


RESEARCH ARTICLE

REVISED **Family violence screening and disclosure response: A public mental health service consumer survey. [version 2; peer review: 1 approved, 1 not approved]**

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Abstract

Background: Family violence (FV) is a significant problem that has a bidirectional link with mental health functioning. This research aimed to investigate family violence screening and response practices in a Victorian public adult mental health service, NorthWestern Mental Health, from the consumer perspective.

Methods: A prospective, cross-sectional, electronic consumer survey was created, utilising the Royal Melbourne Hospital Patient Survey FV screening and response tool. Data were collected over a two-month time period, via ipad. Clinicians invited all consumers (age range 18 to 64 years) attending the service to participate on data collection days, unless any of the exclusion criteria were present: a) clinical interaction occurring in a non-confidential environment; b) acute distress/crisis; c) clinician concerns about affecting rapport; and d) cognitive impairment, known disability or diminished capacity preventing them from reading or understanding the survey questions. Categorical and Likert type survey responses were explored descriptively. All variables collected in the survey were provided, specifically the percentage of responses in each category for each question. Free-text responses were analysed using qualitative description of the text-box response content.

Results: 35 consumers participated. 47% reported being screened for at least one family violence issue on at least one occasion. 26% reported disclosing FV concerns. All those disclosing felt mildly or very supported by the clinician's response, and two-thirds received assistance they found helpful. 9% reported wanting to disclose FV concerns but not feeling comfortable to do so. Consumers indicated that FV should be spoken about more, that receiving assistance is helpful, but that responses varied in quality depending on the discipline of the clinician.

Conclusion: FV screening rates were found to be suboptimal as unmet needs were identified. Further training and services changes

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Any reports and responses or comments on the article can be found at the end of the article.

are required to improve screening rates, increase client comfort to disclosure, and optimise the clinical response to disclosures.

Keywords

Family Violence, Domestic Violence, Screening, Disclosure, Mental Health



This article is included in the [Healthier Lives gateway](#).

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REVISED Amendments from Version 1

We have utilised the reviewers helpful comments to revise the manuscript to include the survey tool as an appendix, clarify existing policies and procedures at the time the survey was conducted, and provide more context for our assertion that family violence screening at the service was sub-optimal.

Any further responses from the reviewers can be found at the end of the article

Introduction

An association between family, intimate partner, and domestic violence (referred to hereafter as FV) and mental ill-health has been well established and appears to be bidirectional. FV impacts on the mental health wellbeing of children and adults who are recipients of FV behaviours¹⁻⁵. Conversely, people who use violence against family members also have high rates of mental health conditions, including posttraumatic stress disorder, depression, anxiety, substance use disorders, and antisocial and borderline personality disorders⁶⁻⁸. Beyond the impact on quality of life associated with mental health conditions, FV also impacts significantly on health, death, and disability^{9,10}. Thus, addressing FV in people requiring mental health care is essential.

The rate of FV experienced in samples of adults with mental health conditions is high. Studies of women with mental health conditions have indicated the self-reported lifetime prevalence of experiencing interpersonal violence in a family or partner context is between 55 and 63 percent¹¹⁻¹⁴. Men with mental health conditions also report high rates of FV and abuse, with lifetime prevalence self-report ranging between 32 and 50 percent^{11,12}.

Much of the research focus has been placed on ways to assess for, and actually assessing, the prevalence of FV in particular cohort groups¹⁵. Fewer studies, however, have looked at rates of health service FV screening and health service users' perceptions of the screening process. A systematic review that evaluated the efficacy of screening for intimate partner violence (a form of family violence) included 13 studies across hospital primary care, emergency department, antenatal and maternal health settings. No mental health studies were found that met the inclusion criteria¹⁶. Recent findings from a large Victorian general adult hospital found that less than half of sampled participants (from the Psychology and Social Work caseloads) were screened for FV at the health service¹⁷. From this group, one quarter had disclosed FV issues to clinicians at the service. One fifth had wanted to disclose, but did not feel comfortable to do so, and three quarters of this group were not screened for FV during their involvement with the service. Interestingly, the majority of patients who had disclosed reported receiving support from staff members and helpful information. Comparatively higher rates of screening were identified in a Victorian maternal health service¹⁸. In this cohort, 87.5 percent of participants had been screened for FV at the health service, with the 12.5 percent who disclosed FV experiences reporting receiving a supportive and helpful

response from clinicians. Unmet FV needs were not identified at this maternal health service, with no consumers reporting they had not felt comfortable to disclose their FV concerns.

Collectively, these findings, outlined above, suggest that rates of both FV screening, and unmet FV needs vary considerably across Victorian health services and settings. This may, in part, be related to differences in practice guidelines for the services. Recommendations for screening have been in place at maternal and child health services in Victoria since 2009. However, most families attending the service the study was conducted at do so after children have passed the age of four weeks (when family violence screening is mandatory)¹⁸. Thus, screening is not mandatory but recommended if professional judgement warrants. In contrast, guidelines for general adult hospital family violence screening were being prepared, but were not yet available or in place, and the adult health service when the study was conducted¹⁷.

Given the bidirectional nature of mental health and FV, there is a clear need for mental health services to screen for and respond to FV. Recommended best practice response guidelines available at the time¹⁹, and those that have been published since^{20,21}, outline a myriad of mental health symptoms that may occur when a person is experiencing family violence. In victim-survivors these include, but are not limited to, clinical depression, anxiety, phobias, low self-esteem, post-traumatic stress disorder, insomnia/sleeping disorders, eating disorders, self-harm and suicide attempts. In people who use violence, these include substance use, personality disorders, and exposure to violence as a child. It is likely that the vast majority of clients being treated at a community mental health service would show at least one of these symptoms. These symptoms fall under Step 1 for screening 'Noticing the Signs' in the family violence procedure recommended under the Strengthening Hospital Responses to Family Violence framework. Under this framework the presence of these symptoms would trigger clinicians to screen for family if they were following best practice principles²². As such, screening for most, if not all, clients in public mental health services is likely to be indicated. Despite this, there is little available information about FV screening rates in Victorian mental health settings, or the quality of the response from a client perspective. This study aimed to explore FV screening and response, from a client perspective, in a Victorian public adult mental health service, NorthWestern Mental Health (<https://www.nwmh.org.au/>), prior to the implementation of a service wide FV response improvement initiative. This research occurred within the context of recently published findings from the Victorian Royal Commission into Family Violence and resulting recommendations, to improve the family violence clinical response at general medical and mental health services²³.

Methods**Ethical approval**

This study was granted Ethical Approval by the Melbourne Health Human Research Ethics Committee (HREC Project 2017.374). As part of the study protocol all safety points in the

'World Health Organization (2001) Putting Women First: Ethical and Safety Recommendations for Research on Domestic Violence Against Women' were incorporated into the study design²⁴. This involved ensuring safety of the participants and research team, strongly protecting confidentiality by not collecting identifying information to help minimize underreporting, appropriately training data collectors in a clinical response if required, minimizing distress, providing access to support services, and using the results to improve processes, policy and the health service response. Clients were provided with information about the study by their clinician, and this was restated again on the first page of the survey, to ensure they were fully informed before agreeing to participate in the study. Due to anonymous data collection, consent was implied upon survey submission, as approved by the human research ethics committee. Anonymous data collection was implemented to support safe participation in this study. Notably, clients may have been more concerned about participation if they were required to provide their name, identifying information, or formal signature of consent. The method and consent procedure was the same as in two previous studies that have used the survey measure^{18,25}.

Study design

A prospective, cross-sectional, electronic survey of consumers treated across four locations of a metropolitan public adult mental healthcare service in Melbourne, Victoria, Australia was conducted. A state-wide guide for responding to family violence in mental health care had not been published at the time the study was designed and data collection was commenced. It was published whilst the data collection was occurring and was yet to be implemented at the mental health service²⁶.

Procedure

Clients of the Victorian public adult mental health service, NorthWestern Mental Health, were invited to participate in the electronic tablet administered online survey over a two-month period (26th July 2018 to 27th September 2018), by six case managers/treating clinicians, which included social workers, social work trainees, mental health nurses and psychologists. The survey was distributed via ipad in person. Clinicians enquired about participation to all consumers eligible for the study. All clients attending the service (age range 18 to 64 years) were considered eligible to participate unless any of the exclusion criteria were present: a) clinical interaction occurring in a non-confidential environment; b) acute distress/crisis; c) clinician concerns about affecting rapport; and d) cognitive impairment, known disability or diminished capacity preventing them from reading or understanding the survey questions.

Measures

The current study utilised the Royal Melbourne Hospital (RMH) Patient Survey FV screening and response tool (see [Appendix 1](#))¹⁸. This survey tool was developed specifically for the Victorian healthcare context, with assessed areas mirroring the Victorian Family Violence Protection Act²⁷. To

allay potential client safety concerns about participation, and in alignment with the ethic committee approval obtained, the survey did not collect any demographic or identifying information, apart from the name of the hospital department(s) the clients had received care from. Thus, the survey responses were anonymous and not re-identifiable, consistent with previous research utilising this measure^{18,25}. However, further information about the client cohort treated at the service can be found in the North Western Melbourne Primary Health Network (NWMPHN) Mental Health Profile report²⁸. Within the catchment and relevant age range for the service, 3.3% of the population are classified as having a severe mental illness, 4.8% a moderate mental illness, and 9.4% a mild mental illness²⁸. There is higher rate of people with lower English proficiency in this catchment and higher rates of anti-psychotic prescriptions, relative to the greater Melbourne region²⁸.

Analysis

Categorical and Likert type survey responses were explored descriptively. Number count and percentage of responses were provided for all quantitative data. Data was organised into tabular format per question, for multiple answer questions, or grouped by questions with similar response options for Likert-type questions. Free-text responses were analysed using qualitative description within a content analysis framework²⁹. The data presentation provided allowed for the viewing of the text data at a manifest level, their own words³⁰. This form of analysis was undertaken due to the small numbers of participants choosing to provide free-text responses to questions that included this option.

Results

35 participants commenced the survey with a total of 34 surveys completed. No clients endorsed having previously filled in the survey before (i.e., there were no duplicate responses) (question one). For specific service utilisation, nine clients had utilised the North West Area Mental Health Service, 15 had utilised the Inner West Area Mental Health Service, six the Mid West Area Mental Health Service, and 11 the Northern Area Mental Health Service, with some utilising more than one service. This indicates that responses were obtained across all four NorthWestern Mental Health data collection sites for the study. Further, 10 participants indicated that they had used the local medical hospital service emergency department (Royal Melbourne Hospital), eight had experienced an inpatient admission at this medical hospital, and one had been treated in an outpatient medical clinic (question two).

Overall, 47 percent ($n = 16$) of participants indicated that they had been screened for at least one FV issue, on at least one occasion. The two most common ways the topic was broached was for consumers to be asked about FV, or about threatening, controlling, or intimidating behaviour ([Table 1](#)). Participants reported being asked about financial/economic abuse, sexual violence/abuse, and neglect the least, out of all of the FV issues listed in the survey.

Table 1. Screening rates by family violence (FV) type ($n=34$) with structured question (question three).

Have you ever been asked if you are experiencing the following family violence issues by a clinician at the Health Service:	Percentage of responses ($n=34$)			
	Yes, more than once	Yes, once	No	Unsure
Family violence	23.53	11.76	58.82	5.88
Feeling unsafe at home	17.65	17.65	58.82	5.88
Physical violence/abuse	14.71	11.76	70.59	2.94
Sexual violence/abuse	11.76	8.82	76.47	2.94
Emotional or psychological abuse	14.71	17.65	61.76	5.88
Threatening, controlling, or intimidating behaviour	23.53	8.82	64.71	2.94
Financial or economic abuse ¹	5.88	8.82	82.35	5.88
Neglect ²	5.88	8.82	73.53	14.71
Witnessing or being exposed to family violence	14.71	14.71	64.71	5.88

¹The data total exceeds 100% for this response as one participant endorsed both "Yes, more than once" and "No" for this item.

²The data total exceeds 100% for this response as one participant endorsed both "Yes, once" and "Unsure" for this item.

Most participants could not recall when they had been screened for FV issues (Table 2). For those that could recall, it appears that this generally occurred early on in their involvement with the service, between screening or their first session and the 5th session/admission, with no participants reporting screening occurring after their 5th session/admission.

26 percent of participants ($n = 9$) reporting disclosing concerns about FV issues to a staff member at the health service, 67 percent reported they had not disclosed ($n = 23$), and 6 percent were unsure ($n = 2$) in question five of the survey. The free text responses received in the text response box for this question are shown in Table 3, along with the text box responses received for the remaining questions. One response indicated the client had disclosed whilst in hospital and the second that the participant had disclosed historical FV that occurred between their parents (question five, response one in Table 3).

Of the nine participants who had disclosed FV concerns, 44 percent ($n = 4$) endorsed feeling mildly supported by the response of the staff member, whilst 56 percent ($n = 5$) endorsed feeling very supported (question six of the survey). Two free text responses were also received (Table 3, question 6). One participant reported feeling supported when discussing FV issues with a psychologist at the service, but that they did not feel as supported when disclosing to doctors. The second response expressed general appreciation for the service.

66 percent of disclosing participants ($n = 6$) indicated that the staff member(s) they discussed the information with provided

assistance they found helpful. One participant reported assistance was helpful on one/some occasion(s) but not others, one participant was unsure, and one reported the helpful assistance was not provided (question seven in survey). One free-text response indicated that the client had been provided with coping strategies and mental health tools. While a second client indicated that they felt they could not answer the question.

The final structured question of the survey asked about unmet FV needs (question eight). Nine percent of respondents ($n = 3$) reported that they had wanted to disclose information about experiencing FV to a staff member at the health service but did not feel comfortable to do so. Of these clients, one was 'unsure' if they had ever been screened, one indicated they had been screened for some, but not all FV issues, and the third had been screened for all issues listed in Table 2, on more than one occasion. A further 12 percent ($n = 4$) indicated that they were unsure about this, while the remaining 79 percent ($n = 27$) answered 'no' to this question. One free-text response was received to this question, which was a comment on how session length impacted on being able to fully discuss issues.

The final section of the survey tool provided a free text box asking participants to provide any further information that you would like to share about the Health Service's response in assisting with FV issues. Six responses were provided in this section. The responses included comments of appreciation about the service, suggestions for improvement and further assistance that would be useful, comments that FV should be discussed more often, and that respondents believed that the service would help people with FV needs (see Table 3).

Table 2. Timing of screening during involvement with the service (n=34) with structured question (question four).

If Yes (to screening), on which visit to the Health Service you were asked:	Percentage of responses (n=34)*				
	Phone consultation/ screening	1st session/ admission	2nd to 5th session/ admission	After 5th session/ admission	I cannot recall
Feeling unsafe at home	16.67	16.67	16.67	-	50.00
Physical violence/abuse	5.88	11.76	17.64	-	64.71
Sexual violence/abuse	6.25	6.25	12.5	-	75.00
Emotional or psychological abuse	7.14	14.28	14.28	-	64.28
Threatening, controlling, or intimidating behaviour	6.67	13.33	6.67	-	73.33
Financial or economic abuse	-	13.33	6.67	-	80.00
Neglect	6.67	-	13.33	-	80.00
Witnessing or being exposed to family violence	-	25.00	6.25	-	68.75

*Sections which received no responses are indicated with -.

Table 3. Free text box responses to survey questions five, six, seven, eight, and nine (n=9).

Free text questions (5-9)	Participant responses (n=9)
5: Have you ever disclosed concerns about family violence issues in any of the areas listed in question 3, to a staff member at the Health Service? Please feel free to provide further information:	<ol style="list-style-type: none"> 1. <i>I disclosed my experiences of historical family violence that occurred between my father and mother.</i> 2. <i>In hospital</i>
6: Overall, do you feel that the staff member(s) at the Health Service responded in a way that made you feel supported? Please feel free to provide further information:	<ol style="list-style-type: none"> 1. <i>When asked by a psychologist I felt supported. When disclosing to doctors I have not [been] as supported.</i> 2. <i>Thank god you are here.</i>
7: Did the staff member(s) you disclosed the information to provide assistance that you found helpful? Please feel free to provide further information:	<ol style="list-style-type: none"> 1. <i>I don't [think] I can answer this question with the options provided.</i> 2. <i>Mainly supported coping strategies and mental health tools</i>
8: Have you ever wanted to disclose information about experiencing family violence to a staff member at the Health Service, but did not feel comfortable to do so? Please feel free to provide further information:	<ol style="list-style-type: none"> 1. <i>Appointments are really short and it can be hard to cover everything</i>
9: Please feel free to provide any further information that you would like to share about the Health Service's response in assisting with family violence issues:	<ol style="list-style-type: none"> 1. <i>I am sure they have helped people who have experienced family violence.</i> 2. <i>Feel like family violence is not talked about enough.</i> 3. <i>Family violence is not something I would put up with.</i> 4. <i>would be good to be over offer material support like food vouchers and phone top ups, having credit on phone could save a life.</i> 5. <i>That the support has been really good at [specific clinic].</i> 6. <i>How to move on from the past and start new life.</i>

Discussion

The results of this study indicate sub-optimal screening rates for FV concerns in a public mental health service. Less than half of participants surveyed could recall being screened for FV issues during their time at the service. Given the well

described nexus between FV and mental health, the findings from this study are of concern and highlight the need for staff training. Mental health issues, including depression, anxiety, panic attacks, trauma response, post-traumatic stress, substance misuse and suicide attempts are all signs family

violence may be occurring, as outlined in best practice guidelines^{31,32}. Given the breadth of these symptoms spanning mood, trauma responses, sleeping, eating and substance use¹⁹⁻²¹, it is likely that the majority of clients receiving mental health care will show at least one of these symptoms. This should trigger family violence screening procedures in most, if not all, clients, if best practice guidelines for noticing the signs of family violence are being followed. Thus, there is validation for screening for FV in the majority of clients being assisted by mental health services. Related to this, some unmet needs were identified in this data set. One client who had wanted to disclose FV concerns was unsure if they had been screened, whilst a further two had been screened for at least one family violence issue but had not felt comfortable disclosing. As such, both screening rates and methods of enquiry could be improved, with repeated opportunities for disclosure (through repeated supportive screening), likely to be necessary. Further clinician training to reinforce the need to screen clients for family violence, and ways to make clients feel safe and comfortable discuss their family violence concerns, is likely to improve both the rates of screening and client willingness to respond.

Positively, all participants who had disclosed FV concerns to a staff member felt supported by the response. Although room for response improvement is clear, as nearly half of those disclosing endorsed only feeling 'mildly supported' (rather than 'very supported'). Qualitative responses indicated that participants perceived receiving a different quality of response, depending on the discipline of the clinician. Room for improvement was also identified in the provision of useful information to disclosing consumers, with only two thirds of those who disclosed receiving information they found helpful.

The rate of FV screening in this study, identified through the client report, was very similar to that reported in a large metropolitan adult medical hospital, utilising the same survey tool¹⁸, but considerably lower than that identified in mothers utilising a maternal-child health service²⁵. Rates of unmet FV needs, those wanting to disclose, but not feeling comfortable to do so, fell in a middle range, between the two previous studies utilising the survey tool. This indicates that FV screening within health services across the state is variable and may differ, depending on the type of health service, client demographics, staffing disciplines and training levels.

Importantly, views expressed by mental health client participants in this study in the free text sections indicated that family violence should be talked about more often, and that support, when received, is appreciated. This is in keeping with research findings that screening is acceptable to clients, asking directly is preferred, and that providing ongoing counselling and support after a disclosure is recommended³³⁻³⁵. Also raised were problems with the constraints of short session lengths, paralleling those describing victim-survivors

feeling rushed by clinicians in the emergency department³⁶. The results indicated that few clients were asked more than once about FV issues, contrasting with recommendations to persist in asking over time³³. Increased opportunities to discuss increase the likelihood of disclosure, as trust in the clinician and service are important, and this may take time to develop³³.

For future research, improvements could be made to the administration of the electronic survey, such that clients are unable to select two responses to questions that are intended to be forced choice (i.e., Table 1). There are also further limitations to this study, including the sample size and the lack of demographic details collected in order to maximise participation. It is also not clear if the results are generalisable across Victorian public mental health services, as the data were collected from four clinics, within a single service. However, it provides useful data, and the patient voice *via* the mental health service clients responses, in their own words. While only a few participants chose to provide free-text responses, all were provided with the opportunity to, if they wished. This reflects a client's right to choose how much they engage with, and disclose on, this potentially traumatic subject matter. The baseline data obtained in this study informed the development of a service-wide transformational change project in FV clinical response, funded by the state government in response to the Royal Commission findings²³. This has involved the development of a service procedure and guideline, the instatement of specialist FV advisor roles, clinician training, and a FV screening workflow in the electronic medical record. The findings of the baseline client research helped the mental health service tailor the new roles and procedures to meet the needs of their client cohort. Further follow-up research to evaluate the impact of these changes within the service would be useful.

Conclusion

FV remains a significant concern in Australian society. Many participants in this study who accessed a public mental health service felt supported by staff responses, when they disclosed family violence concerns. However, screening rates for family violence could be improved, as well as the provision of information following disclosures. Barriers to disclosure also remain, with several clients wanting to disclose FV concerns, but not feeling comfortable to do so. The results indicate that procedural, environmental, and clinical improvements are required to ensure the FV needs of clients accessing public mental health services in the northwest area of Melbourne are adequately addressed.

Data availability

All data underlying the results are available as part of the article and no additional source data are required.

Appendix 1

Patient Survey

Health Service responses assisting consumers experiencing family violence. We are seeking feedback about Health Service responses when assisting consumers experiencing family violence. We are seeking responses from clients who have experienced family violence and clients who have not experienced family violence. For this survey, family violence is defined as a range of behaviours, including:

- physical violence
- sexual abuse or violence
- emotional or psychological abuse
- behaviour that is threatening, or intimidating, or in any way controls - or dominates a person or causes them to feel fear
- financial or economic abuse
- neglect of a vulnerable person (e.g. children, disabled, unwell or elderly)
- witnessing or being exposed to family violence

We invite you to fill in a short survey about your experiences at this Health Service, if you feel comfortable.

The questionnaire only asks questions about the Health Service’s screening and responses to consumers experiencing family violence. It does not ask any questions about your family violence experiences. The survey will take no more than 10 minutes to complete.

This survey is completely voluntary. You do not have to participate. If you do not wish to participate, it will not affect your treatment at the health service in any way.

The survey is anonymous. No identifying information will be collected from you. Once you have filled in the survey, there will be no way to connect you to your survey responses.

If completing this survey raises concerns for you, or results in you feeling distressed, you can let your Health Service clinician know so that they can provide you with support.

Alternatively, you can access assistance through a community support organisation. Your Health Service clinician will provide you with a resource card with the contact details for community support organisations.

Health Service responses assisting consumers experiencing family violence

1. Have you previously filled in this Survey?

Yes No

(If ‘Yes’ is chosen, the survey will skip to the end and thank clients for their involvement)

2. Can you please indicate which Health Service you have used?

(Drop down box selection)

(Clients are able to select more than one service)

3. Have you ever been asked if you are experiencing the following family violence issues by a clinician at the Health Service?

	Yes, more than once	Yes, once	No	Unsure
Family Violence				
Feeling unsafe at home				
Physical violence/abuse				
Sexual violence/abuse				
Emotional or psychological abuse				
Threatening, controlling or intimidating behaviour				
Financial or economic abuse				
Neglect				
Witnessing or being exposed to family violence				

4. If Yes, on which visit to the Health Service you were asked?

	Phone consultation/ screening	1 st session/ admission	During my 2 nd to 5 th session/ admission	After my 5 th session/ admission	I cannot recall
Feeling unsafe at home					
Physical violence/ abuse					
Sexual violence/ abuse					
Emotional or psychological abuse					
Threatening, controlling or intimidating behaviour					
Financial or economic abuse					
Neglect					
Witnessing or being exposed to family violence					

5. Have you ever disclosed concerns about family violence issues in any of the areas listed in question 3, to a staff member at the Health Service?

Yes No Unsure

Please feel free to provide further information: *(text box)*

(If 'No' or 'Unsure' is chosen, the survey will skip to Question 8)

6. Overall, do you feel that the staff member(s) at the Health Service responded in a way that made you feel supported?

I felt very supported

I felt mildly supported

I felt neither supported or unsupported

I felt mildly unsupported

I felt very unsupported

I am unsure how I felt

Please feel free to provide further information: *(text box)*

7. Did the staff member(s) you disclosed the information to provide assistance that you found helpful?

This might include psychological support, useful information or referral to a helpful service.

Yes No On one/some occasions, but not others Unsure

Please feel free to provide further information: *(text box)*

8. Have you ever wanted to disclose information about experiencing family violence to a staff member at the Health Service, but did not feel comfortable?

Yes No Unsure

Please feel free to provide further information: *(text box)*

9. Please feel free to provide any further information that you would like to share about the Health Service's response in assisting with family violence issues: *(text box)*

Thank you for your participation.

If completing this survey raises concerns for you, or results in you feeling distressed, you can let your Health Service clinician know so that they can provide you with support.

They will also provide you with a resource card once you have completed the survey, in case you would like to access community support organisations.

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Open Peer Review

Current Peer Review Status:  

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Reviewer Report 08 September 2023

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Diksha Sapkota

Griffith University Mount Gravatt Campus, Messines Ridge Road, Mount Gravatt, Qld,, Australia

Thank you for providing the opportunity to review this article. Exploring the experience of family violence (FV) screening and identifying barriers to disclosure is an important area of research. The value of the research lies on the focus of the facilitators and barriers to violence screening in mental health setting in Victoria, Australia. However, the manuscript needs significant work for it to be indexable.

Abstract: Rationale for conducting this study is not clearly articulated. The final sentence of the result section is confusing. Results can be summarised more succinctly. There are several errors on sentence structuring and grammar usage. I would suggest using MeSH words while writing keywords. Generally, in academic writing, we don't start our sentence with numbers.

Introduction: There is plenty of literature that have explored violence screening in medical and mental health settings. The literature review, including latest research and guidelines globally and nationally, is inadequately synthesised and disjointed and findings of related articles are not critically examined to identify gaps in literature. Furthermore, there are several studies from Australia that have explored the similar issue (For example Sweeny *et al.*, 2023¹; Creedy *et al.*, 2021²; Gillespie *et al.*, 2023³). However, these studies are not included in the introduction section and the rationale for this research is not clearly articulated. This section would be strengthened if you were to highlight the value of examining facilitators and barriers of FV screening in Victorian health setting and how this study addresses the existing gaps in literature. Other specific comments are:

- There should be a sentence describing different terminologies that are being used to define domestic and family violence and provide a description on how family violence has been described in this paper.
- Sentences need to be restructured. For example, "who are recipients of FV behaviours" is not appropriate as nobody desires to experience violence; instead, they become victims of violence.

- Authors; have said that studies mostly include individuals from particular cohort groups, but there is no explanation on what such particular cohorts are and how this study is different from existing studies.
- The reference given for a systematic review is not correct.
- Citations are confusing and several statements are not supported with relevant references.
- Authors have discussed findings from only one study, and it is insufficient to make a conclusion that screening rates vary across Victorian health services and there are unmet family needs.

Methods: It is not clear how individuals with these criteria [a) clinical interaction occurring in a non-confidential environment; b) acute distress/crisis; c) clinician concerns about affecting rapport] was identified and excluded. Was it self-reported? Clients, participants and consumers have been used interchangeably. Instead of these words, words or phrases that are more empathetic are recommended (such as individuals accessing mental health services or service-users). Several people were involved in data collection, which raises the concern of validity and reliability of data collected. How inter-rater reliability was maintained in this study? Had data collectors received training in data collection? There is little description on how qualitative data were analysed; as such it is difficult to comment on trustworthiness and rigor in qualitative data analysis.

Results: The results are descriptive in nature and includes things that are already known in this topic. Qualitative findings are also descriptive. They are not organised into specific themes or concepts that can be generated from the findings.

Discussion: An effective discussion needs to summarise the key findings in a way that clearly links them to aims of the study and articulates the value of the research to the evidence base. Unfortunately, this was not achieved. Discussion starts with the key finding of the study, “sub-optimal screening rates for FV concerns,” However, in the articles there is no mention of what rates are considered optimal or are anticipated. Recommendations included in the discussion should be based on the findings from the study (for example training to clinicians and repeated screening).

It is not clear why data collection was limited to two-month period as the sample size is still small. Allowing more time for data collection would increase the sample size and facilitate the application of inferential statistics to identify barriers and facilitators to FV screening. Furthermore, having more qualitative response would strengthen the study findings.

References: Several inconsistencies in formatting across the reference list were noted.

The manuscript has several errors in sentence structuring and grammatical usage and thus, needs a good edit.

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Is the work clearly and accurately presented and does it cite the current literature?

No

Is the study design appropriate and is the work technically sound?

Partly

Are sufficient details of methods and analysis provided to allow replication by others?

No

If applicable, is the statistical analysis and its interpretation appropriate?

Not applicable

Are all the source data underlying the results available to ensure full reproducibility?

No

Are the conclusions drawn adequately supported by the results?

Partly

Is the argument information presented in such a way that it can be understood by a non-academic audience?

Yes

Does the piece present solutions to actual real world challenges?

Yes

Is real-world evidence provided to support any conclusions made?

No

Could any solutions being offered be effectively implemented in practice?

Yes

Competing Interests: No competing interests were disclosed.

Reviewer Expertise: Domestic violence; mental health; incarceration

I confirm that I have read this submission and believe that I have an appropriate level of expertise to state that I do not consider it to be of an acceptable scientific standard, for reasons outlined above.

Reviewer Report 07 July 2023

<https://doi.org/10.21956/emeraldopenres.16059.r28876>

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Sabin Fernbacher

Department of Psychiatry, School of Clinical Sciences, Monash University, Clayton, Vic, Australia

This version is a significant improvement to the original article. I support its indexing.

Is the work clearly and accurately presented and does it cite the current literature?

Yes

Is the study design appropriate and is the work technically sound?

Yes

Are sufficient details of methods and analysis provided to allow replication by others?

Yes

If applicable, is the statistical analysis and its interpretation appropriate?

Yes

Are all the source data underlying the results available to ensure full reproducibility?

Yes

Are the conclusions drawn adequately supported by the results?

Yes

Is the argument information presented in such a way that it can be understood by a non-academic audience?

Yes

Does the piece present solutions to actual real world challenges?

Yes

Is real-world evidence provided to support any conclusions made?

Yes

Could any solutions being offered be effectively implemented in practice?

Yes

Competing Interests: No competing interests were disclosed.

I confirm that I have read this submission and believe that I have an appropriate level of expertise to confirm that it is of an acceptable scientific standard.

Version 1

Reviewer Report 20 October 2022

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**Sabin Fernbacher**

Department of Psychiatry, School of Clinical Sciences, Monash University, Clayton, Vic, Australia

I welcome the opportunity to review this article.

Finding out from consumers about their experience of being asked about family violence is a much-neglected area of research. This study can provide valuable insights into this area of practice and is welcome.

However, the article needs further work for it to be indexed.

Firstly, it needs a good edit; it has several mistakes; some sentences make little sense, and others need to be reworked to flow better and follow a better writing style.

Study design/questions:

It is unclear what the actual questions were that participants answered, as those provided in table 1 seem incomplete; are they maybe a shortened version? This leaves the reader confused. If they represent part of the questions, the initial question 'family violence' is problematic; this is due to the many different interpretations and definitions. If this question was used, the study would have missed out on several participants identifying that they have experienced family violence. Research, practice, and policy provide plenty of evidence about the different understanding of family violence and that descriptive language is needed. Clarification of the questions overall and this question will strengthen the article.

Policy context:

While the article makes a brief reference to the MARAM guideline it misses out on other relevant policies, these include the Chief Psychiatrist Guideline and Practice Guide: Family Violence (2018); policies regarding Maternal Child Health Nurses and screening; MARAM guidance on asking questions about family violence (versus universal screening) and clarity on NWMH policies and guidelines about family violence at the time of the study. I outline some of the points about these policies underneath:

1. MCHN have been the only mandated service in Victoria for over ten years to undertake FV

screening; this would explain different rates of screening; you need to clarify this in the article.

2. Victoria does not have universal screening, and this has not changed since the RCFV Violence and publication of the MARAM guideline. The MARAM guideline clearly outlines when and how questions need to be asked but it does not prescribe screening for all.
3. The Chief Psychiatrist Guideline and Practice Guide: Family Violence guides mental health services (published in the same year as the study was undertaken). I suggest you need at least mention this policy.
4. To my knowledge, NWMH had a policy on family violence at the time of the study, this is not mentioned in the article.
5. Implementation of the RCFV is not mentioned – this also represents the wider policy context during which you undertook this study.

Discussion & Conclusion

You claim that the rates of screening are sub optimal – however, you do not provide any explanation of what the expectation should be or what you measured it against. It appears that you have compared this level of screening against MCHN, which, as stated above, is problematic.

You claim that more training is needed, and while this is likely, there is no evidence that you draw on why this should occur.

You claim there is “validation for screening in the majority of clients being assisted by mental health services” – I suggest you need to back up this claim with more evidence. Several Australian research studies have investigated screening for family violence.

You state that this study was the reason for the introduction of a specialist family violence adviser role. If this is the same as the Family Violence Advisor roles that have been funded by the State Government as part of the implementation of the RCFV, then this needs to be acknowledged; if it is a different role, then it is still important to mention that those exist as well.

You have not used any references in the discussion and conclusion to support your claims. You can strengthen these sections by including relevant references and policies.

Note: the reason I ticked 'no' to some of the questions is that the article lacks evidence about the need for training (for example) or that you state that screening numbers are sub-optimal, when you have not explained what the expectations should be. You need more evidence to back up providing solutions. This will strengthen the article and provide food for thought for others. Connect it with the MARAM guideline about how and when to ask questions, again this will provide clarity on what is expected and what - by now - ought to be occurring.

Is the work clearly and accurately presented and does it cite the current literature?

No

Is the study design appropriate and is the work technically sound?

Partly

Are sufficient details of methods and analysis provided to allow replication by others?

No

If applicable, is the statistical analysis and its interpretation appropriate?

Not applicable

Are all the source data underlying the results available to ensure full reproducibility?

No

Are the conclusions drawn adequately supported by the results?

Partly

Is the argument information presented in such a way that it can be understood by a non-academic audience?

Yes

Does the piece present solutions to actual real world challenges?

Yes

Is real-world evidence provided to support any conclusions made?

No

Could any solutions being offered be effectively implemented in practice?

No

Competing Interests: No competing interests were disclosed.

Reviewer Expertise: Gender based violence/trauma responses by clinicians, mental health policy responding to trauma

I confirm that I have read this submission and believe that I have an appropriate level of expertise to confirm that it is of an acceptable scientific standard, however I have significant reservations, as outlined above.
