Antenatal Screening for Family Violence

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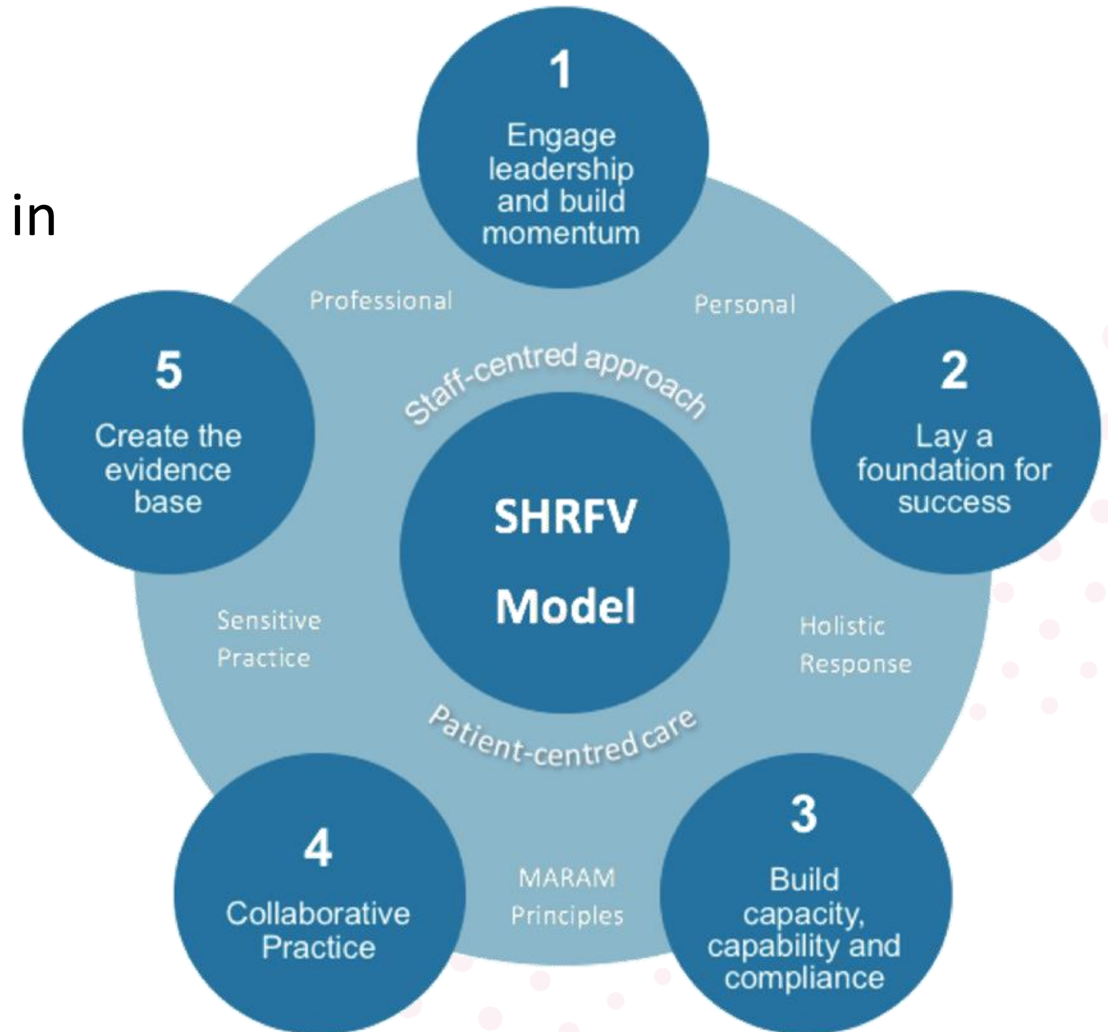
Session overview

- Overview of antenatal screening in Victoria.
- Evidence base – International research and the SUSTAIN project.
- Intersection with the Multi-Agency Risk Assessment and Management. (MARAM) Framework.
- Psychosocial screening at The Women's.

The SHRFV approach

- SHRFV commenced in 2017, now implemented in all Victorian public hospitals.
- SHRFV forms Recommendation 95 of Family Violence Royal Commission (2016).
- Antenatal Screening for Family Violence forms Recommendation 96.
- SHRFV approach is evidence-based, trauma informed and provides a strong project management framework.



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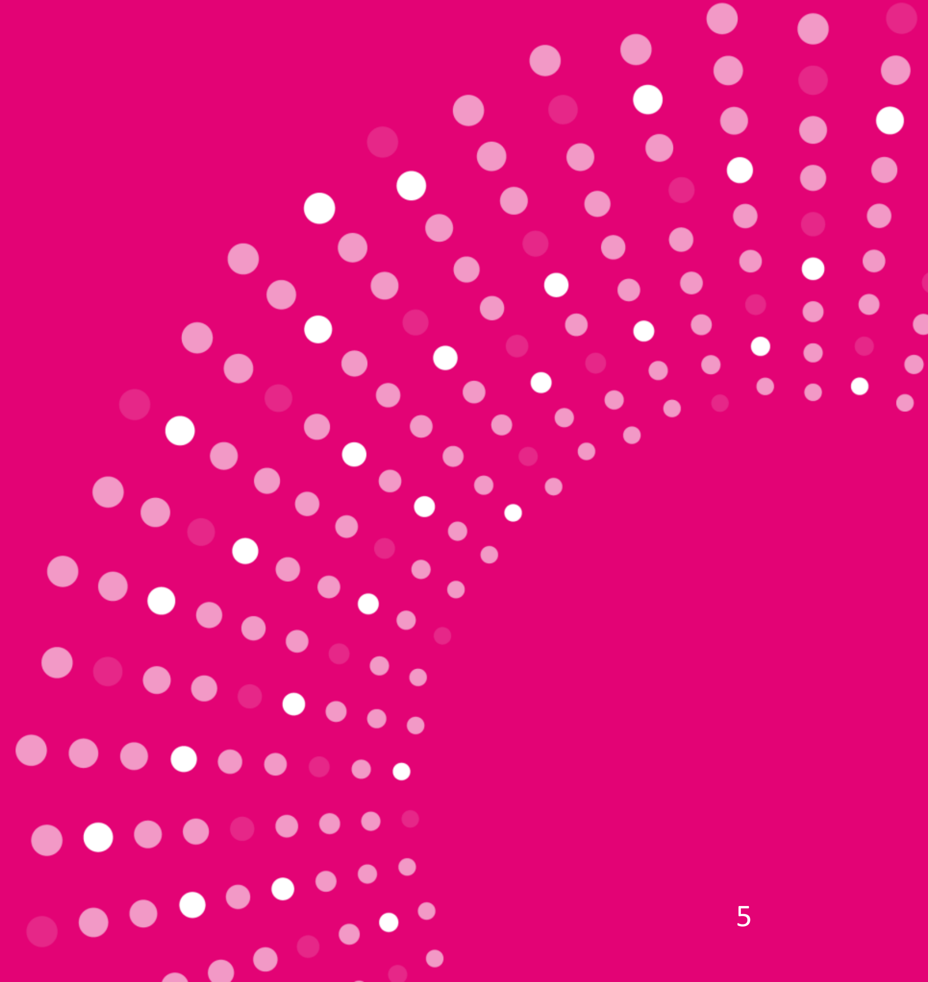
Antenatal Screening Policy and practice context

- Varying maturity of screening programs across Victoria.
- Expectations and leadership in relation to antenatal screening has been variable.
- No specific funding allocated by the Victorian Government to support the implementation of Recommendation 96.
- MARAM now provides guidance regarding screening tool and practice expectations.
- Screening guidance now available in the SHRFV toolkit.

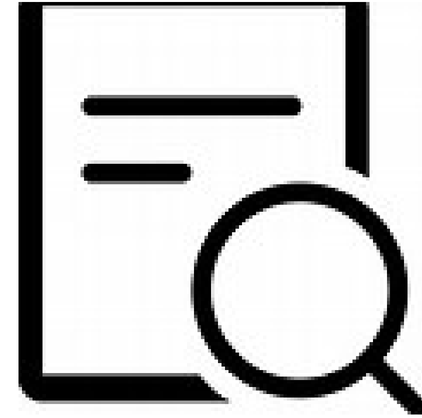
The Evidence Base



Overview

- 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.
- Although the World Health Organisation (WHO) does not recommend universal screening for family violence in all health settings, Recognised in antenatal care there may be enough evidence for screening to benefit women.
- Recommendation 96 of the Victorian Royal Commission into Family Violence (2016) states that routine screening for family violence should be introduced into all public antenatal settings across Victoria.

What is screening?



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

Face to Face vs Distal methods of screening

- Face-to-face interviews are not significantly different to a self-administered written screen regarding how many women disclose family violence (Hussain, 2015).
- Computer-assisted self-administered screen was found to increase the chances 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.

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?).

Is screening acceptable to women?

- Women are largely supportive of routine enquiry (Feder, et al, 2009).
- 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.
- 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

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 (Sprague, et al. 2012).
- In systematic reviews, only half of the health professionals find screening acceptable.
- 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 at the barriers for health professionals to screen?

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 discloses
Patient-related barriers	language, cultural barriers, concerns about confidentiality, including mandatory reporting of children (Hegarty, 2020; O'Rielly, et al. 2018)

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SUSTAIN study, Hegarty et al, 2020

- 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).
- Development of a new transformation model for implementing unstainable screening and response in antenatal care – the REAL model.

How does the work get done?

Why does the work get done?

WOMAN

"All of me"
Context
Time

Timing
Privacy
Partner/family
Cultural fit

CLINIC

Team behind me
"All eyes on it"
Clear roles
Support processes

Ongoing reflection
Training
Feedback loops

Continuity of care
Collaborative team
Holistic assessment
Mentoring

Scripts & tools
Skill building
Clear pathways
Acknowledge experience

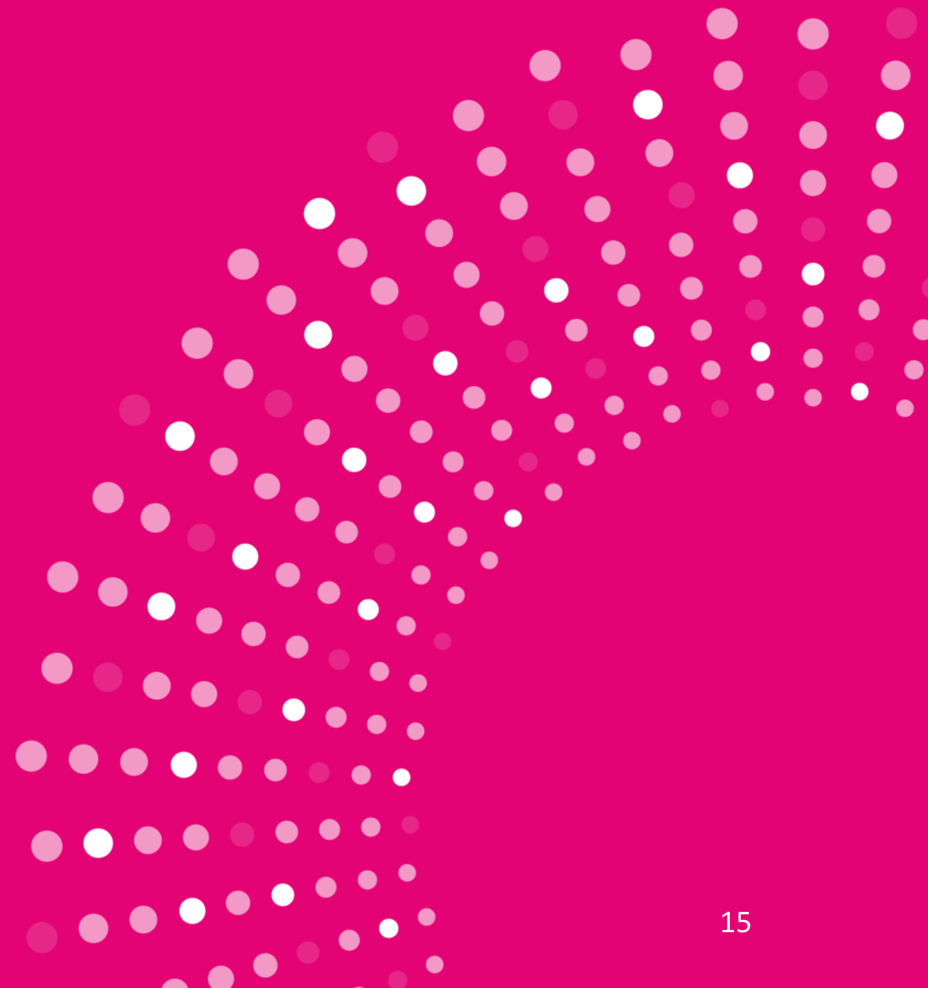
Leadership
Resourcing
Infastructure:
- electronic
- environmental

Accountability
Informed improvements
System reflection for change

PRACTITIONER

HEALTH SYSTEM

Practice



Antenatal Screening

- The aim is not to elicit disclosures, but to promote early intervention for relationships free from violence.
- It is essential that women are screened only when they are alone.
- The majority of women will not disclose during the first antenatal appointment, but it is an important first step in a woman's care.
- Screening must be done sensitively, not just a 'tick box approach'.
- Screening is acceptable to women if asked in a sensitive and non-judgemental manner.

Safe screening environment

- Dedicated Consultation Time.
- Formalised process – supporting staff to screen safely.
- Built into standard appointment time.
- Allows for other sensitive areas of women's health to be discussed.
- Provides formalised, supported opportunity for routine screening.
- Scripting – clinicians really value.

Screening should only occur when:

A woman is on her own and partners and/or other family members (above the age of 2 years) are not in the room

With an official interpreter if required

Managing partners and support persons

- Partners often attend antenatal appointments, especially booking in appointments.
- Hospitals are keen to involve partners in care and may have concerns about excluding partners to screen.
- Some women prefer the attendance of partners/support persons.
- Dedicated consultation time can assist.
- Challenging in the context of Telehealth.

Telehealth and Screening

- Remote communications must be woman-centred and must not increase risk.
- Service readiness to provide digital communications must be carefully and cautiously considered.
- The need for digital services must be clear.
- Goals for digital services must be clearly articulated
- Providing quality services through online forums requires unique training and key skill sets.

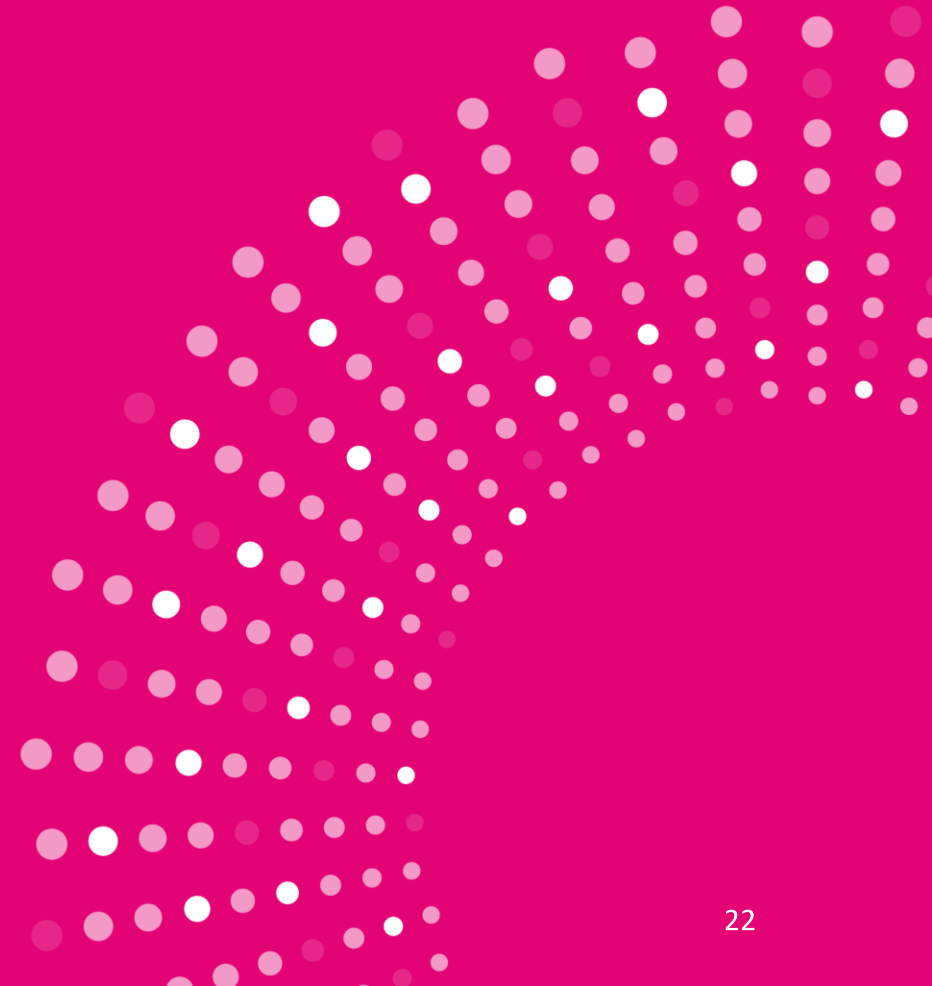
Telehealth – implementation considerations

- Must prioritise safety: need to ensure communication is safe and confidential, being mindful of the risks associated with digital communication.
- Difficult to be certain women are alone – others often present, especially during lockdowns.
- Practice guidance and scripting required to assist with determining safety to inquire.
- Additional guidance required about responding to a disclosure over the phone/telehealth, and managing a violent episode over the phone.

Support for clinicians

- Robust policies, procedures and training
- Clinical Champions
- Practice with case studies
- Reflective practice sessions
- Debrief

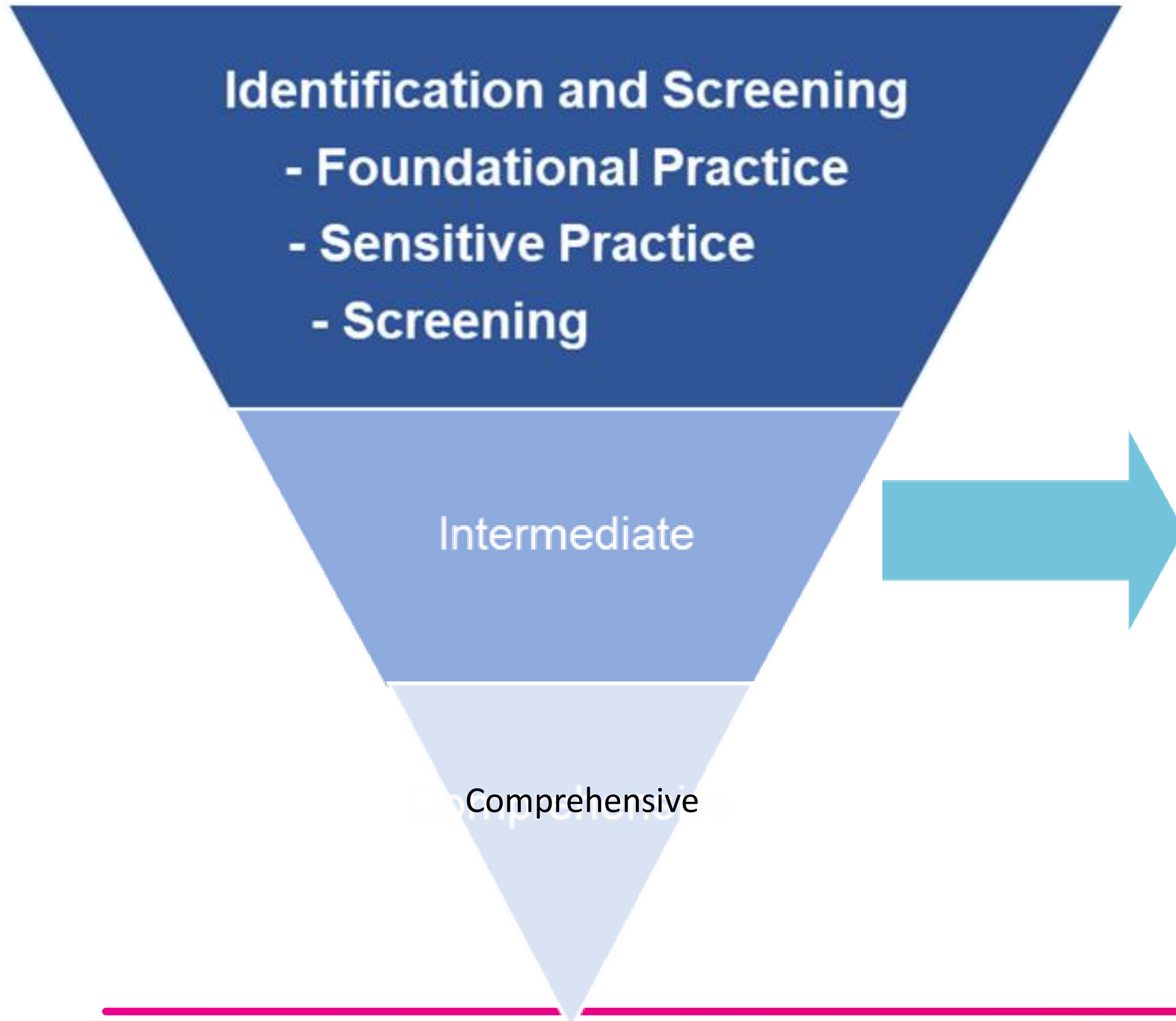
Intersection with MARAM



Multi-Agency Risk Assessment and Management (MARAM) Framework

- Increase the safety of people experiencing family violence.
- Keep perpetrators in view and hold them accountable for their actions and behaviours.
- Guide a range of organisations and sectors who will have responsibilities to identify, assess and respond to family violence risk.

Collaborative Practice under MARAM



- Supports a victim survivor to seek help and support from the whole service system.
- Consistent and collaborative practice.
- Enables comprehensive risk assessment and management.

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Building connections and partnerships

Collaborative Practice focuses on building connections and partnerships with:

- Internal services
- Local family violence services sector
- Wider community services, including Maternal and Child Health services
- Strengthens ability of hospitals to respond to victim survivors
- Provides pathways to specialist family violence support

Communication and Sharing Information

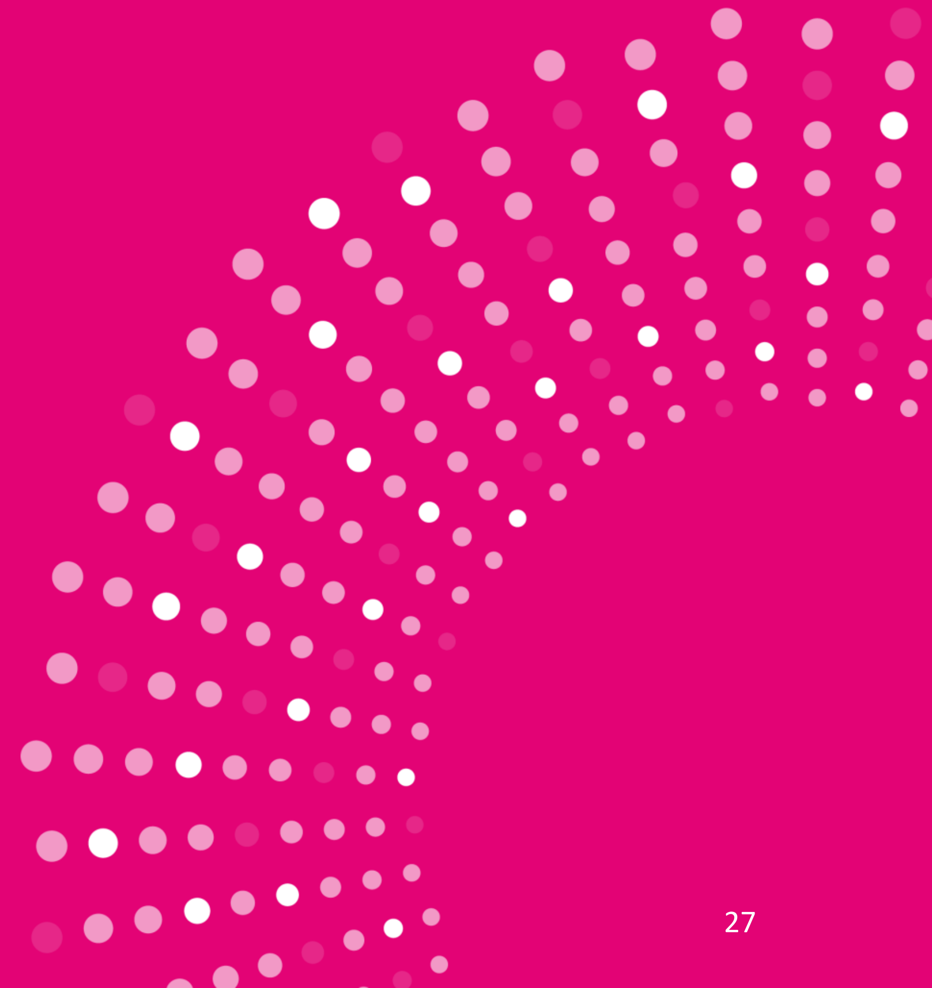
Guiding principles

- Woman centred approach
- Organisational protocols
- Limits of confidentiality
- Family Violence Information Sharing (FVIS)/Child Information Sharing (CIS) Scheme considerations
- Existing legislation

Communication across services

- Shared care
- Pregnancy related high risk women
- FV Specialist and Comprehensive level agencies
- Maternal and Child Health Nurses

Psychosocial Screening at The Women’s



Antenatal screening at the Women's

- Implemented in 2019
- Embedded Dedicated Consultation Time into the first 10 minutes of the booking in appointment
- Psychosocial model
- Paper based form – questions now in EMR
- Self assessment method

Antenatal screening at the Women's

Enablers
Royal Commission
CEO and Executive Strategy and Planning support
The Women's Prevention of Violence against Women Strategy 2017-2021
Clinical Champions
Culture change
Internal relationships with Social Work

Challenges
Concerns about encountering resistance
Women who speak other languages
Training
Specialist clinics

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SHRFV Resource Centre

- SHRFV Resource Centre
- MARAM Alignment Resources
- Project Management Resources
- Training resources
- Family Violence Workplace Support Program Resources
- Communication materials
- SHRFV Forums 2016-2019

Welcome to the Strengthening Hospital Responses to Family Violence Resource Centre

Family violence is patterned, repeated behaviour intended to assert power and control over the victim. Research shows that family violence is a deeply gendered issue that affects people across the life span - disproportionately women and their children. Family violence is a serious health issue that has a profound impact on the psychological and physical well-being of those affected.

The health sector is a critical entry point for identifying people affected by family violence, providing medical care and a pathway to specialist support and assistance. Indeed, for many people, a visit to a health professional is the first, and sometimes only, step enabling them to access support and care. Therefore, strengthening the capacity of health care professionals to identify and support people across the life span is crucial to the prevention of and response to family violence.

SHRFV Resources

SHRFV Resource Centre, Royal Women’s Hospital website

https://www.thewomens.org.au/health-professionals/clinical-resources/strengthening-hospitals-response-to-family-violence/shrfv-project-management-resources/

Thankyou

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