



E-SCREENING TO CONNECT THE DOTS ON RISKS TO FAMILY WELLBEING: A LITERATURE REVIEW^{1,2}

Jamie Lee and Julian Flint
Relationships Australia, SA

Jennifer E. McIntosh
Deakin University, Family Transitions

Devices like computers, laptops, tablets and smartphones are in the offices of nearly all small and medium organisations (Office of the Chief Economist, 2016). People use these devices on a daily basis to handle personal and sensitive information. For example, in 2014, over 75% of Australian GPs used devices and technologies for things such as electronic patient notes or printing prescriptions (Henderson, Pollack, Gordon, & Miller, 2014). And unless they actively opt out by the end of 2018, the health records of every Australian will be digitised and available for all health professionals to see, not just a patient's usual GP or practice (Department of Health, 2017). In early pilot test sites, only about 1 in 50 chose to opt out, demonstrating that most Australians overwhelmingly accept the electronic storage and use of their personal, sensitive information.

However, practitioners in Australian family and relationships services (FARS) use devices less frequently and less widely than in medicine and general healthcare. Some examples exist showing how the sector has overcome the 'bumps in the road' and put new technologies into practice (Knight & Hunter, 2013). However, just 42% of FARS practitioners said in a recent survey that they used digital technology every day to share information with clients or colleagues (Smart, 2017). This means that the FARS sector may be missing an opportunity through technology to make information capture and sharing more efficient. This is important because using a common framework for intake and assessment was recommended both in a recent review commissioned by Family and Relationship Services Australia (Toumbourou et al., 2017) and in its recent government submission (Family Relationship Services Australia, 2017). Technology could have a role in enabling a common framework because it significantly enhances the capture, storage, and sharing of information. Greater efficiency in these areas will help otherwise 'siloes' services coordinate their efforts and provide earlier and more effective responses to families (Family Relationship Services Australia, 2010; Toumbourou et al., 2017).

This article asks key questions about adopting devices and technologies in the FARS sector. It reviews sector-relevant research into devices and new technologies, filling in gaps with learnings from related fields as necessary. It shows how a new app, the Family DOORS app, could potentially provide the known benefits of the DOORS framework (McIntosh & Ralfs, 2012a) with new efficiencies of information collection,

storage and sharing. The DOORS provides a holistic approach to screening, elaborating and assessing risks in families using FARS services. The Family DOORS app provides an electronic alternative to doing paper-based screening on forms like DOOR 1 (McIntosh, 2011), meaning clients can complete screening on iPads, tablets or laptops – or even on the smartphones they typically have in their pockets. Once completed, the e-screening then becomes a secure pdf for practitioners to review, respond to, store, and share as needed.

So, can devices and new technologies bring greater ‘digital maturity’ (Office of the Chief Economist, 2016) to assist the sector to connect the dots with families? Specifically, could e-screening with the Family DOORS help FARS practitioners connect the dots of family wellbeing?

Are devices and technology generally available and acceptable?

The first question to answer is about the general availability of devices and their acceptability in Australia. Surveys show that devices and technology already exist in offices across Australia, with 98% of the small and medium enterprises – where most FARS practitioners work – having internet-connected devices (Office of the Chief Economist, 2016). Furthermore, there are likely to be mobile devices in the pockets and bags of most clients in the waiting rooms. In 2014, 74% of Australians had a smartphone and 68% had used three or more devices in the previous six months, suggesting that many people use devices both at and outside work (Australian Communications and Media Authority, 2015). These devices are therefore widely available. It seems also broadly acceptable to use devices for personal and sensitive matters. For example, 75% of banking interactions in Australia in 2014 were online or through a smartphone, with fewer than 10% being face-to-face in a branch (Bain and Company, 2014). This shows that clients readily share the same sensitive information by devices that they previously did face-to-face. And in terms of acceptability for the DOORS app, information provided by clients would be the same as that provided on the paper versions of DOORS.

People are also frequently relaxed about sharing personal information – even if it’s on unknown or unclear terms or outside of trusted organisations like GPs or banks. A large-scale survey of internet users globally revealed 84% *don’t always* read privacy policies before sharing personal information and 12% say they *never* read them (The Internet Society, 2014). This trend seems unlikely to change given that policies continue to be lengthy and acceptance is a necessary pre-condition of us. (For example, if you are reading this article with Google Chrome, then you clicked ‘Accept’ to confirm that you really read and understood the 6,552 word ‘Terms of Use’.)

FARS clients will already have acknowledged the policies about privacy and confidentiality when first engaging with services, as required by Australian Privacy Principles. These same privacy and confidentiality principles cover sensitive information collected by paper or electronically through the DOORS (or similar tools). Clients are highly likely to see FARS services as trustworthy anyway, as was shown in a 2016 anonymous survey of 973 clients at Relationships Australia SA which found over 89.1% of clients agreed with the statement that, ‘Overall I trust the way Relationships Australia SA handles my private information’. It’s likely that using devices for electronic collection of sensitive information will be as acceptable as pen-and-paper collection. Certainly the high acceptability of asking the DOORS screening questions has been confirmed by anonymous surveys of ‘just screened’ clients (Lee & Ralfs, 2015) and tracking client satisfaction surveys over time after the launch of the paper DOORS (McIntosh, Lee, & Ralfs, 2016).

Do practitioners see devices as acceptable tools for their work?

Turning to practitioner attitudes to devices and acceptability, Zwaanswijk, Verheij, Wiesman, and Friele (2011) found that health professionals used similar deliberative processes as their clients and patients before using devices in practice. Specifically, GPs consciously traded off benefits and risks of devices such as privacy and security versus convenience and efficiency (Zwaanswijk et al., 2011). Health professionals do this knowing that the dynamics of doctor–patient consultations have significantly changed since computers were introduced into consulting rooms many years ago (Frankel et al., 2005). A large systematic review showed health practitioners are concerned that using electronic records will interrupt the flow of conversation while they read electronic notes (Alkureishi et al., 2016); intriguingly, though, patients

overall either didn't notice or didn't care because satisfaction, communications and relationships were unchanged or – if anything – slightly better after using electronic notes. From the other side of the computer screen, patients also confirmed that practitioners' skills improved over time when using electronic health notes (Rose, Richter, & Kapustin, 2014). In fact, using notes fluently in sessions without losing rapport was a teachable skill, according to Lanier, Dominicé Dao, Hudelson, Cerutti, and Junod Perron (2017), meaning that if practitioners' concerns are a barrier then it can be addressed. A rigorous change management perspective is helpful to address other barriers to adoption, according to Boonstra and Broekhuis (2010). And it's not just an attitude of acceptability: a 2013–14 survey of Canadian GPs found 97.5% were using computers and 65.7% were using them for electronic records (Anisimowicz et al., 2017).

In the parenting and child and adolescent mental health settings, online delivery of manualised parenting programs helps families by improving parent competencies (Nieuwboer, Fukkink, & Hermanns, 2013) and reducing child problem behaviours (Kirkman, Hawes, & Dadds, 2016b). Clients doing therapy online benefit similarly to those doing face-to-face sessions, based on systematic reviews of adult, child, and adolescent Cognitive-Behavioural Therapy programs (Andersson, Cuijpers, Carlbring, Riper, & Hedman, 2014; Vigerland et al., 2016). These reviews also confirmed that therapists had significant savings in time and administrative burden by online delivery, showing that online programs are helpful adjuncts to conventional therapy. Elsewhere, Kirkman, Hawes, and Dadds (2016a) compared online delivery of a standardised parent training to conventional face-to-face delivery. Even though practitioners thought their therapeutic alliance was stronger in the face-to-face format, clients rated the alliance in the two formats as equally strong. And while practitioners also thought they were more effective at face-to-face therapy, the outcomes for parents and their children were similar across formats (Kirkman et al., 2016b). Andrews (2014) and Orman et al. (2014) have both described Australia as a 'world leader' in developing and using CBT online, with devices extending the reach of mental health programs outside of a traditional setting, but also enhancing their outcomes. Devices are also cost-effective and may be cheaper as an additional option for mental health care (Musiat & Tarrier, 2014).

With support and reassurance, practitioners seem to accept devices and technology. What do these findings mean for the Family DOORS app? It's highly likely that FARS practitioners who are potential Family DOORS app users will already

have the necessary infrastructure for doing online DOORS administration – otherwise it's highly unlikely they wouldn't be interested or even able to sign into the app. But even for those FARS practitioners who don't have devices or don't wish to use their own devices, there is another option. The Family DOORS app can send a one-time code to clients so they can securely complete the client self-report DOOR 1 part of DOORS on their own device in the waiting room before the practitioner then securely accesses a back-end practitioner-only DOOR 2 report.

Are devices as good as paper-based screening and assessment?

The previous section suggested that in addition to benefits of cost and reach, the 'treatment' component of mental health delivery could be on par with its face-to-face equivalent. These studies of treatment outcomes presume that clients have fully engaged with the device and completed the online service. In other words, the clients in these analyses may be more accepting of devices and technology otherwise they would not have completed the treatment 'per protocol'. This raises the question about the experience of first session clients at the intake, screening, or initial assessment phase.

This question can be answered by studies comparing devices and technology versus paper forms head-to-head for initial clients. A systematic review did this for key adult standardised mental health questionnaires and found mostly no difference and 'adequate' psychometric properties (Wouter van, Riper, Cuijpers, Patricia van, & Smit, 2016). However, there were a few exceptions to the trend such as Patalay, Hayes, Deighton, and Wolpert (2016) finding differences between matched pairs of young people who had either completed paper or online versions of the Strengths and Difficulties Questionnaire (Goodman, 1997). The differences found by Patalay et al. (2016) were attributed to the 'online disinhibition effect' (Suler, 2004), namely that young people were more likely to reveal sensitive or risky information with the anonymity of electronic forms. However, young people reported some risks less often electronically and both formats were anonymous, so this explanation probably is not definitive, and Patalay et al. (2016) concluded that more research would be needed to decipher why.

Another systematic review, by Rutherford et al. (2016), compared studies of preferences for either paper or computer formats in randomised trials. They found no overwhelming preference for one format over the other across the studies, and in

fact there was no clear and consistent trend in preference. This suggests the value in keeping both modes of administration open for clients. A systematic review of self-reported client or patient outcomes showed it didn't matter whether health care patients use paper forms or computer interfaces when they disclose psychological wellbeing or rate their quality of life (Rutherford et al., 2016). The authors concluded that validated paper-based measures could be transferred if wording, format and response options can be as similar as possible. This is important because Marcano-Belisario et al. (2017) found that people navigated and completed mental health screening differently depending on the layout of web forms. Another large trial randomised pregnant women to computer-based or paper-based mental health screening questions (Kingston et al., 2017). No significant difference was found in the levels of mental health risks disclosed, meaning each format was equally sensitive. They also found that women who used computers were more satisfied by their experience and saw more benefit to computer screening generally. In other words, it seems the experience of doing e-screening creates subsequent e-screening converts. This is important when clients are re-screened, as will happen for women being screened for post-natal mental health risks. This finding is consistent with the previous section summarising doctor and patient feedback of adopting electronic health records: things get better with practice and experience.

So overall, people will probably be typically as honest and comfortable with electronic versions of forms as they are with paper versions. The studies named above broadly suggest that devices are as good as paper-based formats for screening and assessment for new clients at intake, possibly even getting better with time as familiarity increases. A survey of 247 'just screened' clients at Relationships Australia SA in 2016 echoes this, finding that only 14.2% disagreed with the statement 'I'd be ok completing DOOR 1 at this office with an iPad or tablet in a private room'. And in early testing of the Family DOORS app prototype, only one person (from the first 30 offered the choice) insisted on a paper version instead of the Family DOORS app. This suggests electronic screening could be unacceptable to around 1 in 7 clients, so keeping a paper copy of screening tools will still occasionally be needed as an alternative. The design brief for the Family DOORS app has followed the paper-based formatting and layout as closely as possible to minimise any error being introduced.

Are there situations where devices are better than paper versions? Or worse?

Some studies suggest there may even be advantages to using devices over paper. Better visual aids made computer-based multimedia formats easier to use than paper-based formats in a test of the Taipei II child development screening tool by Cheng et al. (2017). They found only 0.8% of clients preferred the paper-based format (Cheng et al., 2016) and only 2% of professionals preferred paper-based (Cheng et al., 2017). Given the good psychometrics and comparability of these two different formats, the authors recommended using the new computer-based format.

Wood, Nosko, Desmarais, Ross, and Irvine (2006) found that people using online formats disclosed more differences in sexuality when compared to people using paper versions. They paradoxically found people skipped more questions, giving more 'missing data', when they had a well-intentioned research administrator available to help them. Also Wood et al. (2006) suggested that online was more enjoyable than paper and was less fatiguing to complete. Women screened for Domestic Violence (DV) preferred computer-based screening over paper-based or face-to-face questions, adding they would be comfortable answering these sensitive questions honestly on computer (Renker & Tonkin, 2007). Elsewhere, Renker and Tonkin (2006) found 97% of women screened for DV said they were not embarrassed, angry, or offended by the experience. Nevertheless, they found lower disclosures of DV due to fears of being reported to statutory authorities, with higher disclosures found after women were reassured that this would not happen. This reassurance about non-reporting may not always be the case in all jurisdictions or organisations and it reminds practitioners and researchers to keep the client and the therapeutic frame in mind, not just the questions or the format of the device. It also reminds us that screening should not be totalised as 'the truth' and the only way clinicians can detect violence – practitioner elaboration and practice wisdom will always have a role in keeping families safe (McIntosh & Ralfs, 2012b).

In a young people's mental health setting, a systematic review supported the framework of doing a 'holistic self-complete screen then elaborate by practitioner', though there was no clear preference for paper or computer formats (Bradford & Rickwood, 2012). In a large qualitative study, most young people aged 15–29 said they would prefer using devices to open up about sensitive topics compared to face-to-face questions (Bradford & Rickwood, 2015). But, again,

not all young people expressed this preference for devices, citing worries about non-verbal cues, therefore flexibility and responsiveness are helpful to increase disclosure rates.

Finally, the 'Gottman method' of relationship counselling is built on highly detailed and structured assessments completed by clients at intake, which then enable practitioners to plan their interventions (Gottman & Gottman, 2015). Online versions are now available and have been described as 'The future of assessments' and 'Relationship assessment made simple' (<https://checkup.gottman.com>), naming the benefits of efficiency from automatic scoring and faster turnaround in intervention planning. If practitioners can send online assessments to couples to complete at home online on their own devices before their appointments then this is said to have equivalent psychometrics compared to paper-based assessments (www.johngottman.net).

While there are many situations where devices may be better, there are some situations where devices and technology are unhelpful, misleading, or even unethical. Many mental health apps are available to download at low or no cost from online sources, but – worryingly – few appear to take seriously their duty of care (BinDhim et al., 2016). Specifically, BinDhim et al. (2016) found few apps made robust, appropriate recommendation to 'seek further assistance' for any significant risks. This contrasts with the hype of many of the apps available, some of which offer for example, 'a fast and efficient remedy from emotional stress' or '... fast and simple method to be liberated from ... Post Traumatic Stress Disorder' (based on an iTunes store search in September 2017).

By contrast, we know that clients readily disclose family safety and wellbeing risks on paper forms during universal risk screening with the DOORS, with these disclosures linking strongly to subsequent practitioner actions, such as planning their response or intervention (McIntosh, Wells, & Lee, 2016). Practitioners are under pressure to respond to these risks quickly and efficiently, so they are likely to appreciate the app's freedom from 'data entry' or physical handling of paper such as scanning and uploading of forms. This provides potential cost savings to FARS practitioners and organisations. For these reasons, we believe practitioners will see the benefits of technology like the Family DOORS app on devices in their practice. As an aside, there would have been immense savings from doing 12,000 paper versions of DOOR 1 over four years (at the time of writing) at Relationships Australia SA.

Conclusion: devices and technology usable in the family and relationships sector

The family and relationships sector in Australia has already seen attempts to use devices and new technology to enhance, extend, or replace interactions with clients (Knight & Hunter, 2013; Robinson, 2009). Yet Smart (2017) has shown that overall, our sector uses technology far less frequently and widely than in medicine and general health care, where electronic capture, storage and sharing of information is commonplace and well evaluated (Ross, Stevenson, Lau, & Murray, 2016). This is a lost opportunity. The research reviewed in this article suggests that devices are widely available, acceptable, and offer at least equivalent clinical utility for our sector. Additionally, new technologies have potential benefits for practitioners from efficiencies and may be preferred by many clients for disclosing risks.

Our sector peak body, Family and Relationships Services Australia, has concluded we need a common framework for screening for complex multiple risks (Toumbourou et al., 2017) and has begun lobbying for this to happen (Family Relationship Services Australia, 2017). Elsewhere, we have a framework calling for all of us to notice and respond to the effects of gender inequality during key transitions such as separation and divorce (Our Watch, 2015). We know that effective coordinated screening across multiple risks is more effective in health care than single issue screens (Hale, Fitzgerald-Yau, & Viner, 2014) and that screening for risks makes a difference to practitioner decisions in health (Webb, Kauer, Ozer, Haller, & Sanci, 2016).

We conclude that the Family DOORS app could provide an acceptable and useful innovation which can help our sector with a common tool to notice and respond to risks of people using FARS services. It is based on the DOORS framework, a holistic approach to detecting, responding and assessing a range of victimisation and perpetration risks across the family (McIntosh & Ralfs, 2012a). Successful launches of e-health innovations have addressed the key issues of adaptability, complexity, and cost, according to a systematic review of implementation evaluations (Ross et al., 2016). We believe that the Family DOORS app should meet these needs. Specifically, if adaptability is 'the ability of the technology to be adapted to fit local contexts' (p. 145) then Family DOORS offers adaptability because it has been tested across browsers (Google Chrome, Internet Explorer, and Apple Safari); smartphone and tablet operating systems (Windows Mobile, iOS, and Android); and devices (Windows desktops and Surfaces, and Apple devices). If complexity refers to the overall

'demandingness' for clients, practitioners, and back office staff to learn how to use an innovation, then the Family DOORS app is only as complex as existing electronic client diary or management systems, or even Microsoft Outlook. Because the app uses already-installed internet browsers, users will have an easier learning curve because they are already familiar with many features. For example, printing from the app is via the browser's drop-down menus and the browser's 'padlock' will show that the connection to the DOORS App Server is via secure 256 bit SSL encryption. And in terms of cost, the Family DOORS is available at very low or no cost using existing 'IT infrastructure' through already-installed internet browsers. Because the Family DOORS app is not network-heavy, it will not require acquisition of an especially fast internet and can run on 3G wireless speed.

In this way, we hope the Family DOORS app can have a role in detecting and responding to the multiple risks that many – but not all – FARS clients may face. The app may also have a role in coordinating and organising our responses to clients.

Endnotes

- ¹ This article provides background information to the Family DOORS app and complements a presentation at the FRSA 2017 Conference on *Connecting the dots*. The article reviews literature and research on e-screening and shows its relevance to the app. The actual presentation contains more description of the app itself and a live demonstration.
- ² We are grateful to the input and suggestions from two anonymous peer reviewers coordinated by Dr Adam Heaton, Senior Policy Officer at FRSA.

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