Family violence screening and disclosure response: A public mental health service consumer survey. [version 1; peer review: 1 approved with reservations]

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Abstract

Background: Family violence (FV) is a significant problem with 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 enquired about participation in all consumers (age range 18 to 64 years) attending the service 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. Further training and services changes 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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**Author roles:** Fisher C: Conceptualization, Data Curation, Formal Analysis, Investigation, Methodology, Validation, Writing – Original Draft Preparation, Writing – Review & Editing; Hebel L: Methodology, Project Administration, Supervision; Bray L: Writing – Review & Editing; Withiel TD: Writing – Review & Editing

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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 behaviours. 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 disorders. Beyond the impact on quality of life associated with mental health conditions, FV also impacts significantly on health, death, and disability. 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 their self-reported lifetime prevalence of experiencing interpersonal violence in a family or partner context is between 55 and 63 percent. Men with mental health conditions also report high rates of FV and abuse with lifetime prevalence self-report ranging between 32 and 50 percent.

Much of the research focus has been placed on ways to assess for, and actually assessing, the prevalence of FV in particular cohort groups. 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, while no mental health studies were found that met the inclusion criteria. 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 service. 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 service. 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 suggest that rates of both FV screening, and unmet FV needs vary considerably across Victorian health services and settings.

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. However, 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, prior to the implementation of a service wide FV response improvement initiative.

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 design. 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.

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. At the time of the survey the health service had no standardised procedure for when or how to screen consumers for FV or how to respond to, or document, disclosures.

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 inclusion 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\textsuperscript{18}. This survey tool was developed specifically for the Victorian healthcare context, with assessed areas mirroring the Victorian Family Violence Protection Act\textsuperscript{21}. 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\textsuperscript{18,20}. 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 report\textsuperscript{22}. 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 illness\textsuperscript{22}. 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 region\textsuperscript{22}.

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 framework\textsuperscript{23}. The data presentation provided allowed for the viewing of the text data at a manifest level, their own words\textsuperscript{24}. 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.

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.

<table>
<thead>
<tr>
<th>Table 1. Screening rates by family violence (FV) type ($n=34$) with structured question (question three).</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Have you ever been asked if you are experiencing the following family violence issues by a clinician at the Health Service:</strong></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>---</td>
</tr>
<tr>
<td>Family violence</td>
</tr>
<tr>
<td>Feeling unsafe at home</td>
</tr>
<tr>
<td>Physical violence/abuse</td>
</tr>
<tr>
<td>Sexual violence/abuse</td>
</tr>
<tr>
<td>Emotional or psychological abuse</td>
</tr>
<tr>
<td>Threatening, controlling, or intimidating behaviour</td>
</tr>
<tr>
<td>Financial or economic abuse\textsuperscript{1}</td>
</tr>
<tr>
<td>Neglect\textsuperscript{2}</td>
</tr>
<tr>
<td>Witnessing or being exposed to family violence</td>
</tr>
</tbody>
</table>

\textsuperscript{1}The data total exceeds 100% for this response as one participant endorsed both “Yes, more than once” and “No” for this item.

\textsuperscript{2}The data total exceeds 100% for this response as one participant endorsed both “Yes, once” and “Unsure” for this item.
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

### 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 \((n = 9)\).

<table>
<thead>
<tr>
<th>Free text questions (5-9)</th>
<th>Participant responses ((n = 9))</th>
</tr>
</thead>
</table>
| 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: | 1. I disclosed my experiences of historical family violence that occurred between my father and mother.  
2. In hospital |
| 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: | 1. When asked by a psychologist I felt supported. When disclosing to doctors I have not [been] as supported.  
2. Thank god you are here. |
| 7: Did the staff member(s) you disclosed the information to provide assistance that you found helpful? Please feel free to provide further information: | 1. I don’t [think] I can answer this question with the options provided.  
2. Mainly supported coping strategies and mental health tools |
| 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: | 1. Appointments are really short and it can be hard to cover everything |
| 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: | 1. I am sure they have helped people who have experienced family violence.  
2. Feel like family violence is not talked about enough.  
3. Family violence is not something I would put up with.  
4. would be good to be over offer material support like food vouchers and phone top ups, having credit on phone could save a life.  
5. That the support has been really good at [specific clinic].  
6. How to move on from the past and start new life. |
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).

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, and suicide attempts are all signs family violence may be occurring, as outlined in best practice guidelines. Thus, there is validation on more than one occasion.

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.

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 recommended. Also raised were problems with the constraints of short session lengths, paralleling those describing victim-survivors feeling rushed by clinicians in the emergency department. The results indicated that few clients where asked more than once about FV issues, contrasting with recommendations to persist in asking over time. Increased opportunities to discuss increase the likelihood of disclosure, as trust in the clinician and service are important, and this may take time to develop.

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. 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. 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.

References

22. PHN North Western Melbourne: NWMPHN Mental Health Profile. 2018. Reference Source
Open Peer Review

Current Peer Review Status: 

Version 1

Reviewer Report 20 October 2022

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Sabin Fernbacher
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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.