

Evaluation of a domestic violence screening program in an Australian abortion service

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Introduction

1 in 3 women experience domestic violence (DV) globally with a lifetime prevalence of 23% in high-income countries such as Australia.¹ It is a serious preventable health problem and the leading contributor to death, disability and illness in Australian women of reproductive age.² As DV is under-identified by health workers and under-documented in medical records, routine screening is recommended as the best approach.³ Despite this information and the recent rise in national awareness, only NT and NSW have implemented routine DV screening programs of women in healthcare contexts.⁴

Pregnancy has been identified as both a potential protective factor and risk factor for DV is also an important time to screen as:

- 76% of women were pregnant at the time of the violence and 38% reported that violence occurred for the first time during the pregnancy.⁵
- DV is thought to be about 6 times higher for Indigenous women.⁶
- DV during pregnancy increases rates of miscarriage, stillbirth, premature birth, termination of pregnancy and postnatal depression.⁷
- DV often begins or escalates during pregnancy and pregnancy can result from reproductive coercion when DV is already occurring.⁸
- Unplanned pregnancy is more common amongst women experiencing DV and these women are twice as likely to have terminations.¹

A 2009 UK study of anonymously surveyed women found those requesting a termination were six times as likely to suffer physical abuse in the current relationship (5.8% versus 0.9%); and five times as likely to suffer emotional abuse (9.9% versus 1.8%) than those attending antenatal clinics. Of the 274 women requesting a termination, only ten mentioned DV as a contributing factor.⁹ While it is important to consider DV in women seeking terminations, there is clear evidence that women are unlikely to disclose their experience of domestic violence unless the health worker directly asks them about it.¹⁰ Routine screening provides opportunities to engage with and open conversation, about these issues.⁴

The American College of Obstetrics & Gynecology has recommended that all pregnant women be screened for DV since 2012, based on evidence that intervention has a positive effect on reducing exposure to DV and reduction in reproductive coercion.⁹ Although there is no consensus on the best screening methods, direct questioning in private is generally considered acceptable by women and has been introduced in the UK, USA, NT and NSW.¹¹ In addition to identifying victims, screening can increase responsiveness to DV by heightening alertness to DV, enhancing the understanding of links between DV and specific health problems, increasing capacity to make appropriate referrals and providing more comprehensive care.⁴

Background

The current South Australian Perinatal Practice Guidelines instructs clinicians to:

*‘Assess the woman on her own at some point in the consultation to establish that her request for a termination of pregnancy is not made under coercion especially by someone accompanying her’.*¹²

In practice this is not always followed, as a woman’s partner is frequently present throughout the consultation.

The Pregnancy Advisory Service (PAS) at Flinders Medical Centre (FMC) decided to implement a DV screening program following a review of their current practices against the evidence based audit guidelines published by the UK RCOG. That audit of the service found that although there was a very high standard of care provided, vulnerable women were not being identified or assisted. Thus the PAS DV screening program was established in May 2016 with the following components:

- Posters on the wall in every consultation room indicating that clinicians are open to DV disclosure.
- Small DV resource cards placed in the pre-appointment information pack.
- Seeing each woman on her own, to provide a safe disclosure environment.
- Further discussion of DV with women who seem unsure about responses to DV screening questions and/or where clinician suspects there may be DV experience.
- Where risk is identified, the clinician is to complete the DV risk assessment tool.
- When a risk assessment is completed, the clinician will notify the social worker to follow up.

Aim

This was a retrospective study, to evaluate the first 3 months of the DV screening program, establish a baseline and structure for future review and to provide feedback for initial quality improvement.

Methods

There is no agreed gold standard for DV screening and while now included in both USA and UK guidelines, neither SA Health nor the national RANZCOG provide any explicit guidelines in this area, despite the Australian government’s National Evidence-Based Antenatal Care Guidelines citing Grade B evidence for screening.¹¹ The NSW Health Domestic Violence Policy and Procedures was selected as our best practice standard as it has been in place for 13 years, has a good evidence base and has published annual reviews since inception.

Their published audits include the following data:

- Number of women attending the service
- Number of women screened
- Responses to the questions
- Key actions taken, including reports and referrals

A number of practical considerations limited data collection methods including significant staff leave periods, limited capacity and lack of data collection practices already in place. For the purposes of this audit, data was gathered via survey of PAS doctors and nurses and from clinic attendance records. Social work advised that they do not currently compile relevant records. The questions related to the first 3 months of the intervention, immediately prior to data collection.

Results

We found that 78% of women attending the service were screened for DV and 2% of women attending PAS reported they were affected by DV. This compares reasonably well (Figure 1) with the statistics from NSW DV screening in maternity contexts, where 88% of women were screened and 4% of women reported being affected by DV.¹³

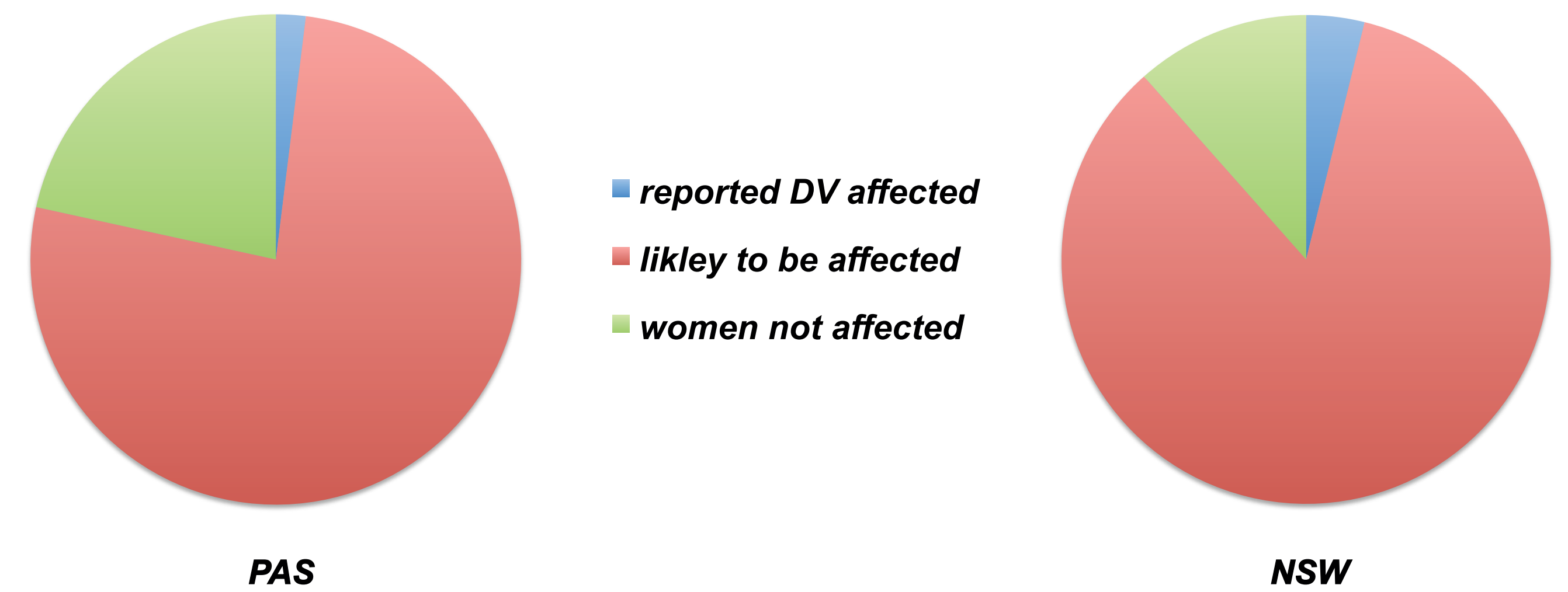


Figure 1: PAS and NSW DV screening

However, if we compare the number of women identified by screening and the likely number of unidentified women in the screened population we can see that we are likely to be under-identifying a significant population, shown in Figure 2.

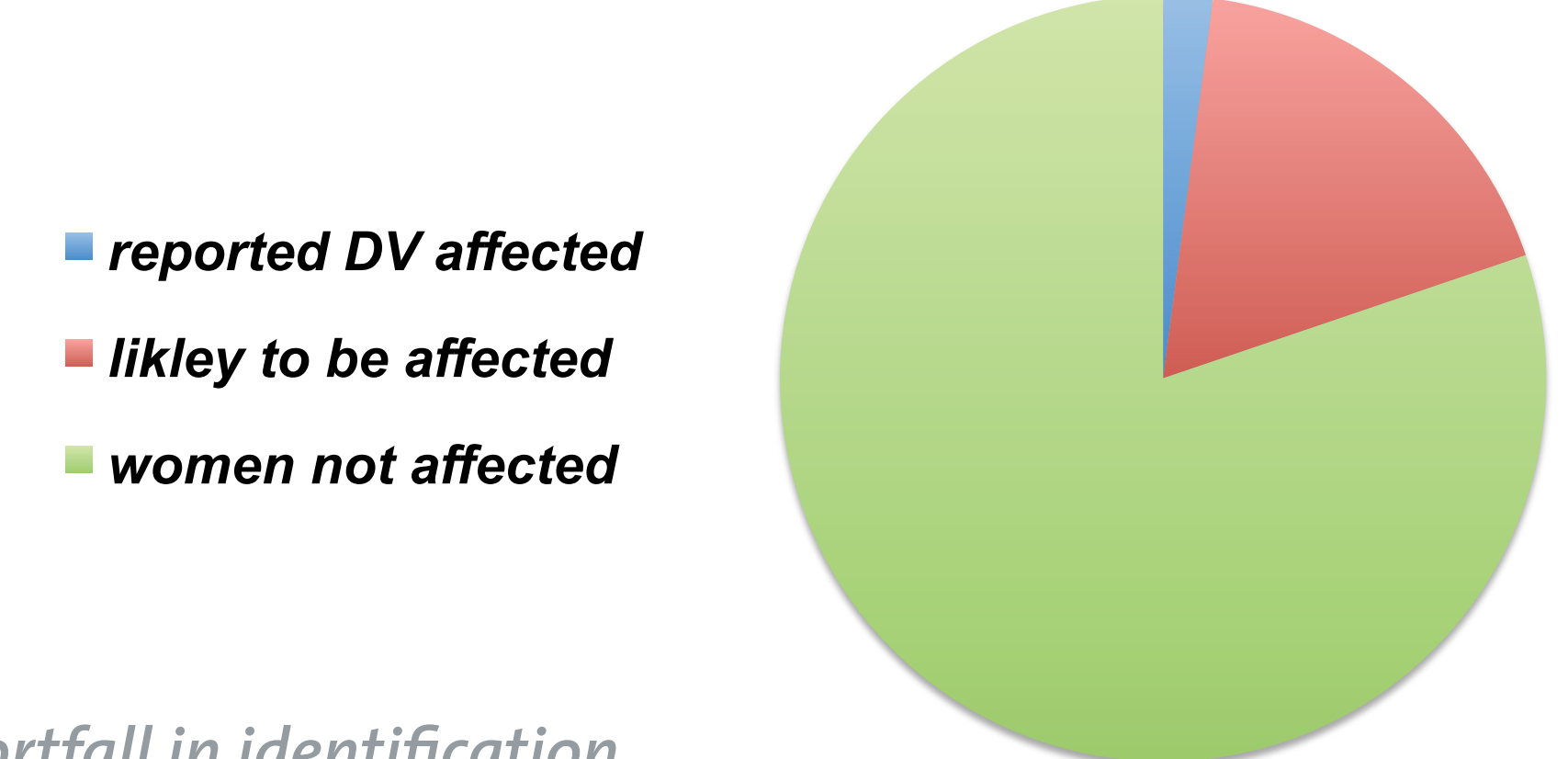


Figure 2: PAS DV screening likely shortfall in identification

Discussion

While the screening rate and reported incidence were similar in PAS and NSW data, 66% of PAS women who reported DV accepted referral compared to 28% of women at NSW services. In NSW, support and options were discussed with further 3% of women, while 25 mandatory reports and 21 police notifications were made. This shows that while the PAS is likely under-identifying the number of vulnerable women, the women who have been identified appear to be more willing to accept support than in NSW. As this data was based on clinicians’ recollections, there is a need to record the data to ensure reliability.

While the process between SW & PAS was outlined before implementation, communications with SW staff revealed that there is currently poor coordination and no record keeping in place. Worrying, no DV risk assessments were recorded despite this being a part of the program. During interviews it was apparent that staff are somewhat confused about the process of reporting and risk assessment.

Recommendations

Overall, the DV screening program is an important step forward in recognizing and responding to this serious and preventable health issue. This audit found that there is some room for improvement in the PAS DV screening and recommends the following steps:

- Conduct DV training for all staff.
- Clarify processes for responding to positive screening answers.
- Implement a clear data recording process and review statistics annually.
- Extend screening to all obstetrics clinics at FMC.
- Compare anonymous self-reported incidence with DV screening data.

Conclusion

DV is a complex but important issue that has been long overlooked and often ignored in women’s healthcare, despite presenting a significant burden of disease in women of reproductive age. Identifying vulnerable women can improve health outcomes for women and their children in both the short and long term. Screening can also help to improve awareness and reduce tolerance of DV in both clinicians and patients.

A 2014 Cochrane review found that while evidence to support the use of routine screening to improve outcomes for women is limited and difficult to determine, this is largely because the studies have not yet been done.¹⁴ There is evidence however that screening results in more victims being identified for example in NSW, where introduction of screening resulted in a substantial increase in disclosures and women agreeing to assistance.⁴

The DV screening program implemented at PAS is an important step towards addressing this health issue, however we need to provide training and support for staff and ensure adequate data collection. Once we have refined this program, it can then be extended into the rest of FMC’s obstetrics services to provide comprehensive care for as many women as possible.

References

1. WHO 2013, *Global and regional estimates of violence against women*, Geneva.
2. VicHealth 2004, *The health costs of violence: measuring the burden of disease caused by intimate partner violence*, Melbourne.
3. NSW Health 2006, *Domestic Violence - Identifying and Responding*, North Sydney.
4. Australian Institute of Health and Welfare (AIHW) 2015, *Screening for domestic violence during pregnancy*, cat. no. PER 71, Canberra.
5. Australian Bureau of Statistics (ABS) 2013, *Personal Safety Survey*, cat. no. 4906.0, Canberra.
6. Brown SJ, Weetra D, et al 2015, *Improving Aboriginal women’s experiences of antenatal care: findings from the Aboriginal Families Study in South Australia*, Birth 42:27–37.
7. Taft A, Watson L & Lee C 2004, *Violence against young Australian women and association with reproductive events: a cross-sectional analysis of a national population sample*, Australian and New Zealand Journal of Public Health 28:324–9.
8. Weil, A 2016, *Intimate partner violence: diagnosis and screening*, UpToDate.
9. Feder G, Ramsay J, et al, 2009, *How far does screening women for domestic (partner) violence in different health-care settings meet criteria for a screening programme?*, Health Technology Assessment, 13(16).
10. Power, C, Bahnisch L, McCarthy D 2011, *Social work in the emergency department – Implementation of a domestic and family violence screening program*, Australian Social Work, 64(4):537–554.
11. Australian Health Ministers’ Advisory Council (AHMAC) 2012, *Clinical Practice Guidelines: Antenatal Care – Module 1*, Canberra.
12. SA Health 2014, *Clinical Guideline, South Australian Perinatal Practice Guidelines - First trimester medical and surgical termination of pregnancy*, Adelaide.
13. NSW Health 2014, *Domestic Violence Routine Screening*, Snapshot 12, North Sydney.
14. Jahanfar S, Howard LM & Medley N 2014, *Interventions for preventing or reducing domestic violence against pregnant women*, Cochrane Database of Systematic Reviews.