Antenatal screening for family violence

Evidence Brief

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Routine screening for family violence in antenatal care

The Australian Institute of Health and Welfare has defined screening as a process which attempts to identify victims of violence or abuse in order to offer responses that can lead to beneficial outcomes.[1] This is the first step in risk and safety assessment and can allow a first line response and referral.

Although the World Health Organisation (WHO)[2] does not recommend universal screening for family violence in all health settings (Table 1 and 2), it is acknowledged that in antenatal care there may be enough evidence for screening to benefit women.

Thus, Recommendation 96 of the Victorian Royal Commission into Family Violence (2016), [3] states that routine screening for family violence should be introduced into all public antenatal settings across Victoria. Further, antenatal settings are a key workforce for implementing the MARAM framework, which requires targeted and continued training, specific guidelines and clinical support, and collaborative practice.[4]

It is important to note that the aim of routine screening for family violence is not only to elicit disclosures, but to promote early engagement to promote respectful relationships free from violence. An empathic and professional response from a trusted nurse, midwife, social worker, doctor or other health provider can reinforce a woman's understanding that they are entitled to healthy, non-violent relationships. By respecting a woman's decision and offering a range of options, health care providers, and particularly midwives and obstetric medical staff, play a vital role in ensuring that her health and safety needs are met. Such first line responses have the potential to support women, their unborn baby and children affected by family violence and contribute to enhanced health outcomes.

Table 1. Definitions of screening and case finding

Screening	**Case finding**
Consistent use of a validated set of short questions to detect family violence in all patients	Using the opportunity of the clinical encounter to check for family violence in symptomatic patients

Identification: Screening or Case Finding?

Many practitioners, policy makers and researchers misuse the term 'screening' to mean asking people about family violence. In the health context it has a specific meaning of a consistent use with all patients of a set of short questions to detect family violence. A Cochrane systematic review[5] reinforces that evidence suggests that screening and initial response by a health professional increases identification with no increase in referrals or changes in women's experience of violence or wellbeing.

This does not mean midwives, doctors and nurses should not ask if patients (mostly women and children) are presenting in any health setting with symptoms and signs of family violence (case finding). This is good clinical assessment to include inquiry about family violence when a patient has a clinical indicator. There is no evidence or recommendation to screen all men or children, rather case finding is appropriate. Below this brief outlines the different settings in hospitals and health care and who should be asked about family violence (Table 2).

Table 2. Health setting and identification method based on systematic review evidence[5]

Setting	Who to ask about family violence?
Antenatal Care	Screen all pregnant patients using a set of questions using a sensitive inquiry approach.
Emergency Department	Ask patients who have indicators of underlying family violence (e.g. unexplained injuries, mental health issues, reproductive health issues and chronic pain).
Mental Health and Alcohol and Drug services	Ask all patients as they already have a strong indicator as they have mental health symptoms or substance use issues.
Sexual Assault services	Ask about other abuse as they are very strongly associated with sexual assault.
Inpatients	Ask patients who have indicators of underlying abuse (e.g. injuries, mental health issues including suicide, reproductive health issues e.g. premature labour and low birth weight).
Outpatients	Ask patients with indicators. Particular clinics should ask most, if not all patients. These include for example chronic pain clinics, miscarriage clinics.

Is screening acceptable to women?

Studies have found that women are largely supportive of routine enquiry. Women felt being asked was acceptable, that family violence was an important thing to ask about, and were generally willing to disclose if asked in a sensitive and non-judgement manner.[6] However, women may not always feel able to disclose immediately. Reasons for not disclosing include:

- not considering the violence serious enough
- embarrassment and shame
- fear of the perpetrator finding out
- cultural and religious barriers
- not feeling comfortable with the health professional

How should we ask: is face-to-face or distal methods (paper, online) more effective?

A systematic review[7] of six randomised controlled trials showed face-to-face interviews are not significantly different to a self-administered written screen with how many women disclose family violence. However, a computer-assisted self-administered screen was found to increase the odds of domestic violence disclosure by 37% in comparison to a face-to-face interview. Disclosure was also 23% higher for computer-assisted self-administered screen in comparison to self-administered written screen. This has implications for development of online screening and responses as some women prefer online disclosure.

Who should screen?

All health practitioners have a role in screening and responding to family violence. In a national community survey, half of the women experiencing domestic violence sought help, mostly from family and friends. The highest professional group approached for support was health professionals, with general practitioners being the main group.[1]

The SUSTAIN study (Figure 1)[8] found that consensus existed across most antenatal practitioners that the role of screening might best fit with midwives, who have an initial role in assessment and management, and that social workers are best placed to provide a comprehensive response.

What should we ask women?

Validated screening tools are best used when screening or routinely inquiring about family violence. Validated screening tools mostly rely on behavioural items (e.g. hit, kicked) or emotion questions (e.g. fearful, safe), rather than labelling questions (e.g. are you a family violence victim?). These type of items are more likely to elicit disclosures of family violence than stigmatising questions that include having to identify as experiencing family violence (e.g. are you experiencing domestic violence or are you experiencing physical abuse?).[8]

There are many validated screening tools in use in antenatal settings, the most common tools tested being the Abuse Assessment Screen, Woman Abuse Screening Tool, HITS (Hurts, Insults, Threaten, Scream) tool.[9] The Women's Hospital in Victoria, uses the ACTS (Afraid, Controlled, Threat, Slapped or otherwise physically hurt) tool, a validated screening tool developed as part of the SUSTAIN study.[8] There is also a screening tool embedded within the Victorian electronic Birthing Outcome System, an electronic platform used by the
majority of maternity clinics.

Figure 1. SUSTAIN Study

SUSTAIN STUDY

The aim of the study was to support integration of evidence-based screening, risk assessment and first line responses to Domestic and Family Violence into antenatal care.

A case study across six hospital antenatal clinics in Victoria and New South Wales allowed the research team to examine system barriers and facilitators for implementing and sustaining screening and responses.
This involved :
-surveying 1219 women at two Vic. Sites, -conducting 12 focus groups (91 antenatal staff at six hospitals) --convening two in-depth researcher workshops to synthesise data for a new transformation model for implementing sustainable screening and response in antenatal care (Figure 5).

The Multi-Agency Risk Assessment and Management (MARAM) screening tool is an evidence-based tool which should be used as part of an antenatal screening program in Victoria (please see antenatal screening for family violence implementation guide).

How many women are likely to disclose?

In Australia, the 2015 snapshot of the NSW Health Domestic Violence Routine Screening program showed that just over three percent of women screened antenatally identified as experiencing current abuse, with approximately one fifth accepting an offer of assistance at time of screening.[10] Similarly, in

the southeast Queensland study, disclosure of domestic violence was two percent, and most women at risk of or experiencing violence declined referral.[11]

This disclosure figure is lower than the expected prevalence in the last 12 months of family violence in pregnancy, which ranges from 4% to 8% in studies.[12] The SUSTAIN study surveyed women in the waiting room across two Victorian antenatal sites, finding a prevalence of 14.2% and rate of screening positive on ACTS of 8.3%.[8] This is not surprising as women experiencing family violence may not speak up when the subject is first raised but may choose to open up later when they feel sufficient trust and confidence in the health professional, possibly at a subsequent visit with the same person.

Timing and frequency – How often should women be asked in pregnancy?

There has been some evidence suggesting that practitioners should ask about family violence more than once as women may not be ready to disclose on the first occasion.[13, 14, 15] Relationships may change over time and sometimes rapport and trust need to be developed before disclosure can occur.[8] In NSW, women are asked once during pregnancy care. In Queensland, women are screened on three occasions during their pregnancy – at the first antenatal appointment, at 28 weeks and at 36 weeks or at any unplanned presentation.

Is screening acceptable to health professionals?

Evidence suggests that while many health professionals think screening is important, some are reluctant to enquire about family violence.[16] In systematic reviews, only half of the health professionals find screening acceptable.[17, 6]

A study conducted at The Women's in 2019 about midwives' acceptance of technological approaches to antenatal screening found that many clinicians perceived electronic screening mechanisms acceptable, and that they felt technology would improve their ability to implement screening.

What are the barriers for health professionals to screen?

There are many barriers to sustained screening by practitioners.[16] Barriers can be grouped into:

- personal barriers (personal discomfort about the topic, worry about personal safety from perpetrator),
- resource barriers (women being accompanied to appointments, lack of training and time in the consultation, lack of referrals),
- perceptions and attitudes (seen as not the health professional's role, health professional's attitudes to violence),
- fear (patients will be offended, not knowing what to do if a woman disclosed) and
- patient-related barriers (language, cultural barriers, concerns about confidentiality, including mandatory reporting of children).[8]

Process barriers include lack of seeing women alone, lack of continuity of care and variations in timing and the manner in which screening takes place. Resource barriers are significant and include lack of training, referral options and support services, lack of peer supervision and employer support for any distress of health practitioners.[18, 19]

Factors increasing a health professional's likelihood of screening women included having previously screened women, having a therapeutic relationship with the woman, knowledge of prior abuse, recognising silent cues, having scripted questions, interdisciplinary collaboration and access to resources and referral services.[20]

Which response is best after identification? – woman-centred care

The WHO recommends a first-line response as important for all women who disclose family violence called LIVES (Figure 2).[21] An Australian government review of evidence[20] found that effective encounters are characterised by direct asking, care (showing interest, respect and non-judgement), acknowledgement of the violence, familiarity with the health professional, and relevant referrals.

Figure 2: World Health Organization first line response

The SUSTAIN Study also emphasised two areas that require a focus in training which are *assessing safety and risk*, and tailoring responses to women's *readiness to take action*.[8]

Practitioners value having an immediate onsite social work response. Although, this may be challenging in rural areas with staffing shortages, where social workers may not often be readily available.[8]

In addition to LIVES, which is *what* practitioners should do, a systematic review of 31 interview and focus group studies globally with women suggest *how* practitioners should approach women. Women expect from health practitioners a LIVES response in the context of a CARE model (Figure 3). The SUSTAIN study (2020), found that all health practitioners valued such woman-centred care and agency for women experiencing family violence.[8]

Figure 3: CARE Model for first line

Which referral interventions are effective for family violence?

A systematic review found that there is insufficient evidence to assess the effectiveness of interventions for family violence on pregnancy outcomes.[22] However, brief advocacy interventions (providing information and support to access community resources, including legal, police, housing and financial services) delivered in the community may provide small short-term mental health benefits and reduce physical abuse.[23] It is important that referrals for further comprehensive safety assessment by specialist support services are made if this is acceptable to women [20] It is also important to note that among women attending antenatal care, many women may not wish to access family violence services.[8]

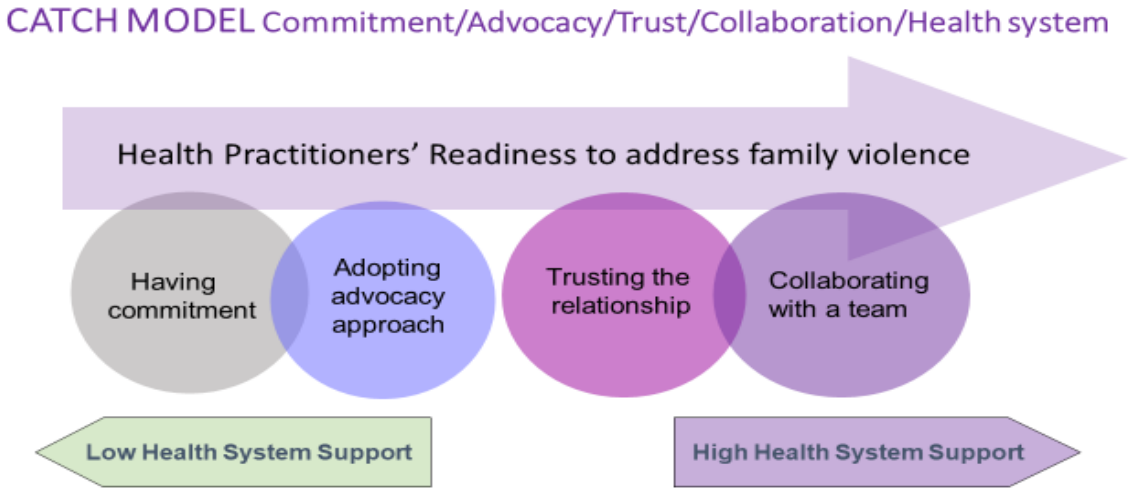
Are there different considerations in rural and regional antenatal clinics?

The SUSTAIN study found that rural sites identified complexity in managing confidentiality and privacy for women where health practitioners' and women's lives are intertwined. Further service support responses are challenging in rural areas with staffing shortages, where social workers may often not be readily available. Some of the specific challenges for implementing a family violence health systems change model, such an antenatal family violence screening program in a rural setting may include recruiting facilitators, access to health practitioners, absence of family violence services in the community and safety from perpetrators who may also be known to the practitioners. Further, lack of resources was heightened in rural areas, in particular accommodation for women leaving violence, exacerbated by long distances, isolation and women's lack of access to transport. On the positive side, relationship building across teams in rural areas is often easier because of the existing connections in rural communities.[8]

What assists health professionals to be ready to screen and respond?

Addressing readiness in education and training is more likely to enable clinicians to become physically and emotionally ready for the work. A recent systematic review of 47 qualitative studies exploring health professionals' readiness to address family violence provides some insight into areas on which to concentrate.[24] Five themes were identified as enhancing health professional readiness: Having a commitment; Adopting an advocacy approach; Trusting the relationship; Collaborating with a team; and Being supported by the health system- CATCH Model (Figure 4).

Figure 4: CATCH Model



The commitment practitioners might have to this area might arise from human rights, child rights or a feminist lens or a personal experience of family violence. Trying out a woman centred or advocacy approach with survivors and getting positive feedback encouraged health practitioners. Trusting that the relationship in a health setting is a good place to do this work and being supported by working with other members of a team also assisted professionals to undertake this work. However, health systems support is needed and if this is low then it was difficult for practitioners to engage with the work needed to address family violence.

What does the health system need to provide support to health practitioners?

A whole of system response involves *in addition to women or patient centred care* promoting at the health provider level:

- a culture of gender equitable attitudes;
- trauma informed principles (respect, privacy, confidentiality, safety);
- a context of sufficient time allowed in consultations;
- supportive environment with leaflets and posters;
- an awareness about protocols and referrals;
- bilingual responsiveness for women from diverse cultural and language backgrounds;
- procedures and/or an information system that supports the screening approach

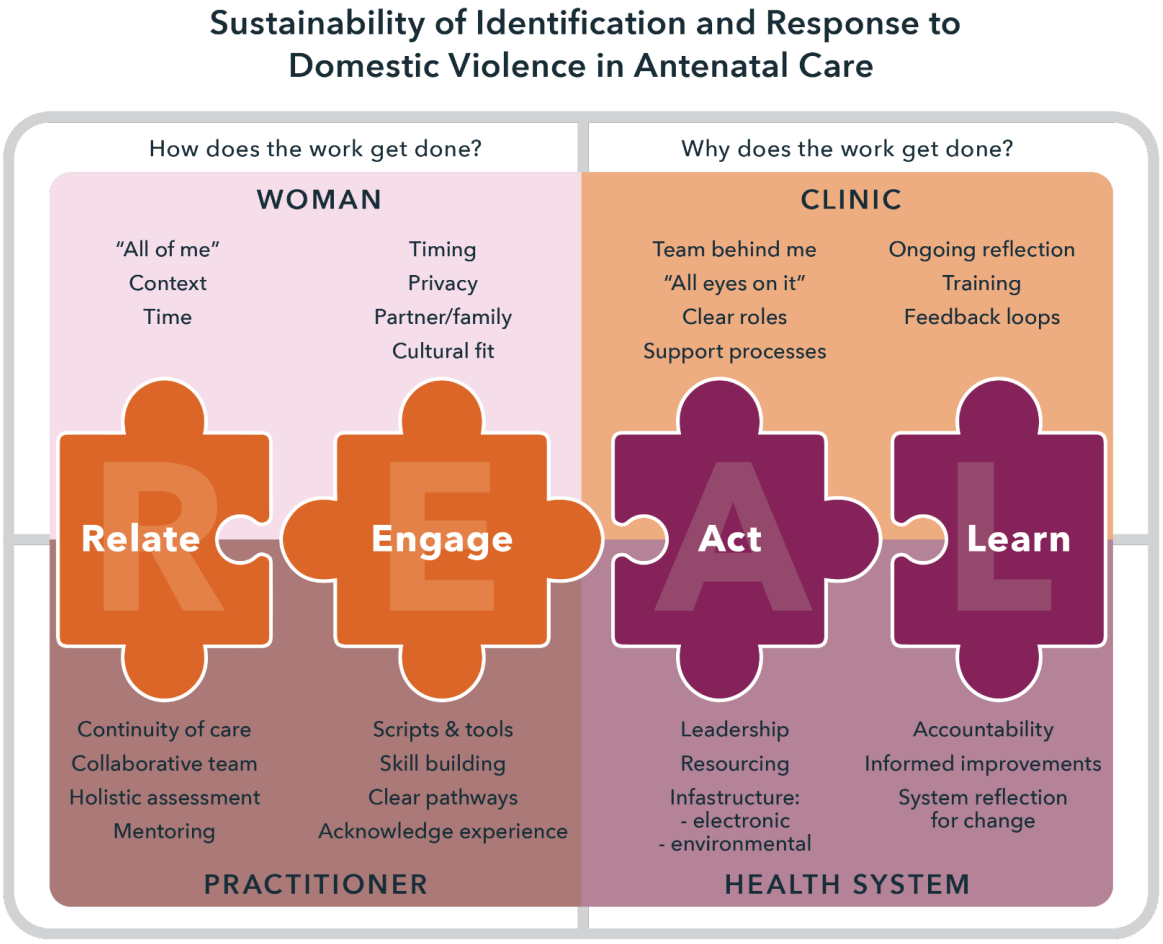
At the system level there needs to be:

- coordination of internal and external referrals;
- protocols;
- workforce support and mentoring;
- appointment of champions;
- finances need to be allocated to services for family violence;
- leadership and governance demonstrated by policies;
- appropriate design of spaces; and
- information systems for evaluation.[25]

How can we make screening and response sustainable in antenatal care?

The SUSTAIN study developed the REAL model (see https://www.dvhealthtools.com/) consisting of factors that are important for how and why the work gets done, which are key questions to answer in any complex intervention such as screening and response in antenatal care (Figure 5).

Figure 5: REAL Model



Conclusion

In summary, sustaining screening practice in antenatal care requires all levels of the health system to change. Sensitive inquiry using a woman-centred approach is critical, and must be supported by training, policy and procedure. Support for health practitioner's own experience also needs to be considered. Further, the health setting needs to be structured as a team approach, with clear roles, allowing sufficient time for feedback and reflection. Finally, leadership, resourcing and environmental infrastructure and information systems are essential for transformation of the health system to sustain screening to improve women's lives.

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