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Exploration of barriers to screening for domestic violence in the perinatal period using an ecological framework

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Abstract

Aims: To explore Australian healthcare providers' perspectives on factors that influence disclosure and domestic violence screening through the lens of Heise's (1998) integrated ecological framework.

Design: This paper reports the findings that were part of a sequential mixed methods study with survey data informing interview questions. Participants for interviews were recruited after expressing an interest after completing surveys, as well as via snowball sampling.

Methods: Semi-structured interviews were undertaken in 2017 with 12 practicing healthcare providers delivering care to women in the perinatal period in Greater Western Sydney, NSW, Australia. Data were analysed using Braun and Clarke's (2006) six-step thematic approach.

Findings: The findings were framed within Heise's integrated ecological framework under four main themes. The main themes were 'Ontogenic: Factors preventing women from disclosing'; 'Microsystem: Factors preventing healthcare providers from asking'; 'Exosystem: Organizational structures not conducive to screening'; and 'Macrosystem: Cultural attitudes and socioeconomic influences affecting screening'.

Conclusion: Organizational policies are needed for better systems of reminding healthcare providers to enquire for domestic and family violence and mandating this within their practices. Mandatory domestic and family violence education and training that is suitable for the time constraints and learning needs of the healthcare provider is recommended for all healthcare providers caring for perinatal women. Further research is needed in addressing culturally specific barriers for healthcare providers to enquire about domestic and family violence in a culturally appropriate way.

Public and Patient Engagement and Involvement in Research (PPEI): No Patient or Public Contribution was embedded into the research reported in this paper as this research was specifically exploring healthcare providers' perspectives on domestic violence screening within their own practice experience.

KEYWORDS
barriers, domestic violence, healthcare providers, midwives, nurses, screening

1 | INTRODUCTION

According to the World Health Organization (WHO) violence against women continues to be a public health problem, depriving women globally of their human rights and preventing achievement of the United Nation's (UN) sustainable development goals (World Health Organization, 2019). According to this report, 35% of women internationally have experienced either physical or sexual violence, or a combination of both, by an intimate partner (World Health Organization, 2019). In the Australian context, the 2016 Personal Safety Survey by the Australian Bureau of Statistics estimated that 17% of women have experienced violence from their partner since the age of 15 (ABS, 2017). In this paper, violence experienced by women from a current or previous intimate partner will be referred to as domestic violence.

Globally, domestic violence is a predominant concern for pregnant women. In a 19-country study in, rates of partner violence during pregnancy ranged from 2% to 8% with over half of the countries averaging between 3.8% and 8.8% (Devries et al., 2010). In Australia, 18% of pregnant women reported experiencing partner violence from a current partner and 48% reported experiencing violence from a previous partner (ABS, 2017). A Canadian study reported that out of 8400 women who had experienced any form of abuse, 30.4% experienced abuse during pregnancy and 15.6% experienced abuse both before and during pregnancy (Urquia et al., 2011). Violence during pregnancy is associated with many consequences for both maternal and infant health and well-being (Wong & Mellor, 2014; World Health Organization, 2012). Exposure to domestic violence in early childhood can persist into later adulthood, causing an intergenerational cycle of violence (Moncrieff, 2018).

Assessing pregnant and postnatal women for domestic violence by their healthcare providers is important in not only identifying domestic violence but also providing supportive care and services that are appropriate for the woman and her circumstances. Yet inconsistencies and barriers exist among healthcare professionals in their domestic violence assessment practices. This research explores this from the perspectives of practicing healthcare providers.

1.1 | Background

The concept of domestic violence screening is contentious, with the World Health Organization (2013) reporting on research that indicates universal screening, also known as routine enquiry, while successful in increasing identification of intimate partner domestic violence, has not been linked to notable benefits in a reduction of domestic violence rates. A more recent WHO global status report, 'Addressing violence against women in the health and multisectoral policies' recommends that a clinical enquiry approach should be used in place of universal screening for identification of domestic violence (World Health Organization, 2021). A clinical enquiry approach involves asking about domestic violence when women present with conditions that may have been caused by partner violence (World Health Organization, 2021). An enquiry-based approach is also supported by evidence presented in a systematic review of literature on domestic violence screening in the clinical contexts that reported domestic violence screening initiated through research studies is not sustained in the clinical area after research completion (Miller et al., 2021).

Further contention lies in the inconsistency of healthcare sector policies and processes for partner domestic violence identification both across the globe and within countries. Exemplifying this, both New Zealand and the United States recommend healthcare providers routine enquiry for domestic violence with all women of childbearing age (Commonwealth of Australia, 2018; Miller et al., 2015), while Canada and the United Kingdom do not recommend routine domestic violence screening (Commonwealth of Australia, 2018). In the Australian context, most states and territories support routine domestic violence screening of perinatal women (Commonwealth of Australia, 2018; Queensland Health, 2018; State Government of Victoria, 2022). While routine domestic violence screening is favoured across Australian States and Territories, with common questions used in some jurisdictions, overall domestic violence screening approaches vary considerably (Commonwealth of Australia, 2018).

Despite differences in domestic violence screening practices, the perinatal period, defined for the purposes of this paper as the period from the beginning of pregnancy to the end of first postnatal year, has been identified as an opportunistic time to assess women for domestic violence due to frequency of healthcare provider interaction (Australian Institute of Health and Welfare, 2015; Campo, 2015). Moreover, it has been established that women have

Impact

What problem did the study address?

Identifies key factors that influence disclosure by women, and domestic violence screening of practicing healthcare providers, as well as recommendations for addressing key barriers.

What were the main findings?

Using Heise's ecological framework the main findings were presented under the themes; Factors preventing women from disclosing (Ontogenic); Factors preventing healthcare providers from asking (Microsystem); Organizational structures not conducive to screening (Exosystem) and Cultural attitudes and socioeconomic influences affecting screening (Macrosystem).

Where and on whom will the research have an impact?

It is hoped that findings from this research will prompt healthcare providers, organizations and policy makers to promote better domestic violence screening practices in the workplace; and for time to be afforded for education and training of healthcare providers.

positive perceptions of screening by healthcare providers when participating in trial screening and intervention programs (Spangaro et al., 2019). Despite women's reported comfort with domestic violence screening the literature suggests ongoing healthcare providers' discomfort in domestic violence screening and a lack of training (Saletti-Cuesta et al., 2018; Wyatt et al., 2019). Literature on barriers to screening predominantly focus on individual issues such as lack of time, training and support (Saletti-Cuesta et al., 2018; Wyatt et al., 2019), rather than analysing the issue through a holistic, socio-ecological lens.

As domestic violence inquiry can be a complex, multifaceted process, there are many issues for healthcare providers to consider and barriers to overcome. In 1977, Bronfenbrenner developed the ecological systems theory to distinguish between individual, relational, structural and cultural factors as relating to the individual, as well as the interactions between. Since then, socioecological models have been further modified and applied to the issue of partner violence, such as Heise's (1998) integrated ecological framework. These ecological theories have been used internationally in the general study of domestic violence, as they enable researchers to understand the multi-level intersections of domestic violence within a specific geographic area (Sabbah et al., 2017; Willie & Kershaw, 2019). While literature exists that reflects the use of the ecological model in identification of factors affecting domestic violence, such as the model used by the Centers for Disease Control and Prevention (n.d.), fewer studies have used the model in understanding factors that influence disclosure by women and DV screening by healthcare providers.

2 | THE STUDY

This qualitative paper reports findings from a broader sequential mixed method study undertaken in 2016–2017 (O'Reilly & Peters, 2018). The larger study, underpinned by Pragmatism, involved a survey that explored the domestic violence screening practices of healthcare providers in primary care settings. Survey results informed interview questions for the second phase of the study which is reported in this paper. A qualitative descriptive design, using semi-structured interviews and thematic analysis, was used to provide further depth and understanding of factors influencing women's disclosure and domestic violence screening from the perspective of primary-based healthcare providers.

2.1 | Aims

This paper aims to explore the Australian healthcare providers' perspectives on factors influencing disclosure and screening for domestic violence through the lens of Heise's (1998) integrated ecological framework. It also aims to provide recommendations to healthcare providers, policymakers and researchers working with the complex issue of domestic violence.

2.2 | Sample/participants

The study was located in Greater Western Sydney, New South Wales, Australia. This district was selected due to the population comprising notably high rates of unemployment, Aboriginal people, people with disability and people with culturally and linguistically diverse backgrounds, which are all domestic violence risk factors (Parliament of Australia, 2014).

Criteria for participation included community healthcare providers working with perinatal women in Greater Western Sydney, NSW, Australia. As diversity in disciplines was sought, participants included Women's Health Registered Nurses, General Practice Registered Nurses, General Practitioners, or Privately Practicing Midwives (referred to hereon in as Midwives or Midwife). A sample size of at least 10 was anticipated, which is considered adequate for qualitative interview data where collecting information-rich data that provides in-depth understanding of the topic under study is a priority (Sandelowski, 1995). Participants were self-selected and were recruited by either answering an invitation for an interview at the end of the phase one survey, or by snowball sampling.

2.3 | Data collection

In-depth, semi-structured interviews were used to enquire about participants' professional experiences and perceptions regarding domestic violence screening in the perinatal period. The researchers used open-ended questions to enquire about the participants' perspectives on domestic violence screening, their screening practices and how they managed a positive screen (see Table 1). This paper reports the findings about healthcare providers' experiences and perceptions of factors that influence disclosure and domestic violence screening.

Face to face interviews were conducted by Rebecca O'Reilly and Hazel Keedle, both females with Registered Nurse and Registered Midwife qualifications, PhDs and experience in research interviewing. At the time of the study, the interviewers were nursing and midwifery academics. Interviews took place in a private location of participants' choice and lasted approximately 45–60 min. The researchers continued interviewing until there was rich information that provided extensive data. While the participants were from differing disciplines and cultures, they were all primary healthcare-based health care providers and therefore considered homogeneous in respect to this study. Data saturation was achieved when analysis revealed rich accounts of participants' experiences with domestic violence screening and consistency emerged in themes.

The same interview guide was used for all interviews. Initially, participants' demographic data were collected. The researchers then used open-ended questions to enquire about participants' perspectives on domestic violence screening, screening practices, managing a positive screen; improving healthcare providers' domestic violence screening practices and, appropriate care provision for women and children experiencing domestic violence. With participants' consent, the interviews were audio-taped and transcribed verbatim.

TABLE 1 Interview concepts and questions

Overarching concepts	Interview questions
Participant demographics	What type of Healthcare Provider are you? What area do you work in? What is your highest educational qualification?
Knowledge on domestic violence screening	Have you ever received training for domestic violence screening? If yes – ask to explain what this entailed If no – ask how they feel about this and if they would have liked this?
Screening Practices	Can you please explain what your current domestic violence screening practices entail in relation to antenatal and postnatal women? Can you tell me what domestic violence screening tools you use? Can you tell me if you know of any other domestic violence screening tools? How do you feel about screening for domestic violence? Can you explain what would encourage you to carry out domestic violence screening? Can you explain what would stop you from carrying out domestic violence screening?
Knowledge on what to do with a positive screen	Can you tell me about what you have done or would do if you detected domestic violence during the care of an antenatal or postnatal woman? Are you aware of the domestic violence services you can refer to and if yes which ones? Have you ever referred women to domestic violence services? Explain. Do you provide follow-up for women who you have detected domestic violence with?
Suggestions for improving healthcare provider screening practices and appropriate care provision for women and children experiencing domestic violence	Do you have any suggestions for what is needed to increase domestic violence screening by community-based healthcare providers? What support would be beneficial?

TABLE 2 Braun and clarkes phases of thematic analysis (Braun & Clarke, 2006)

Phase	Process description
1. Familiarizing yourself with your data	Transcribing data (if necessary), reading and rereading the data, noting down initial ideas
2. Generating initial codes	Coding interesting features of the data in a systematic fashion across the entire data set, collating data relevant to each code
3. Searching for themes	Collating codes into potential themes, gathering all data relevant to each potential theme
4. Reviewing themes	Checking in the themes work in relation to the coded extracts (Level 1) and the entire data set (Level 2), generating a thematic map of the analysis
5. Defining and naming themes	Ongoing analysis to refine the specifics of each theme, and the overall story the analysis tells; generating clear definitions and names for each theme
6. Producing the report	The final opportunity for analysis. Selection of vivid, compelling extract examples, final analysis of selected extracts, relating back of the analysis to the research question and literature, producing a scholarly report of the analysis

2.4 | Ethical considerations

The Human Research Ethics Committee of Western Sydney University, Australia (approval number H11294), provided ethics approval prior to recruitment. Informed, written consent was received by each participant after they were provided with a study information sheet.

2.5 | Data analysis

The qualitative interview data were analysed using Braun and Clarke's (2006) six-step thematic approach (see Table 2) and results were framed within Heise's (1998) integrated ecological framework. Potential themes were delineated collaboratively after the authors each generated initial codes through reading and re-reading the data. The software package NVivo 12 was utilized to record and delineate codes and themes by the research team.

2.6 | Rigour

The COREQ checklist criteria were addressed to ensure rigour. All authors played a role in the analysis of the interview data and the final themes presented within the ecological framework. Credibility was further achieved with the interviewers seeking clarification during the interview with the participant for clarification of their responses. As all of the researchers are healthcare providers,

specifically Registered Nurses and/or Privately Practicing Midwives, bias was reduced by bracketing was used by using an iterative approach to data analysis, revisiting the data multiple times and framing the language of the findings within the ecological framework (Fischer, 2009). Confirmability was met by three of the researchers (Christina Usanov, Rebecca O'Reilly and Hazel Keedle) coding independently, then sharing initial coding, and later concurring on final themes. Any differences in coding were discussed and the fourth researcher (Kath Peters) confirmed agreement with the final themes.

3 | FINDINGS

Interview participants included six General Practitioners, three Midwives, two General Practice Registered Nurses and one Women's Health Registered Nurse. Of these participants, two were males (both General Practitioners) and 10 were females. Findings from participants' transcripts are presented using Heise's (1998) ecological framework. This integrated ecological framework classifies factors as ontogenic (individual's experiences or attitudes), microsystem (individual's direct interactions), exosystem (formal and informal structures indirectly affecting the individual) and macrosystem (overarching cultural beliefs and values of society; Heise, 1998). Using the Ecological Framework classifications (Heise, 1998), qualitative data are presented under four main themes. Each main theme is supported by sub-themes as presented in Table 3.

3.1 | ONTOGENIC: Factors preventing women from disclosing

In this paper, ontogenic factors refer to the personal attitudes or beliefs of the healthcare providers that hinder an individual from disclosing their domestic violence experience. It became apparent from the narratives of participating healthcare providers that they felt that women did not disclose for a variety of reasons, ranging from financial dependence to feeling ashamed. When specifically asked what would stop healthcare providers from screening for domestic violence, both General Practice Registered Nurses 1 and 2 stated 'If the patients refuse to answer.' Similarly, Women's Health Registered Nurses1 reported that 'If you ask questions they might say, well, I don't want to answer any of those questions.' The woman not wishing to disclose was also perceived by healthcare providers to be related to fearing physical, financial and relational consequences.

3.1.1 | Physical, financial and relational consequences: 'Fear of the ramifications'

Healthcare providers speculated that patients chose not to speak up about their experience of domestic violence for different reasons, with one general assumption being that patients feared the uncertainty and relative danger of disclosing domestic violence and the subsequent actions that disclosure would require. General Practitioner2 stated, "we can't guarantee that the partner won't find them… you [women who have experienced domestic violence] do feel trapped and for whatever that reason that might be, sometimes leaving is more unsafe than staying." General Practitioner4 added to the discussion by bringing in concern of potentially lethal physical harm; they said, "in the news we do hear about people going and killing their ex-spouses and doing terrible things."

Fearing loss of financial support due to dependence on the partner was identified by healthcare providers as being another cause for patients to not disclose, and a concern for the healthcare providers as General Practitioner2 stated '…we can't guarantee that they'll be able to leave with their possessions…', and how General Practitioner4 states, "they just lose a lot of financial gain." The potential loss of financial support may also be heightened by the patients when there are concerns about the care of their children. General Practitioner4 pointed out that there is "a lot to lose", especially for women who "might be not working" and "might have young children". In addition to concern that their children would be

TABLE 3 Themes and sub-themes

Theme	Sub-themes
ONTOGENIC Factors preventing women from disclosing	• Physical, financial and relational consequences: 'Fear of the ramifications' • Self-blame and rationalization of abuse: 'It's my fault' • Ashamed to disclose: 'Shame, stigma, not wanting to tell anyone'
MICROSYSTEM Factors preventing health care providers from asking	• Caring for both women who have experienced domestic violence and their perpetrators: 'Conflicts of interest and whatnot' • Not knowing what to do: 'Fear of opening a can of worms' • Lacking knowledge and awareness: 'Education's a huge thing' • Someone else does it: 'Screening happens in the hospital'
EXOSYSTEM Organizational structures not conducive to screening	• Inhibited by time constraints: 'Under a lot of time pressure' • Lacking physical resources and emotional support: 'We do not seem to have much support' • Not at the forefront: 'Off your radar'
MACROSYSTEM Cultural attitudes and socioeconomic influences affecting screening	• Ethnic considerations: 'Culture has a lot to play with things' • Socioeconomic assumptions: 'There is class everywhere'

affected physically, or financially, another concern was that of having their children taken away from them.

> But it's common sense to me that women are afraid to disclose anything, because the fear is if you are living with domestic violence then I would be scared that the doctor is going to take my children away, to put it very simply.
>
> (Midwife2)

3.1.2 | Self-blame and rationalization of abuse: 'It's my fault'

According to the healthcare providers, many women experiencing domestic violence will often resist disclosure due to their rationalization of the abuse as a reasonable response to their own personal deficiencies, thus resulting in self-blame and acceptance of the abuse. Midwife3 highlighted some common thoughts of self-blame presented by women who had experienced DV, such as, "I made it happen. It's my fault. If I didn't get him so angry. I've got to learn not to ask him those questions is a classic one. I've got to learn when he comes in a bad mood, just not to get at him. I get at him all the time. It's my fault." During the interviews, healthcare providers also discussed the prevalence of patients not disclosing because they had come to accept domestic violence as a normal occurrence. Healthcare providers pointed out that when individuals accept domestic violence, they tend to minimize the extent of the abuse and rationalize it as a short-term situation that will be resolved. Midwife1 verbalizes how women who have experienced DV rationalize perpetrators' behaviour, "look it's fine, he's just angry and it will all just settle down and it will be okay."

On the other end of the spectrum, some healthcare providers may view disclosures of potential domestic violence from the patients as not being relevant, and unintentionally encouraging the woman to accept the behaviours of the partner being reported.

> Occasionally you'll just hear a counsellor that you just think, they just didn't pick it up, they didn't sense that that was one of the main issues, and that women was just encouraged to accept what was actually something that shouldn't be accepted.
>
> (General Practitioner 1)

3.1.3 | Ashamed to disclose: 'Shame, stigma not wanting to tell anyone'

In addition to not disclosing for fear of consequences or rationalization of the abuse, healthcare providers considered how experience of domestic violence was associated with feelings of shame and stigma, which was a contributing factor to patients not disclosing even to their friends and family members. General Practitioner5 explains this "They are ashamed to say to their neighbours, friends. Often the neighbours know what's happening in the house. They all know. So they need someone to trust." Healthcare providers perceived many patients would choose to remain silent about their experiences of domestic violence rather than bring shame to their family, decrease their standing in the community, or risk losing their means of financial support. General Practitioner4 adds to the discussion,

> There can be cases of domestic violence in the family setting and usually they don't always take it to the police. There is a shame and sometimes that person who's causing the domestic violence is the key breadwinner. So we take him away, what's going to happen to the rest of the family.

This connects the idea of shame and stigma from reporting domestic violence back to fear of financial loss. Some HCPs even connected it back to broader systemic and societal levels, which directly influenced the individual's perceptions of the supposed unacceptability of domestic violence disclosure. Women's Health Registered Nurses1 connects these ideas, "it's not advertised and I guess it's because of all of the issues around shame, stigma, not wanting to tell anyone that this has happened to you, all of that sort of stuff."

3.2 | MICROSYSTEM: Factors preventing healthcare providers from asking

The microsystem factors are those that prevented the healthcare providers from screening for domestic violence. Prominent factors identified by participants were the conflict arising for caring for both women who have experienced domestic violence and their perpetrators of domestic violence; uncertainty of knowing what to do with a positive response to screening; lacking knowledge and awareness of domestic violence screening and intervention; and believing that another healthcare providers would have asked the woman about domestic violence.

3.2.1 | Caring for both women who have experienced domestic violence and their perpetrators: 'Conflicts of interest and what not'

Many of the participating healthcare providers in this study were working with families. As such, a common barrier voiced among participants was related to the perpetrator also being cared for by the healthcare providers, or within the same practice setting. As General Practitioner 6 indicates, "Victim and perpetrator. If we're seeing them as a family unit, or had been seeing them as a family unit, it becomes very tricky."

This relational dynamic increased the complexity of domestic violence inquiry and provided the healthcare providers with a moral

dilemma regarding their obligation to care for both the women who have experienced domestic violence and their perpetrators. General Practitioner6 argues that when "you're also seeing other members of the family, it becomes a bit difficult sometimes with conflicts of interest and whatnot." Midwife3 states that when they "didn't know the partners… there was a much healthier scepticism about them." However, when they care for both individuals, as MW3 states, "you are very much more connected to the partner."

The duality of caring for both the woman who had experienced domestic violence and the perpetrator was a clear issue when both were present during a consultation. When asked what would stop them from carrying out domestic violence screening one of the participating General Practitioners stated 'Probably if the partner was in the room….' (General Practitioner 2).

Similarly, General Practice Registered Nurses 1 and 2 admitted that if '…the husband was there or something like that, that's probably not a good idea to ask'.

3.2.2 | Not knowing what to do: 'Fear of opening a can of worms'

During the interviews, a major barrier identified was that of healthcare providers not knowing what to do should the individual disclose experience of domestic violence. As described by Women's Health Registered Nurses1 'I think sometimes people feel very uncomfortable to ask those questions because they're maybe they're frightened about what to do afterwards.' A similar response was shared by Midwife1,

> I think they are [SIC] screening tools but then people are really scared to even ask that screening tool in a way that they are going to maybe get a woman to express that she is experiencing it. Because people [health care providers] just do not know what to do … But I think that is the biggest fear is that someone's saying yes and what do I do now?

In addition to not knowing what to do if a woman disclosed she had experienced DV, some healthcare providers articulated they were fearful of what could happen to their patient following such disclosure. General Practitioner6 revealed that there is "a fear that you may cause more problems by bringing it up for the victim, especially if the abusive partner finds out."

3.2.3 | Lacking knowledge and awareness: 'Education's a huge thing'

A common theme communicated by participants was the lack of awareness and knowledge that many practicing healthcare providers have around domestic violence screening and intervention. This may be an important component for the fear of screening that healthcare providers outlined in the theme above.

> I believe that there may be just a lack of knowledge in knowing how to deal with it, with probably a lot of General Practitioners, but I can really only speak for myself.
>
> (General Practitioner 6)

Lack of knowledge and awareness was attributed to inadequate education and training and this was identified as a major barrier to domestic violence enquiry. Midwife1 argues that 'education's a huge thing', because "people just don't know what to do." Further to this was the suggestion that education and training are essential for not only promoting healthcare providers confidence in screening for domestic violence but for to having the skill set to work with women experiencing domestic violence.

> I think I would like - I really love education. I think it's the key to most - to be able to improve many health outcomes. … and to be able to have it [education] at our fingertips, have the knowledge updated regularly so that when we do have a real cases that come through our doors we can work with it.
>
> (General Practitioner 4)

Recognition of education as more than a formal course or training program was also raised. Learning from other healthcare providers was identified as valuable, which Midwife3 described as 'multidisciplinary'. Midwife3 continued,

> I think if we all got in the same room together and learnt from each other, I think that would not only enhance education, but it would enhance multidisciplinary communication around the issue.

Expanding the importance of education beyond the HCPs practice, participants expressed the need to align education and training with public awareness. 'So obviously education and maybe raising the awareness a little bit more'. Women's Health Registered Nurse1 affirms the same need;

> …and the stigma - busting down the myth as well, around who experiences DV … it's training, it's awareness, it's getting it out there.

3.2.4 | Someone else does it: 'Screening happens in the hospital'

Participants believed that screening for domestic violence could be overlooked at times due to some healthcare providers assuming

that another healthcare providers had attended to this. General Practitioner 2 shares their personal experiences,

> To be honest, I probably don't screen everyone at the same time. Part of the reason is because I know that screening happens in the hospital setting once they go in for their formal antenatal sessions.

Healthcare providers acknowledged that because they thought other healthcare providers had screened the patient they would only inquire if there were blatant signs of domestic violence. As General Practitioner 3 states,

> No. I am aware that the hospital does as part of their screening…I don't specifically go down that road unless I'm suspicious that there might be a problem.

Some healthcare providers admitted they did not view domestic violence screening as part of their scope of practice, and deflected to other healthcare prioviders for such screening. General Practice Registered Nurses 1 and 2 admitted that they 'usually discuss these issues with doctors, to be honest'.

3.3 | EXOSYSTEM: Organizational structures not conducive to screening

Within the context of this paper, the barriers in the exosystem relate to organizational factors that inhibit the healthcare providers from screening for domestic violence. Participants made reference to a lack of organizational structures and supports being in place that hampered their screening practices. Not surprising was that time constraints were placed as a major reason for their inability to implement domestic violence screening. Other barriers to domestic violence screening included a lack of organizational and external resources; and domestic violence screening not being on their radar. As one participant stated 'What would encourage me [to screen]? Time, resources. I think those would be the major things.' (General Practitioner 3).

3.3.1 | Inhibited by time constraints: 'Under a lot of time pressure'

There was a consensus across all participating disciplines that, for General Practitioners in particular, time constraints were by far the greatest barrier to screening for domestic violence. General Practitioner6 referred to a 'lack of time', stating that it was 'pragmatically a real consideration'. Midwife3 verified this barrier experienced by General Practitioners;

> we [independent midwives] have the luxury of not have the 15-minute clock, but when I think about a General Practitioner who has got all these very short timeframe, he doesn't want to open Pandora's box, because he hasn't got time for it. So you can understand that time becomes a constrainer on what you ask.

It was apparent that General Practitioners were feeling pressured to see as many patients as possible in their working day. There were numerous references made to General Practitioners only having 10- to 15-min appointment timeslots for their patients which meant their focus was on the presenting issue for the patient and did not facilitate domestic violence screening. "In a conventional GP practice, where you're under a lot of pressure to see someone every 10 or 15 minutes," General Practitioner1 describes "it could be something that gets submerged with other things." Further to the pressure of short appointment times was the pressure felt when the healthcare providers would have a full waiting room. General Practitioner1 shares this frustration, "If you see five people in the waiting room, you feel a bit uncomfortable taking an hour." General Practitioner1 elaborates on how more time is necessary when screening for domestic violence, "when you look at complex social issues you need a lot of time to do it well, and complex physical health is interwoven." While not routinely implementing screening per se, several of the healthcare providers were not frightened of or resistant to addressing risk factors or women's disclosures of DV, even if this meant they would run late for other patients. "Sometimes honestly if it's an obvious issue I will go there regardless." General Practitioner3 shares while bringing in a personal example, "I did today with a patient and that was a good hour-long consultation, which is why I am running late today." However, as one of the Midwives revealed, initial identification and conversations with women about domestic violence are not isolated to one consultation. Time for discussions at future consultations and follow-up is necessary which requires a further time commitment. Midwife1 summarizes this;

> "you've got to know that you've got time after that conversation, that that's not the end of your appointment with the woman. You've got to be able to have time in case someone does disclose and then to be able to sit and have those conversations and help put it in place a plan for them."

3.3.2 | Lacking physical resources and emotional support: 'We don't seem to have much support'

It was apparent that healthcare providers did not feel adequately supported on several levels. At a primary level, and on top of time restraints, the lack of practice-based screening tools was raised as an issue. General Practitioner1 states that this is something they personally do not utilize;

> I don't actually have a screening tool that I use religiously on all pregnant and postnatal women. But now that I've thought about your topic, I have decided that perhaps I should.

At the secondary level, once a woman was identified as experiencing domestic violence, the healthcare providers were not confident that there would be sufficient or any resources to refer the woman to. Midwife1 shares;

> I think people are so scared to ask the questions because they don't feel like they're going to be supported and it's going to be left up to them.

General Practitioner 3 further supports the concerns of insufficient resources;

> Lack, of resources is a big thing. I think that person who - not being able to absolutely assure that person that there is something waiting for her is difficult and you can't. You can't.

One of the participating General Practitioners recounts a time where domestic violence was identified as a potential concern for a woman but felt helpless to properly support her due to a lack of resources. General Practitioner 6 reported that "At the time, I remember feeling very - not having the right tools, so incapable of giving direct help." Participating midwives alluded to the need for a more multidisciplinary and shared approach to supporting women as well as each other. Midwife1 verbalizes this;

> Do you know what I think that hasn't happened? I think community services need to start talking to each other……and know who's supporting who and how we can support each other.

3.3.3 | Not at the forefront: 'Off your radar'

Many participants identified that undertaking domestic violence screening with all of their women patients was just not on their radar. General Practitioner1 asks, "how do you make sure you ask every time, how do you make sure it's in there somewhere, so it doesn't slip off the dial with everything else that comes up? A solution posed by some participants to place domestic violence screening 'onto their radars' was to incorporate screening tools and reminder systems into the workplace. General Practitioner1 adds to this conversation by suggesting having "a tool where we make sure we check in with those women too… I think it's just a good way of making sure that you ask every time."

3.4 | MACROSYSTEM: Cultural attitudes and socioeconomic influences affecting screening

The macrosystem refers to the factors that encompass broader societal and cultural attitudes affecting screening and disclosure of domestic violence that the healthcare providers are confronted with. In this study, barriers that fall within the macrosystem were identified as ethnic and cultural considerations and socioeconomic assumption.

3.4.1 | Ethnic considerations: 'Culture has a lot to play with things'

Healthcare professionals were able to identify the impact different cultures have on attitudes about domestic violence and in screening practices. General Practitioner4 pointed out that "We live in a very multicultural society" and suggested viewing domestic violence within the context of cultural experience, stating, "I think it would be nice to look at different cultural groups, the way that they think of domestic violence." General Practitioner3 described some of the challenges she experiences due to cultural differences among Australian women;

> I find it quite challenging at times and quite confronting and very difficult to understand, when I see very well-educated women, brought up in Australia, who will cop a lot of violence in the home and not go out and do something about it.

How women from different cultural backgrounds feel when they are screened for domestic violence at the hospital appointments was discussed by some healthcare providers; and raised yet another barrier to initiating screening in the primary-based practice setting. General Practitioner 3 addresses this with personal experiences of patients,

> I've had patients who have … taken into a room privately to be interviewed and asked whether they were any issues with their husband. They felt a bit confronted and they felt sometimes a bit judged. That they might have been targeted because they were [a certain religion] and therefore they are being asked whether there are domestic violence issues.

One healthcare provider discussed how women may be accompanied by their male partner. As noted in theme 2 partner presence was highlighted as a barrier to domestic violence screening in itself. In certain cultural groups, this may be emphasized further; as narrated by General Practitioner3, "They would always come in with their husbands, who interpret for them and who guide them through the consultation, who are more Aussie aware."

To better support women across diverse cultures, participants recognized the need for culturally specific domestic violence resources, as General Practitioner2 verbalizes, "… if there were resources which were more culturally appropriate for this area, maybe we can look at it during our screenings." The need for more culturally specific domestic violence refuges was also raised by General Practitioner3, who described such a shelter;

> They've got a refuge that they use, just for women [of a particular religion/culture]. Women particularly coming out of that environment are very reluctant to go into a refuge, to live with - just - I think there is still a lot of perceived what stigma attached. It's difficult. But that home is always packed

The role of culture within the community was highlighted as important when enquiring about domestic violence as General Practitioner 4 alluded that "dealing with culture is important, understanding how the networks work." Further, cultural context about the insidious nature of domestic violence and the role of women in society was viewed as potentially impacting on women disclosing abuse. As Midwife3 shares;

> Realising that I'm not blaming culture and anything, but that ability to absorb almost that it's acceptable comes from what's modelled around you and the invisibility and the disempowered nature that sometimes women have in our world.

3.4.2 | Socioeconomic assumptions: 'There is class everywhere'

In addition to cultural factors are the factors of socioeconomic class, the beliefs of which can influence screening for domestic violence. Midwife3 describes this common stereotype;

> ... there always was that belief that, you know, nice middle class, upper class women don't have this happen to them. This is something that happens to the lower socioeconomic classes.

The same participant goes on to provide an example of the assumptions that can be made by healthcare providers and which women would be more at risk of experiencing domestic violence, and a reason for not screening for domestic violence. Midwife3shares about these interactions;

> I've had these conversations with obstetricians - yeah, yeah, but we deal with the nice women. Well, why is this about nice women? That's not the definition of domestic violence.

However, even when acknowledging that domestic violence can occur within any class, healthcare providers working in lower socioeconomic areas revealed the difficulties with accessing resources. As highlighted in Theme 3, the Exosystem, knowing there is a lack of available resources may act as a barrier to healthcare providers screening for domestic violence. General Practitioner4 elaborates on this;

> ... domestic violence can occur in any socioeconomic but we seem to have a lot of low socioeconomic situations here. So I've really got to tap into our social workers fairly early - and they can't afford counsellors.

There was also a stereotype of domestic violence not being of concern with educated and well-presented women. This meant that identification of domestic violence for these women may be overlooked, which General Practitioner3 clearly identified though a personal narrative about;

> A very highly educated woman ... married somebody in IT, so fairly highly educated as well ... Her English is actually pretty good, so we converse with the husband in the room.

However, General Practitioner3 states that despite not seeing any red flags, 1 day they received a call from this client, "I got a challenging phone call one day to say this is the situation. I'm being controlled. He's hit me a few times." In another example a General Practitioner4 describes how domestic violence can be hidden through the pretence of appearance;

> I had one a few years back of an [particular culture] family, and the mum always presented herself immaculately. Her husband was a businessman and he ran a successful business. But one time she came by herself absolutely looking tired and dreadful. So I had no idea, because they hid it so well, and then she just came out and showed me all the bruises and said my husband has been doing this to me for a long time. But I felt enough was enough and I'm telling you now.

4 | DISCUSSION

Findings of this study highlighted the multiple barriers healthcare providers face when working with women and families experiencing domestic violence, and that these barriers often impede initial domestic violence screening and identification. The findings also presented suggestions from participants on how their practice could be improved to ensure they screened for domestic violence and were equipped with the knowledge and skills to intervene when domestic violence was identified.

Evident in this study was the interplay between the microsystem and exosystem, where organizational barriers of time constraints directly impact the microsystem barriers of healthcare providers lacking knowledge, awareness and confidence with domestic violence screening. The barrier of time constraints directly impacts healthcare providers' ability to improve and increase their knowledge in domestic violence screening and intervention; a key barrier that resonates with findings from other studies (Hegarty, McKibbin, et al., 2020; Hegarty, Spangaro, et al., 2020; O'Doherty et al., 2015; O'Reilly & Peters, 2018). It is clear that educational programs must be developed and delivered in a manner that provides ample content to enhance

knowledge and confidence in screening for domestic violence, best practice for supporting women who have experienced domestic violence, as well as meeting the ever-decreasing time availability of healthcare providers. Participants in this study identified education as a key requirement to enhancing the knowledge and confidence to screen for domestic violence and offer support when required. This was supported by findings of a qualitative meta-synthesis undertaken by Hegarty, McKibbin, et al. (2020). While time constraints for healthcare providers to address domestic violence in their day to day practice, as well as attend to education were presented in this study, and are highly cited barriers (Hegarty, McKibbin, et al., 2020; Hegarty, Spangaro, et al., 2020; O'Doherty et al., 2015; O'Reilly & Peters, 2018), this conundrum continues to persist.

A lack of organizational domestic violence screening protocols and policies was another key barrier to domestic violence screening and intervention evident within the exosystem. Participants in this study acknowledged that domestic violence screening is not often at the forefront of their minds during patient consultations. This may be partially incited by the healthcare providers' perception that someone else in the woman's health service providers will undertake the domestic violence screening, removing it from their responsibility. This finding is not widely reported in the literature and warrants further research.

Suggestions by participants in this study to bring domestic violence screening to the forefront of their practice were for organizations to have workplace reminder systems and protocols in place specific to domestic violence screening. Hegarty, Spangaro, et al. (2020), also reported that healthcare providers wanted clear processes for screening women for domestic violence. Similar findings were concluded in a mixed method study with primary healthcare physicians in Hong Kong (Lam et al., 2020); and a questionnaire of Royal College of Physicians and Surgeons in Canada (Long et al., 2019). The perinatal period is an opportune time to screen for domestic violence due to this being a high contact period for women with their primary-based healthcare providers (Campo, 2015), therefore, more focus on supporting healthcare providers with tangible screening tools and protocols is recommended.

This study has brought to light revelations within the macrosystem of the way in which healthcare providers perceive culture and socioeconomic status to play a role in domestic violence screening needs of women in their care. A greater understanding of the cultural needs of perinatal women, specifically how to identify and intervene for domestic violence in a culturally appropriate way is needed by healthcare providers. Other literature cites the need for screening practices, tools and resources that are culturally sensitive (Hegarty, Spangaro, et al., 2020; Williams et al., 2021). Also raised in other literature is the difficulty for culturally diverse women to disclose domestic violence due to the negative stigma attached (West, 2016). This brings to attention the need for healthcare providers to be able to access appropriate education in domestic violence screening and intervention that include cultural and sociodemographic components.

Since this study was undertaken the world has experienced the Covid-19 pandemic which has had deleterious impact on women's and children exposure to, and safety around, domestic violence. This has coincided with community-based healthcare providers experiencing greater pressure on service provision, which may be a result of a reduction in women accessing specialist domestic violence services during times of lockdowns (Evans et al., 2020; Pfitzner et al., 2020), becoming more reliant on the services of primary-based healthcare providers. With changes to healthcare delivery also occurring in the Covid-19 imposed restrictions, and the likelihood that many of these changes will remain, it is even more pressing that healthcare providers are well versed and confident in identifying and reacting appropriately to domestic violence.

4.1 | Limitations

Limiting of the study site to Greater Western Sydney may be considered as a limitation for this study as the sociodemographic of this area is not represented across Australia. This was mitigated somewhat by the diversity in healthcare providers interviewed. Another potential limitation was the gender skew to female participants. Further research on a national level and a more balanced gender presentation of participants would be valuable.

4.2 | Recommendations for policy, practice and research

Revelations from this study and supporting research indicate that more proactive organizational policy and protocols for domestic violence screening are needed. Reminder systems and awareness of, and access to, screening processes and tools being implemented with the healthcare providers workplace are highly recommended.

Given the ever-increasing time demands on healthcare providers day to day practice, healthcare services must navigate this, giving time to the healthcare providers in their employ to develop knowledge and confidence in domestic violence screening and intervention. Consideration to a variety of educational modes and clear policy, protocols and processes for domestic violence screening in the workplace will support healthcare providers in developing the skill set required to screen for domestic violence and provide appropriate intervention. Importantly, domestic violence screening and intervention practices must be accessible, sustainable and evidence-based so as to ensure effectiveness across the variations of abuse type and different populations of women (Hegarty, Spangaro, et al., 2020).

As the state of world health fluctuates, and with many westernized countries being culturally and sociodemographically diverse, continuous research on best practice for community-based healthcare providers in culturally appropriate domestic violence screening and intervention is needed. Healthcare providers must be encouraged by their workplace to keep abreast of current evidence-based practice and these should be included in workplace policies, protocols and processes.

Finally, with the recommendation of promoting accessible education for busy healthcare providers, research on best designs and platforms to deliver such education is warranted.

5 | CONCLUSION

This study has presented the voices of healthcare providers who were current community-based practitioners at the time the study was undertaken. Considering the study findings in light of other research on barriers to domestic violence screening and intervention practices, a greater understanding of the need for supporting healthcare providers' education and confidence development in this area has been endorsed. Addressing the organizational barriers of time constraints for healthcare providers accessing ongoing education in this area, along with poorly applied or no application of policy, protocols and processes have been identified as priority areas to address. Acknowledging that it is difficult to address these issues, using sustainable models based on evidence-based research is highly recommended to ensure healthcare providers are well supported in identifying and supporting women experiencing domestic violence.

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