Interventions for intimate partner abuse in antenatal and primary care in Victoria

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Overview of studies

Completed- Background

- Partner abuse study of prevalence
- Women’s Emotional Abuse (WEB) study
- ANEW way of Supporting Women in Pregnancy project

Current

- Diamond study - Longitudinal study
- MOSAIC study
- WEAVE study
Domestic Violence or Partner Abuse

Type of Abuse

- Physical
  - Person
  - Property
- Emotional
- Sexual
- Verbal
- Economic
- Social
- Harrassment
Survivor 1

“At the time I felt that it was not really abuse but the longer I thought about it the more that I felt it was abuse. Emotional abuse is more severe than physical abuse as there is no outward marks or bruises. When this was realized by myself I got out. Living alone is far better than what was happening in the relationship”
Lifetime & 12 month prevalence

ED AN COM GP

Lifetime 12 month

0 10 20 30 40 50

20

12

10

8

6

4

2

0
Composite Abuse Scale

- **Severe Combined Abuse (8 items)** e.g. locked in bedroom, kept from medical care, used a knife or gun, raped, not allowed to work
- **Emotional Abuse (11 items)** e.g. told ugly, crazy, kept from family, blamed for violence, upset if housework not done
- **Physical Abuse (7 items)** e.g. pushed, kicked, slapped, beaten up
- **Harassment (4 items)** e.g. followed, harassed at work, hung around
- Reliability >0.85 for each subscale
How common is partner abuse in general practice? (N=1836)

- Severe Combined Abuse: 4.4%
- Physical & Emotional Abuse/Harassment: 4.9%
- Physical Abuse alone: 5%
- Emotional Abuse/Harassment alone: 5.3%
Women’s Emotional Well Being Study (WEB)

Kelsey Hegarty, Jane Gunn,
Department of General Practice,
University of Melbourne
Rhonda Small, Angela Taft,
Centre for the Study of Mothers’ and Children’s Health, Latrobe University
WEB Depression and partner abuse

(Hegarty, BMJ 2003) (N=1218)

Percentage of women

Depressed Not depressed

OR 5.8
OR 7.9

24.6 16.4 4 8.1 5.4 3.6 2.2 6.2

SCA PA&EA PA EA

0 20 40 60 80 100

WEB Depression and partner abuse

(Hegarty, BMJ 2003) (N=1218)
Lifetime Depression & Ever abused (N=1257)

Percentage of women

Depressed: 64.7%
Not depressed: 31.5%
Abused (N=163) and Non Abused (n=779) Women’s report of symptoms last 4 weeks

O.R. 5.0 (3.1-8.0)

OR 2.8 (2.0-4.0)
Socio-demographic features of Abused (163, 17.3%) & Non Abused Women (N=972)
Survivor 2

“I used to go, telling them that I cannot sleep. What I’m hoping is they are asking me what is wrong. I think I’m scared to tell them sometimes. I don’t say it’s hurting here, they don’t ask, how the hurt came. And I think that was because of the fear of being denied that it’s happened.”
Factors facilitating women disclosing

- That the doctor listens
- That the doctor is sympathetic
- Perception that the doctor would help them
- That the doctor would not tell anyone
- Allowing time
- Asking her (Hegarty, 2002)
Influence GP inquiry on disclosure rate

- Women are 2.5 times more likely to disclose if GP inquires
Who should you ask? The Great Evidence Divide

Screening
Consistent use of a validated set of short questions to detect partner violence in all of an asymptomatic population

Case finding:
Using the opportunity of the clinical encounter to check for partner violence and associated health problems in symptomatic people
Why formal psychosocial risk assessment?

- Current levels of disclosure are low
- Cues are often missed
- Providers of maternity care are concerned that they lack the skills to respond if psychosocial problems become apparent
  - SO
- Should ‘risk assessment’ be a routine part of antenatal care? Should there be screening?
Systematic Reviews - Screening

- Increases in identification (3-14%) from low baseline levels (0-3%)
- Methodological weaknesses common
- Training does not increase screening rates
- Health professionals less likely to ask without a protocol
- Overall, no evidence that screening is effective

UK (Ramsey, 2002 - 9 studies included)
USA (Nguyen, 2004; Nelson, 2004);
Screening for risk of child abuse
(Lumley)

- 13-item checklist developed for use by Health Visitors (UK)

- *Its use in a population of 10,000 families would yield 1228 ‘high risk’ of whom 1195 would be false alarms: 35 of every 36 identified by the check-list.*
ANEW - A new approach?

Responsive care providers who are aware of psychosocial risk will be able to identify and explore concerns in a more appropriate way than a check-list approach. and will be able to negotiate appropriate management plans with the woman.....
Aims

- To develop, implement and evaluate a universal intervention that might improve the detection and management of psychosocial issues in pregnant women

Listening

"It is as though he listened and such listening as his enfolds us in a silence in which at last we begin to hear what we are meant to be"

Lao-Tze
Survivor 3

“I just wanted the doctor to take some time and listen to me. I was scared he wouldn’t believe me and would be angry with me.”
ANEW intervention

- Multifaceted, responsive intervention that addresses contextual issues
  - Strong management support
  - Organisational change
  - Evidence about common issues
  - Communication skills training - 16 hours
  - Peer support
  - Debriefing / ‘supervision’
ANEW Evaluation (Birth, 2006&7)

- **Before ANEW**
  - survey at 30 weeks of 584 women (response rate 76.1%)
  - survey of participating health professionals

- **Workshops/Small Group meetings**

- **After ANEW**
  - survey at 30 weeks of 481 women (response rate 72.7%)
  - survey of 24 health professionals (response rate 89%)
Life events in past year

- Finances: Pre ANEW 57.9, Post ANEW 54
- Move/ren.: Pre ANEW 50.6, Post ANEW 47.8
- Rel. change: Pre ANEW 17.9, Post ANEW 16
- Infertility: Pre ANEW 13.2, Post ANEW 14.1
- Death: Pre ANEW 9.2, Post ANEW 10.5
Women who felt health professionals really listened to them

<table>
<thead>
<tr>
<th></th>
<th>Pre-ANEW</th>
<th>Post ANEW</th>
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<tbody>
<tr>
<td>Midwives</td>
<td>66.0</td>
<td>66.9</td>
</tr>
<tr>
<td>Hospital doctors</td>
<td>41.2</td>
<td>40.5</td>
</tr>
<tr>
<td>Shared care GPs</td>
<td>77.5</td>
<td>80.0</td>
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Health professional asked questions that helped them to talk about emotional and social problems...
Women felt comfortable talking about feeling low or depressed.
Health professional comments

I thought I was competent at my job and thought ANEW would be "preaching to the converted" but I really learned a lot about REALLY LISTENING!"

“I have taken more time with interviews asked the women what they wanted to know. Asked the women if it was OK for me to follow some of my agenda but only after theirs had been met."

“Well run, quite confronting but in a supportive environment. I do much better first visit with patients— they actually talk to me now. ANEW is one of my best experiences in fifteen years of being a midwife. Thank you”
Health Professionals comfort asking about DV (n=24)
Satisfaction in asking directly about sensitive issues

Very satisfied: 8.3, 17.4
Moderately satisfied: 60.9
Unsure: 17.4
Moderately dissatisfied: 16.7
Very dissatisfied: 0

Pre vs. Post
ANEW findings
(Gunn, 2005, Hegarty, 2007)

- Successfully implemented - strong organisation support
- Rated very highly by the participants and changes on self-reported behaviour
- Some improvement in women’s evaluation of health professionals
- Train the trainer
- Rolled out across 4 other hospitals
- Adapted for Postnatal PINC La Trobe
What interventions are effective for women once they have disclosed in health care settings?

- **systematic review of 19 studies**
  - 8 advocacy (3 trials, 2 parallel groups, 3 B&A)
  - 1 support group (B&A)
  - 10 psychol. (4 RCT, 5 parallel groups, 1 B&A)
- **north American studies**
- **quality varied & outcomes not comparable**
  (Ramsay, 2007)
What interventions are effective for women once they have disclosed in health care settings?

- sufficient evidence that advocacy and support groups reduce abuse in women who have actively sought help from community services (particularly refuge populations)
- some evidence that psychological interventions improve depression
Outcomes not studied in DV interventions

- Wellbeing of mother
- Economic status of mother/debt
- Homelessness/sense of community
- Absence of fear, sense of safety or stability
- Impact on children
- General health of mother and children
- Adverse effects of intervention
What do survivors of partner violence experience & expect from health care providers?

- before disclosure/questioning
  - try to ensure continuity of care
- when issue of partner violence raised
  - don’t pressurise women to fully disclose
- immediate response to disclosure
  - *non-judgemental validation is key*
  - ensure that the women feel that they have control over the situation, and address safety concerns
- response in later interactions
  - understand the chronicity of the problem and provide follow up and continued support
  - Feder, 2006
Current research:
Longitudinal study of partner abuse and depression
- DIAMOND
RCT of interventions that look at social support and advocacy
- MOSAIC
RCT of screening, guidelines, education, counselling and systems intervention
- WEAVE
Brief Project Description

- **GP based prospective longitudinal cohort study**
- **Aims** to describe over time
  - pathways of care
  - system characteristics e.g. GP integration and health outcomes
  - patient characteristics e.g. gender, partner abuse and health outcomes
30 GPs recruited (randomly selected)

17,781 patients (aged 18-75 years) screened (600 per GP)

791 patients with depressive symptoms recruited

FOLLOW UP

3 mth 6 mth 9 mth 12 mth
MOSAIC (MOtherS’ Advocates In the Community): a community randomised trial

Angela Taft, Rhonda Small, Kelsey Hegarty and Judith Lumley
La Trobe University, Victoria
MOSAIC aims 1

Through provision of mentor mother support for 12 months, MOSAIC’s primary aims are:

- to reduce **IPV or depression** by 16% among women pregnant or with children under 5 whom GPs or Maternal and Child Health nurses identify as at risk of, or experiencing partner violence
- to strengthen the **health and wellbeing and attachment** of at-risk or abused women to their children
MOSAIC aims 2

- to enhance GP and Maternal and Child Health nurse case management of family members living with partner violence
- to strengthen infrastructure support for GP and Maternal and Child Health nurse management of partner violence, by enhancing effective inter-sectoral collaboration between health providers and community-based family violence networks
MOSAIC design:
cluster community randomised trial

- 24 GP practices and 6 MCH nurse team clusters
- MOU, 6 hours IPV training then randomisation
- Comparison arm
  - Upskilled practitioners
- Intervention arm
  - Upskilled practitioners and mentor mothers for up to 12 months
- Vietnamese sub-study
MOSAIC cont.

- **Process evaluation**
- **Economic evaluation**
  - Log of intervention data and costs calculated against outcomes and QALYs.
- **Outcome measures:**
  - partner violence (CAS), depression (EPDS), social support (MOS), health and wellbeing (SF36), attachment (PSI-SF)
The intervention program: MOSAIC mentor mothers

- Open, compassionate, non-judgmental and diverse local women
- Upskilling in domestic violence, depression, parenting support and emotional intelligence
- Provide befriending, a 'listening ear', empowerment, advocacy and support
- Contact at least once a week at home or another safe place or by phone for up to 12 months
How are things at home?

You don't have to tell us...

but you can.

Maternal and Child Health Nurses have had training about domestic violence and will listen and understand, and help you find the support you need

For advice you can also call Women’s Health West on 9689 9588
weave

Women’s Evaluation of Abuse and Violence care in general practice
Primary aims are to see if a multi-faceted practice based intervention in general practice involving
– screening for intimate partner abuse,
– health provider education, guidelines,
– brief problem solving intervention and
– practice organizational change increases Abused women’s safety behaviours and planning

mental health status and quality of life
Secondary aims are to see if a practice based system intervention increases

- Abused women’s *readiness for change* and action with regard to the abuse
- Abused women’s *comfort to discuss* intimate partner abuse to general practitioners (GPs) and/or practice nurses (PNs)
- GP’s and/or PN’s *inquiry about safety* of women and children
Questions

- Which pilot practices?
- Practitioner versus practice?
- What to use as the screen for abuse?
- Discuss outcome measures
- How to notify GP?PN of women’s visits?
- When to get woman to make appointment?
Other resources

- Book- Intimate partner abuse and Health professionals
- Guidelines
- Cochrane protocols
- CDC compendium of measures
- Education manuals – ANEW, MOSAIC
Conclusions

- No current evidence to support screening for domestic violence in antenatal care—trials underway in NZ, Canada and Australia

- Further research into natural history (longitudinal studies) and what interventions might help women (RCTs)

- Advocacy shows most promise—MOSAIC
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