



Identifying and responding to domestic violence in antenatal care

Key findings and future directions

ANROWS

AUSTRALIA'S NATIONAL RESEARCH ORGANISATION FOR WOMEN'S SAFETY
to Reduce Violence against Women & their Children

RESEARCH TO POLICY & PRACTICE
ISSUE 06 | MARCH 2020

ANROWS Research to policy and practice papers are concise papers that summarise key findings of research on violence against women and their children, including research produced under ANROWS's research program, and provide advice on the implications for policy and practice.

This is an edited summary of key findings from ANROWS research *Sustainability of identification and response to domestic violence in antenatal care: The SUSTAIN study*. Please consult the ANROWS website for more information on this project and the full project report: 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.

ANROWS acknowledgement

This material was produced with funding from the Australian Government and the Australian state and territory governments. Australia's National Research Organisation for Women's Safety (ANROWS) gratefully acknowledges the financial and other support it has received from these governments, without which this work would not have been possible. The findings and views reported in this paper are those of the authors and cannot be attributed to the Australian Government, or any Australian state or territory government.

ANROWS research contributes to the six National Outcomes of the *National Plan to Reduce Violence against Women and their Children 2010-2022*. This research addresses National Plan Outcome 4—Services meet the needs of women and their children experiencing violence.

Acknowledgement of Country

ANROWS acknowledges the Traditional Owners of the land across Australia on which we work and live. We pay our respects to Aboriginal and Torres Strait Islander Elders past, present, and future, and we value Aboriginal and Torres Strait Islander histories, cultures, and knowledge. We are committed to standing and working with Aboriginal and Torres Strait Islander peoples, honouring the truths set out in the Warawarni-gu Guma Statement.

Acknowledgement of lived experiences of violence

ANROWS acknowledges the lives and experiences of the women and children affected by domestic, family and sexual violence who are represented in this report. We recognise the individual stories of courage, hope and resilience that form the basis of ANROWS research.

Caution: Some people may find parts of this content confronting or distressing. Recommended support services include: 1800 RESPECT—1800 737 732 and Lifeline—13 11 14.

Suggested citation

Australia's National Research Organisation for Women's Safety. (2020). *Identifying and responding to domestic violence in antenatal care* (Research to Policy and Practice, 06/2020). Sydney, NSW: ANROWS.

IN BRIEF

Identifying and responding to domestic violence in antenatal care

- Domestic violence (DV) is prevalent among pregnant women using antenatal services.
- Women using antenatal services find DV screening acceptable.
- DV screening rates and referrals vary across different screening contexts and between urban and rural sites.
- Health practitioners value woman-centred care that includes DV screening.
- Rural and regional areas present specific challenges for DV screening and response.
- A whole-of-system approach is required for sustainable DV screening and response.
- This research proposes a new transformation model for implementing sustainable DV screening and response in antenatal care: the REAL Transformation Model.

KEY RECOMMENDATIONS FOR POLICYMAKERS:

- Implement a comprehensive system approach for optimal DV screening.
- Implement standardised DV screening tools that incorporate screening and risk assessment questions, guide interpretation and referral pathways and provide tailored information for women.
- Facilitate the implementation of tools with electronic record systems, by building bilingual capacity.
- Resource clinics with onsite social work response capacity to support practitioners.
- Implement, and properly resource, systems to ensure ongoing and updated data collection.
- Evaluate program accountability and improvement over time to ensure value for money

Domestic violence risk is heightened during pregnancy

One in six¹ (1.6 million) Australian women have experienced physical or sexual violence by a current or former partner since the age of 15 (Australian Bureau of Statistics [ABS], 2017). Domestic violence (DV) damages the mental and physical health of individual women, men, young people and children (World Health Organization [WHO], 2013a) and is a leading contributor to death and disability for women of child-bearing age (Ayre, Lum On, Webster, Gourley & Moon, 2016). A significant number of women experience DV during pregnancy, and for one quarter of women who experience DV, the violence commences during this time (ABS, 2017). Given the high prevalence and associated risks of DV during pregnancy and postpartum periods, these factors underscore the need for antenatal DV screening (ABS, 2013); however, simply mandating screening will not produce the desired outcomes.

¹ This figure jumps to one in four Australian women who have experienced intimate partner violence when you include non-co-habiting partners, like dates and current/ex boyfriends and girlfriends with whom the respondent has not lived. See ANROWS's Accurate use of key statistics for more information: https://d2rn9gno7zhxqg.cloudfront.net/wp-content/uploads/2019/01/19030556/ANROWS_VAW-Accurate-Use-of-Key-Statistics.1.pdf

Antenatal domestic violence screening

Pregnancy presents an opportune time for early intervention for women and their families—for them to receive support, risk assessment and safety planning—due to the frequent and ongoing contact with health services (Campo, 2015; WHO, 2013b). Antenatal tools and responses need to address varied perpetrators of domestic and family violence, and various types of abuse. They need to be well tested and validated for relevance across different populations and contexts. They need to be flexible, short, easy to administer, and broadly acceptable to both health professionals and pregnant women.

There are no universally accepted guidelines for, or consistent approaches to, healthcare provider practices in DV screening across Australia (O'Reilly & Peters, 2018). Investigating, implementing, expanding and evaluating evidence-based maternity care models for at-risk women, including women experiencing DV, was identified as an action area in the *National Maternity Services Plan 2010* (Australian Health Ministers' Conference, 2011). Australian jurisdictions have responded to this imperative with a variety of screening approaches, ranging from routine screening, to targeted screening, to other mechanisms that prompt screening questions, using a variety of different screening tools (Australian Institute of Health and Welfare, 2015). Early engagement by health systems, and the sustainability of identification and the first-line response, are both imperative to effectively address DV.

Sustainability of identification and response to domestic violence in antenatal care: The SUSTAIN study by Professor Kelsey Hegarty, Professor Jo Spangaro, Professor Jane Koziol-McLain, Jeannette Walsh, Dr Amelia Lee, Dr Minerva Kyei-Onanjiri, Robyn Matthews, Dr Jodie Valpied, Jenny Chapman, Dr Leesa Hooker, Elizabeth McLindon, Kitty Novy, and Dr Kim Spurway

The aim of this study was to understand and support the integration of evidence-based, effective screening, risk assessment and first-line response to DV into the complex system of antenatal care. The researchers explored the complicated area of addressing DV in antenatal care from multiple perspectives using a WITH Health Systems Implementation Model framework that arose from previous ANROWS research (Hegarty et al., 2017). Taking a case-study approach across six hospital antenatal clinics in Victoria and New South Wales, each operating at different levels (relating to maternal complexity) and with differently sized health facilities, allowed the researchers to examine system barriers to and facilitators for implementing and sustaining DV screening and responses. By encompassing rural, regional and metropolitan study sites; healthcare users (women) and healthcare practitioners; and differing levels of DV screening practices, the study brought to the fore significant factors essential to an evidence-based, system-wide identification of and response to DV in antenatal settings.

The case study involved:

- examining workplaces: collecting hospital antenatal clinic context data and auditing readiness to respond to DV
- listening to women's voices: surveying 1219 women at two Victorian sites, supplemented by interviewing five women at two NSW sites to provide insight into the complexity of the pathways to disclosure and safety
- listening to practitioners' voices: conducting 12 focus groups and eight interviews with 91 antenatal staff members at six hospitals
- proposing a new transformation model for implementing sustainable DV screening and response in antenatal care
- developing the SUSTAIN Guidelines to assist hospital antenatal services' and practitioners' readiness to respond to DV via reflective questions and practical scripts (see Appendix A).

Quotes appearing in this paper come from interviews with women and practitioners carried out as part of the study, and also appear in the full report.

See www.anrows.org.au for the full report.

Key findings

DV is prevalent among pregnant women using antenatal services

- The researchers found 8.3 percent of participants had experienced DV in the 12 months preceding the survey, based on yes/no screening items.
- Types of behaviours experienced included fear of partner/ex-partner (5.6%), controlling behaviour (4.7%), threatening behaviour (1.7%), and being slapped/kicked/hurt (1.2%).
- Additional participants, when screened using a longer abusive behavioural checklist, brought the overall total of women experiencing DV to 14.2 percent.

Women found domestic violence screening acceptable

Regardless of whether they had experienced abuse or not, women using antenatal services greatly valued support for physical and emotional health, parenting, personal safety and sexual health issues during pregnancy.

- While DV experience is typically not identified by health providers, some women are open to getting help. The study found only 26% of participants who had been fearful of a partner had ever talked to a doctor or midwife about it, with 16% of all respondents saying they would consider using help from a doctor or midwife for this issue.
- Women are okay to be asked about DV, whether they had experienced abuse or not. Only a small minority of women (4%) thought health providers should not ask about DV. Most thought it should be asked, with around half of the women saying it should be asked about at every visit, a third at some visits and 14 percent at the first visit only.
- About 13 percent of women thought health professionals were there only for pregnancy care, but this was more prevalent in women who indicated they had experienced abuse (24%) than those who did not (12%). Abused women were also more likely (20%) than non-abused participants (10%) to think the doctor was too busy to listen. Only a small percentage of participants thought the same thing about midwives (4%).
- The women in this study, whether recruited from established screening sites or sites which are yet to mandate routine antenatal screening, expressed support for screening.
- None of the women studied reported any adverse effects from DV screening and response.



“I think it’s important, because I wasn’t aware I was a victim of domestic violence.”

(Anna)

DV screening rates and referrals vary

All six publicly funded health services hospitals where the SUSTAIN study was implemented (across both NSW and Victoria) demonstrated a readiness to respond to DV using a World Health Organization checklist (WHO, 2017). Despite this readiness, there were variations in DV screening rates and referrals across the states, and between rural and urban sites.

- In Victoria, where routine screening is being introduced, less women (41%) were asked about their safety than in NSW (82.4–98.9%), where routine DV screening has been in practice for around a decade.
- At the larger Victorian urban site, 40 percent of women were referred to other hospital services, while at the regional site 25 percent were referred to social work. In NSW, referral rates varied from 40–82.4 percent to multidisciplinary case discussions (SAFE START)² across hospitals, and from 41–47 percent to social work.

Health practitioners value woman-centred care

- Health practitioners at all sites valued woman-centred care, including asking directly, seeing all of the woman, asking alone for privacy, and responding holistically in a way that supported choice and agency.
- The core theme fundamental to woman-centred care in the context of screening for DV was ensuring that asking occurred in the context of a relationship, rather than being process-driven.
- Health practitioners identified four support needs to provide woman-centred care: continuity of care, a collaborative team, holistic assessment and mentoring.
- Consensus existed across practitioners that the role of screening best fitted with midwives who have an initial role in risk assessment and management, with social workers best placed to provide a comprehensive response that was ideally onsite and immediate.
- The workplace needs to provide structural support to enable practitioners to respond to women, by incorporating all professional groups in DV identification and response and by having in place clear roles, support processes, ongoing reflection, initial and ongoing training, and feedback loops to improve practice.
- A focus on providing bilingual responsiveness supports working with women from diverse cultural and language backgrounds, which also requires extra time.
- Practitioners discussed the need to respect women's choice and agency and at the same time keep safety of the woman and her children in sight, including fulfilling relevant mandatory reporting requirements.



“You don't want her to feel like you're just there asking questions, you want her to feel like she's being cared for and nurtured so that she can disclose information to you.”

(Site V3, Focus group 1, Midwife 1)



“If we have to call in [child protection agency] ... due to child protection ... they don't care about the mum. It is about the child for them, whereas I care about both. So, it's actually building that relationship and supporting that woman through what is probably a terrifying ordeal for them.”

(Site N1, Social worker)

² SAFE START is NSW Health's model of universal psychosocial assessment, depression screening and follow-up care and support during the perinatal period. See: https://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2010_016.pdf

Rural and regional areas have specific challenges for DV screening and response

The research showed that rural and regional areas face added complexity in managing confidentiality and privacy for women where health practitioners' and women's lives are intertwined. A lack of resources is also heightened in rural areas, in particular accommodation for women leaving violence, exacerbated by long distances, isolation and women's lack of access to transport. Responding to DV is made challenging through staffing shortages, meaning social workers may often not be readily available. This means these findings may not be generalisable to other states and territories, particularly those with remote health services.

A whole-of-system response is required

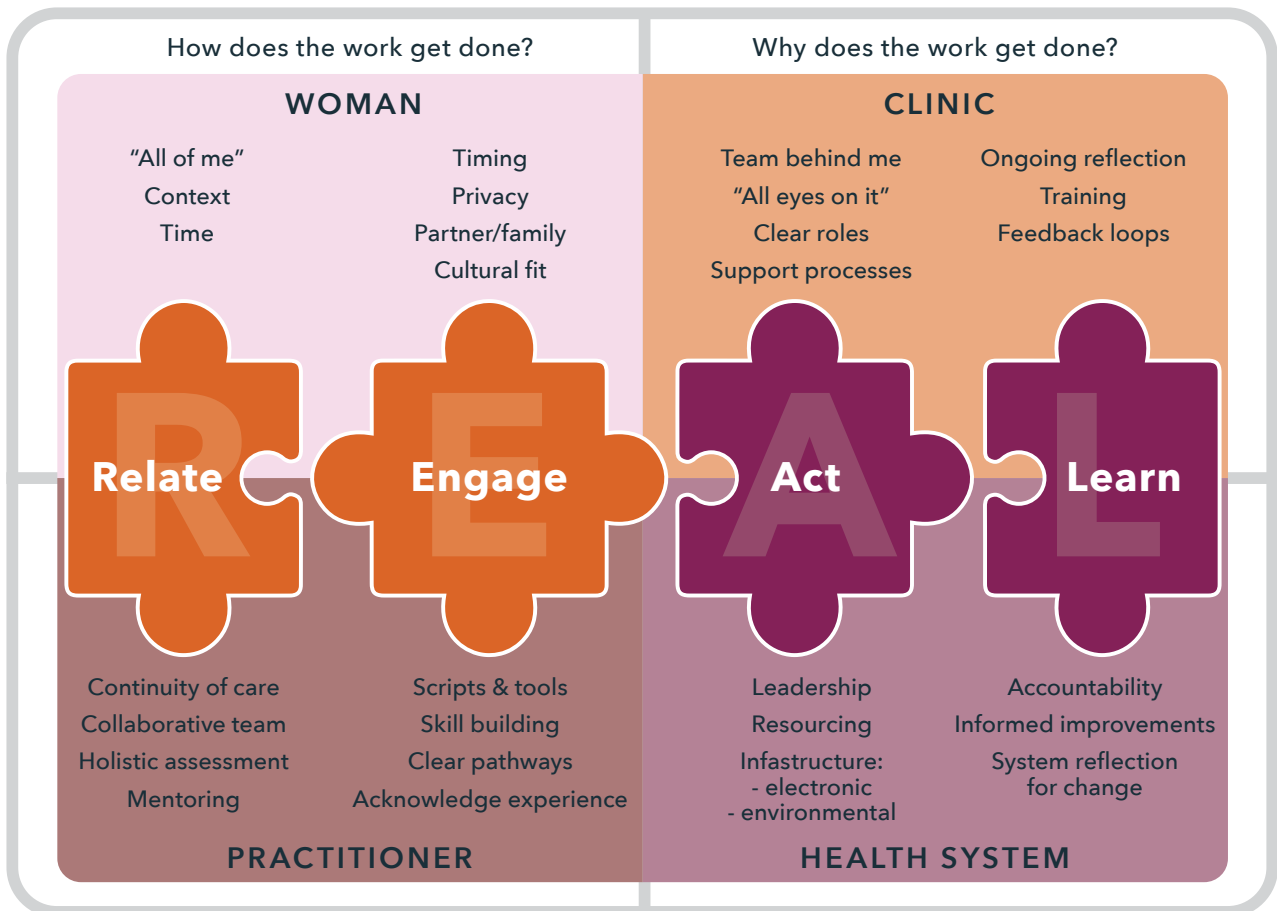
A “whole-of-system” health service response and systems change are required to support optimal DV screening in antenatal care. System audits need to be undertaken to enable a deep understanding of the whole system that supports screening and first-line response in antenatal care. At a workplace level, there is a need for a culture of gender equity, enactment of trauma-informed principles (respect, privacy, confidentiality and safety), clear staff roles, protocols and referral pathways. At a systems level, there is a need for provision of workforce support, including for staff who experience DV; appointment of champions; infrastructure both environmental and financial; and information systems for evaluation.

The “REAL” Transformation Model

The research identified a new model for implementing sustainable DV screening and response in antenatal care. The “REAL” Transformation Model is outlined in Figure 1. Essential elements pertaining to four different levels of the system—the woman, the practitioners, the clinic and the health system—were identified. The “how” pertains to characteristics of the *relationship* between women and their practitioners, and important elements that facilitate effective *engagement* of a woman. The “why” concerns practical *actions* required within the clinic and health system, as well as activities related to *learning* to enable reflection on practice and systems to build practitioners' knowledge and skills and strengthen existing systems. Practical scripts and reflective questions for each element of this model can be found in the SUSTAIN Guidelines available in Appendix A.

Figure 1 The “REAL” Transformation Model: Sustainability of identification and response to domestic violence in antenatal care

Sustainability of Identification and Response to Domestic Violence in Antenatal Care



Implications for policymakers

- Simply mandating DV screening will not produce the desired outcomes. Higher screening rates in NSW, where systematic screening was established, versus lower rates at Victorian sites where this is only now starting to occur, indicate that a comprehensive system approach is a more effective way to identify and respond to pregnant women who might be experiencing DV. The impact and effectiveness of DV screening using the SUSTAIN Guidelines will be seriously limited if practitioners are left to act in isolation.
- Standardised screening tools that incorporate screening and risk assessment questions, guide interpretation and referral pathways and provide tailored information for women are required.
- Electronic record systems and building the bilingual capacity of the practice through bilingual workers and trained interpreters can facilitate both the reach of safe implementation of tools at designated times and team communication.
- Clinics may also require onsite social work response to support practitioners, with tailored solutions in rural/regional areas.
- Systems to ensure ongoing and updated data collection require further attention and resourcing across states.
- A means to evaluate program accountability and improvement over time to ensure value for money is paramount in any policy implementation plan.

Test a screening tool and undertake system audits to ensure sustainability across Australia

There is a clear gap in validated DV screening and audit tools for the Australian antenatal setting, which address the broad range of types of abuse women experience, including controlling behaviours by partners and other family members. There is a need for sector-wide consultation to determine the best approach for such tools and the best way to support achievement of standards across systems and services. The resulting tools need to incorporate explicit screening questions, guidance on interpretation and use, and information for women. This process should consider whether there needs to be culturally appropriate and inclusive screening tools, particularly for high risk populations and areas where access to services are limited. System audits need to be undertaken to enable a deep understanding of the whole system that supports screening and first-line response in antenatal care.

Implications for practitioners, service providers and hospitals

SUSTAIN study findings endorse World Health Organization recommendations, based on research and survivor voices, that antenatal health care provides holistic, tailored care; adequate time; and an environment conducive to relationship building and engagement (WHO, 2013b). Used in conjunction with the REAL Transformation Model, the SUSTAIN Guidelines can assist hospital antenatal services' and practitioners' readiness to respond to DV via reflective questions and practical scripts (see Appendix A).

RELATE

- Facilitate woman-centred care by enabling consideration of a woman's individual context and through ongoing contact with practitioners (continuity of care).
- Ensure adequate time for care processes.
- Support strategies that encourage a collaborative team, including mentoring of staff.

ENGAGE

- Procedures for screening need to attend to timing of asking questions and building rapport, including provision of bilingual services.
- Private spaces to engage are essential to woman-only consultation time.
- Balance a focus on woman-centred care with providing family-centred care catering to children, as well as partners who may be using violence—if safe to do so.
- Practitioners need scripts, tools and skill-building that acknowledges their own experiences.

ACT

- To facilitate DV screening and response, health practitioners require a supportive workplace with strong leadership, resourcing and infrastructure.
- Health practitioners seeing women with complex needs value, and feel supported by, multidisciplinary teams, including social work, mental health, drug and alcohol, and child protection services.
- Practitioners need to respect women's choice and agency and at the same time keep safety of the woman and her children in sight, including fulfilling relevant mandatory reporting requirements.
- Implementation plans need to focus on multiple health professions, as women may disclose to a subsequent practitioner they see, pointing to the need for clear roles and referral pathways for all practitioners and continuity-of-care models in antenatal care.

LEARN

- Ongoing training, peer support, case discussions and a whole-of-team approach are measures that will build both capability and confidence.
- Ongoing reflection, training and feedback loops will improve practice.

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Further reading

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APPENDIX A

SUSTAIN Guidelines: The “REAL” Transformation Model

The “REAL” Transformation Model

Sustainability of Identification and Response to Domestic Violence in Antenatal Care



**About
the “REAL”
Transformation
Model**

2



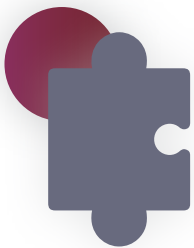
Relate

3



Engage

4



Act

5



Learn

6



**Scripts for
SUSTAIN
guidelines**

7

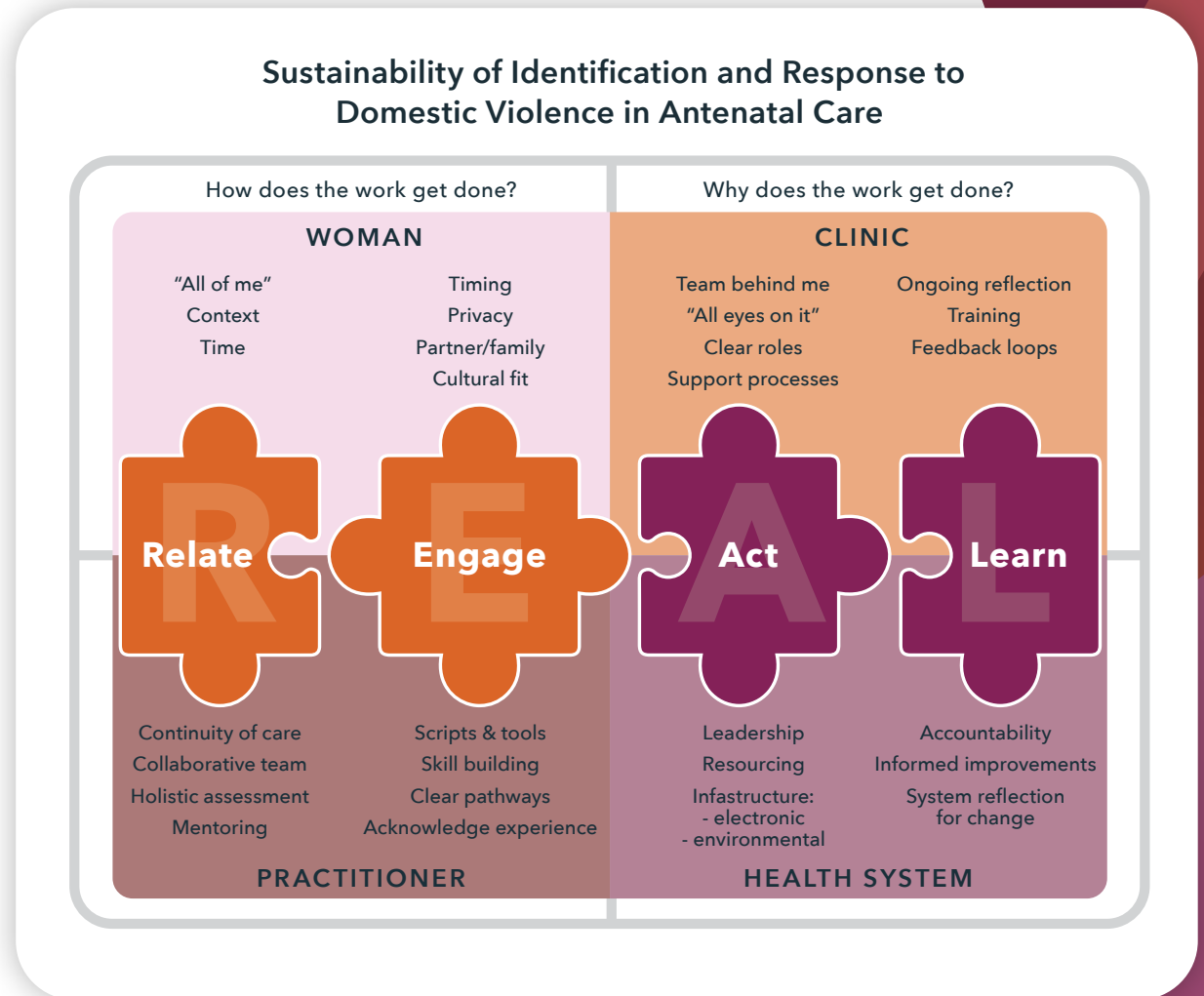
About the “REAL” Transformation Model

A model for the sustainability of identification and response to domestic violence in antenatal care—the “REAL” Transformation Model—was developed by researchers drawing on the experiences of women and practitioners across six hospital antenatal clinics in Victoria and New South Wales.

The development of the “REAL” Transformation Model is detailed in the ANROWS Research report *Sustainability of identification and response to family violence in antenatal care: The SUSTAIN study* (available at anrows.org.au and dvhealthtools.com). Essential elements pertaining to four different levels of the system—the woman, the practitioners, the clinic and the health system—were identified.

“How” pertains to characteristics of the **relationship** developed between women and their practitioners, and important elements that facilitate effective client-practitioner **engagement**.

“Why” concerns practical **actions** required within the clinic and health system that support identification and response to domestic violence, as well as activities related to **learning** to enable reflection on practice and systems in order to build practitioners’ knowledge and skills and strengthen existing systems.





Relate

Relate in our model refers to the initial contact with women, including screening and identification of domestic violence (DV). This may involve practitioners establishing a rapport, raising awareness and signalling that they have a safe space to discuss issues as well as conduct screening.

For women, important aspects of "relate" were:

- a whole-person approach to care: seeing "all of me"
- consideration of their unique circumstances or context
- adequate time for care processes.

Health practitioners valued:

- continuity of care for their clients through ongoing contact
- a collaborative team
- employing holistic assessment for domestic violence, which involves acknowledging and addressing patients' various needs
- mentoring.

See Scripts for SUSTAIN guidelines.

Relate WOMAN

Reflective questions

Are you aware of the feelings and thoughts behind her words?

Are you aware of her body language and what it is indicating?

Are you attending with your body and words?

Have you heard what she says and does not say about her needs?

Do I provide options so that women can choose what they want to do?

Do I take extra time if needed with a woman who has disclosed abuse?

Relate PRACTITIONER

Reflective questions

What does continuity of care mean to you?

Do I feel people have my back if I am responding to a disclosure?

Do you discuss issues across the scope or breadth of women's lives?

Do you look beyond her pregnancy, symptoms or presentation?

Have I had a chance to discuss with senior colleagues any issues I have addressing DV?

Is there someone I can talk to if I am unsure what to do?



Engage

Engage in our model refers to ongoing relationships and factors required to facilitate disclosure or ensure an adequate response to domestic violence (where a disclosure is made).

For women, essential characteristics of this engagement were:

- appropriate timing for identification and response to domestic violence
- privacy
- partner/family involvement in care (if safe to do so)
- cultural fit, including provision of bilingual services.

Health practitioners valued:

- having scripts and tools
- skill building
- having clear pathways to guide clinical decisions
- acknowledgement of their various experience.

See Scripts for SUSTAIN guidelines.

Reflective questions

How do you engage women from the first moment you meet?

Do you ask alone?

Do you ask when the time is right, using your professional judgement to take any opportunities presented?

Do you ask what would help the most right now and later?

Do you revisit screening on subsequent occasions?

Do you think about how to engage with the partner or other family members if safe to do so?

What referral pathways and strategies are in place for a partner to stop their use of violence?

How do you feel if you suspect DV but she doesn't acknowledge the experience?

Reflective questions

Do I have the words to be able to ask and respond?

How do you feel if you suspect DV but she doesn't acknowledge it?

Are scripts and tools available if I need them?

Do I have tools, resources or strategies I can offer the woman in the interim?

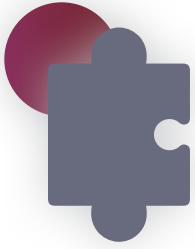
What strategies do I use to develop trust and rapport?

How do I build confidence to ask and respond to disclosures?

Do I know:

- what to say if a woman discloses?
- what to do if a woman discloses?
- what safety strategies are available to the woman?
- the available supports and referral pathways?

Do I have clear, immediate pathways for women in crises or at serious or high risk?



Act

Act refers to the practical actions which support domestic violence identification and response within the health system, as well as activities related to learning for the strengthening of existing systems.

At the clinic level, important elements for domestic violence and response were:

- having the support of a team: having a “team behind me”
- different categories of practitioners playing their part: “all eyes on it”
- having clear roles
- having support processes.

At a health-system level, support for the work requires:

- strong leadership
- resourcing
- provision of infrastructure (electronic and environmental).

Reflective questions

Does everybody in the team have a shared understanding of the nature and dynamics of DV?

Does the team talk about this issue on a regular basis?

Are the roles for screening and response within the clinic clear and defined?

Is there support from my organisation to do the work?

Reflective questions

Is somebody within the clinic team/clinic overall/hospital responsible for leading the screening and response program?

Is there adequate funding for

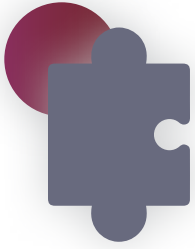
- initial and ongoing training?
 - clinical champions?
 - referrals?
-

Are physical spaces and intake procedures welcoming, comfortable, safe and private?

Is the electronic system for recording private and safe?

Is there sufficient time allocated for antenatal visits?

Is there access to specialist services outside the health setting if needed?



Learn

Learn related to learning to enable reflection on practice and systems, to build practitioners' knowledge and skills and strengthen existing systems.

At the clinic level, learn involves:

- ongoing reflection
- training
- establishing feedback loops.

Within the health system, the learning should be supported by:

- accountability
- informed improvements
- system reflection for change.

¹Short, J., Cram, F., Roguski, M., Smith, R., & Koziol-McLain, J. (2019). Thinking differently: Re-framing family violence responsiveness in the mental health and addictions health care context. *International Journal of Mental Health Nursing*, 28, 1209–1219. doi:10.1111/inm.12641

Learn CLINIC

Reflective questions

Do we reflect as a team or clinic how we are addressing DV?

How and with whom will I review to see if what we are doing is creating safety for her and her children?¹

Are all members of the team trained initially and recurrently?

Is there a mechanism for new staff requiring training?

Does training involve simulation of cases to enable practice?

Does the clinic receive screening and response data?

Learn HEALTH SYSTEM

Reflective questions

How does the organisation monitor DV practice to achieve effective outcomes?

Are data fed back to staff?

Are the voices of diverse women captured to inform improvements?

How can we do better?

Is feedback to staff and managers from audits delivered flexibly?
(Peers or managers, oral or verbal, on multiple occasions)

Are specific targets set for what needs to be changed?

Scripts for SUSTAIN guidelines

Relate

Introducing screening questions

Screening about domestic violence does not have immediate relevance to a pregnancy, and some women will be unprepared to be asked these questions, so it is important to provide some explanation before you ask about DV. In some instances, a woman may tell you something which could be, or is, reportable to the statutory child protection agency in your state, and so it is also ethical to warn them about limited confidentiality. Here we suggest some words you can use.

Confidentiality

Some women will decide not to disclose abuse they are experiencing, often because of fears of losing their children. In this case, even the information that abuse is common and that the health service is aware of the issue can be important for women to hear. It may also prompt them to open up at a later point.

Support

It is also useful to provide a wallet-sized information card to all women regardless of whether they disclose or not, recognising the likelihood of under-disclosure. A useful explanation is:

“

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 and kindness, and feel safe and supported.”

OR

“

In this clinic we ask all women some questions about safety in relationships, because abuse by a partner is quite common and it can affect your health and the health of your baby.

You don't have to answer the questions if you don't want to.

“

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.

“

We give every woman this little card with some information and numbers on it. You might know someone who'd find it useful. If you don't want to take it, you can leave it in the waiting room.

Engage

Establishing privacy to ask

It's unsafe to ask screening questions with other adults or children aged three years and over present in the room. Asking an attentive partner or other family member to simply leave and/or directing women to attend appointments alone can raise suspicion, where a controlling relationship exists, or be experienced as not family-friendly.

It is suggested that where women attend with a partner, time alone is also offered to the partner to ask questions.

The following words may be useful to establish privacy in instances where women attend with partners or other family members:



Part of our visit today will involve some one-on-one time. We do this with all our patients, as we find that many women and also their partners have questions for us they might not feel comfortable asking in front of others.

Midwives have told us that establishing private time also provides space to ask about other issues which women may not have told partners or family members about, such as previous pregnancies/terminations or mental health issues.

Some midwives ask partners to book the next appointment during this period to make this private space easier to establish.

By offering partners time alone as well, midwives can provide a useful service, for example, promote the partner supporting breast-feeding, or answer questions about sexual activity during/after pregnancy.

Where midwives have concerns about a very present ("Velcro") partner, they may invite the woman to the bathroom to complete a urine test to gain time alone.

Asking about abuse

Screening relies on women feeling attended to, and not judged. Your attitude, presence in the space and non-verbal communication will be the most important tools you have, and they will shape women's responses. It is important to face the woman while you ask these questions and give her your whole attention, rather than typing/writing responses down. At the same time, it is useful to think carefully about *what* you ask. Evidence suggests, and women have also told us, that direct questions asking explicitly about abuse are best. It is also suggested that more than one question be used, rather than a single question such as "*Do you feel safe at home?*"

More than 18 different tools for asking about domestic violence have been developed and validated against longer, more comprehensive surveys such as the Composite Abuse Scale or Conflict Tactics Scale. The idea is to find a short number of questions that can accurately identify domestic violence, if the woman is willing to disclose. Some useful tools include:

NSW Health screening questions

1. Within the past year have you been hit, slapped or hurt in other ways by your partner or ex-partner?
 2. Are you frightened of your partner or ex-partner?
- If YES to either 1 or 2:*
3. Are you safe to go home when you leave here?
 4. Would you like some assistance with this?

The Royal Women's Hospital Relationship and Safety tool

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

(Tool aligned with MARAM: Multi-Agency Risk Assessment and Management - Screening and Identification Tool; Family Safety Victoria, Victorian Government available at <https://www.vic.gov.au/maram-practice-guides-and-resources>)

Responding to disclosure

Commonly women will “test the waters” and may give a partial or ambiguous response, even to direct questions. They may indicate that domestic violence has occurred in the past and is no longer current. It is useful to say something like:



That sounds like it must have been difficult for you. Can you tell me some more about that?

When a woman discloses it's important to respond positively and immediately, even if you are unsure what you need to do next. It can be useful to say something like:



Thank you for telling me this. It's not okay that you are being hurt like that. I am going to help you get the support you need, so you can be safe/this doesn't happen again.

OR



Thank you for telling us about what has been happening in your relationship. You don't deserve to be hurt, and you have the right to feel safe. A midwife, doctor or social worker can support you and connect you to helpful programs.

It's important not to make promises that you can't keep, such as that you will keep the disclosure a secret.

Asking again later

Some guidelines suggest that re-screening should occur. Women who experience abuse have also reported that this can be helpful. Useful words to raise this issue again with women include:



At your first visit you might remember I asked you some questions about your relationship. Sometimes things change during your pregnancy. Can I check in with you again about that?

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ORGANISATION FOR WOMEN'S SAFETY
to Reduce Violence against Women & their Children



Further resources:

Sustainability of identification and response to family violence in antenatal care: The SUSTAIN study

www.anrows.org.au/project/the-sustain-study/

REAL model (online version)

www.dvhealthtools.com

Safer Families Centre

www.saferfamilies.org.au

Safer Families Toolkit

www.saferfamilies.org.au/toolkit

Strengthening Hospital Responses to Family Violence (SHRFV) Toolkit

www.thewomens.org.au/health-professionals/clinical-resources/strengthening-hospitals-response-to-family-violence

Clinical Handbook, World Health Organisation (WHO)

www.who.int/reproductivehealth/publications/violence/vaw-clinical-handbook/en/

Manual for Health Managers, World Health Organisation (WHO)

www.who.int/reproductivehealth/publications/violence/vaw-health-systems-manual/en/

© ANROWS 2020

Published by

Australia's National Research Organisation for Women's Safety Limited (ANROWS)
PO Box Q389, Queen Victoria Building, NSW 1230 | www.anrows.org.au | Phone +61 2 8374 4000
ABN 67 162 349 171

Identifying and responding to domestic violence in antenatal care / ANROWS (Ed.).

Sydney : ANROWS, 2020.

Pages ; 30 cm. (Research to policy and practice, Issue 06/2020)

I. Domestic violence -- Screening. II. Pregnant women -- Australia. III. Antenatal care -- Risk assessment -- Domestic violence -- Response.

I. Australia's National Research Organisation for Women's Safety.

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Please note that there is the potential for minor revisions of this paper.

Please check the online version at www.anrows.org.au for any amendment.

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