The "REAL" Transformation Model

Sustainability of Identification and Response to Domestic Violence in Antenatal Care

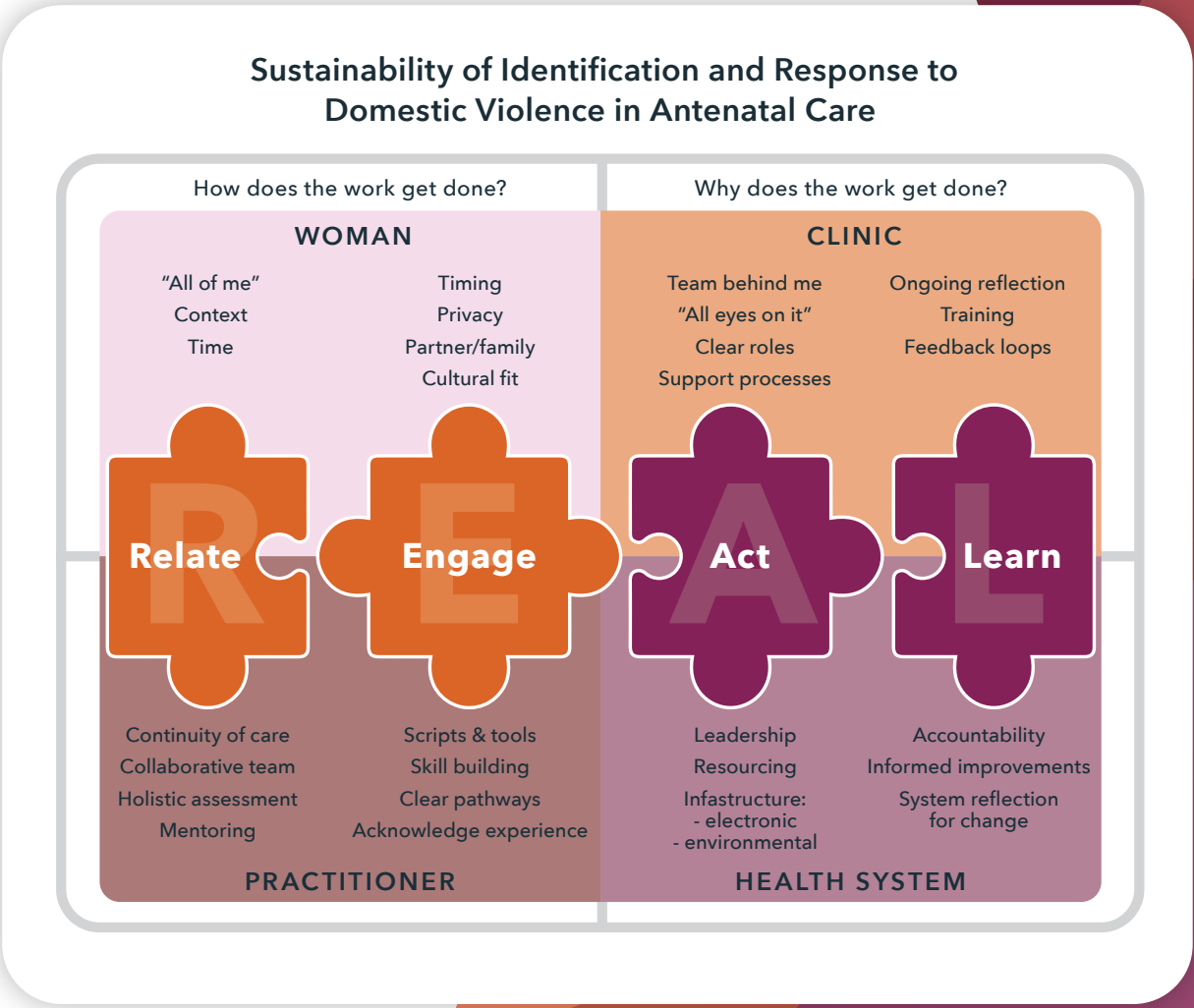
About the "REAL" Transformation Model

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.

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?

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.

[1]Short, 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

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?

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.

> *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.*

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.

> *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.*

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 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?*

ANROWS

AUSTRALIA'S NATIONAL RESEARCH ORGANISATION FOR WOMEN'S SAFETY

to Reduce Violence against Women & their Children

CENTRE OF RESEARCH EXCELLENCE
Safer Families

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/