.3 | Data collection

The interview schedule consisted of questions exploring the routine mental health responses involved in clinical practice, including the use of domestic violence screening tools; as well as difficulties/challenges/barriers, and facilitators regarding detecting, reporting, and providing supportive interventions to mental health clients experiencing domestic violence. To ensure participant anonymity, no demographic data was collected. Participants included social workers (n = 7), psychiatrists / psychiatry registrars (n = 2) and clinical nurses (n = 3).

3.4 | Data analysis

Transcripts were read and independently analysed by two researchers using the Braun and Clarke reflexive thematic analysis process (Braun & Clarke, 2006). Data collection was concluded when data saturation, as described by Glaser and Strauss (1967), was achieved: no new responses were being obtained from participants, while increasingly homogenous responses were described. Codes were generated within the transcripts, and a six-step process of reiterative examination and coding took place until all transcripts had been analysed. Provisional themes were developed and refined as the data analysis continued over time. Results were additionally checked by three other researchers.

3.5 | Ethics

Hospital Health Service and University approval for this study was obtained from the relevant Human Research Ethics Committees. Participants were assured data would be treated with confidentiality and that they may withdraw at any time. All participants provided written consent for their data to be used in this study.

4 | CONFIRMABILITY

4.1 | Creditability, transferability and dependability

Once all identifying information had been removed, the transcripts were read by all members of the research team to gain an initial sense of the main themes. Two researchers, one who conducted all the interviews and another researcher, to limit potential bias, independently analysed the interviews. Once the analysis was completed, both researchers discussed and agreed on the main themes. The final themes were also discussed with the other members of the research team at a research team meeting and at the bi-monthly advisory group meeting which was set up at the beginning of the research and included various members of the mental health team, domestic violence advocates and clients. The findings of the research were also presented at a hospital in-service and conference where the research had been conducted, and members of the mental health team who participated in the study were present at both.

5 | REFLEXIVITY

As one of the researchers also worked clinically with some of the mental health team involved in the research, they needed to be very much aware of their preconceptions and values. It was also important that they did not misinterpret the interview data or influence any part of the research. To avoid this, the researcher kept an ongoing journal and diary and discussed their thoughts and feelings with the other members of the research team and advisory group. In addition, further rigour was conducted by the findings being independently analysed by another researcher within the research team.

6 | RESULTS

After a process of iterative coding and analysis was undertaken alongside recruitment and interview transcription, the researchers determined that they had achieved appropriate information power (or saturation) after twelve mental health clinicians from a public mental health service were interviewed (Sandelowski, 2001). No new topics in the data were identified after approximately two-thirds of the interviews had been conducted. This does not mean that new and unique perceptions or opinions do not exist. However, it does indicate that the study has obtained the opinions of the majority of clinicians at this location, and that further interviews were unlikely to obtain data value relative to the cost of data collection. The main themes to emerge from the study were *staff training and experience; prioritizing domestic violence screening; attitudes to domestic violence; and victim support*.

***"We don't have the skills"* - Staff training and experience.**

One factor mentioned by every single interviewee was the importance of domestic violence education and training; there was a shared belief that training should be increased and made mandatory for all staff. Participants reported that training of staff was inconsistent, infrequent, and dependent on staff interest and availability. Many also reported their staff felt ill-equipped to deal with domestic violence disclosure.

> "It's not part of our regular sort of assessment…. in our risk assessment there is actually a history of domestic or family violence, yes or no, and vulnerability… But I don't think we've had any real training as to how to question around that. Then if they do disclose there's domestic violence at home, where to go with that."
>
> (G).

It was evident from the interviews that the staff had not considered the simple fundamentals of domestic violence screening and safety. For example, one participant highlighted that some staff had not thought about the basics of screening, such as talking to the woman on their own.

> "…when I've talked to them [staff] about, making sure they separate the man and the woman, and see her separately, and suggested how they might be able to do that. They hadn't even thought about things like that."
>
> (B).

Many stated that mandatory training would be ideal but may not work in reality due to the demands of other mandatory training and the workload included in their role.

> "I would love to do that [education], but I've got huge caseloads. I've got other things that I need to do. Other priorities, you know? That's what I would see it as. I would love to do it, and I can do it, but it's just I need [that] amount of time to do it."
>
> B.

"It's something we're just not even automatically thinking of" **– prioritizing domestic violence screening.**

There are several factors involved in staff decisions around the screening and detection of domestic violence for their clients. Currently, in the public mental health service where this study was conducted, staff were not mandated by hospital guidelines and policies to automatically screen on admission for domestic violence. Many of the staff interviewed did not even consider screening for domestic violence.

> "I think we don't invest any energy into building capacities in practitioners to respond more effectively to domestic violence because it's just not on the agenda. The agenda is what's happening in the body. Even in psychiatry, the agenda is what's happening in the head."
>
> (L).

It was also evident that even in times when there was no mental health crisis in place, staff did not consider domestic violence screening as a priority.

> "…but in the general wards, I think that there isn't any domestic violence screening to my knowledge, there isn't anything that's kind of really pushing people to make sure that it is part of all of their intervention. I think there should be something."
>
> T.

Staff discussed the "medicalisation" of the public mental health services as a barrier to fully appreciating all factors surrounding a client's health and emotional wellbeing. Participants described the issues inherent in a public mental health service context and having to respond primarily to the presenting clinical mental health needs of a client before asking about domestic violence.

> "…if they're still psychotic, I guess we tend to address that first and that's [domestic violence] probably down the list of our priorities."
>
> (G)

> "Most of the time I would say people experiencing domestic violence go undetected…. I think it's quite medicalised…. Some of the clinicians have never really had experience working with women – never had any training in family violence, so I don't think they deliberately ignore it, I just think … they're trained from a medical perspective…. fixing whatever is wrong with them and moving on - and not really looking at it from a holistic perspective …."
>
> B.

"Why don't you just leave" **– attitudes to domestic violence.**

Another barrier to detecting and responding to domestic violence, included staff and client attitudes toward domestic violence. Misconceptions around domestic violence in the hospital and the community were linked by interviewees to a lack of training and education. Staff believed that education would provide them with the necessary knowledge and tools to be able to support women in such circumstances.

> "I think sometimes there can be some judgement shown if a victim does not want to leave the relationship and/or doesn't quite feel safe to leave at that time. I have a sense that for some clients that can sometimes be a hindrance and can prevent victims from presenting to the emergency again, because they think, I've gone there four times."
>
> K.

"Some people only have their perpetrators to rely upon" **– Victim support.**

Research participants identified that, even when domestic violence screening, reporting and training had been undertaken,

community support agencies, needed to be available and accessed promptly. Clients experiencing domestic violence needed to feel adequately supported before they could feel empowered to address their abusive and often dangerous situation. A lack of victim support and resources could be a barrier to clinician inquiry, as many interviewees described feeling helpless and ineffectual after screening. This was particularly evident when describing support for women whose first language was not English, and who may be financially dependent on the perpetrator.

> "How can they escape from that when they don't even speak the language? Some of them manage to escape, so then it's around, they have to have English classes and they have to link in with TAFE and then they have to have - that costs money, and they have to have the right visa, and they have to have the right whatever…so all that kind of system puts up a lot of barriers and they feel like then they're trapped, and so they'll return to the relationship because they see that as their only option - because we make it so difficult for them to navigate."
>
> C.

There was a recognition and frustration among participants about the lack of safe and available accommodation for families.

> "…we definitely need more housing and more emergency accommodation in general. So that women aren't having to wait too long in the emergency department to seek refuge"
>
> K.

7 | DISCUSSION

While routine screening is becoming a common aspect of health care in many hospital settings, the data from a large metropolitan public mental health service indicates that knowledge, confidence and expectations to screen are not always priorities within the sphere of mental health responses. The immediate concern identified by many, despite the intersection of mental health and domestic violence, is the presenting "clinical" symptoms of mental illness; such as suicide, self-harm, psychosis or even physical illness as the main focus of treatment rather than the screening and identification of domestic violence. Past studies have found an association between trauma and psychotic symptoms; however, these domestic violence-related traumas were rarely reported in patient notes, indicating that these types of traumas are not commonly inquired about by mental health clinicians (Cunningham et al., 2016). Standardized documentation templates that capture domestic violence in greater detail would support the implementation of domestic violence screening (Department for Child Protection and Family Support, 2015). Formulations and management plans also need to consider domestic violence, for example, carrying out a risk assessment, safety planning or trauma-focused therapy (Howard, 2012).

This "medicalisation" of care is often discussed in the literature; whereby clinicians concentrate on physical and psychiatric findings and overlook or underestimate the psychological, social and environmental associations of illness, particularly domestic violence (Husso et al., 2012). Crisis presentations lead to health professionals prioritizing safety planning and presenting mental illness aspects of care. This may seem reasonable; however, the interrelatedness of physical, psychological and environmental factors (such as domestic violence and associated trauma) and their impact on hospitalization, make a focus on mental health responses to domestic violence an important issue (Xiao et al., 2016). Adoption of models that promote the consideration of trauma, such as the biopsychosocial model, social-ecological model and the trauma and violence-informed care model, may be beneficial (Borrell-Carrio et al., 2004; Centers for Disease Control and Prevention, 2021).

Two major themes discussed by participants involved the identified need for further skill development and training and a lack of confidence and ability in the area of domestic violence. This is not uncommon, with many studies describing the main barriers to screening being lack of training, knowledge, time constraints, privacy and language barriers, including cultural competency (Cleak et al., 2020; Eustace, Baird, Creedy, Saito, 2016). Regularly implementing domestic violence training within existing mental health trauma-informed training may enable mental health professionals to assess the impact of domestic violence and promote a culture of safety for clients (Kezelman & Stavropoulos, 2019). Formal domestic violence training has been found to improve mental health clinicians' confidence and ability to administer assessments and safety plans. Organizational support was also seen to increase staff participation in training (Sutton et al., 2020). Providing innovative modes of delivery (e.g. interactive webinars, recorded sessions, online learning, one-hour workshops over several weeks) may increase the uptake of the training. Educating health professionals about the domestic violence-related community agencies available, and the role of health services in detecting and responding to domestic violence, are also important aspects of training. Providing information about the services available in the local region is helpful so that clinicians can refer appropriately to these organizations. Previous research in the hospital and health service of interest indicated that 39% of participants had difficulties making appropriate referrals to community services for women experiencing domestic violence, suggesting that there is limited awareness about the services available (Creedy et al., 2021). While there are several online modules available for staff, it is not clear if they are frequently accessed or utilized (Queensland Government, 2020).

Staff and client attitudes were also described as a barrier to appropriate responses to domestic violence. Prior studies indicated that staff only consider the treatment of a client experiencing domestic violence successful if the person leaves the partner (Beynon et al., 2012; Mezey et al., 2003). These attitudes are pervasive and systemic within the general community and are

difficult to detect and amend. Further targeted skill-based education and training (specifically addressing values and attitudes); appropriate access to clinical supervision; and exposure to mental health consumer advocates or peer support workers with lived experience of domestic violence, can increase awareness of these issues and begin addressing some of these gaps in public mental health service provision.

Having a domestic violence specialist officer within public mental health services, who can provide regular training, or as-needed consultation and advice, is another approach to overcoming the barrier of insufficient training and education. One study found that having an Independent Domestic Violence Advisor on site, with a dedicated space and regular face-to-face engagement, was extremely beneficial in terms of clinician and client support and addressing some of the issues identified in this study (Dheensa et al., 2020).

Several participants in this study made particular mention of the needs of women from culturally and linguistically diverse (CALD) backgrounds as being particularly vulnerable (Gharfournia & Easteal, 2018). Participants mentioned a lack of culturally appropriate victim support, with few places for women to go to once they decided to leave a violent relationship. For those who have minimal friends or family, support mechanisms outside of the relationship, or have limited English, leaving or addressing the violence they are experiencing is particularly problematic. Advocacy of more non-governmental and governmental support agencies in the community, specifically catering for CALD populations, is required to adequately provide for this vulnerable population.

While a fuller discussion about the intersection of domestic violence and vulnerable populations is beyond the scope of this paper, it is important to acknowledge this is an area which requires recognition and further research. In recognition of this shortcoming, in 2017, the Australian Government Department of Social Services funded the CALD PAR initiative. The project involved 26 projects across Australia aimed at preventing violence against women and creating safer pathways to respond to domestic violence in CALD communities. The report identified that there were many shortfalls in meeting the needs of CALD communities, highlighting the need for, and the importance of, intersectional practice that would connect with communities to learn more about how oppression, privilege, and colonial structures intersect in local contexts; identify the inequalities in power and privilege between project teams and different community groups; and collaborate with community groups, services and individuals to strive for systemic change (Koleth et al., 2020).

Other barriers to detection lay in the lack of general community resources, and limited access to support agencies related to domestic violence response and support. Should domestic violence be detected within the mental health client population, further issues arise for mental health clinicians around how to appropriately care for women and refer on to additional specialist services. In particular, the lack of community support agencies, including housing and protected refuges for victims, is a major deterrent to positive detection; as staff may be unable to provide ongoing assistance and support for women who disclose abuse. Not having available refuges and shelters to escape abuse is particularly problematic as it is the most widely used intervention for domestic violence (Wathen & MacMillan, 2003). Increased availability of local and national domestic violence services is required to ensure women are appropriately cared for in relation to the myriad of psychosocial issues related to domestic violence (e.g. accommodation, legal services, food support, financial help, custody of children). Having such advocacy-based interventions has been found to reduce abuse, and increase community resources, safety behaviours, social support and quality of life (Feder et al., 2009).

8 | LIMITATIONS

The study utilized an open-question, semi-structured interview guide to better explore all lived experiences and levels of knowledge and understanding that may exist within the sample. Despite this, a qualitative approach may compromise the generalizability, and therefore, the reliability of these research results. Interviews and surveys involving clients and a wider range of clinical roles, medical chart audits and recruitment from other sites would greatly benefit the knowledge of these important areas. The data were collected in one hospital and health service, and therefore, the findings cannot be generalized.

9 | CLINICAL IMPLICATIONS AND FUTURE DIRECTIONS

While the response to domestic violence in hospitals and community health settings is still an important topic of research conducted worldwide, the intersection of this issue with mental health is far more complicated. Clinicians must be able to quickly and safely assess how to capture and prioritize the many potential factors affecting clients, including the physical impacts of acute and chronic illness, violence, self-harm or misadventure; psychological and psychiatric manifestations, and the numerous environmental and socio-economic factors often seen in the mental health population; including domestic violence, homelessness and substance use. Improved training methods and tools to provide access to knowledge and resources would need to be created; linking to services designed with both domestic violence and mental health in mind. Further research and development into improved training methods and resources is warranted.

10 | CONCLUSION

This study of qualitative research identified a variety of barriers to disclosure in mental health services. It also uncovered a complex interface of factors that impact the delivery of domestic violence

responses to mental health clients with the lived experience of domestic violence. While routine screening is becoming a common aspect of health care in many hospital settings, the findings indicate that knowledge, confidence and expectations to screen are not always priorities within the arc of mental health responses. The immediate concern identified by many is the presenting "clinical" symptoms of mental illness rather than the screening and identification of domestic violence. The study highlights a number of potential strategies to improve clinician knowledge, confidence and ability to attend to domestic violence clients; such as mandatory education and training; written guidelines and resources; and embedded domestic violence screening questions.

11 | RELEVANCE STATEMENT

Several mental health nurses, social workers, and psychiatrists were interviewed to gain an in-depth understanding of their experiences with domestic violence screening within a large mental health service provision. Hospital policies or procedures implemented to support clinicians address some of the issues raised in this paper would benefit and support mental health clinicians to care for clients and improve client disclosure rates, improve referral rates to community services and provide immediate support for all clients experiencing domestic violence.

AUTHOR CONTRIBUTIONS

KB, AC and KT contributed to the conception and design of the study. KG, GB and KT aided in recruitment and data collection. KG and GB completed the preliminary data analysis. KG wrote the draft manuscript, and all authors edited and approved the final manuscript.

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CONFLICT OF INTEREST

No conflict of interest to declare.

DATA AVAILABILITY STATEMENT

De-identifiable transcripts were used in the study and may be made available upon request.

ETHICS STATEMENT

On behalf of all the authors, I wish to advise that the paper is the authors' original work, has not received prior publication and is not under consideration for publication elsewhere. All authors have seen and approved the manuscript being submitted and abide by the copyright terms and conditions of the Journal.

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