**Women Find Safety Planning More Useful Than Referrals in a Maternal And Child Health IPV Intervention**

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**Category:** Women’s health

**Study type:** Randomised controlled trial

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**Commentary  
*Implications for practice and research***

* This study raises critical points about establishing trust before screening and that women used safety plans more than referrals.
* Inclusion of women with intimate partner violence (IPV) in the intervention development phase and examining use of social supports and their influence on referral use are areas that could shed light on these findings.
* Incorporating a trauma-informed approach to IPV screening interventions that recognises trauma across the lifespan would be welcomed insight for future practice.
* The impact of the quality of provider-client relationship on screening and referral rates should be explored.
* Identifying how this intervention can be adjusted for geographical differences, such as urban versus rural areas1 and cultural variation should be investigated.

***Context***  
Interventions involving screening women for IPV are well documented. 2,3The United States Preventative Services Task Force recommends universal IPV screening and referral for women of childbearing age.4 With growing momentum for this policy, identifying best practices for healthcare providers is critical. Provider barriers to screening include discomfort, education needs, attitudes and time. Novel approaches such as self-report and the use of technology IPV5 have been introduced to address these barriers.

***Methods***This cluster randomised controlled trial tested the Improving Maternal and Child Health Care for Vulnerable Mothers (MOVE) nursing model of care. The aim of MOVE was to increase maternal child health (MCH) team screening rates, IPV disclosure, safety planning and referrals over 12 months and programme sustainability beyond 24 months. Mothers with babies ≤12 months attending community-based MCH centres in Australia were included. Researchers used a theory-informed participatory process to design the intervention. They hypothesised after 12 months, the intervention group (IG) would produce higher rates of screening, IPV disclosure, safety planning and referrals compared with the comparison group (CG) and sustained after 24 months. Eight MCH teams were allocated to the IG (4 teams and 80 nurses) and the CG (4 teams and 83 nurses) yielding *n* of 6381 consultations and 7638 respectively at 4 months. Women in the CG were screened at four weeks postpartum. Women in the IG used a self-complete health and wellbeing checklist at three or four months postpartum containing questions on general health and domestic violence. Nurses responded to women’s self-identified concerns about intimate relationship and violence first and assisted women with developing safety plans and referrals to community resources. Nurse mentors supported nurses with implementation and difficult consultations. Primary outcomes measured were rates of: 1) screening for domestic violence; 2) disclosure of domestic violence; 3) nurse safety plans; 4) referrals.

***Findings***A gradual increase in routine screening was achieved, reaching its highest point of 56% at week four but not exceeding 36% over a year-long rate. The MOVE IG screened at higher proportions than the CG and demonstrated a statistically significant increase in safety planning.

***Commentary***  
The study presents an alternative approach to IPV screening that addresses provider challenges such as discomfort and need for reinforcement training and support.6 Nurses in the IG initiated discussion about IPV in response to women’s self-disclosure on the check list, thereby reducing anticipation about how women might react to being screened. Nurse mentors provided reinforcement support activities that helped sustain the intervention demonstrating their value in offering on-going support to the MCH team. Involving nurse consultants during intervention development ensured that it complemented current practice. The higher dose of DV advocacy/liaison may have positively impacted the team’s confidence and uptake of referrals. Identifying the optimal dose needed to achieve this outcome and what facilitated nurse comfort with IPV screening was not discussed. Expanding on the role that reflective practice plays in improving implementation could help answer this question as would examining the impact of the quality of provider-client relationships. Given the trauma history of study participants, incorporating a trauma-informed approach to IPV screening interventions within the MOVE approach warrants investigation.

**Commentator details**

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**Competing interests**

None