Surveying Public Health Units to learn the process health units undertook to implement the Routine Universal Comprehensive Screening (RUCS) protocol

By

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Introduction:

Woman abuse is a prevalent social and health concern in Canada today. The World Health Organization (Krug et al., 2002) and the National Clearinghouse on Family Violence (2002) assert that woman abuse is associated with significant short and long term health implications for its victims. It has been estimated that women subject to abuse have a sixty percent higher incidence of health consequences on physical, sexual, reproductive and mental health (Campbell, 2002). Health risks associated with woman abuse include, but are not limited to: injuries (such as broken or fractured bones or teeth), chronic pain, gastrointestinal disorders, gynecological disorders, substance abuse, depression and anxiety disorders, phobias and ultimately death (Krug et al., 2002; National Clearinghouse on Family Violence, 2002).

How common is woman abuse in Canada today?

The prevalence of woman abuse remains unknown as many cases of such abuse go undisclosed, unreported or underreported. Still, attempts to estimate the prevalence of woman abuse in Canada have been made. According to Statistics Canada, seven percent of women have experienced violence at the hands of their current or previous partner between 1999 and 2004.

Forty four percent of women who have experienced abuse suffered injuries due to the abuse. Thirteen percent of these have sought medical attention for the sustained injuries.

Violence against women

7% - the estimated percentage of women in a current or previous spousal relationship who experienced spousal violence during the five years up to and including 2004. Rates of spousal abuse were highest among certain segments of the population: those aged 15 to 24; those in relationships of three years or less; those who had separated; and those in common-law unions.

23% - the percentage of female victims who reported that the most serious form of violence experienced was being beaten, choked, or threatened by having a gun or a knife used against them.

44% - the percentage of female victims of spousal abuse who indicated that they suffered injury because of violence, with 13% seeking medical attention.

38% - the percentage of women who reported the abuse to the police who sought a restraining order.

24% - the percentage of Aboriginal women who said they had suffered violence from a current or previous partner in the five-year period up to 2004. The overall rate of Aboriginal spousal violence (both men and women) was 21% during this period, compared with 6% for the non-Aboriginal population.

The Issue: To Screen or not to Screen?

The use of screening tools for woman abuse by health care providers has been a subject of interest in recent years in response to growing understanding of the link between woman abuse and its impact on victim's health. A variety of research in support and opposition of universal screening of woman abuse in health care settings has grown. In Ontario, the use of such screening tools has been recommended by The Task Force on The Health Effects of Woman Abuse (Middlesex-London Public Health Unit, 2000) as well as by the RNAO Best Practice Guidelines (2005) and has been implemented by a number of Public Health Units (PHUs) as well as other health care providers.

A number of studies have noted the effectiveness of screening tools for woman abuse in health care settings as an intervention with the purpose of woman abuse detection and safety increase. In her systematic review, Trabold (2007) has argued that universal screening for woman abuse increases identification of woman abuse. Further, when comparing the rate of disclosure of woman abuse upon inquiry by nurses with the rates of self-report of woman abuse, MacFarlane et al. (1991) have found a higher disclosure rate of woman abuse amongst women who were inquired by nurses.

Similarly, when a woman abuse screening protocol was introduced by social workers in obstetrics and gynecology, detection has increased. That is, woman abuse detection in the intervention group was 41%; compared with 14% identification rate in the control group (Norton et al., 1995). Rates of woman abuse disclosure were higher, moreover, when routine screening was conducted verbally. That is, when screening for woman abuse in pediatric settings, disclosure rates were 16% when screened verbally, compared to 0% in written screening assessments (Anderst et al., 2004). In their study, Soglin et al. (2009) explored three methods of woman abuse identification at a general medicine practice in an urban centre. Firstly, researchers asked female patients to participate in an anonymous survey upon registration for visit. Additionally, physicians in the clinic have reviewed 330 charts of women that were seen in the clinic.

Finally, a nursing focused routine inquiry woman abuse intervention was conducted as patients' vital signs were taken. Soglin et al. (2009) noted that the identification of lifetime woman abuse in routine inquiry by nursing staff was significantly higher when compared with chart review by physicians. However, screening for woman abuse does not merely benefit women in abuse identification. Screening women for abuse may provide avenues for such interventions as connecting positively screened women to health and social supports, advocacy and case management (Krasnoff et al., 2002; Trabold, 2000). Furthermore, MacMillan et al. (2009) have noted that the quality of life for women screened for woman abuse using a written, self-report version of the WAST (Woman Abuse Screening Tool) has improved. Likewise, depression scores for women who completed WAST have improved (MacMillan et al., 2009).

Routine screening for woman abuse by health care providers is not *only necessary, but it has also been noted to be accepted and appreciated by women*. Carlson Gielen et al. (2000) confirm this in their study looking at women's opinions regarding universal screening and mandatory reporting of woman abuse. More specifically, Carlson Gielen et al. (2000) have noted that 86% of women (both in the case and the control groups) agreed

that routine screening made disclosure of woman abuse simpler for victims. Further, 96% of all study subjects noted that they would appreciate inquiries about abuse by health care providers. Interestingly, women from the case group supported routine screening at a higher rate than women in the control group (Carlson Gielen et al., 2000). Further, 74.5% of women from the case group who were screened by a health care provider for abuse felt that the experience was helpful (Carlson Gielen et al., 2000). This finding corresponds with MacMillan et al (2009) and Cole (2000)'s findings. In particular, MacMillan et al (2009) and Cole (2000) note that screening for woman abuse has not lead to retaliation of violence or to decrease in quality of life among screened women compared to non-screened women.

While some research has supported the use of routine, universal screening of woman abuse by health care providers, some studies present a differing view. Particularly, MacMillan et al. (2009) concluded that routine screening of women for woman abuse was ineffective in reducing violence or improving health outcomes for women. Namely, in their randomized control trial, MacMillan et al. (2009) used the Woman Abuse Screening Tool (WAST) to conclude that such factors as woman abuse recurrence, PTSD symptoms and mental health problems declined over time among both screened and non-screened groups. Additionally, no difference was noted between access to violence related health and social services between the groups.

Challenges of Screening:

One of the greatest challenges associated with routine universal comprehensive screening of woman abuse is related to implementation and practice of screening. While it has been argued that the use of screening tools for woman abuse is beneficial, the implementation and use of these tools remain inconsistent and low (Waalen et al., 2000). Rodriguez et al. (1999) surveyed four hundred medical doctors across California for the use of screening tools for Intimate Partner Violence (IPV). It became evident that routine screening for IPV was significantly less common than indicator based screening or screening in response to physical injury. To illustrate, 79% of surveyed physicians claimed to always or often ask patients with injuries about abuse, as opposed to 9% who asked routinely (Rodriguez et al., 1999). This inconsistency in screening tool implementation and use is caused by various barriers to screening.

A number of barriers have been identified for routine woman abuse screening. These can be divided into three main categories: patient related barriers, health care provider related barriers and mutual barriers (Rodriguez et al., 1999). Patient related barriers are the most influential obstacles for IPV disclosure. These are associated with patient fears of partner retaliation, police involvement and lack of follow up (Rodriguez et al., 1999; Waalen et al., 2000). Health care provider related barriers are generally due to lack of training, fear of offending the patient by asking about woman abuse, lack of time/opportunity to ask the patient and lack of follow up resources to provide to patients (Rodriguez et al., 1999; Waalen et al., 2000). Finally, mutual barriers are associated with cultural and language differences, as well as lack of privacy (Rodriguez et al., 1999; Waalen et al., 2000). Additional barriers discussed by Waalen et al. (2000) include: population is not likely at risk of woman abuse, health care provider forgot to ask, and

screening is not mandated as a professional responsibility. There are numerous approaches to screening as noted in table 1 below:

Table 1: Approaches to screening for IPV by health care providers (adapted from London Middlesex Health Unit, 2000).

Approach to Screening	Description
Indicator Based Diagnosis	Health care provider inquires client about abuse after noticing two or more **indicators** of abuse.
Routine Screening	Health care provider asks client about abuse upon **regular interactions** with the client, regardless of indicators of abuse presence.
Comprehensive Screening	Health care provider inquires whether client has (in the **past**) or is (**currently**) experiencing any form of physical, sexual or emotional abuse.
Universal Screening	Health care providers ask **all** clients over a certain age about their experiences with past/present abuse.

The Routine Universal Comprehensive Screening (RUCS) Protocol –

Background

Following a number of fatal incidents of woman abuse in the late nineties, the Middlesex – London Public Health Unit initiated a domestic violence committee whereby the Routine Universal Comprehensive Screening (RUCS) protocol was developed for screening for woman abuse in health care settings. Beginning in 2002, the Honourable Marion Boyd, a member of the Ontario Public Health Association (OPHA) Violence Prevention workgroup, has co-ordinated and provided training to numerous public health units across Ontario to facilitate the implementation of the RUCS tool within public health units.

Purpose of Inquiry:

The purpose of this inquiry is to inform the OPHA Violence Prevention Workgroup on the process the respective health units undertook in implementing the RUCS protocol. More specifically, the workgroup has sought to find out which health units have implemented the RUCS protocol and if they received training.

Methods:

A survey tool was developed by Inna Uretzki, practicum student from Factor – Inwentash Faculty of Social Work, University of Toronto as directed by the OPHA Violence Prevention Workgroup in consultation Angela Loconte, field instructor from Toronto Public Health to inquire about the process undertaken by health units in implementing the RUCS protocol (see appendix A for survey tool sample). The draft survey tool was then circulated among a number of the OPHA violence prevention workgroup members, namely Dia Mamatis (Toronto Public Health), Lori Snyder McGregor (Region of Waterloo Public Health), Lynn Gates (Halton Public Health) and Rhonda Usenik (Thunder Bay District Health Unit) for feedback and suggestions. Once reviewed and finalized, the survey was pilot tested with a violence prevention workgroup member, Rhonda Usenik (Thunder Bay District Health Unit) prior to wider survey administration.

A list of all Public Health Units in Ontario was obtained from the Ontario Ministry of Health and Long Term Care website. This list was synthesized with a list of health units that received training in RUCS from Marion Boyd (see table 2 below). All Ontario public health units were contacted to recruit staff responsible for RUCS or woman abuse in the respective public health unit. The staff was then informed of the inquiry and an information letter, a consent form and a copy of the survey were emailed or faxed to the staff (See Appendix B). This was followed by a phone call to the staff to schedule a survey interview date. Survey interviews were conducted over the phone and in person between October 2009 and March 2010. Twenty three of thirty four health units in Ontario have participated in the survey.

Results and Discussion:

Collected data was recorded and analyzed and findings follow in the section below.

Table 2: Listing of Public Health Units within LHIN catchment area in relation to RUCS training and implementation along with survey participation.

LHIN	Public Health Unit	Received Training in RUCS	Did not Receive Training in RUCS	RUCS Implemented	RUCS wasn't Implemented	Responded to the Survey (Y-yes, N-No)
Erie St. Clair	Chatham-Kent Health Unit	✓		✓		Y
	Lambton Health Unit		✓	✓		Y
	Windsor-Essex County Health Unit	✓		✓		Y
South West	Huron County Health Unit	✓				N
	Middlesex-London Health Unit	✓		✓		Y
	Grey Bruce Health Unit	✓		✓		Y

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LHIN	Public Health Unit	Received Training in RUCS	Did not Receive Training in RUCS	RUCS Implemented	RUCS wasn't Implemented	Responded to the Survey (Y-yes, N-No)
South West	Elgin-St. Thomas Health Unit	✓		✓		Y
	Perth District Health Unit	✓		✓		Y
	Oxford County Public Health & Emergency Services	✓		✓		Y
Waterloo Wellington	Wellington-Dufferin-Guelph Health Unit	✓		✓		Y
	Region of Waterloo, Public Health	✓		✓		Y
Hamilton Niagara Haldimand Brant	Brant County Health Unit	✓				N
	City of Hamilton - Public Health & Social Services	✓				N
	Haldimand-Norfolk Health Unit	✓				N
	Niagara Region Public Health Department		✓		✓	Y
Central West	Peel Public Health	✓		✓		Y
Mississauga Halton	Halton Region Health Department	✓		✓		Y
Toronto Central	Toronto Public Health		✓		✓	Y
Central	York Region Public Health Services	✓		✓		Y
Central East	Peterborough County-City Health Unit	✓		✓		Y
	Haliburton, Kawartha, Pine Ridge District Health Unit		✓			N
	Durham Region Health Department		✓			N
South East	Hastings and Prince Edward Counties Health Unit	✓		✓		Y
	Kingston, Frontenac and Lennox & Addington Health Unit	✓				N
Champlain	Leeds, Grenville and Lanark District Health Unit	✓		✓		Y
	Eastern Ontario Health Unit	✓		✓		Y
	Ottawa Public Health	✓				N
	Renfrew County and District Health Unit	✓				N

LHIN	Public Health Unit	Received Training in RUCS	Did not Receive Training in RUCS	RUCS Implemented	RUCS wasn't Implemented	Responded to the Survey (Y-yes, N-No)
North Simcoe Muskoka	Simcoe Muskoka District Health Unit		✓			N
North East	Timiskaming Health Unit	✓			✓	Y
	North Bay Parry Sound District Health Unit	✓				N
	Algoma Public Health Unit	✓		✓		Y
	Sudbury and District Health Unit	✓			✓	Y
	Porcupine Health Unit		✓			N
North West	Northwestern Health Unit		✓			N
	Thunder Bay District Health Unit	✓		✓		Y

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RUCS Protocol Implementation amongst PHU's across Ontario:

Representatives of twenty three of the thirty six public health units (PHU) across Ontario who agreed to be interviewed constituting a PHU response rate of 64%. Of these twenty three responding public health units, eighteen PHU (or 78.3%) have implemented the RUCS protocol and continue to implement RUCS at the time of inquiry, while five PHU (or 21.7% of respondents) have not implemented the RUCS protocol (see figure 1 below).

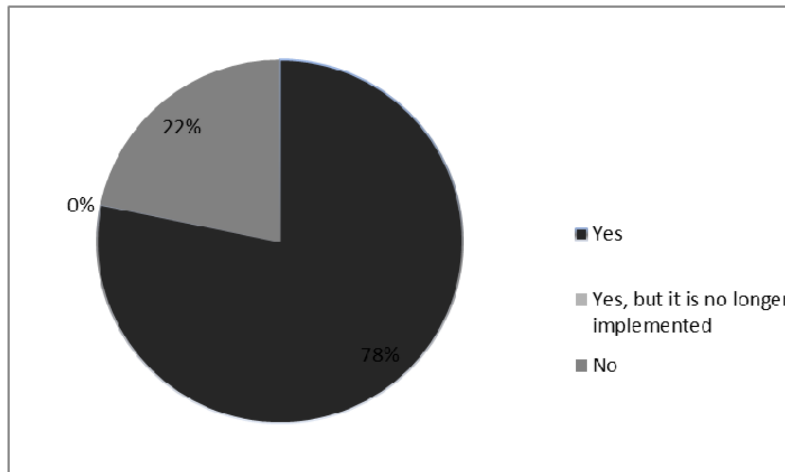


Figure 1: Percentage of PHU that are currently using RUCS as a screening tool when working with the public (based on 23 HU that participated in the survey)

Timeline for RUCS protocol Implementation:

RUCS protocol has not been implemented uniformly among the surveyed PHU. That is, its implementation time was unique to each PHU (see table 3 and figure 2), with seventy two percent of responding PHUs implementing the protocol between 2003 and 2005. More specifically, six of the responding PHUs have implemented RUCS in 2003. Additional three PHUs have implemented the protocol in 2004, while four PHUs have implemented RUCS in 2005. It is important to note that Early Childhood Development funding was provided to PHUs between 2003 and 2005 which might account with greater implementation trends within 2003-2005 time period.

Table 3: RUCS Protocol Implementation by year.

Implemented prior to 2003	**Implemented in 2003**	**Implemented in 2004**	**Implemented in 2005**	**Implemented after 2005**
Middlesex London Public Health	Peel Public Health Unit	Chatham Kent	Grey Bruce Public Health	York Region Public Health Services
Algoma Public Health Unit	County of Oxford	Hasting Prince Edward County Public Health	Peterborough County-City Health Unit	Perth District Health Unit
	Region of Waterloo Public Health	Thunder Bay District Health Unit	Lambton Health Unit	
	Windsor- Essex County Health Unit			
	Wellington Dufferin Guelph Health Unit			
	Leeds, Grenville and Lanark District Health Unit			

Differential introduction/implementation Process of the RUCS Protocol amongst PHU:

While RUCS initiation/introduction took different forms, some introduction/initiation methods were common among the PHUs. For example, a number of PHUs have cited that RUCS was introduced through general education and training sessions on woman abuse and woman abuse prevention for nurses and family health staff to introduce RUCS. Additionally, staff in some PHUs has received RUCS specific training from Hon. Marion Boyd. Additional factors in RUCS introduction was the HBHC home visiting program. Some respondents, furthermore, have cited the assistance of the early years funding as well as funding for injury prevention programs as factors responsible for RUCS introduction. Another common introduction method was the incorporation of RUCS into the documentation process of some PHUs. In particular, it

was incorporated into the HBHC home visiting documentation process. Some PHUs noted the formation of a steering committee or community committees to introduce RUCS. These committees assisted in coordination training in woman abuse and developing RUCS specific policies. Some PHUs have relied on the Ontario Medical Association guidelines and the RNAO guidelines to introduce RUCS.

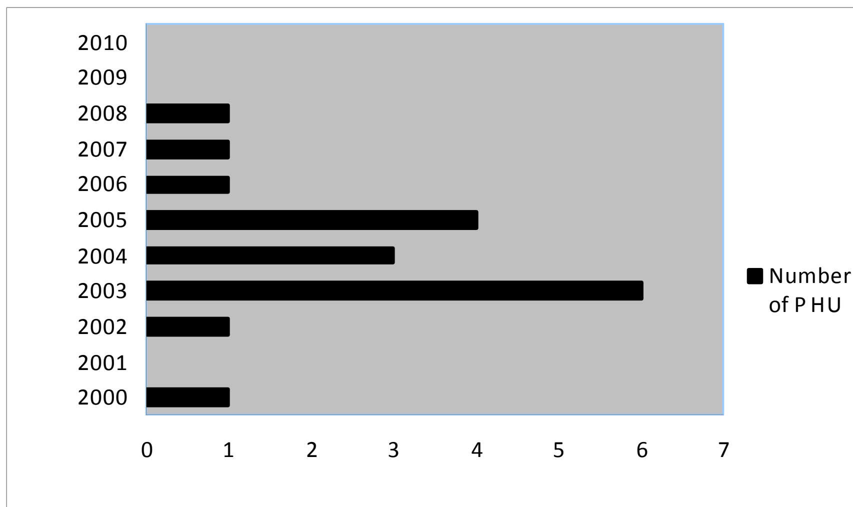
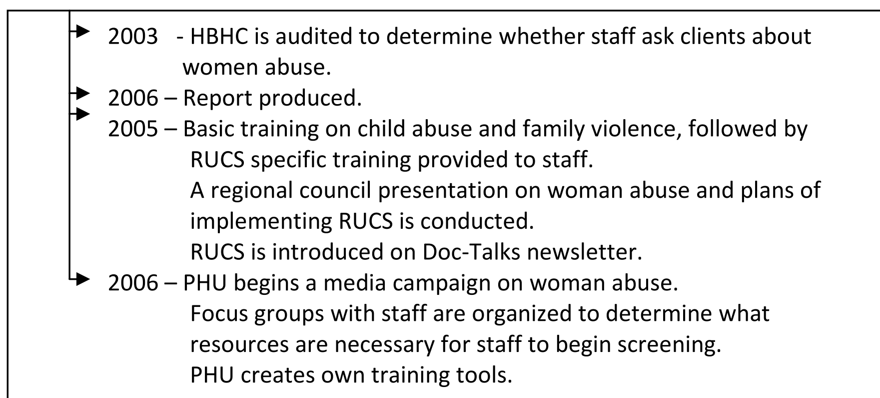


Figure 2: Number of PHUs that have implemented RUCS protocol in relation to year of implementation.

Of particular interest was the introduction of RUCS by York Region Public Health Unit. Initially, HBHC program was audited to examine whether PHNs are asking clients about woman abuse. This was followed by providing all PHU staff with general family violence training and RUCS specific training. Finally, PHU took part in a media campaign on woman abuse and developed own training materials (see chronological chart/figure 3 below).



2003 - HBHC is audited to determine whether staff ask clients about women abuse.
2006 – Report produced.
2005 – Basic training on child abuse and family violence, followed by RUCS specific training provided to staff.
A regional council presentation on woman abuse and plans of implementing RUCS is conducted.
RUCS is introduced on Doc-Talks newsletter.
2006 – PHU begins a media campaign on woman abuse.
Focus groups with staff are organized to determine what resources are necessary for staff to begin screening.
PHU creates own training tools.

Figure 3: RUCS Introduction to York Region Public Health Unit: Chronological Order of Events.

Programs/ service areas that have implemented RUCS:

RUCS protocol has been implemented into various PHU programs or service areas (see table 4). Some PHU have implemented the protocol into more than one program/service area. Most commonly, RUCS has been implemented into the HBHC program. Likely, this is due to the availability of ECD funding which was provided specifically for the HBHC program which was corroborated by a large number of PHUs who cited this funding as a facilitating force in the implementation of RUCS (see figure 6). Overall, RUCS protocol has been implemented into the following programs/service areas as noted below:

Table 4: Quantitative distribution of service areas that have implemented RUCS in PHUs across Ontario.

Service Areas within which RUCS was Implemented:	Number of PHU That have Implemented RUCS
HBHC	18
Family planning and STI/sexual health clinics	14
Family health/reproductive health program	10
Infant-child development programs	4
Parental programs and school based nursing	1

As can be seen above, it would appear that RUCS has not been implemented uniformly across service areas within PHUs. Further, there is no standard list of programs/ service areas for all PHUs in Ontario. Hence, the same programs/ service areas may be named differently in different PHUs. Furthermore, there may be overlap between programs/service areas that have implemented RUCS.

Factors that Facilitated the Implementation of RUCS:

Responding PHUs that have implemented RUCS protocol have identified a number of factors that facilitated its implementation. Factors included: External and internal policy regarding woman abuse, support from management, a champion in the health unit, ECD funding, availability of other funding, training for staff, as well as other internal and external supports for staff. *The single most important factor for RUCS implementation identified by the respondents was managerial support for staff, as 88.9% of respondents selecting this factor.* Training for staff was identified as an important factor for facilitating the implementation of RUCS by 83.3% of respondents. Following these factors, both ECD funding and a champion in the health unit have been deemed significant facilitating factors for the implementation of RUCS, with 72.2% of the respondents selecting these. 66.7% of the respondents felt that the implementation of

RUCS in their health unit was facilitated by the internal policy regarding woman abuse developed in their respective PHU. While external policy regarding woman abuse, external supports for staff, internal supports for staff and availability of other funding were also identified as facilitating factors, these were less significant (see figure 4 above).

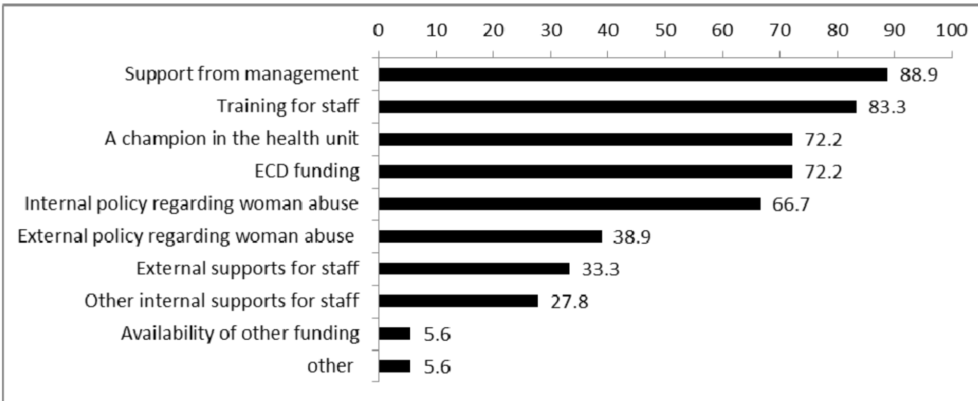


Figure 4: Percentage distribution of factors that facilitated the implementation of RUCS (PHU respondents that have implemented RUCS).

All PHUs that have implemented RUCS have incorporated the protocol into their documentation process. Still, only 38.9% of PHU respondents that have implemented RUCS have established a RUCS related committee. The purpose of these committees ranged from: advisory committees, to training and peer support committees, and planning and policy developing committees. Still, most committees were established in around the time of RUCS introduction into the PHU. That is, not all established committees continued to function at time of inquiry. Similarly, merely 5 PHUs, or 27.8% of responding PHUs that have implemented RUCS, have conducted formal evaluation of the protocol. The process respective PHU's undertook to implement RUCS protocol is noted in table 5 below.

Table 5: Number of PHUs that have Undertaken A Process to Facilitate RUCS

Process Undertaken by PHUs to Facilitate RUCS Implementation:	**Number of Responding PHUs that have implemented this process:**
Incorporated in the documentation process	18
Have established a committee	7
Have conducted a formal evaluation	5

RUCS Training:

Twenty six of the thirty six PHU across Ontario have received formal training on RUCS from Hon. Marion Boyd (refer to Table 2)**.** Eighteen of these twenty three respondents noted that their health unit has received training in RUCS. That is, 79% of all respondents have received training in RUCS. Additional three PHUs (i.e. 13 percent of respondents) were offered training, but have not pursued it. One PHU (4% of respondents) was never offered training.

Training was provided to different service areas within PHUs. Namely, RUCS training was provided to the following service areas: HBHC (72% of all PHUs that have received training), Sexual and Reproductive Health (72% of all PHUs that have received training), Family Health (67% of PHUs that have received training involved family health), Infant/Child Development (50%) and Health info line (5%).

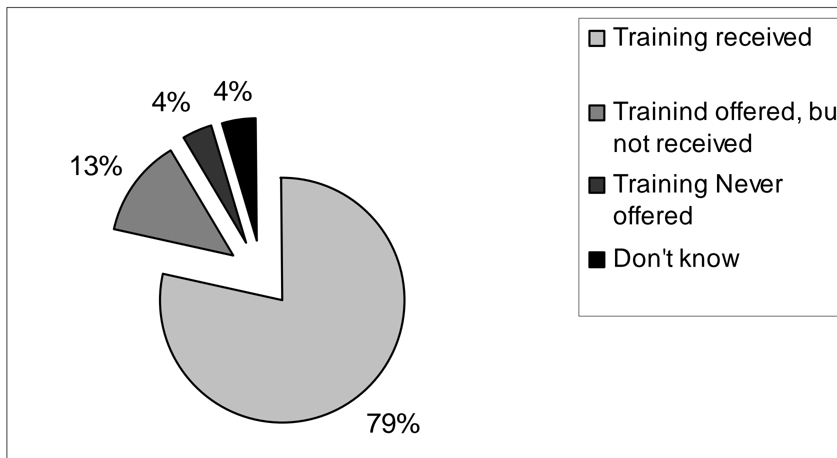


Figure 5: Percentage distribution of training percipiency based on responding PHUs.

It is important to keep in mind that while PHUs follow the same general guidelines for service areas, some services are provided by different departments across the PHUs. For example, some PHUs contain child development service in the family health services. Alternatively, some PHUs separate sexual health/STI clinics from reproductive health. In turn, the above numbers may not be accurate across all PHUs.

Further, different staff designations were trained in RUCS Protocol. That is, some PHUs have only provided training for Registered Nurses (RN), while PHUs have provided training for RNs as well as other health professionals, including but not limited to: home visitors, dieticians, mental health/ addiction workers, dental workers, educators and administrative staff.

Thirty nine percent of the PHUs that have received initial training on the RUCS Protocol have also received follow up training (as can be noted from Table 2). Generally, the follow up training took place within one to two years since its implementation.

Additionally, some PHUs continued to provide RUCS Protocol training on a yearly basis. Fifty percent of PHUs that have received initial RUCS Protocol training have not pursued follow up training. Additional two respondents (amounting to eleven percent of respondents) were not sure whether the PHU has received training. Only thirty three percent of respondents that have received RUCS Protocol training were interested in obtaining future follow up training in RUCS Protocol.

Stuff turnover was accommodated in a number of ways for training purposes. Providing RUCS Protocol training during orientation to service area and providing new staff with self learning packages were the most common means of accommodating staff turnover, with sixty seven percent of responders. Seventeen percent of respondents provided regular in service to staff in their service areas. An additional eleven percent accommodated staff turnover via informal staff/colleague mentoring. Finally, five percent of respondent (one PHU) has also responded to staff turnover via video training.

***Factors that would Facilitate RUCS Implementation in PHUs that haven't Implemented the Protocol:*:**

In PHUs where RUCS was not implemented, respondents were asked for factors that would have facilitated the implementation of the protocol. The following facilitating factors were identified: additional training (60% of respondents), research evidence of effectiveness (60%), more support to staff (other than training) and policy or procedure developed by your health unit or OPHA (40%), more commitment to woman abuse prevention on behalf of the board of health members/ senior management and other mandated explicitly as a ministry of health standard (20%). None of the respondents felt that better knowledge of and access to referral network or accessibility or availability of services for abused women in the community would facilitate RUCS implementation.

Respondents from PHUs that have implemented RUCS were asked about their involvement in facilitating RUCS implementations for others in the community. Ten of the 18 PHUs that have implemented RUCS have helped to initiate/facilitate RUCS for others in the community. Seven of the PHUs have not facilitated/initiated RUCS for community organizations, while one respondent was not sure whether the PHU has facilitated or initiated RUCS for others in the community (see table 2).

Only nine PHUs (i.e. 39.1%) were aware of RUCS protocol utilization by others in the community, while fourteen (60.9%) of the responding PHUs were unaware of others in the community that utilized RUCS protocol. The nine PHUs came from the following LHINs: Erie – St. Clair, Central West, Central East, South West, Waterloo – Wellington, and Champlain.

Table 6: Rate and percentile representation of initiation/facilitation of RUCS to others in the community by PHUs that have implemented RUCS.

	Number of Health Units	Percentage of respondents
Yes	**10**	55.6
No	**7**	38.9
Don't know	**1**	5.6

Inclusion of Woman Abuse Prevention within PHUs Plans:

Eighty three percent of responding PHUs include woman abuse prevention within their plans, under the following categories: sexual health, HBHC, family health, injury prevention and chronic disease prevention. The distribution of woman abuse prevention planning by categories can be seen in the figure below.

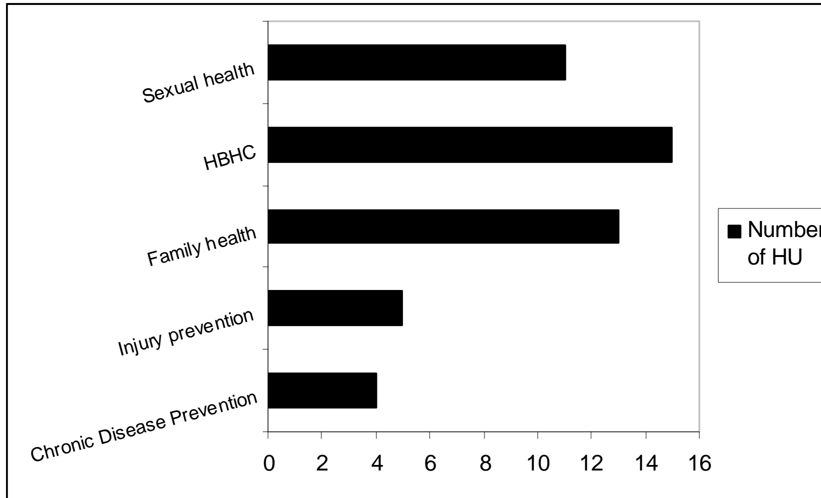


Figure 6: Distribution of PHUs Woman Abuse Prevention Planning by Service Categories.

Could the OPHA Violence Prevention Workgroup be useful to your PHU?

When asked about ways in which the OPHA Violence Prevention Workgroup could be of assistance for PHUs, respondents noted a number of options. Mostly, respondents felt that the OPHA Violence Prevention Workgroup should act as a communicator between health units. That is, respondents felt that the group should act as an information sharing group and provide updates about practices amongst the PHUs. Additionally, respondents wanted the group to provide PHUs with various resources, including latest research and evaluation of effectiveness, support and training resources, and follow up training provision. Some PHUs wanted the group to assist them with funding for RUCS Protocol implementation. One PHU wanted the group to assist them through advocating for RUCS to be added to ISCIS (HBHC data base for charting).

Anecdotal evidence:

In addition to the quantitative data obtained via the survey, respondents provided qualitative data that largely reflected their own experience with RUCS protocol in their PHUs. Generally, respondents identified both productive factors in RUCS implementation and the obstacles to its implementation.

Respondents noted that the inclusion of RUCS protocol in the RNAO practice guidelines has facilitated the introduction and implementation of the protocol into PHUs. Similarly, some respondents have noted that managerial support was correlated with program success. That is, in PHUs where management prioritized woman abuse, supported RUCS protocol implementation, and provided the staff with appropriate training and resources, RUCS was implemented successfully. Alternatively, where management was not supportive of RUCS, respondents noted that implementation was not as successful. This finding is consistent with quantitative findings described above indicating that managerial support for staff was the most important factor for RUCS implementation.

Some obstacles associated with RUCS implementation related to staff training. It became apparent that the training process undertaken by PHUs was not standardized but rather has varied amongst PHUs. A limited number of staff were able to attend training by Hon. Marion Boyd from PHUs. Hence, PHUs that have implemented the protocol were generally responsible for training staff on their own. Furthermore, the training was not a consistent, standardized process. That is, PHUs developed their own training, using different areas of woman abuse screening as a focus point of the training. As a result, some PHUs trained staff on general woman abuse topics rather than on RUCS specific woman abuse screening. Moreover, there were variations in training provision for service areas within health units. That is, only selected departments within the PHU have received RUCS training. For example, some PHUs have only provided training to HBHC and family health service areas. This was mainly a result of funding allotment to these service areas (HBHC funding). One respondent felt that this difference in training patterns among service areas should have been accounted for since department respond to different needs.

Some respondents noted that staff felt reluctant to inquire about woman abuse for fear of a positive answer. That is, some PHU staff did not feel ready to deal with woman abuse. Respondents felt that this was due to limited training/ education about woman abuse. Similarly, some respondents felt that this was a resulted of limited resources and supports for staff availability. Additionally, one respondent felt that the practical application of the screening tool (i.e. RUCS) was problematic since fathers were often present during post partum visits. Additionally, some respondents felt that there was a disconnect between screening for woman abuse and referring positively screened women for further services, particularly in PHUs in more remote locations, where services for victims of abuse were simply unavailable.

Furthermore, factors such as staff turnover, internal staff/managerial resistance to RUCS implementation, and lack of funding impeded RUCS implementation. These factors are interrelated, as funding is needed for training new staff (due to turnover). One respondent, moreover, felt that RUCS Protocol was not a true screening tool, but rather an assessment tool. The responded also noted that her PHU would like to see a reevaluation of the tool.

RUCS evaluation findings:

Grafton et al. (2006) evaluation of RUCS implementation within selected PHU's found that training in the RUCS protocol was primarily provided to public health nurses that work with women. In some health units, all employees were trained in the protocol. Additionally, trainees were provided with resources about woman abuse and referral resources in their communities (Grafton et al., 2006; Middlesex - London Public Health unit 2002). Furthermore, it has since been successfully incorporated into the postpartum component of the Healthy Babies Healthy Children program (Grafton et al., 2006). More specifically, a retrospective chart inquiry has revealed an almost twenty fold increase in woman abuse documentation following RUCS introduction (Grafton et al., 2006). Further, the introduction of RUCS was noted to reduce "targeted" woman abuse identification. That is, its introduction has eliminated demographic differences between those screened and those who were not screened as RUCS is a universal, not indicator based, tool (Grafton et al., 2006). Finally, Vanderburg et al. (2010) have looked at the implementation of RUCS protocol within Algoma Public Health Unit and noted that since program implementation, practices around safety and privacy of women have improved.

CONCLUSION:

The inquiry was conducted to inform the OPHA Violence Prevention Workgroup on the process the public health units undertook in implementing the RUCS protocol. The inquiry yielded quantitative and qualitative responses on the process of RUCS implementation. Seventy eight percent of responding PHUs have implemented RUCS protocol from 2000 to 2008. The protocol was introduced to PHUs via training and staff education on topics of woman abuse. Additionally, the protocol's incorporation into the documentation processes of the PHU was instrumental in its introduction to the respective PHUs. RUCS was primarily incorporated into the family planning/STI clinics, family health and prenatal/child health service areas. Respondents noted a number of factors that facilitated the incorporation of RUCS into the PHU. Managerial support, training for staff, champion in PHU, ECD funding and internal policy in the PHU were identified as imperative factors for RUCS implementation. Seventy nine percent of respondents have confirmed receiving RUCS training.

SUMMARY REMARKS:

A number of respondents have suggested that the OPHA Violence Prevention Workgroup provide assistance to PHUs in the following areas:

1. Information and resource sharing with a focus on research findings and evaluation effectiveness.

2. Support and training resources in addition to provision of follow-up training.

3. Assistance in the acquisition of funding for RUCS protocol implementation.

4. Advocating for RUCS documentation to be added to ISCIS (HBHC data base for charting)

RECOMMENDATIONS:

The OPHA Violence Prevention Workgroup deliberate on action steps needed to accommodate the respondents suggested areas of assistance.

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Appendix A:

For researcher use only:
☐ Written consent received
☐ Verbal consent received

Ontario Public Health Association – Violence Prevention Workgroup:

"Surveying Public Health Units to learn the process health units undertook to implement the Routine Universal Comprehensive Screening (RUCS) Protocol"

Interviewee code:
Public Health Unit and Department:
Date of Interview:

Background

Following a number of fatal incidents of woman abuse in the late nineties, the London-Middlesex Public Health Unit initiated a woman abuse committee whereby the Routine Universal Comprehensive Screening (RUCS) protocol was developed for health care professionals in screening for woman abuse.

Starting from 2002, the Honourable Marion Boyd, a member of the Ontario Public Health Association workgroup, has co-ordinated and provided training to numerous public health units across Ontario to facilitate the implementation of the RUCS tool within public health units.

Purpose of Inquiry:

The purpose of this inquiry is to inform the OPHA Violence Prevention Workgroup on the process the respective health units have undertaken in implementing the RUCS protocol. More specifically, our workgroup would like to find out which health units have implemented the RUCS protocol and what facilitated the implementation of the RUCS.

Interview questions:

1. Is your public health unit currently using RUCS as a screening tool for woman abuse as part of routine screening when working with the public?

☐ **Yes**

I would like to find out the process undertaken by your health unit in implementation.

a) When did your health unit begin the implementation of RUCS?

b) How did your health unit initiate or introduce RUCS?

c) Which programs/service areas in your health unit have implemented RUCS?

d) What facilitated the implementation of RUCS in your health unit?

- ☐ External policy regarding woman abuse (please name: __________
- ☐ Internal policy regarding woman abuse
- ☐ Support from management
- ☐ A champion in the health unit
- ☐ ECD funding
- ☐ Availability of other funding
- ☐ Training for staff
- ☐ Other internal supports for staff: please describe:
- ☐ External supports for staff; please describe:
- ☐ Other: ______________________

Comments:

e) Was RUCS incorporated into the documentation process in the service areas where it was implemented?

Yes

No

f) Did your health unit establish a RUCS committee?

☐ **Yes**

1. If yes, what has been the role of this committee?

- ☐ Planning/steering committee
- ☐ Advisory
- ☐ Other:

☐ **No**

g) Has your health unit conducted a formal evaluation of RUCS?

Yes

a) What was the purpose or focus of the evaluation?

b) Was a report produced?

Yes (If it is a public document, how can a copy be obtained?)

No

No

Go to Q. 2

☐ **Yes, but it is no longer implemented**.

I. Please elaborate on the reasons for ceasing to implement RUCS

- ☐ Change in policy
- ☐ Funding availability
- ☐ Lack of support for staff
- ☐ Lack of consistent training
- ☐ Found ineffective upon evaluation
- ☐ Other: __________________

Comments:

Go to Q. 2

☐ **No**

h) Could you state the reason for not implementing?

- ☐ Lack of senior management support
- ☐ Lack of support for staff (e.g., training)
- ☐ Funding availability
- ☐ Lack of consistent training
- ☐ Change in policy
- ☐ Other: __________________

Comments:

i) Is your health unit currently using another domestic violence screening tool?

Yes, which one(s) and in which service areas etc.

Tool: Service Area: _________________

Tool: Service Area: _________________

No

2. Has your health unit received training in RUCS?

☐ Yes, received training

a. Which service areas have received training?
b. Which staff designation has received training?
c. Did your health unit receive follow up training?
    - **Yes**
        a) After how many months/years did the follow-up occur?
        b) How many training sessions were provided over the previous five years?
    - **No**

d. Are there any plans for follow up training at your health unit?
    - ☐ **Yes**
    - ☐ **No**
e. How does your health unit accommodate staff turnover from RUCS training perspective?

    a) Offers training on RUCS during orientation to the service area

    b) Offers regular in-service training to staff in the service area

    c) Provides self-learning package to new staff in the service area

    d) Other: ____

f. How useful was the training, overall, in helping the service areas to implement RUCS?
    a) Extremely useful
    b) Useful

c) Somewhat useful
d) Not very useful
e) Not at all useful
f) Don't know

If it wasn't useful, how could it have been more effective? ___________________

☐ No, training was never offered

☐ No, training was offered but the health unit did not pursue it. Please elaborate.

Answer 3, if your Health Unit is not implementing RUCS or has ceased to implement RUCS

3. Which of the following would facilitate the implementation and use of RUCS by your health unit?
   a. Additional training
   b. More support to staff (other than training)
   c. Better knowledge of and access to referral network
   d. More commitment to woman abuse prevention on behalf of the board of health members/ senior management
   e. Policy or procedure developed by your health unit or OPHA
   f. Research evidence of effectiveness
   g. Accessibility or availability of services for abused women in the community
   h. Other ________________________

   Comments:

4. Did your health unit initiate or facilitate the implementation of RUCS for others in the community?
   a. Yes.

      ☐ To which organizations/individuals?
      ☐ How did you support this organization?

Organization/Group	Info/Promotional materials (buttons, pens, posters, brochures, etc)	One training session only	One training session & one follow-up session	Series of training sessions	Other

b. No.

5. Do you know of others in the community that are utilizing the RUCS protocol in their program service areas?

☐ Yes

Organization	Contact Information

☐ No

6. Could the OPHA Violence Prevention Workgroup be useful to your health unit in any way with respect to implementing the RUCS or with anything else?

7. Does your health unit include woman abuse prevention within its plans and under which category?

a. Yes

- ☐ Chronic disease prevention
- ☐ Injury prevention

- ☐ Family health
- ☐ Healthy Babies Healthy Children
- ☐ Sexual Health

b. No

8. Additional Comments:

Would you like to receive a copy of the final report?

- ☐ Yes
- ☐ No

Thank You for your time. Shall you have any questions following this survey, please do not hesitate to contact Inna Uretzki at (416) 338 0931 or via email, at iuretzk@toronto.ca

Appendix B:

To Whom It May Concern:

Re: Surveying Public Health Units to learn the process health units undertook to implement the Routine Universal Comprehensive Screening (RUCS) protocol.

The Ontario Public Health Association (OPHA) Violence Prevention Workgroup would like to invite you to participate in a post implementation survey of a domestic violence screening tool known as the Routine Universal Comprehensive Screening (RUCS) protocol which was developed by the London-Middlesex Public Health unit and distributed to all Public Health units. nearly five years ago. As an MSW student with this workgroup, I will coordinate the following survey and carry out this survey in consultation with other workgroup members.

Purpose of the survey:

As you may be aware, Marion Boyd, a member of our workgroup, has coordinated training sessions on the use of the RUCS protocol across the province to a number of public health units. The purpose of this survey is to inform our workgroup on the process the respective health units have undertaken in implementing the RUCS protocol. More specifically, our workgroup would like to find out which health units have implemented the RUCS protocol and if they received training

What does participation in the survey involve: survey procedure and methodology

The above described survey is designed to provide our workgroup with greater understanding of the RUCS protocol implementation process.

Your kind participation in this survey will involve two stages. First, you will be contacted by me via email. That is, you will receive a package that will consist of an explanatory letter, consent form and a copy of the survey. Once you decide to participate in the survey, I would request that you fax me your consent form at (416) 338 0921. Following this, I will contact you to schedule a teleconference time, during which I will call you and go over the survey with you. The teleconference should take up about an hour. During the teleconference, I will record your answers to the survey.

All interviews will be kept in a locked cabined for the duration of the survey. After the data from the surveys is recorded, it will be analyzed for the report. Upon study completion, all surveys will be destroyed. Finally, a report of the inquiry will be produced.

Compensation:

There is no monetary compensation for your participation in the above described survey. If you are interested, however, you can request you a copy of report summary upon survey completion.

Please indicate your interest in receiving a copy of the report summary in the consent form you will fax to me prior to interview.

Confidentiality:

For purposes of interview recruiting, I will collect names and positions within the health unit of potential interviewees. The names will be recorded on a name chart, and each interviewee will be given a numeral code that will be recorded on the survey. The name chart will be kept in a locked cabinet for the duration of the inquiry, and will be destroyed immediately after survey completion. Non identifiable responses to survey may be shared with workgroup for the duration of the survey. After survey completion, all identifiable information will be destroyed.

Individual surveys and responses will be kept confidential both throughout the survey and after its completion. While direct quotes from surveys may be used in the report and in consultation with the OPHA violence prevention workgroup, no identifiable information will be used along with these quotes.

Your participation in this survey is greatly appreciated. However, participation is voluntary. As such, you may refuse to participate in the survey or choose to refuse answering specific questions. You may withdraw from the survey at any time. Your wishes in regards to refusal or withdrawal will be respected and any information about you or provided by you will be deleted from the survey.

Risks and benefits associated with participation in the survey:

There are no known risks to participation in the described survey. Benefits associated with the survey include a better understanding of RUCS protocol implementation. Further, the results of this inquiry may be used to improve RUCS implementation. This survey may also suggest a future direction for domestic violence screening tools for health units' use. Finally, you may find this survey beneficial for your work.

Consent:

As mentioned previously, I would like to receive a signed consent form from you prior to initial survey teleconference. Shall you have any questions about the inquiry, please do not hesitate to contact me at 416-338-0931 and/or iuretzk@toronto.ca.

Thank you greatly for your participation,

Inna Uretzki
MSW Student
Urban Issues Team
Policy & Planning
Toronto Public Health

Informed consent for "Surveying Public Health Units to learn the process health units undertook to implement the Routine Universal Comprehensive Screening (RUCS) Protocol"

Date:

Researcher(s): Inna Uretzki with the OPHA Violence Prevention Workgroup

I have read the information letter attached to this consent. The information letter has detailed the purpose of the study, what the participation in the study involves, compensation, confidentiality, and risks and benefits associated with the study. .

Your participation in this study is completely voluntary, and you may choose to stop participating in this study at any time.

I, (participant's name) have understood the nature of this study. I consent to participate in "Surveying Public Health Units to learn the process health units undertook to implement the Routine Universal Comprehensive Screening (RUCS) Protocol" conducted by Inna Uretzki. Shall I have any additional questions about this research; I will contact Inna at (416)338 0931 or iuretzk@toronto.ca

Research Participant's signature: ___________________________________

Date: ___________________________

Researcher's signature: ____________________________________

I would like to receive a copy of report summary upon study completion

Yes☐ No☐

Please complete this form and fax to: (416) 338 0921