# Antenatal Screening Practice Example

## The Women's Model

the women's
the royal women's hospital
victoria australia

This resource provides hospitals with a practice example of antenatal screening undertaken at The Women's. It is important to note that this work is intended to be in alignment with the Victorian Multi-Agency Risk Assessment and Management Framework (MARAM) however antenatal screening at the Women's was implemented prior to the release of all practice guides. As hospitals become prescribed the Women's will continue to review and update its screening processes where necessary to reflect contemporaneous best practice evidence.

# 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. This is an acknowledgement that family violence is common in antenatal settings and that pregnancy can be a high risk time for first episode of, or heightened family violence. In order to meet the hospital's obligation to Recommendation 96, The Women's formed a multi-disciplinary working group coordinated by the Strengthening Hospital Responses to Family Violence (SHRFV) team, chaired by the Director of Maternity Services. This group included expert representation from the Centre for Family Violence Prevention, the Centre for Women's Mental Health and The Women's Alcohol and Drug Service who guided the development of an integrated psychosocial antenatal screening model. The work was also informed by the SUSTAIN study[1], which consulted women as consumers about how they would like to be asked and how often, with regards to screening in pregnancy for family violence.

Implementation was via a staged rollout. A pilot model was trialled at both antenatal clinics of The Women's at Sandringham and the Red Clinics at Parkville. After evaluation, the model was successfully embedded in all mainstream antenatal clinics across The Women's. Midwives at The Women's have undergone additional training and have truly embraced the change, understood the meaning of responding to family violence as an important part of their maternity care and worked together to improve the care of women receiving antenatal services.

# 2. Psychosocial assessment model

While the impetus for antenatal screening was to meet the obligations of Recommendation 96 of the Royal Commission into Family Violence, it was evident during consultations with all stakeholders that this project offered the opportunity to implement and embed a best practice, standardised, early intervention approach for mental health, drug and alcohol and family violence in pregnancy. Evidence demonstrates that family violence, mental health and substance use are often linked[2], and that screening for these psychosocial issues in pregnancy offers a unique opportunity for early intervention and support.

Collaborative work across disciplines enabled The Women's to develop a women-centred psychosocial antenatal screening model. Women who attend their first booking in antenatal appointment complete the Emotional Health and Wellbeing Tool, which includes the Edinburgh Postnatal Depression Scale and a Drugs Alcohol and Smoking Assessment prior to their consultation. The woman is then invited into the consultation alone to discuss their responses with the midwife during their private Dedicated Consultation Time, where they are safely and sensitively screened for family violence via the Relationship and Safety Tool.

# 3. Dedicated Consultation Time (DCT)

The safe implementation of screening for family violence in busy antenatal clinics can be challenging for a number of reasons, but perhaps the biggest barrier is creating a safe place where women are alone in which

[1] 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

[2] World Health Organisation (2013). Global and regional estimates of violence against women: prevalence and health effects of intimate partner violence and non-partner sexual violence. Geneva, Switzerland: WHO

to conduct the screening. As consultation times contract, and clinic numbers increase, creating privacy for women is increasingly hard to achieve. To manage this, The Women's developed Dedicated Consultation Time (DCT).

This time refers to a brief period of the antenatal clinic appointment where the woman is seen on her own by the clinician midwife without a partner, support person/s or children accompanying her. This principle is consistent with the World Health Organisation Clinical Handbook minimum standards for family violence inquiry[3], which is that women are alone when this occurs. DCT also allows for other sensitive areas of women's health to be openly discussed, relevant to a woman's antenatal care, such as sexual health, reproductive abuse, contraception and abortion history. The first booking in appointment (40 minutes) at The Women's was chosen to include DCT and screen for family violence, as subsequent review appointments throughout the pregnancy journey are scheduled for shorter periods of time (20 minutes).

After a successful pilot at two clinic sites, in July 2019 The Women's formally integrated DCT into the pregnancy journey. At the first/allocated antenatal clinic appointment women are informed by the administrative staff explaining that there is a policy that all women will be seen alone for the first 10 minutes of their appointment. The midwife then approaches the woman in the waiting room to invite them to spend the first ten minutes of the consultation time on her own, then asking the support person/s to join the consultation after this point. This was a significant practice change for midwives, who were concerned that partners would not respect this policy, and that it could be viewed as inconsistent with family-centred care. Despite this concern, since DCT was routinely introduced, midwives have found the practice supported by the majority of women and partners, with only one partner objecting during the initial 8-week pilot period. Once the policy was clearly explained, this partner was happy to accommodate the DCT.

Although staff are advised that DCT is standard practice for all women in their first antenatal visit, if enforcing this practice will jeopardise a woman's safety or the woman insists on including a partner or support person, staff have been trained and supported to include others in the first appointment, and attempt DCT again in subsequent clinic visits, and/or refer the case to social work for further assessment and management.

## 3.1. Organisational considerations

At The Women's, the organisation made it very clear that any dedicated time for family violence screening must be integrated within the existing consultation time (currently 40 minutes for booking in). To implement DCT at your hospital, you may need to review existing work practices, and look for opportunities that may be available in your own context.

A strategy that was employed to assist with this expectation was the introduction of a "Maternity Trigger form", which women were asked to complete in the waiting room prior to their appointment. Not only did midwives and doctors find this helpful in getting women to think about relevant clinical information prior to the consultation (e.g. date of last known period etc), it also removed some routine questions from the consultation.

At the time of introducing DCT and the Maternity Trigger form, the clinical environment was using paper-based records, therefore it was appropriate for the woman to complete the form, which would then be filed into her paper based medical record. In a clinical environment that utilises an electronic or digital medical record, consideration must be given to how, and when, the information is transcribed into the electronic format. If choosing this strategy, thought must be given to how information is recorded in the medical record, and if there are any implications for transcribing information in a timely fashion, and by which staff member.

Language services are an important consideration when developing and implementing DCT. Language Services were engaged early in the consultation process, and The Women's interpreters were provided with specific antenatal screening family violence training. It was important to be clear about roles and responsibilities in regard to DCT, as interpreters were anxious that managing this interaction would rest with the interpreter. In all antenatal training for interpreters and clinical staff, as well as the Clinical Practice

[3] World Health Organisation. (2013). Responding to intimate partner violence and sexual violence against women. In *WHO clinical and policy guidelines*. Geneva, Switzerland: WHO

Guideline, it was clearly articulated that it was the clinician's (midwife/doctor) responsibility to manage this interaction, not the interpreter. This was supported by both clinical staff and interpreting staff.

### 3.2. Practical scripting

The Women's produced written resources, including scripting, to assist staff to implement DCT and the Maternity Trigger screening. This information was communicated to staff during training, and during multidisciplinary case meetings.

#### Communication material

Information regarding this procedure should be provided to women at time of arrival, and state that:

'*as part of standard maternity care here at the [insert org name], all women will be seen in private for the first ten minutes of the appointment. This is important for all women's health and wellbeing*.'

At The Women's, this information is provided on a laminated card for all women when they arrive at the desk for their booking in appointment. Administrative staff hand each woman a clipboard with the requisite maternity forms, as well as the laminated card.

#### Suggested scripting for managing DCT

'*Good Morning Jane and John. My name's Tara and I'm a midwife here at [insert org name] Jane, would you like to come into the consultation now? We'll see you on your own for the first ten minutes and then we can invite John in, as you wish. John if you want to get a coffee or put money in the parking meter, now's probably a good time*.'

#### If confusion or questions arise use your discretion and professional judgement

'*It's a policy here at [insert org name] that we see all women on their own first in the first antenatal visit*.' '*We will be doing routine examinations in this part of the consultation*.'

If there is further resistance from the woman and/or support person, use your discretion and judgment and see the couple together. If you see any clinical risk indicators of family violence or other forms of violence, please seek secondary consultation with social work regarding your concerns.

## 4. Self-Assessment Method

International evidence regarding methods for screening for family violence in antenatal settings demonstrates that screening may be most effective via paper-based or digital screening tools.[4] This method was adopted at The Women's, and further emphasised by the SUSTAIN findings that self-administered screening tools may be more effective in eliciting disclosures than face-to-face encounters, and are very acceptable to women.[1]

This approach was also preferred and supported by the midwives, as instead of being required to focus on asking direct questions about family violence, they could focus on building rapport and providing a sensitive, non-judgemental first-line response if a disclosure was made. On a few occasions, midwives reported that women may have answered negatively to the screen and then chose to disclose in conversation with the midwife during dedicated consultation time.

## 5. Relationship and Safety Tool

The Relationship and Safety Tool (RST) is a screening and identification tool that was developed by The Women's, led by Professor Kelsey Hegarty (see Appendix 1). The tool forms the foundation of the routine screening for family violence model implemented at The Women's in 2019. Although this tool was developed as a paper-based resource, as The Women's transitions to an electronic medical record, this tool

[4] Hussain N, Sprague S, Madden K, Hussain FN, Pindiprolu B, Bhandari M. (2015). A comparison of the types of screening tool administration methods used for the detection of intimate partner violence: a systematic review and meta-analysis. *Trauma Violence Abuse*. 2015;16(1):60-69. doi:10.1177/1524838013515759

has been integrated into the EMR. To maintain the self-assessment component of this method, women's interaction with electronic devices, privacy and translation into other languages needs to be considered.

The tool begins with four evidence-based screening questions which are followed with immediate and elevated safety questions. This model was adopted by The Women's as an acknowledgement that it was important to screen and then be able to identify any immediate danger or high risk indicators to enable an appropriate, timely, woman-led response.

### IMMEDIATE AND ELEVATED SAFETY QUESTIONS

If a woman answers positively to any of the four screening questions, she is required to complete both the immediate and elevated safety questions. The immediate safety questions provide guidance on the woman's safety needs on the day. The elevated safety questions assist to identify if there are any high risk indicators present. These questions are all high risk indicators for family violence lethality, as identified by the Victorian Coroner's Court and the MARAM Framework. This part of the process is about the midwife identifying and risk factors rather than performing a risk assessment.

### PERPETRATOR INFORMATION

This allows all staff to keep the perpetrator in view. This information will also be helpful when managing information sharing, visitors and potential alerts.

### SAFE CONTACT DETAILS

It is important to consider the safest way to contact the woman. If a brief, first-line response is all that can be provided on the day, and a referral to Social Work or external service is accepted, it is critical that safe contact details are discussed with the woman and provided to the referring agency. Social Work and others are often unable to contact the woman for any follow up assessment without this information.

### REFERRAL INFORMATION (INCLUDING AFTER HOURS)

Recording referral information is important to ensure effective communication between the multidisciplinary team.

### ACTION PLAN: (LIVES)

Recording an action plan is important to ensure that all members of the team are aware of the outcome of the encounter. In addition, if a woman declines a social work referral this is an appropriate place to document a brief safety plan which may include asking the women the following questions:

- *"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?"*

### FORM COMPLETED BY

Consistent with good clinical documentation

## 6. Referrals

At The Women's, Social Work, Women's Alcohol and Drugs Services (WADS) and Women's Mental Health Services are available for internal referral or consultation should women screen positively for the Emotional Health and Wellbeing or Relationship and Safety Tools. It is important that screening is not a disclosure driven process, and women's choice and autonomy is respected at all times as they are the best judges of their own safety.

If any high risk indicators for family violence are noticed or disclosed, it is important to offer a referral to an internal specialist service, such as Social Work. If this support is declined, external referral to specialist family violence services should also be offered. If a woman declines all referrals for support, and the midwife is concerned about immediate safety, it is important that basic safety planning is addressed as per the action plan outlined above. At The Women's, a referral for secondary consultation can be made to Social Work to support the midwife and the treating team, with or without the woman's consent.

Further considerations may include the timing of the antenatal clinics, are they provided in or after-hours, are social work on site and available or available on-call, are clinic appointments face-to-face or over the phone, provided individually or in a group?

## 7. Training and Support

It was important that training and support was provided for midwives regarding DCT and psychosocial antenatal screening. Face to face training was delivered to midwives to improve confidence and competence in identifying and caring for women experiencing family violence. The training package was built with the assumption that maternity staff attending had already undertaken SHRFV module one and module two training. This allowed a more tailored package to be delivered. In addition, the training was co-facilitated by representatives from Mental Health and The Women's Alcohol and Drug Service.

Anecdotally, midwives at The Women's stated that the implementation of DCT and managing the reactions of partners and support persons was the most anxiety-provoking part of the screening process prior to implementation. Training for clinical staff about screening for family violence and DCT should include clear advice about managing partners and support persons (and DCT if this is implemented), and the opportunity for clinicians to view and/or act out role plays.

Case reviews and reflective practice sessions were offered during the pilot and post implementation of screening across all clinics. It must be noted, however, that access to clinical staff for training and reflective practice in busy antenatal clinics has been challenging and remains a key issue. All training was provided face-to-face within one hour, delivered weekly, during double staff time. Despite this intensive resourcing over an extended period of time, reaching all antenatal clinical staff was a challenge.

In January 2020, The Women's mandated psychosocial training for all antenatal clinical staff (midwives and medical staff) and the SHRFV team are currently developing an antenatal psychosocial e-learning module for use within The Women's which will support this mandatory competency.

## 8. Key enablers to introducing routine screening

- Royal Commission recommendations 95 & 96
- CEO and Executive Strategy and Planning support
- The Women's Prevention or Violence Against Women Strategy 2017-2021
- Intensive training and support by SHRFV team; Modules 1 & 2 training and refresher sessions, staff support, working groups, case- reviews
- Key clinical champions in trial areas: midwives reminding staff of screening and acting as a resource for family violence questions
- Growing culture of awareness of family violence as a health issue: an opportunity to seize on this favourable environment and time in the Victorian health sector
- Relationship with clinical social work services to ensure an integrated, woman-centred approach to sensitive inquiry and clinical response

## 9. Evaluation

The Women's has been involved in projects from the Centre for Family Violence Prevention such as the SUSTAIN project1 and the System Audit Family Violence Evaluation (SAFE) project where a System Audit

Tool was implemented in November 2019 that examined identification, first line response and follow up practices. Findings from these projects have resulted in recommendations for continuous quality improvement in the areas of screening practice, policy and systems.

Quality improvement methodologies were also used to address processes to ensure the safe, effective, patient centred and equitable delivery of care to women. Furthermore, audit and feedback mechanisms were utilised to provide timely information to SHRFV and antenatal clinic staff to communicate screening and disclosure rates. This evaluation work is vital for changing ongoing health practitioner behaviour.

## Appendix 1

Relationship and Safety Tool

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# Relationship and Safety Tool

UR number: _____

Surname: _____

Given name/s: _____

Date of birth: _____ Gender: _____

(AFFIX PATIENT LABEL)

## INSTRUCTIONS FOR USE

- We know that many pregnant women have issues with their relationships and this can affect their health, so we ask all women who come into our service a set of questions about home life and relationships.
- Answering these questions will help us understand how we can best provide care. All mothers deserve healthy relationships where they are treated with respect, kindness and feel safe and supported.
- Your midwife or doctor will ask if you wish to talk about your answers.
- Below we ask about your recent experiences in your relationship/s with your partner or ex-partner, boyfriend or girlfriend or other family members.

## YOUR RELATIONSHIP

**In the last year, has a partner, ex-partner or other family member:**

| | | | |
|---|---|---|---|
| **A** | Done something that made you feel afraid? | ☐ Yes | ☐ No |
| **C** | Controlled your day to day activities (e.g.who you see, where you go) or put you down? | ☐ Yes | ☐ No |
| **T** | Threatened to hurt you in any way? | ☐ Yes | ☐ No |
| **S** | Hit, slapped, kicked or otherwise physically hurt you? | ☐ Yes | ☐ No |

If you answered YES to any of the above questions please answer the below individual safety and needs assessment

| | | |
|---|---|---|
| **Do you feel unsafe when you leave here today?** | ☐ Yes | ☐ No |
| **Are you worried about the safety of your children or anybody in your family?** | ☐ Yes | ☐ No |
| **Would you like help with this?** | ☐ Yes | ☐ No |
| **Would you like to speak to someone today?** | ☐ Yes | ☐ No |

If you answered yes to any of the above questions, your midwife or doctor may ask you more questions about your safety. You could help us further understand your safety by answering the questions below.

## YOUR SAFETY

| | | |
|---|---|---|
| Has any physical violence increased in severity or frequency in the last year? | ☐ Yes | ☐ No |
| Has your partner or ex-partner or family member recently: | | |
| - been obsessively jealous or possessive of you? | ☐ Yes | ☐ No |
| - threatened or used a weapon against you? | ☐ Yes | ☐ No |
| - assaulted or beat you up during pregnancy? | ☐ Yes | ☐ No |
| - tried to choke or strangle you? | ☐ Yes | ☐ No |
| - forced you to have sex? | ☐ Yes | ☐ No |
| - threatened to kill you? | ☐ Yes | ☐ No |
| Do you believe it is possible they could kill or seriously harm you? | ☐ Yes | ☐ No |
| Do you believe it is possible they could kill or seriously harm children or other family members? | ☐ Yes | ☐ No |

It would help us to know who has done these things to you: (please tick all that apply)

☐ Partner / spouse ☐ Ex-partner ☐ Parent
☐ Carer ☐ Family member ☐ Other: _____

What is the safest way for us to contact you for any follow up?

☐ Phone ☐ Email ☐ SMS ☐ Letter

**If any of this is happening to you, thank you for telling us. You don't deserve to be hurt and you have the right to feel safe. A midwife, doctor or social worker can support and connect you to helpful programs.**

RELATIONSHIP AND SAFETY FORM MR/2084

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# Relationship and Safety Tool
## FOR STAFF ONLY

UR number: _____

Surname: _____

Given name/s: _____

Date of birth: _____ Gender: _____

(AFFIX PATIENT LABEL)

## REFERRALS

☐ Brochures / telephone numbers provided ☐ Client declined to accept referrals

## INTERNAL REFERRALS (IN HOURS)

☐ Social Work
☐ Aboriginal Health Liaison Officer
☐ Women's Alcohol and Drug Service
☐ Other:_____
☐ Centre for Women's Mental Health (**PARKVILLE**)
☐ Abortion and Contraception Service
☐ Sexual Health Clinic (**PARKVILLE**)

## EXTERNAL REFERRALS

☐ Safe Steps *(24/7 family violence crisis response service including support, accommodation, advocacy and referral Phone: 1800 015 188)*
☐ 1800 RESPECT (*National Sexual Assault and Family Violence Crisis Service Phone: 1800 737 732 )*
☐ Inner Melbourne Community Legal (**PARKVILLE**) *(Phone: 9013 0495 Lawyer onsite at the Women's)*
☐ Police *(Phone: 000)*
☐ Centres Against Sexual Assault (*Phone: 1800 806 292)*
☐ Other community agency Please specify _____
☐ Other Legal or Mental Health Service Please specify _____

## PARKVILLE - AFTER HOURS CONSULTATIONS AND REFERRALS

☐ After Hours Manager *(Ext. 2020)* ☐ Sexual Assault Crisis Line SACL *(1800 806 292)*
☐ Safe Steps Referral (*Phone: 1800 015 188*)
☐ Social work on call Saturday / Sunday 0900-1700 *(After hours via After Hours Manager)*
☐ Child Protection *(Phone: 13 12 78)*

## SANDRINGHAM - AFTER HOURS CONSULTATIONS AND REFERRALS

☐ Midwife in Charge ☐ Sexual Assault Crisis Line SACL *(Phone: 1800 806 292)*
☐ Safe Steps Referral (*Phone: 1800 015 188*) ☐ Child Protection *(Phone: 13 12 78)*

## ACTION PLAN (Listen, Inquire about needs, Validate, Enhance safety, Support – LIVES)

_____
_____
_____
_____
_____
_____
_____

## FORM COMPLETED BY

Unable to complete Please specify reason:

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Print name: _____ Signature: _____

Designation: _____ Date: / /