

Domestic violence screening in Maternal & Child Health nursing practice: a scoping review.

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Abstract

This scoping review explores the breadth of literature on domestic violence (DV) screening by nurses, within the well child setting. The review followed the introduction of universal DV screening into the Victorian Maternal & Child Health (MCH) service, in Australia.

A scoping review provides a panoramic overview of a chosen topic that may be later used to influence policy and practice. This review explored the literature in the well child area, with a view to identifying further research priorities.

The 'Arksey & O'Malley (2005) framework' was used to ensure methodological rigor. There was little relevant research on DV screening in the well child setting. Emergent themes included barriers and enabling factors associated with DV screening and children at risk. From this research we can conclude that further research is required on the appropriateness of DV screening, risk assessment and referral in MCH practice.

Keywords: scoping review, violence, child health, nurse, screening, postnatal, well child.

Introduction

Domestic violence (DV) is a major public health issue globally (Campbell, 2002; Garcia-Moreno, Jansen, Ellsberg, Heise & Watts, 2006; Krug, Mercy, Dahlberg & Zwi, 2002) and within Australia, one in three Australian women will be subjected to physical and /or sexual violence in their lifetime. Greater prevalence rates exist within indigenous women's groups, women with disabilities and women from culturally and linguistically diverse backgrounds (Australian Bureau of Statistics, 2005). The aim of this research was to explore the breadth of literature on DV screening in Maternal & Child Health (MCH) practice by undertaking a scoping literature review. This was initiated following the introduction of routine DV screening into the Victorian MCH service.

Violence against women comes at an enormous cost to the individual, family and community (Department of Families, Housing, Community Services & Indigenous Affairs (FaHCSIA), 2009). This cost is growing, with government estimates stating that violence against women costs the nation \$13.6 billion annually. This figure is expected to rise to \$15.6 billion by 2021 (FaHCSIA, 2009). In Victoria, Australia, DV is responsible for an estimated 9 per cent of the total disease burden for women under 45 years, with the greatest proportion of the disease burden associated with mental health problems (60%). DV has the greatest impact on the health of Victorian women between the ages of 15-44 than any other known risk factor (VicHealth, 2004).

Individual health costs include significant mental and physical health problems, including loss of life. Common physical health symptoms associated with DV include gynaecological symptoms and poor reproductive health outcomes (Gazmararian et al., 2000; Taft, Watson & Lee, 2004). Violence often occurs or escalates during times of pregnancy, with the estimated prevalence during pregnancy being between 4-8% (Campbell, 2002). DV has also been associated with higher rates of unplanned pregnancy, abortion, miscarriage, low birth weight, premature birth and foetal injury (Gao, Paterson, Carter & Iusitini, 2008; Gazmararian et al., 2000; Taft Watson & Lee, 2004; Walsh, 2008). Less direct physical health outcomes include headaches, irritable bowel syndrome, sexually transmitted infections and self harming behaviours such as drug abuse or unprotected sex (Campbell, 2002; VicHealth, 2004). The most prevalent mental health outcomes from DV are depression and post traumatic stress

disorder, with associated behaviours including substance abuse, suicide or attempted suicide (Golding, 1999; Hegarty, Gunn, Chondros & Small, 2004). These effects also impact on women's parenting abilities, with poor outcomes for children (Carpenter & Stacks, 2009; Department of Planning and Community Development (DPCD), 2007).

Recent data from the National Homicide Monitoring Program (Australian Institute of Criminology) report an increase in female victimisation, with 112 women murdered in 2007-2008 compared to 81 the previous year (Virueda & Payne, 2010). This data revealed that intimate partner homicides comprised 60% of domestic homicides. However historical trends suggest that femicide rates remain consistent with previous years. The exception to this are indigenous women, who have had consecutive increases in the rates of homicide since 2003-2004 (Virueda & Payne, 2010).

A strategy to reduce the burden of DV in Victoria has been to introduce routine DV screening into the MCH service (Department of Education and Early Childhood Development (DEECD, 2009b). The Victorian MCH Service is a comprehensive primary health care service for families with children from birth to 6 years (school age). The service aims to provide a focused approach for the promotion, prevention, early detection, and intervention of the many factors affecting young children and their families (DEECD, 2009c). This is a similar role to public health nurses and health visitors in other countries, who provide primary health care in the immediate postnatal period (birth to 6 weeks), with ongoing support until school age.

Maternal and Child Health nurses provide home visits within one week of birth. This potentially places them in an ideal position to identify early and refer, women and children who are at risk, for ongoing support and safety. This service and unique role allows women to access nurses at a time when they may be vulnerable, with evidence indicating an increased prevalence rate of DV in the child bearing years, especially associated with pregnancy (Bowen, Heron, Waylen & Wolke, 2005; Burch & Gallup, 2004; Gazmararian et al., 1996; Gazmararian et al., 2000; Goodwin et al., 2000; Webster, Sweett & Stolz, 1994).

Although DV awareness and its subsequent management are not new for MCH nurses, the Victorian service only introduced a policy on DV screening in late 2009 (DEECD, 2009b). Considering the significant burden of disease from DV (VicHealth, 2004), screening may provide early detection and intervention through appropriate counselling and referral. However this practice remains controversial, with evidence from systematic reviews

suggesting that DV screening does not improve health outcomes for women and children (MacMillan et al., 2009; Nelson, Nygren, McInerney & Klein, 2004; Ramsay, Richardson, Carter, Davidson & Feder, 2002; Wathen & MacMillan, 2003).

Despite this, the new MCH Service: Practice Guidelines (DEECD, 2009b) and the MCH Service: Key Ages and Stages Framework (DEECD, 2009a) require nurses to routinely ask women about DV at the 4 week postnatal visit and then at any other visit if professional judgement warrants. The Common Risk Assessment Framework (CRAF) for MCH nurses has been developed to assist nurses in undertaking further risk assessments, safety planning and referral (DPCD, 2008).

Given the prevalence and disease burden associated with DV, a better understanding of the practice of DV screening within MCH nursing is needed. The aim of the scoping review was to map the international evidence on DV screening within MCH practice (or similar well child services). Gaps in the literature and future research opportunities were identified by examining the range, extent and nature of the literature with a view to improve decision-making and policy direction within MCH services.

Method

Scoping methodology was used to explore the breadth of literature on DV screening by nurses, within the MCH setting and was initiated following the introduction of universal DV screening into the new Key Age & Stages, Victorian MCH framework. This method is used to synthesise and analyse research literature and as such provides a panoramic overview of the chosen topic that may be later used to influence policy and practice (Davis, Drey & Gould, 2009). Although there is an abundance of literature on DV, there appears to be no available summary of DV within the MCH (well child) context. Clinicians require evidence based examples of effective and accepted means of the management of DV within their community practice. Quality evidence on the appropriateness of DV screening, risk assessment and referral in the MCH nurse practice setting are yet to be established (Evanson, 2006).

This scoping review was carried out based on the methodology outlined by Arksey and O'Malley (2005) and further advanced by Levac and colleagues (Levac, Colquhoun & O'Brien, 2010). The format and headings of this paper follow their recommendations to further guide reporting and enhance transparency (Levac et al., 2010).

There is an increase in the number of nursing and allied health researchers using this methodology to produce academically robust studies to satisfy and advance evidence based practice (Arksey & O'Malley, 2005; Brien, Lorenzetti, Lewis, Kennedy & Ghali, 2010; Forbes ,While, Ullman & Murgatroyd, 2007). Some topics that have been addressed include; scoping reviews on health system report cards (Brien et al., 2010), children's choice in health care (Coad & Shaw, 2008), housing and dementia care (O'Malley & Croucher, 2005), nurses contribution to child health services (Forbes et al., 2007) and complementary and alternative medicine in the mass media (Weeks & Strudsholm, 2008).

As with primary research, scoping reviews require the same strict academic rigor of transparency, credibility and validity. The five stages of the 'Arksey & O'Malley framework' (Arksey & O'Malley, 2005; Levac et al., 2010) were used in this review. These stages include identifying the research question and relevant studies, study selection criteria, charting the data and finally, collating, summarising and reporting results.

Despite the linear appearance of this method, the actual process and stages are iterative and reflexive (Arksey & O'Malley, 2005; Levac et al., 2010). Moving through each stage and repeating and modifying steps when necessary ensures a comprehensive and broad coverage of the literature. The use of the framework enhances rigor within the scoping review and ensures a systematic, methodical and analytical process (Arksey & O'Malley, 2005; Levac et al., 2010). Several approaches to reviews of the literature have been identified (Grant & Booth, 2009). Three major approaches are systematic, scoping and narrative reviews.

In a scoping review, a large amount of contrasting literature both quantitative and qualitative in nature can be analysed. The iterative nature of a scoping review differentiates it from a systematic review and assesses the literature based on relevance, credibility and its contribution rather than on a rigid order and appraisal of the quality of the evidence (Brien et al., 2010; Grant & Booth, 2009). It is also differentiated from a narrative review, where a range of subject matters at different levels of completeness and comprehensiveness are based on the analysis of literature that may be research findings (Grant & Booth, 2009).

Stage One - The research question

This first stage of a scoping review requires the researcher to identify the area of interest and to consider concepts such as the target population, interventions or outcomes. The research question will then guide the search strategy. In this review the research question was;

“What is the breadth and nature of literature on DV screening in MCH practice?”

Stage Two - Identifying relevant studies

To identify relevant studies and subsequently answer the research question, researchers must perform a comprehensive search of different sources to obtain the required documents (Arksey & O'Malley, 2005). A range of peer reviewed and grey literature sources were searched to answer the research question. Areas searched included electronic databases, reference lists and public domain websites.

Due to the nature of a scoping review, it is expected to obtain many different forms of literature in the initial search e.g. editorials, newspaper articles and discussion pieces. These types of documents may provide essential insight and although are more tedious to source at times, must be included. This is what makes scoping reviews a much more thorough and extensive process than a systematic review, which often dismiss anything that is not a randomised controlled trial.

Electronic databases

The international literature was sourced from relevant electronic databases with search term assistance from the faculty librarian. Electronic databases including the Cumulative Index of Nursing & Allied Health Literature (CINAHL); Medline; EMBASE; Cochrane Library; Centre for Reviews and Dissemination; Expanded Academic; Social Science Abstracts; PsycINFO; ProQuest Central and Informit Complete were used. These electronic databases were chosen as they were relevant to the research question covering a broad area of medical and nursing literature (Table 1). [Insert Table 1 here]

The search for literature used free text key words that were applicable to the research question. The initial search terms included intimate partner violence, domestic violence, family violence, partner abuse, battered women, spouse abuse, postnatal, postpartum, nurs*

and screen*. This was performed in combinations using the Boolean operators ‘AND’ and ‘OR’ and ‘NOT’. Excluded terms (NOT) included antenatal, prenatal and emergency department.

Primary studies, reviews and discussion papers from English only papers, published between 1995 and 2010 were included. The specified search time line (1995-2010) coincides with the United Nations (UN) Fourth World Conference on Women held in 1995, which identified violence against women as a major public health concern which needed to be addressed by all countries (Krug et al., 2002; United Nations, 1996).

In this review, the electronic database search became an iterative process as it was found that limiting the search to the postnatal setting resulted in significant loss of literature and it was decided that excluding ‘postnatal’ from the search, would broaden the scope of the review. This iteration is recommended by Aksey & O’Malley (2005) who suggests that it is necessary to repeat steps to ensure comprehensive coverage of the literature. Studies that did not include this postnatal period could later be further excluded during the study selection stage. This process was also needed for terms such as antenatal, prenatal and emergency department, as including these terms in the search resulted in a significant increase in inappropriate results.

Grey literature

Grey literature is any document that is not published by commercial publishers and includes (but is not limited to) government reports, conference proceedings and theses. The need for searching of grey literature within a scoping review is essential to ensure comprehensive selection of data on the topic is captured. Through consultation with colleagues, researcher knowledge and clinical experience, a relevant list of Australian public domain websites were identified and searched (Table 2). [Insert Table 2 here]

On completion of the electronic database search, appropriate local public domain websites were selectively searched using modified search terms and strategies. Modification was necessary due the differences in the terminology used for MCH nurses, throughout Australia and the varying website structures. Due to the volume of inappropriate content retrieved, it was decided that a hand search would be more appropriate (Brien et al., 2010). Hand searching (via links) of specific areas within a site were initially completed, most commonly research or publication areas/links. Further searches using the websites search engine were

performed using the search terms ‘violence’, ‘screening’, ‘Maternal & Child Health Nurse’ and modified accordingly. To ensure transparent and consistent website searching, a log was kept of the site searched, steps to links reviewed and documents retrieved throughout the process.

Reference lists

The reference lists of all the full text documents from the electronic database and website search were reviewed until saturation was reached. This process involved repeatedly searching the reference lists until no new documents emerged. Endnote reference software, OmniPage Professional 17 and the use of a specifically designed inclusion criteria form were used during the data collection process. These tools allowed for accurate collation, storage, screening and management of search results.

Stage Three - Study selection

The study selection stage requires a systematic process of sorting through the abundance of literature found in the review. The use of inclusion/ exclusion criteria facilitates this process and is developed and refined as the researcher becomes increasingly familiar with the literature (Arksey & O'Malley, 2005). The flow chart of the scoping review process is shown in Figure 1. [Insert Figure 1 here]

To answer the research question, the following inclusion criteria were used. Only documents that included:

- Any women of child bearing age, presenting to well child health service.
- Any routine, universal DV screening (or case finding approach) by nurses (Maternal and child health nurse, child health nurse, family health nurse, public health nurse or health visitor).
- Maternal & Child Health, Community Health Nursing, Public Health Nursing, Health Visitor, Family Health Nursing, Paediatric Nurse Practitioner in a well child clinic.
- Any outcomes specifically relevant to Maternal & Child Health Nursing Practice.

This rigorous screening process and use of the inclusion criteria form was also replicated for all literature retrieved from reference lists and the grey literature.

Title review

Initially two researchers independently reviewed all titles from the list of 792 citations. Three hundred and thirty seven citations were removed due to duplication (Figure 1). To further assist with exclusion we used the search function in Endnote (as a screening tool). Titles with irrelevant key words in the title field were viewed and removed if they did not meet the inclusion criteria. This team review approach ensured a transparent and replicable process in all stages of study selection. Titles that were ambiguous or in which researchers were unsure of inclusion were retained for the next level of study selection-abstract review.

Abstract review

After the extensive title review, 280 citations remained (Figure 1). Of these abstracts, 59 had been downloaded into endnote without abstracts (text in the abstract field). This provided a challenge to the continued use of Endnote as a screening tool. For each of these 59 documents, the full abstract was retrieved via the university library database, document delivery or photocopied from hard copy periodicals. Introductions or executive summaries were used for those items without a specified abstract. The abstracts were then manually added to the Endnote abstract field using character recognition software (Omni Page Professional 17). This allowed for consistent methodological processes and although time consuming, it made the abstract screening stage simpler.

The 280 abstracts were independently reviewed by two researchers using the same screening process as for titles. The inclusion criteria form was used to facilitate study selection (Arksey & O'Malley, 2005; Levac et al., 2010). A pilot of the form was performed to ensure reliable results. The team met on two occasions to discuss uncertainties and ensure adherence to inclusion criteria. Uncertain abstracts were sent to a third reviewer. Two independent reviewers piloted the use of the inclusion criteria form. The inter-rater reliability was confirmed using a kappa analysis (SPSS) of 20 abstracts (kappa= 0. 83). From the 280 abstracts, 20 documents were identified for full text review (Figure 1).

Full text review

From the electronic database search, the full texts of the 20 documents were obtained. These were assessed against the inclusion criteria, with eight documents finally identified as relevant for charting. Excluded documents (n=12) were mostly in the antenatal setting or hospital postnatal environment. An additional nine documents from websites and reference lists were included totalling 17 documents for final charting (Figure 1).

Stage Four - Charting the data

Stage four of the Arksey and O'Malley framework (2005) requires development of a data extraction form and interpretation of the content within the selected documents. This synthesis and interpretation of the data further assists in answering the research question.

The 17 full text documents in this study, were charted on an excel spreadsheet and classified according to author, date, country of origin, document type and design, clinical area, intervention or focus and outcome or conclusion. This process required frequent review of appropriate headings within the table and modification to ensure the capture of relevant content and that the data extracted was consistent with the research question and purpose (Levac et al., 2010) (Table 3). [Insert Table 3]

Stage Five - Collate, summarise and report results

This is the final stage of the 'Arksey & O'Malley framework' and requires a qualitative descriptive approach to summarise and synthesise the results. This includes a descriptive numerical summary of the final documents, type of document, country of origin and year of publication, with subsequent analysis of the themes within. A final discussion is required that will apply meaning to the identified results. Qualitative thematic analysis is described by Levac et al. (2010) as the most appropriate form of analysis for a scoping review. It is a method of describing and summarising data through the coding and categorisation of concepts within the literature (Liamputtong & Serry, 2010; Sandelowski, 2000).

Descriptive summary and thematic analysis

The data described in Table 4 indicates the number of publications by year. It would appear that the number of documents on this topic have gradually increased since the mid nineties with a peak in interest in 2006. [Insert Table 4 here] The majority of the international literature originated from Canada (n=5) and Australia (n=5). Other research documents were from the United States of America (n=2), the United Kingdom (n=3) and New Zealand (n=2) (Table 3). The Australian literature consisted of three government reports, one qualitative research document and a discussion paper on an enhanced Maternal & Child Health service model.

The included documents varied from narrative literature reviews, discussion and editorial pieces, to primary research. The well child clinical area and terminology also varied between countries and was dominated by a focus on home visiting - public health nurses from Canada (Table 3). The clinician's roles vary between countries and may differ in educational preparation, scope of practice and professional responsibilities, depending on country of origin.

This numerical analysis of the results attempts to answer the research question by improving our understanding of the breadth and nature of literature on DV screening in MCH practice and gives us an overview of the discussion on the international literature on the topic. The following themes were identified within the retrieved documents: barriers to screening, potential enablers to screening and children at risk.

Barriers to screening

There was frequent discussion on the need to ask women about violence and that nurses have a duty of care and an ethical responsibility to enquire about DV (Hornor, 2005; Stanley, Yarwood, Brook & Watson, 2007; Wilson & Koziol-McLain, 2007). However, although screening increases identification rates (NSW Department of Health, 2006; Stanley et al., 2007; Vanderburg, Wright, Boston & Zimmerman, 2010) nurses continue to confront barriers to routine screening in their practice and subsequently, fail to demonstrate universal screening of all women (Evanson, 2006; NSW Department of Health, 2006). Barriers to screening for DV were similar among the clinical areas in which nurses attend to mothers and well children. The most commonly reported individual barriers included nurses lacking privacy, knowledge, education and resources (Evanson, 2006; Jack, Jamieson, Wathen & MacMillan, 2008; NSW Department of Health, 2006; Webster, Bouck, Wright & Dietrich, 2006). Screening at the home visit (HV) also provides challenges to implementing screening programs. Other barriers included fears and personal beliefs, lack of time and language barriers in some cases (Frost, 1999; Jack et al., 2008; Peckover, 2003; Webster et al., 2006).

Privacy

Although these barriers are not unique to this setting (Buck & Collins, 2007; Taft, Broom & Legge, 2004; Waalen, Goodwin, Spitz, Petersen & Saltzman, 2000; Yonaka, Yoder, Darrow & Sherck, 2007), it is evident that privacy appears to be one of the most problematic hurdles to overcome in the well child setting (Bateman & Whitehead, 2004; Evanson, 2006; Jack et

al., 2008; NSW Department of Health, 2006). Ensuring privacy and confidentiality, such as a safe place to talk promotes opportunities for possible disclosure (Evanson, 2006).

Women are frequently accompanied by partners or other family members during the early post natal visits, making privacy for disclosure difficult. The family member's presence often means DV screening is postponed to another time, if at all (Jack et al., 2008; NSW Department of Health, 2006).

There is some debate in the literature as to when a young child's presence counts as a potential safety breach. In the study by Jack et al. (2008) no screening was performed in front of children over 18 months of age, whilst 2-3 years became the upper age limit for other studies (Bateman & Whitehead, 2004; Grafton, Wright, Gutmanis & Ralyea, 2006). There appears to be no guiding principles on this issue in the current Victorian guidelines (DEECD, 2009b; DPCD, 2008).

Timing of screening-Home visit

The majority of documents were set in the home environment or asked nurses about screening at the initial post natal HV (Dickson & Tutty, 1996; Grafton et al., 2006; Jack et al., 2008; Vanderburg et al., 2010; Webster et al., 2006). Jack et al. (2008) identified many barriers nurses faced whilst screening at this HV and suggests DV screening is not suitable at this time due to lack of rapport, privacy, time and higher parental priorities. The early post natal period is a time of acute anxiety for many parents, with common concerns such as breast feeding issues and sleep-settling problems (Webster et al., 2006). These common issues at the HV act as a barrier to screening as nurses felt that client centred care is the most appropriate model and that not addressing parent's immediate concerns may prevent the mother from wanting to talk about her experiences of violence (Webster et al., 2006).

Although the HV is an ideal time for "picking up on cues" (Cox, Cash, Hanna, D'Arcy-Tehan & Adams, 2001) and assessing the family environment and function (Cox et al., 2001; Evanson, 2006), it is suggested that a case finding approach (asking direct questions to women only in the presence of risk factors) is more suitable when consulting women in their home and that nurses working as advanced practitioners should call on their experience and clinical judgement when assessing families, rather than screening all women (Jack et al., 2008). Routine screening of all clients may not necessarily be the best option in the well child setting.

Extended home visiting (EHV) was also discussed within the literature. Evanson (2006) describes how EHV has been shown to improve child abuse outcomes, but not DV prevalence rates or outcomes for women (Eckenrode, cited in Evanson, 2006). EHV involves offering extra consultations in the home environment and is often extended to families who have been identified as needing additional support. A discussion paper by Edgecombe & Ploeger (2006) describing an outreach model for enhanced MCH nursing in Victoria, Australia states that ongoing evaluation of the model will be used to provide proof of efficacy. To date there appears to be no further research on this model in the literature.

Lack of knowledge

Nurses frequently felt that they did not have the background knowledge or skill base to respond to women in an appropriate manner following disclosure (Cox et al., 2001; Dickson & Tutty, 1996; Frost, 1999; Jack et al., 2008; Peckover, 2003; Webster et al., 2006). Some HV nurses recalled having no undergraduate education on DV at all (Jack et al., 2008). They expressed a need for training and further education on DV, going beyond learning how to use a screening tool to become effective in risk assessment, safety planning and referral. Needs included developing practical skills such as interviewing techniques through role play to build confidence and improve responses to disclosure (Dickson & Tutty, 1996).

Documentation of women's disclosure was difficult for some nurses, with physical signs of abuse easier to record than emotional or sexual abuse (Peckover, 2003). Care needs to be taken with documenting DV as abusers may have access to child health records in the future (Cox et al., 2001; Stanley et al., 2007) and documented evidence of violence in the home may be used to initiate child protection proceedings (Stanley et al., 2007).

A distinct lack of discussion on DV within the professional arena exacerbates barriers to screening as nurses are less aware of the prevalence and effects of DV on their community of practice (Bateman & Whitehead, 2004; Peckover, 2003).

Potential enablers to screening

Despite the many barriers identified within the literature, there were also approaches that facilitated the process of screening women for DV. These included the use of clinical practice guidelines, referral pathways and supportive organisational structures that provided ongoing education and encouragement of reflective practice through clinical supervision or debriefing

(Bateman & Whitehead, 2004; Cox et al., 2001; DPCD, 2008; Dickson & Tutty, 1996; Edgecombe & Ploeger, 2006; Grafton et al., 2006; NSW Department of Health, 2006; Peckover, 2003).

Ongoing education and clinical guidelines

The lack of education was an overwhelming theme throughout the literature, with nurses wanting more education and subsequent knowledge and skill development around screening and violence. The use of clinical guidelines and aide memoirs (DPCD, 2008) has been introduced in an attempt to improve screening rates and DV identification in the well child setting (DPCD, 2008; Grafton et al., 2006; NSW Department of Health, 2006). The introduction of a sustained education program, with set policy and screening tools by Grafton (2006) led to a greater understanding of the complexity of DV and significantly helped to overcome screening barriers. An evaluation of the introduction of routine screening into health service districts in NSW has shown that ongoing training is needed to reinforce the engagement of nurses to screen (NSW Department of Health, 2006).

However a literature review by Evanson (2006) noted that there was mixed results on the sustained effectiveness of evidenced based clinical practice guidelines. The findings stated that introduction of an evidence based manual initially interested 90% of nurses; however, only 4% had actually used them 6-9 months later. Evanson (2006) suggests that the lack of sustained use of the guides may have been due to the fact that they were not developed from 'best practice' evidence in the well child setting, but from other settings or disciplines and thus were not particularly relevant to child health nurses.

Organisation support and access to debriefing

There was frequent discussion in the literature on the need for self care strategies; debriefing and more support for nurses around handling disclosure situations (Bateman & Whitehead, 2004; Dickson & Tutty, 1996; Edgecombe & Ploeger, 2006; Webster et al., 2006). These strategies may improve the clinician's ability to manage the complex needs of women who are experiencing violence. Webster et al. (2006) discusses the process nurses go through when incorporating screening into their clinical practice and states that it is not a static process but one of cyclical change, from coming to terms with abuse and being more aware of it in your client population to eventually accepting the women's decisions and "walking with" and supporting the women through the process (Webster et al., 2006). Supportive management and the availability of community resources are essential for effective referral (Stanley et al., 2007; Webster et al., 2006).

For rural nurses, self care and risk avoidance strategies such as informing colleagues of travel plans, time frames and mobile phone numbers as well as an awareness of professional boundaries, are essential when working with women affected by violence (Cox et al., 2001).

Children at risk

There was limited focus on children and DV screening. This was surprising considering the client population in the well child setting. Most comments were around the increased risk of violence during pregnancy and the effects of increased stress on the foetus and child (Hornor, 2005; Vanderburg et al., 2010).

Children witnessing violence or being physically injured suffer significant psychopathology and DV may co-exist with other forms of abuse such as physical and/or sexual abuse and neglect (Bateman & Whitehead, 2004; Hornor, 2005; Wilson & Koziol-McLain, 2007).

Early work by Dickson & Tutty in Canada (1996) identified that nurses were aware that DV may affect the mother's ability to parent and that there is a need to enquire about the children's safety when DV is disclosed (Dickson & Tutty, 1996). Few studies addressed the ethical dilemmas and decisions nurses face at times, such as mandatory reporting to child protection services (in accordance with the countries legislation) (Hornor, 2005; Stanley et al., 2007).

Discussion

The scoping review revealed that despite the abundance of literature on DV, the discussion on DV screening in the well child setting is limited (Figure1). Several barriers to screening have been identified and highlight the challenges to implementation of a DV screening program in the well child setting. Additional education and skills training, resources and support are required. The final documents identified were mostly descriptive in nature, with most primary research focusing on home visiting in Canada. Much of this focus was on the appropriateness of DV screening at the first home visit and does not fit with the adopted screening model in Victoria, Australia (DEECD, 2009b).

It appears that certain countries have greater research activity and discussion on the topic of DV in the well child setting, with Canada most active and the United Kingdom least so (Bateman & Whitehead, 2004). Bateman & Whitehead (2004) acknowledge a lack of research in the last decade in relation to health visitor practice with regard to DV. Australia too appears to have limited research on DV in MCH, with only two documents identified in this review relevant to Victorian MCH nursing practice. DV research and discourse in the professional arena are essential elements to policy development and quality improvements.

Circumstances such as a lack of privacy and knowledge on DV screening cause significant barriers to MCH nurse practice with ongoing education, specific guidelines and opportunities for debriefing, enhancing nurses abilities to implement screening practices. Nurses have expressed a need for DV education, ongoing training and support, with utilisation of clinically appropriate clinical guidelines. The most recent evaluation of screening in NSW shows that screening rates remain low despite interventions to reduce barriers (NSW Department of Health, 2006). This may be due to timing in that women are often asked about DV at the first initial visit they have with the nurse. This does not allow time for nurse's clinicians to build rapport with women and families. Women are more inclined to disclose information to health care providers they are familiar and feel comfortable with and continue to see on an ongoing basis (Feder, Hutson, Ramsay & Taket, 2006). However, rapport building implies continuity of care which cannot always be guaranteed in busy multi nurse clinics.

This review identified that there is a lack of international discussion regarding children's safety and DV. This omission in the consideration of children's welfare is a concern. A recent report by Sety (2011) has indicated that over one million children in Australia are affected by DV. There is growing evidence that DV causes significant harm to children's emotional, social, behavioural and physical health and that witnessing violence is not just a passive process but one that may have ongoing and serious impacts on the child's developmental health outcomes (Sety, 2011). Ongoing research is needed regarding children's safety and DV in the MCH setting. Nurses may need further education on the harm that witnessing DV has on infants and young children.

Screening has its origins in the bio medical model of health care, where it is often employed to identify illness (Talbot & Verrinder, 2010). DV is a complex social problem and

management by approaches that are employed to treat or cure disease may not be appropriate (Feder et al., 2009; Taft, 2001). Women have reported that interventions that protect their safety, privacy, and autonomy are most valued (Chang et al., 2005; Feder et al., 2006; Varcoe & Einboden, 2011). Screening aims to identify women who have experienced or are experiencing DV in order to offer interventions leading to beneficial outcomes. However, evidence to support the use of screening is controversial (Feder et al., 2009; Nelson et al., 2004; Ramsay et al., 2002; Wathen & MacMillan, 2003). Despite this, the introduction of screening and clinical practice guidelines has been widely introduced into health care settings.

In Victoria, Australia, routine DV screening at the 4 week postnatal consultation was introduced in late 2009, following a piloted trial. The documents to support this new government policy appear to lack clarity of rationale, evidence or discussion on the timing of this routine screening (DEECD, 2009b) with the supporting documents for nurses (DPCD, 2008) describing a case finding approach (based on identified risk indicators) rather than routine screening (DPCD, 2008). Recent results from the evaluation of the introduction of the new *Key Ages and Stages* framework state that, DV screening is not occurring as recommended, with nurses lacking confidence in the implementation of DV screening. Recommendations are for MCH nurses to have additional and ongoing training in the area of DV (Centre for Community Child Health, 2011).

It has been suggested that a change in terminology from screening to risk assessment and response, is required (Ford-Gilboe, Varcoe, Wuest & Merritt-Gray, 2011). The change in terminology expands the nurse's role and reinforces that follow up is needed. It moves away from identification of the disease (disclosure) being the only outcome, as it is in a screening paradigm. Some argue that screening is an incremental step in addressing the significant impact DV has on health, as it improves identification rates, is acceptable to women and may reduce stigma by raising awareness of DV by women and possibly the wider community (Feder et al., 2006; Moracco & Cole, 2009; Spangaro, Zwi & Poulos, 2009; Spangaro, Zwi & Poulos, 2011).

Limitations and recommendations

There were several limitations to this review, these included search restrictions and balancing the breadth and comprehensiveness of the review, versus the feasibility and scope

of the study. The search was restricted to English only studies and the grey literature search was confined to specific Australian websites. A more extensive search including further hand searching of key journals, citation searches and an expanded search of the grey literature, beyond Victoria and the Australia and Domestic Violence Clearing house website, may have increased the yield. These limitations must be considered prior to interpreting the search outcomes and summary of results.

The use of the Arksey & O'Malley (2005) framework in this scoping review provides a methodological foundation from which to build the research. This framework attempts to add rigour and trustworthiness of the reviews results, providing a systematic and transparent guide to answering the research question (Arksey & O'Malley, 2005). However, some areas of the review process are poorly explained in the literature (Davis, Drey & Gould, 2009) and while Levac et al. (2010) was most useful in guiding the process and ensuring methodological rigor, further methodological transparency is needed to enhance the usefulness of scoping reviews.

The breadth and panoramic nature of scoping reviews allows a unique look at what has been discussed previously on a topic and aids in the identification of further research (Anderson, Allen, Peckham & Goodwin, 2008). In this scoping review, the inclusion of non-research literature and the subsequent broad over view of the topic has allowed the researchers to become more aware of the “conversation” on the topic. Levac et al. (2010) would suggest that the iterative and reflexive nature of the scoping review is also a strength.

Further research is required on the appropriateness of DV screening, risk assessment and referral in MCH practice. There is a need for evidenced based guidelines and referral pathways specific to the well child setting. This study has identified that there are knowledge gaps related to the impact DV has on children in the context of MCH practice. More research is needed to explore MCH nurse's decision making around client assessment, child safety and follow up referral and care.

Conclusion

DV is a significant public health issue, with immediate and long term health consequences. The use of routine screening in the health care setting remains controversial; despite this its introduction has become widespread in many health care settings. Although routine DV screening has been introduced into MCH practice, screening rates remain low. Key issues identified in this review include barriers to DV screening, enablers that may sustain screening

and concern regarding the lack of discussion on children's safety and DV in the well child setting. This review reveals that more evidence is needed on screening in MCH nursing practice. This includes the development of appropriate and ongoing training, education and specific resources for nurses working in this area to improve efficacy of practice. This will enhance the evidence base and ensure a safe and confidential environment for women and children.

Figure 1. Flow diagram of the scoping review process.

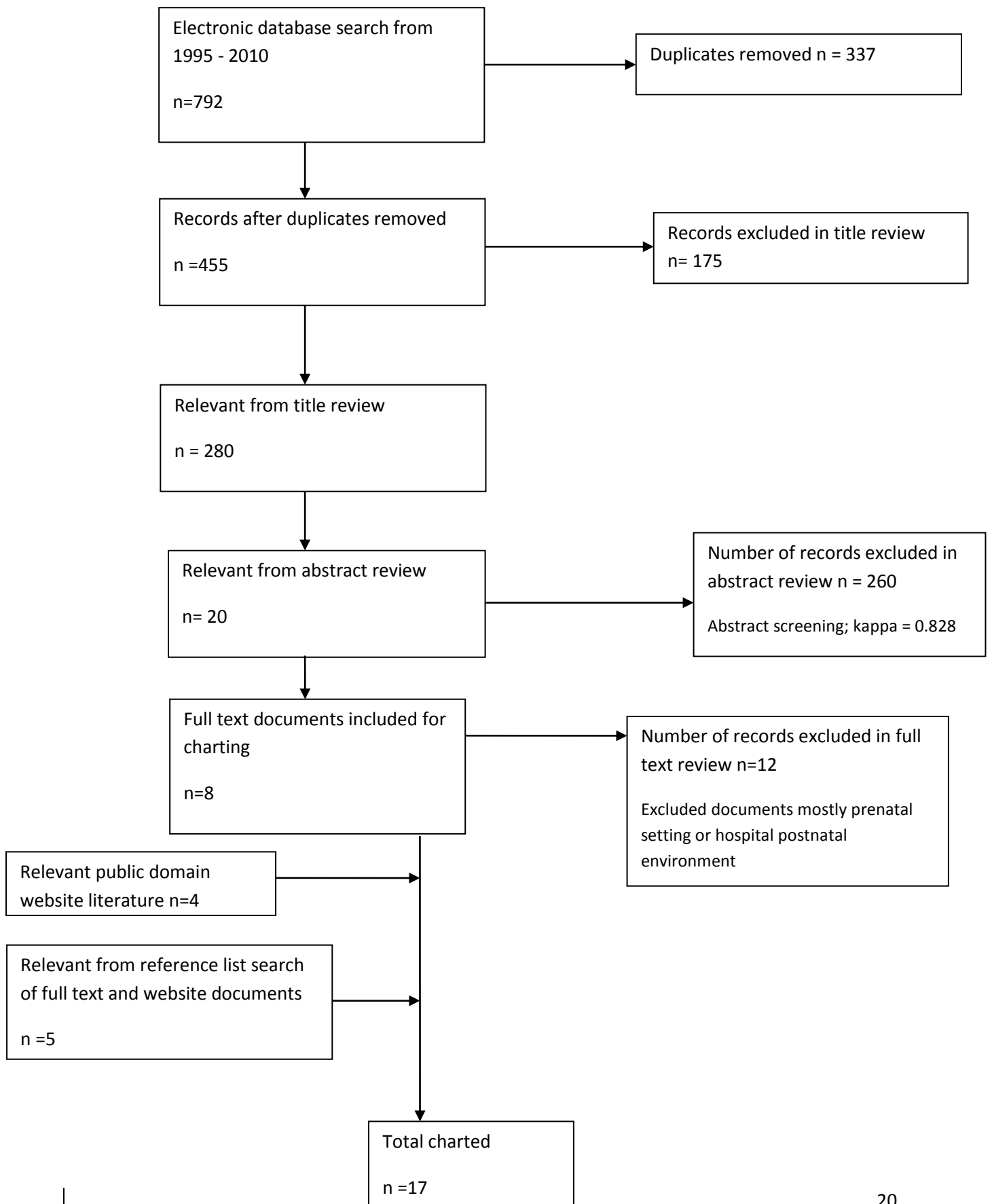


Table 1. Electronic database search results

Table 1. Summary of results from Electronic Databases Searched for Scoping Review	Number of titles to be reviewed after search n=792
CINAHL	123
MEDLINE	170
EMBASE	171
Cochrane Library	3
Centre for Reviews and Disseminations	2
Expanded Academic	14
Social Science Abstracts	13
PsycINFO	146
ProQuest Central	140
Informit Complete	10

Table 2. Public domain websites searched for scoping review

Table 2. Public domain websites searched for Scoping Review
Australian Domestic & Family Violence Clearinghouse http://www.austdvclearinghouse.unsw.edu.au/
Royal Children’s Hospital, Melbourne http://www.rch.org.au/rch/index.cfm?doc_id=1495
Victorian Department of Human Services http://www.dhs.vic.gov.au/home
Victorian Department of Education and Early Childhood Development –Early Childhood Professional-Maternal & Child Health Nurses http://www.education.vic.gov.au/ecprofessionals/mchnurses/default.htm
Women’s Health Victoria http://whv.org.au/

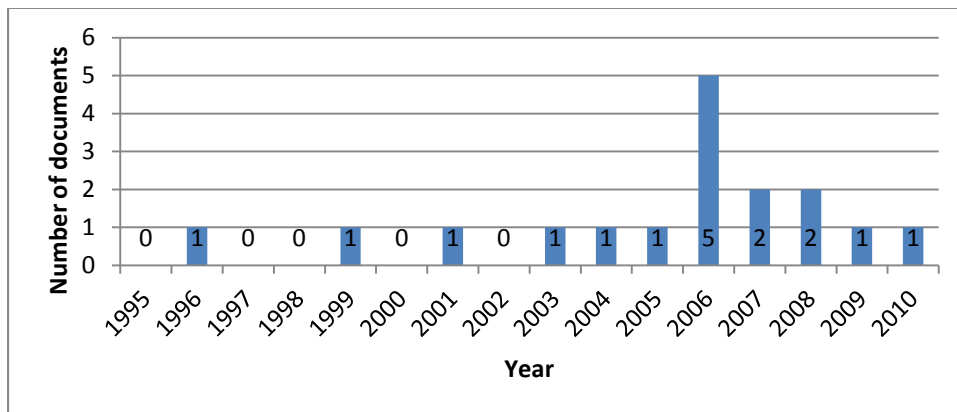
Table 3. Charted documents

Author and date	Title	Citation	Country of Origin	Document type	Design	Clinical area	Intervention or focus	Outcome or conclusion
Bateman, W. and K. Whitehead (2004).	Health visitors (HV) domestic violence routine questioning tool: An exploration of women's experience, effectiveness and acceptability.	International Journal of Health Promotion and Education: 42 (1):14-22	United Kingdom (UK)	Primary research	Qualitative-interviews	Health Visitor	Acceptability of a screening tool by HVs and clients. Women's experience of DV and exposure to DV screening using tool from 34 weeks to 8w post partum. n=56 clients & 6 HV.	Lack of research into HV practices in regard to DV. Clients accept screening and feel the relationship is more informal than that of the GP and feel HV could provide better continuing help & support. Clients trusted them to act in their best interest.
Cox, H., P. Cash, et al. (2001).	Risky business: stories from the field of rural community nurses' work in domestic violence	The Australian journal of rural health 9(6): 280	Australia	Primary research	Qualitative design-focus groups	Maternal & Child Health(MCH)	Rural MCH nurses experience of dealing with Intimate Partner Violence. n=24	Risky business of being a rural MCH nurse. Discusses a case finding approach. Barriers nurses face and the way they adapt to improve rural women's and children's safety. Self care also discussed.
Department of Education & Early Childhood Development (2009).	Maternal and Child Health (MCH) Service: Practice Guidelines 2009.	Maternal and Child Health Service: Practice Guidelines	Australia	Government report	Narrative content analysis	Maternal & Child Health	Revised framework for 10 Key Ages & Stages consultations. Aims to improve the outcomes for children and families.	10 Key consultations. The new framework set out evidence based activities for each age and stage visits with emphasis on health promotion that address both maternal and child health and wellbeing.
Department of Planning & Community Development (2008).	Family Violence Risk assessment and risk management - Identifying Family Violence; Maternal and Child Health Nurses' Training Handbook.	Family Violence Risk assessment and risk management - Identifying Family Violence; Maternal and Child Health Nurses' Training Handbook.	Australia	Government report	Narrative content analysis	Maternal & Child Health	Risk assessment & management tool for Victorian MCH nurses. This document is a modified form of the generic Common Risk Assessment Framework (CRAF).	Developed to assist key professionals working with victims of FV to develop common standards and practices when dealing with FV. These include improved skills in identifying and responding to FV.
Dickson, F. and L. M.	The role of public health	Public Health Nursing(PHN)	Canada	Primary research	Qualitative design using standardised	PHN	Assess the extent to which PHN discuss and	PHNs come across barriers to addressing IPV however they felt

Tutty (1996).	nurses in responding to abused women.	13(4): 263-268.			measure, the Public Health Nurses (PHN) response to women who are abused scenario and questionnaire.		address DV and what issues are raised for the clinician. n=125	comfortable addressing the issue. More education needed.
Edgecombe, G. and H. Ploeger (2006).	Working with families experiencing violence: the Ploeger Model of Enhanced Maternal and Child Health Nursing Practice.	Contemporary Nurse: A Journal for the Australian Nursing Profession 21(2): 287-296.	Australia	Discussion	Narrative content analysis	Enhanced MCH Service	Describes model used in Enhanced home visiting service by team in Geelong, Victoria.	Use of intensive home visiting support service to at risk families living in DV environments.
Evanson, T. A. (2006).	Addressing domestic violence through maternal-child health home visiting: what we do and do not know.	Journal of Community Health Nursing 23(2): 95-111.	United States of America	Narrative literature review	Narrative content analysis	Community Health Nurses (Home Visiting)	A literature review on the impact MCHNs home visiting has on DV prevention & intervention	This critical review of the literature shows that multiple gaps in knowledge exist. Minimal research around the practices of MCHN home visiting. Suggests all nurses to screen, best placed to observe home environment, validate women's feelings (if discloses) and ensure safety plan and referral.
Frost, M. (1999)	Health visitors' perceptions of domestic violence: the private nature of the problem.	Journal of Advanced Nursing 30(3): 589-596.	United Kingdom	Primary research	Qualitative phenomenology-interviews	HV	What are the HV perceptions of DV? n=24	HV in contact with clients involved in DV. Abuse as a private matter was an overwhelming theme. Barriers to screening included fears and knowledge deficits.
Grafton, D., B. L. Wright, et al. (2006).	Successful implementation of universal woman abuse inquiry.	Public Health Nursing 23(6): 535-540.	Canada	Primary research	Retrospective chart audit	PHN	Chart audit pre & post IPV routine screening at home visit (low risk mothers)	Pre IPV routine screen= small % case finding approach. Increased screening post intro of screen and during a 12month education program.
Hornor, G. (2005).	Domestic violence and children	Journal of Pediatric Healthcare 19(4): 206-212.	United States of America	Discussion	Narrative content analysis	Pediatric Nurse Practitioner	Child at risk	Children are at risk when DV is identified and there is a need to reduce exposure to violence & refer family to mental health support.
Jack, S. M., E. Jamieson, et	The feasibility of screening for	Canadian Journal of Nursing	Canada	Primary research	Qualitative interviews	PHN	PHN experiences of IPV screening during home	Explored PHN perceptions of IPV screening, feasibility of screening at

al. (2008).	intimate partner violence during postpartum home visits	Research 40(2): 150-170.					visit n=6	home visit, screening practices and training needs.
NSW Department of Health (2006).	Routine screening for domestic violence program: snapshot report 3 & 4.	NSW Department of Health (2006). Routine screening for domestic violence program: snapshot report 3 & 4. Sydney, NSW Department of Health.	Australia	Government report	Narrative content analysis	Child & Family Nurse	Routine screening evaluation in NSW area health services.	Introduction of routine screening in key areas including early childhood services (ECS). Privacy is the main barrier to screening. Evaluation suggests ongoing training needed to sustain screening rates.
Peckover, S. (2003).	Health visitors' understandings of domestic violence.	Journal of Advanced Nursing 44(2): 200-208.	United Kingdom	Primary research	Qualitative-interviews	HV	Exploration of HV work in relation to DV. n=24 with data collected in 97-98.	Variation by HVs in DV awareness in client caseloads. Limited knowledge base and lack of professional DV discourse contributed to barriers in identification.
Stanley, T., J. Yarwood, et al. (2007).	Nurses assessing family violence-some hidden dangers.	Kai Tiaki Nursing New Zealand (Wellington) 13(8): 20-21.	New Zealand	Discussion	Narrative content analysis	Plunket Nurse	Risks of screening	Lack of resources to match demand, increased demand to 'get it right', increased workloads, documentation care.
Vanderburg, S., L. Wright, et al. (2010).	Maternal child home visiting program improves nursing practice for screening of woman abuse.	Public Health Nursing 27(4): 347-352.	Canada	Primary research	Retrospective chart audit	PHN	Introduction of screening in a home visiting program	Disclosure rates increased at home visit screening. Education needed to reinforce need for privacy during screening.
Webster, F., M. S. Bouck, et al. (2006).	Nursing the social wound: public health nurses' experiences of screening for woman abuse.	Canadian Journal of Nursing Research 38(4): 137-153.	Canada	Primary research	Qualitative interviews	PHN	Nurses experience of screening n = 11. Education to cover the nurse readiness stages of dealing with DV- (Novice to expert).	Nurses can be at various levels of readiness/competency to deal with clients exposed to DV- Use non linear stages to develop education strategies for professional development, debriefing & undergraduate education.
Wilson, D. and J. Koziol-McLain (2007).	Family violence: the imperative for nurses to respond	Nursing Praxis in New Zealand 23(2): 2-4.	New Zealand	Editorial	Narrative content analysis	Plunket Nursing	Screening is essential	If disclosure occurs then children are at risk and nurses must not be indifferent. Effective parenting by the Mo is compromised in the abusive environment.

Table 4. Number of documents by year of publication



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