Screening for Family Violence in Antenatal Clinics – Clinical Practice Guideline

1. Background

Recommendation 96 of the Victorian Royal Commission into Family Violence (2016) directed all publicly funded antenatal clinics in Victoria to routinely screen for family violence. The hospital system is an early contact point for many people who have experienced family violence. Family violence affects people across their lifetime. Physical assault whilst pregnant or following a new birth is an evidence-based high-risk factor with an increased risk of the victim being killed or almost killed. Research shows that women often experience their first assault during pregnancy, or experience an increase in the form or intensity of violence (Australian Bureau of Statistics, 2012). As such, maternity services at [insert org name] are in a unique position to ensure routine and early identification of these concerns for the benefit of women experiencing family violence.

1. Purpose

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| **Implementation consideration**  This example clinical practice guideline has been developed to be used in conjunction with the existing SHRFV [Identifying and Responding to Family Violence: Sensitive Practice](https://www.thewomens.org.au/health-professionals/clinical-resources/strengthening-hospitals-response-to-family-violence/shrfv-project-management-resources) procedure recognising they are both assigned to the Identification and Screening MARAM level of response. Each hospital should consider where this guideline sits within their existing family violence identification and response policy and procedure framework. |

This clinical practice guideline outlines [insert org name]’s expectations and processes for staff mapped at the Identification and Screening level of response who will undertake routine screening for family violence in antenatal clinics only.

n.b. [insert org’s name] Identifying and Responding to Family Violence: Sensitive Practice procedure is required to be used outside of the antenatal clinic setting when family violence is suspected or disclosed.

The practice requirements of Screening are in alignment with the Victorian Government’s Family Violence Multi-Agency Risk Assessment and Management Framework (MARAM).

At this level, under MARAM staff have a responsibility to:

* Have a shared understanding of the nature and dynamics of family violence
* Provide first-line support to individuals who are identified as experiencing or at risk of experiencing family violence
* Engage respectfully, sensitively and safely and prioritise the safety of victim survivors
* Facilitate an accessible, culturally responsive environment for safe disclosure of information
* Tailor engagement with adults, children and young people, including Aboriginal people and people from diverse communities
* Competently and confidently assess for the presence and risk of family violence as part of routine antenatal screening for family violence.
* Competently and confidently address immediate risk and safety concerns
* Be aware of the evidence-based family violence risk factors and explanations
* Undertake basic safety planning and recognise and address barriers that impact a person’s support and safety options
* Provide a pathway to specialist family violence support, and use information sharing, secondary consultations and referrals
* Contribute to the organisation’s responsibility to share information, and collaborate at a multi-agency level

As child abuse and neglect often occurs within the context of family violence, it is required that all staff responding to family violence are also familiar with the [insert org name] Child Safe Standards. This will support staff to identify unborn babies, infants or children who are at risk of harm. It is also recommended that this guideline is read in conjunction with:

* [Insert relevant Identifying and Responding to Family Violence Policy]
* [Insert relevant Identifying and Responding to Family Violence Procedure: Sensitive Practice]
* [Insert relevant Information Sharing policy and procedures]
* [Insert relevant Child Safe Standards]

1. Definitions

[insert org name] uses the following operational definition of family violence

Family violence is defined by the [Family Violence Protection Act 2008 (Vic)](http://www5.austlii.edu.au/au/legis/vic/consol_act/fvpa2008283/) as behaviour that occurs in family, domestic or intimate relationships that:

* Is physically, sexually, emotionally, psychologically or economically abusive, threatening, coercive; or in any other way controls or dominates and causes a person to feel fear for their safety or wellbeing or that of another person.
* Causes a child to hear or witness, or otherwise be exposed to the effects of the behaviour.

The Act recognises that family violence can occur in family relationships between spouses, domestic or other current or former intimate partner relationships , in other relationships such as parent/carer–child, child–parent/carer, relationships of older people, siblings and other relatives, including between adult-adult, extended family members and in-laws, kinship networks and in family-like or carer relationships

The Victorian Indigenous Family Violence Task Force (2003) defines family violence in the context of Aboriginal communities as:

* An issue focused around a wide range of physical, emotional, sexual, social, spiritual, cultural, psychological and economic abuses that occur within families, intimate relationships, extended families, kinship networks and communities. It extends to one-on-one fighting, abuse of Indigenous community workers as well as self-harm, injury and suicide.’ The definition also acknowledges the spiritual and cultural perpetration of violence by non-Aboriginal people against Aboriginal partners which manifests as exclusion or isolation from Aboriginal culture and/or community.

The definition of family violence in Dhelk Dja, the Aboriginal ten year family violence agreement (2018) also acknowledges:

* The impact of violence by non-Aboriginal people against Aboriginal partners, children, young people and extended family on spiritual and cultural rights, which manifests as exclusion or isolation from Aboriginal culture and/ or community.
* Elder abuse and the use of lateral violence within Aboriginal communities. It also emphasises the impact of family violence on children.
* That the cycle of family violence brings people into contact with many different parts of the service system, and efforts to reduce violence and improve outcomes for Aboriginal people and children must work across family violence services; police, the justice system and the courts; housing and homelessness services; children and family services; child protection and out-of-home care; and health, mental health, and substance abuse.
* The need to respond to all forms of family violence experienced by Aboriginal people, children, families and communities.

1. Responsibilities

MARAM outlines 10 responsibilities for risk assessment and management which combine to create an effective response to family violence across the integrated service system and cover all aspects of practice. The practice expectations outlined in this clinical practice guideline align to the MARAM Identification and Screening level of response tailored to the health clinical operating environment referred to as Screening. Staff groups who operate at this level are required to competently perform and fulfil MARAM responsibility 1 & 2, and contribute to responsibilities 5, 6, 9 & 10.

Staff have a responsibility to engage respectfully, sensitively and safely AND undertake sensitive enquiries of patients to identify if family violence is occurring through use of a screening tool in order to refer for support AND be aware of and contribute to the organisation’s responsibility to share information, refer for specialist support and collaborate at a multi-agency level.

1. Guideline

Sensitive Practice for antenatal screening

Screening for family violence in an antenatal setting should be guided by the adapted six step model of Sensitive Practice. This is used to support clinicians to identify and respond to patients experiencing family violence. The primary goal of Sensitive Practice is to facilitate feelings of safety, choice and control for the woman during their interaction with health professionals (Schater, 2008).

See Appendix 1 – Antenatal screening for family violence flowchart: response options

* 1. STEP ONE: Create a safe environment

Screening for family violence must occur only when the woman is alone. It is not safe to ask about family violence in the presence of others including children who are verbal (above the age of 2). It is important to take steps to facilitate an appropriate, accessible, culturally responsive environment where the woman feels safe to talk about her experiences of family violence and receive a response that is respectful, sensitive and safe. Before you start asking questions, ask yourself whether the conditions are right to proceed. Consider the following:

# Can the conversation be overheard? You must use a private environment when asking about sensitive and personal information

# Make the woman feel safe and ask about the things she needs to feel comfortable

# Consider any barriers to communication. Organise an interpreter or other communication tools. When using an interpreter it is important to ask if the woman would prefer a person of the same gender.

# Engage in a culturally sensitive manner i.e. would the woman benefit from an Aboriginal liaison officer?

* Be mindful of one’s own potential biases and reflect on how it may influence practice or reinforce stigma, stereotypes or discrimination.

# Has the woman been informed about the limits of confidentiality and how her information can be shared? You must clearly explain your role, information sharing requirements and confidentiality as outlined by [insert relevant policy]. Inform the woman any disclosure of family violence is voluntary.

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| **Implementation consideration**  Your hospital or health service may consider introducing a formal process to ensure women are seen on their own for a brief period of a specified antenatal visit to screen for family violence. This time can also be used to discuss other sensitive areas of women's health relevant to a woman's antenatal care, such as sexual health, contraception and abortion history. The SHRFV Antenatal Screening Implementation Guide addresses in detail the use of Dedicated Consultation Time in this setting to ensure that women are screened only when they are alone. |

If there is resistance from the woman and/or partner or support person regarding being seen alone or the conditions are not right to proceed, use your discretion and judgment and see the couple together. Document that it was not safe to screen for family violence and attempt again at a later date. If you see any [observable signs of trauma](https://www.vic.gov.au/maram-practice-guides-and-resources) that family violence is occurring, please consult with your manager or social work regarding your concerns.

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| **Implementation consideration**  Your hospital or health service may choose to screen for family violence more than once during a women’s pregnancy care, recognising that risk is dynamic, relationships may change over time and sometimes rapport and trust needs to be developed before disclosure can occur. Processes and communication methods need to be in place to ensure that all staff members are aware of:   * when antenatal screening for family violence has been performed, and * if it has not been possible to screen for family violence, that it should be completed at the next available consultation. |

* 1. STEP TWO: Screen sensitively

# Structured Professional Judgement

# Like Sensitive Practice, Screening for family violence relies on a Structured Professional Judgement model to establish whether a woman is experiencing family violence and their level of risk. Research supports the accuracy of a victim survivor’s assessment of their own level of risk. Within the Structured Professional Judgement model, the victim survivor – whether adult or child – is represented at the centre of the model, highlighting the importance of keeping a victim survivor at the centre in all of our work.

Structured Professional Judgement is informed by:

* a person’s self-assessed level of risk, safety and fear
* assessment against evidence-based risk factors

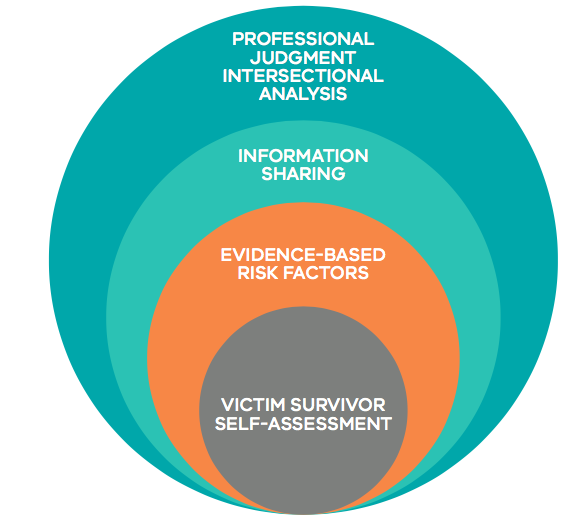
(ascertained by using the MARAM screening questions/tool)

* information sharing to inform assessment

(Sensitive Practice staff are not required to seek information directly from external services, but to seek secondary consultation and support from internal specialist/senior staff)

* professional judgement using an intersectional lens

In addition to the Structured Professional Judgement model outlined above, clinicians should also consider the presence of protective factors and other contextual information that is risk relevant, to inform assessment of the seriousness of the risk.



Beginning the conversation

Whilst seeing the woman alone, you may like to begin with a prompting or lead in statement beforehand. For example:

*"Pregnancy can be a high risk time for family violence which is why we routinely ask women about safety in their relationship. Is it ok if I ask you a few questions about how things are going at home?”*

Ensure the woman is informed about the limits of confidentially and how her information can be shared.

“*What you say will remain confidential to this health service, unless you tell us something that indicates there are serious safety concerns for you or your children. If that was the case, we would talk to you about that first, wherever possible*” (Hegarty et al. 2020).

See Appendix 2 – Antenatal screening for family violence screening tool

The screening tool asks the following questions:

1. *Has anyone in your family done something to make you or your children feel unsafe or afraid?*
2. *Have they controlled your day-to-day activities (e.g. who you see, where you go) or put you down?*
3. *Have they threatened to hurt you in any way?*
4. *Have they hit, slapped, kicked or otherwise physically hurt you?*

Screening for family violence should also include asking the woman about what her child/ren might be experiencing directly or being exposed to from a person who may be using violence (even if the person does not live with them).

If a woman isn’t ready or isn’t in a position to respond to questions about family violence, you need to respect this and let her know that if she is ready in the future to talk about any experience, you are open to doing this. It is also important to remain aware of any clinical indicators throughout the pregnancy, and sensitively inquire later in the pregnancy if you suspect that family violence is occurring.

If a staff member strongly suspects and/or has serious concerns for a woman’s safety or the safety of her children, the staff member must seek secondary consultation with a social worker or senior staff member about these concerns, as per the [insert org-name] child at risk policy or equivalent.

* 1. STEP THREE Respond respectfully

How clinicians respond is crucial to eliciting feelings of safety, respect and control for the woman. Women must be recognised as the experts in their own experience and responses should be woman led. Use the World Health Organisation model LIVES model as a guide for the remainder of the screening process.

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| **LISTEN** | Listen to the woman closely with empathy and without judging |
| **INQUIRE** | Assess and respond to their various needs and concerns – emotional, physical, social and practical |
| **VALIDATE** | Show that you understand and believe the woman. Assure her that she is not to blame |
| **ENHANCE SAFETY** | Discuss a plan to protect herself from further harm if violence occurs again |
| **SUPPORT** | Support her by helping her connect to information, services and social support |

If the woman answers **NO** to **ALL** four screening questions: No disclosure of family violence

* Thank the woman for answering the questions and inform her about the help that is available and that she is able to contact your service in future should she ever experience family violence.
* You must respect this. The woman might not be ready or not feel comfortable to talk to you about the family violence she is experiencing. She may also not be experiencing family violence.
* Offer pregnancy support card
* No further action is needed.

If you still suspect that family violence may be occurring, or you notice any clinical indicators it is important to sensitively inquire again throughout their antenatal care or use secondary consultation to explore these indicators more fully.

If the woman answers **YES** to **ANY** of the four screening questions: Family violence is disclosed

Reassure the woman that you believe her and state clearly that the violence is not her fault and continue with three additional questions to determine any immediate risk:

1. *“Do you have any immediate concerns about the safety of your children or someone else in your family?”*
2. *“Do you feel safe to leave here today?”*
3. *“Would you engage with a trusted person or police if you felt unsafe or in danger?*

* You will be required to offer a referral to the Social Work team or other appropriate role. Include information about any immediate danger. You may choose to respond with:

“*It must be difficult going through what has happened to you. You have the right to feel safe. There are services that can help you with your safety and wellbeing, either here at the hospital or in the community. Can I refer you to a social worker/care co-ordinator who can help you further?”*

If the woman does not consent to a Social Work referral or if there is no social worker immediately available – see STEP FOUR.

* 1. STEP FOUR: Respond to Risk

If the woman discloses that family violence is occurring by answering **YES** to **ANY** of the screening questions (1-4), and declines an internal referral OR there is no social worker immediately available, you must consider their responses to the immediate safety questions (5-7).

If the woman answers **NO** to question **5** and **YES** to question **6** – this indicates the woman is not in immediate danger but is at risk:

* Let the woman know that if her circumstances change she should seek assistance
* Provide information about help and support that is available, including specialist family violence services and Victoria Police
* Discuss a brief safety plan
* Consider whether a child is at risk and mandatory obligations apply
* Provide pregnancy support card
* Suggest a social work follow up at another appointment
* Seek secondary consultation with social work/manger

If the woman answers **YES** to question **5** or **NO** to question **6** – this indicates the woman is in immediate danger:

This response may indicate an imminent threat to the woman’s life, health, safety or welfare. Remember that a woman’s self-assessed level of fear, risk and safety is a good indicator of risk.

It is important that if the woman discloses they are in immediate danger you seek support from your manager so that the organisation’s escalation process can be enacted, and if required a multi-disciplinary and multi-agency response.

Practical ways to respond to this risk may include some or all of the following:

Lead in statement ”*I am very concerned about your safety and would like to help you get assistance today. How do you feel about us contacting specialist assistance?*”

* Perform a brief safety plan (outlined below)
* Consider information sharing obligations, including in relation to children at risk and any mandatory reporting obligations [Insert link to relevant Information Sharing policy and procedures].
* Provide information and referrals about help and support that is available. (outlined in STEP FIVE)
* Let the person know that if their circumstances change, they should seek assistance
* Seek secondary consultation with Social Work/manager
* Suggest a Social Work review at another appointment
* Consider contacting Victoria Police (000) – be guided by the woman. Victoria Police are the only service that can respond to immediate danger. Consult with your manager or social work department

If the woman answers **NO** to question **7**, ask the following questions:

* *“Is there a reason you would not contact or would be hesitant to contact police?”*
* *“Is there something I can do to support you to feel confident in contacting police?”*
* *“Would you contact another support service, such as a family violence service who could provide you with support?”*

It is important to be aware of how a woman’s circumstances or previous experiences with police may impact on her decision to contact them. Particular groups may be more concerned about police involvement, such as Aboriginal women or women on temporary protection immigration visas. In this situation, it is important that clinicians are respectful of these experiences and discuss with the woman the role of the police in assisting people experiencing family violence.

If the woman is not wanting police assistance, consult with your manager or your social work department to determine if the police need to be contacted without the woman’s consent, and whether your hospital needs to share information under the Family Violence Information Sharing Scheme (FVISS).

* If there is an immediate threat, calling the police is an appropriate response. However, if the woman indicates that calling police may increase her risk, this information needs to be provided to the police to inform their response.
* A woman should be informed about any action taken irrespective of whether they give consent.
* Consider whether a child is at risk and mandatory reporting obligations apply.
* Consider information sharing obligations, including in relation to children at risk and any mandatory reporting obligations [Insert link to relevant Information Sharing policy and procedures].

Children and young people

You should always ask the woman about what their child/ren might be experiencing directly or exposed to from a person who may be using violence (even if the person does not live with them). This includes if a child is being exposed to the aftermath of family violence (for example, broken furniture or an upset or injured victim survivor). Explain to the woman that they may be experiencing family violence and that it may be impacting their children.

It is important for you to also ask:

* *“What are your worries for each of your children?”*
* *“What have you noticed about how this is affecting the/your child/ren?”*

Basic safety plan

If a woman has disclosed that they are experiencing family violence and have declined a social work referral or a social worker is not available, you should develop a brief safety plan with her (Appendix 2). Every safety plan will be unique and based on the needs of the woman. You should be guided by the victim survivor on what is important and safe for them in their basic safety plan. The safety planning process should also consider the needs of children/young people.

Example lead in statement: “*From what you have told me, I am concerned about your safety. Do you have a plan of what you would do if you needed to leave or if X happened?*”

* *“If you need to leave home in a hurry, where would you go?”*
* *“Is there someone close you can tell about the violence or ask to call the police on your behalf?”*
* *“Do you need to arrange anything for anyone in your care? i.e children/older people”*
* *“Do you have access to a phone or internet?”*
* *“What essential things like documents, keys, money, clothes or other things should you take with you when you leave? Do you have access to these?”*

**Key message: Although clinicians are not expected to be family violence experts, when a woman is declining an internal or external referral, or a social worker or equivalent staff member is not available, it is important to explore how the woman will manage their own immediate safety.**

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| **Implementation consideration**  The above safety planning questions included in the sample screening tool (Appendix 2) are based on the safety plan outlined in [MARAM resource Responsibility 2: Appendix 4 – Flow Diagram of Response Options and Safety Plan](https://www.vic.gov.au/maram-practice-guides-and-resources). The questions above are not as extensive as those outlined in this resource. Hospitals and health services can access this resource to further tailor this safety plan to suit their operating requirements. |

## STEP FIVE: Referral

Connecting the woman to support services both internal and external can be an important strategy for providing a pathway to safety. Appropriate referrals are important in ensuring women experiencing family violence access professionals and services that can comprehensively assess and manage the risk associated with family violence.

It is appropriate for clinicians to facilitate internal referrals for patients experiencing family violence and to contact Victoria Police if there is an immediate threat. For external services, clinicians are expected to provide information about referral options only. This allows the woman to make an informed self-referral. Alternatively, clinicians can refer to those clinicians or professionals who are able to facilitate external referrals [insert departments or services which hold higher MARAM responsibilities and can assist with referrals].

Where an internal referral is not accepted, provide the woman with information about which external services can assist and how they can be contacted. It is essential to first discuss with the woman whether providing leaflets or written information could compromise her safety. Alternatively, it may be safer to save the number discreetly in her phone, or record in some other way.

Internal

* Social work department during and outside of business hours (where available)
* Hospital coordinator
* Appropriate internal care-coordination roles
* Aboriginal Health Liaison Officer
* Mental Health Clinicians

External

* Victoria Police 000
* Safe Steps Family Violence Response Centre (24 hour State-wide Crisis Response Service) Phone: 1800 015 188.
* 1800 RESPECT (National Sexual Assault and Family Violence Crisis Service) Phone: 1800 737 732
* InTouch – Multicultural Centre Against Violence Phone: 1800 755 988
* W/Respect – Provides resources and advice for LGBTIQ+ people Phone: 1800 542 847
* Djirra – Provides culturally safe support to Aboriginal people Phone: 1800 105 303
* The Orange Door [insert appropriate contact details for region]
* Community legal centres [insert appropriate contact details for region]
* Centres against sexual assault [insert appropriate contact details for region]
* Regional specialist family violence service (including local Aboriginal family violence services) [insert appropriate contact details for region]

5.6 STEP SIX: Documentation

It is important that you succinctly and accurately document the following information in the woman’s medical record:

* + - * + If the screening questions and immediate risk questions were completed.
        + Risk relevant information, including the woman’s reported level of fear and safety.
        + The reasons why the screening was not able to be performed (if relevant).
        + If family violence has been identified as present or not present.
        + Any additional signs or risk factors that indicate family violence may be occurring.
        + Has immediate danger been identified?
        + If an interpreter was required and used.
* Children’s details and if they were present.
* Perpetrator details if known.
* Contact details for the victim survivor, including method of contact (such as text before call) and time it may be safe to make contact.
  + - * + Emergency contact details of a safe person if the victim survivor cannot be contacted.
* Any actions you have undertaken or that have been referred to another person/role. Including details of secondary consultation with either internal or external services.
* Safety plan details.

1. Information Sharing

To ensure you are contributing to information sharing with other services under MARAM in accordance with [Insert relevant Information Sharing policy and procedures] you must:

* Ensure the woman is informed about the limits of confidentiality in relation to these legislations and have provided consent to share information. This must be documented.
* Ensure the woman’s records are up to date with risk relevant information that was disclosed and any risk assessment or safety plans that have been prepared.
* Ensure any information about the woman you believe is risk relevant is communicated with the person(s) responsible for managing the information sharing responses at [insert org name] or escalate to your manager if unsure.

1. Endnotes
2. Schachter, C.E., 2008. Handbook of Sensitive Practice for Health Care Practitioners: lessons from adult survivors of childhood sexual abuse. Ottawa. Public Health Agency of Canada.
3. State of Victoria, Department of Health and Human Services, 2018. [‘Dhelk Dja: Safe Our Way - Strong Culture, Strong Peoples, Strong Families’](https://w.www.vic.gov.au/system/user_files/Documents/fv/Dhelk%20Dja%20-%20Safe%20Our%20Way%20-%20Strong%20Culture%2C%20Strong%20Peoples%2C%20Strong%20Families%20Agreement.pdf). Melbourne. Victorian Government.
4. Victorian Government, Family Safety Victoria, 2018. Family Violence Multi-Agency Risk Assessment and Management Framework. Melbourne. Victorian Government.
5. Hegarty, K., Spangaro, J., Koziol-McLain, J., Walsh, J., Lee, A., Kyei-Onanjiri, M. ... Spurway, K. (2020). Sustainability of identification and response to domestic violence in antenatal care (The SUSTAIN study) (Research report, 06/2020). Sydney, NSW: ANROWS
6. Legislation/regulations related to this clinical practice guideline

[Family Violence Protection Act 2008](http://www.legislation.vic.gov.au/Domino/Web_Notes/LDMS/PubStatbook.nsf/edfb620cf7503d1aca256da4001b08af/15A4CD9FB84C7196CA2570D00022769A/%24FILE/05-096a.pdf)

[Child Youth and Families Act 2005](http://www.legislation.vic.gov.au/Domino/Web_Notes/LDMS/PubStatbook.nsf/edfb620cf7503d1aca256da4001b08af/15A4CD9FB84C7196CA2570D00022769A/%24FILE/05-096a.pdf)

[Child Wellbeing and Safety Amendment (Child Safe Standards) Act 2015](http://www.legislation.vic.gov.au/Domino/Web_Notes/LDMS/PubStatbook.nsf/edfb620cf7503d1aca256da4001b08af/690DA8EB155B14D6CA257F0E000657C6/%24FILE/15-063aa%20authorised.pdf)

1. Appendices

Appendix 1 – Antenatal screening for family violence flowchart: response options

Appendix 2 – Antenatal screening for family violence screening tool

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Appendix 2 – Antenatal screening for family violence screening tool



