BEST PRACTICE SCREENING WOMEN FOR DOMESTIC VIOLENCE
IN PRIMARY CARE SETTINGS

by

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SIGNED: Valerie Nicole Crawford
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ABSTRACT

Domestic violence during pregnancy affects many women. Despite increased awareness about domestic violence during pregnancy many healthcare providers do not routinely screen pregnant women for domestic violence at their prenatal visits. The purpose of this project is to develop recommendations for best practice for screening for domestic violence among pregnant women during prenatal care visits. A review of the current literature regarding screening pregnant women for domestic violence will be presented. Lastly, a plan for the implementation and evaluation of a screening tool used to screen pregnant women for domestic violence at prenatal visits will be proposed.
CHAPTER I: INTRODUCTION

Introduction

The purpose of this project was to develop recommendations for best practice for screening for domestic violence among pregnant women at their prenatal care visits.

Worldwide approximately one in every three women will be victimized by domestic violence in their lifetime (Family Violence Prevention Fund, 2006). In the United States alone, approximately one-third of women have experienced domestic violence during their lives, through physical, psychological, or sexual abuse (Centers for Disease Control and Prevention, 2007). Approximately 5.3 million cases of domestic violence occur each year in the United States to women aged 18 years and older (Centers for Disease Control and Prevention, 2007).

Fortinash and Holoday Worret (2004) define domestic violence (DV) as:

“Learned behaviors used by one or more persons in an intimate or family relationship for the purpose of controlling the behavior of others. Violence may take the form of physical, psychological, sexual, or emotional abuse, intimidation, threats, isolation, economic control, or stalking.” (p. 667).

Unknown too many individuals DV takes many different forms and is not limited to physical or sexual abuse. Factors known to increase the risk of DV include drug use, poverty, pregnancy, and unemployment (Urbancic, 2004).

Problem Statement

DV during pregnancy is a concern for healthcare providers (HCPs), including physicians and nurse practitioners, because it can lead to complications of pregnancy and potentially the death of expectant mothers and their unborn infants. Second only to car
accidents, homicide is the most prevalent cause of traumatic death during pregnancy and is responsible for 20% of maternal deaths (Chang, Berg, Saltzman, & Herndon, 2005). Two well publicized accounts of the murders of pregnant women have heightened public awareness of the serious problem of violence against women during pregnancy. Laci Peterson was, a 27 year old 7 ½ month pregnant woman of Modesto, California, who was reported as missing on December 24, 2002 (Couric, 2006). Her husband, Scott Peterson, lead police and the media to believe he was a concerned husband searching for his missing wife. Later it was discovered that he had actually murdered Laci and thrown her pregnant body into the San Francisco Bay (Couric, 2006). Most recently, Jessie Davis, a 26 year old pregnant Canton, Ohio, woman and mother of one, was missing for 10 days before her body was discovered. Jessie had been murdered by the father of her son and unborn infant (Cable News Network, 2007). Through the media attention given to these two cases, the severity of the problem of violence against pregnant women has gained public awareness. The question then arises, could DV screening and interventions during prenatal care visits have prevented the deaths of these two pregnant women?

Despite increased awareness that violence against women occurs during pregnancy, fewer than 10% of general HCPs screen for DV (Rodriguez, Bauer, McLoughlin, & Grumbach, 1999). Regular screening for DV is conducted by less than half of reproductive healthcare providers (National Coalition Against Domestic Violence, 2006). There is an increase in DV screening when women present as patients in the labor and delivery units of hospitals, however DV screening at this time is often too late. If DV
could be detected earlier for more pregnant women, many injuries and deaths might be prevented.

Purpose of Project

The purpose of this project is to develop recommendations for best practice for screening for domestic violence among pregnant women during prenatal care visits. A review of the current literature regarding screening pregnant women for domestic violence will be presented. Lastly, a plan for the implementation and evaluation of a screening tool used to screen pregnant women for domestic violence at prenatal visits will be proposed.

Significance

Approximately 5.3 million cases of domestic violence occur each year in the United States to women aged 18 years and older, while 3.2 million cases occur to men (Centers for Disease Control and Prevention, 2007). Approximately 324,000 women each year are abused by their partners during pregnancy (Gazmararian, Petersen, Spitz, Goodwin, Saltzman, & Marks, 2000). Victims of domestic violence during pregnancy are more likely to encounter pregnancy complications including: low birth weight infants, infections, anemia, bleeding during the first and second trimesters; these women may also suffer from depression, substance abuse, and suicide (National Coalition Against Domestic Violence, 2006).

Screening for domestic violence and providing support measures are both ways that the healthcare provider can help DV victims before the abuse escalates and results in death (Family Violence Prevention Fund, 2006). Healthcare professionals had seen 44%
of the women as patients who were intimate partner homicide victims in the year preceding their deaths (Centers for Disease Control and Prevention, 2007).

Background

Domestic violence as previously defined includes economic, emotional, physical, psychological, and sexual abuse, as well as behaviors such as stalking and threatening.

The first abusive episode may occur at any one of the following times: pregnancy, the time of first sexual relations, marriage, after the first child is born, or after a quick courtship that results in marriage (Wilson, personal communication, August 15, 2007). Pregnancy related effects of DV include: bleeding, delayed prenatal care, fetal injury or death, low birth weight infant, miscarriage, and preterm labor (Centers for Disease Control and Prevention, 2007). The psychological effects of DV include: depression, flat affect, low self esteem, post traumatic stress disorder, substance abuse, and suicide (Centers for Disease Control and Prevention, 2007). Women may choose to stay in their current relationship even though they are experiencing DV because their partner promises to change, they have an low self esteem and are not mentally strong enough to make the decision to leave, due to fear of retaliation, or they are isolated from friends and family and the only economic resource they have is their current partner (Wilson, personal communication, August 15, 2007). On average, it takes a woman 7 to 10 times to safely leave a situation where domestic violence is occurring (The Brewster Center, 2007).

Pregnant women are at high risk for domestic violence because of greater physical and emotional vulnerability than during nonpregnant times. This stress may manifest as DV towards the woman and her unborn child. Due to the pregnant woman’s physically
changing body she often becomes the target of violence. “The enlarged gravid abdomen is a frequent target during an assault because the batterer intends to harm the fetus” (Saunders, 2000, p. 45). Many times pregnant women are punched, kicked, shot, and stabbed in their abdomen (Saunders, 2000). During pregnancy women also become emotionally labile due to fluctuations and changes in hormones. This emotional lability in turn creates added stress on the woman’s relationship with the father of the baby. The woman may become tearful for no apparent reason and this may frustrate her partner. If the father is unable to communicate with the woman he may become angry and yell or hit her. Pregnancy also creates added financial stress related to the cost of obtaining care for the woman throughout her pregnancy and delivery, as well as the costs to care for a baby. “The physical, emotional, and financial changes associated with pregnancy can be seen as an opportunity for an abusive partner to establish power and control over the woman” (Saunders, 2000, p.44).

Significance to Nursing

DV has become an increasingly severe problem affecting both public and social health (Cromwell, 2001). As a result, advanced practice nurses and physicians who provide prenatal care are playing a significant role in identification, diagnosis, and treatment interventions for expectant mothers experiencing domestic violence (Cromwell, 2001).

Currently in many hospitals nurses are screening pregnant women for DV as they present for delivery and to triage rooms, which is often too late for initial screening to occur because in many cases, DV has already occurred. It is important to have a plan in
place to screen these women as they present for routine prenatal visits, and provide them with interventions as needed.

DV interventions include patient education about abuse and providing the woman with information about local resources, such as shelters and DV centers. The shoe card is a resource card small enough to fit in a woman’s shoe beneath the removable sole of the shoe. This card has the names and phone numbers of local agencies who provide resources to victims of DV, as well as information on safety measures and developing a safety plan. Another resource that may be provided to the pregnant woman is the Domestic Violence Survivor’s Guide. This informational guide provides names and phone numbers for available DV resources, as well as provides lay legal advice for individuals residing in Pima County. Topics covered in the guide include: DV hotlines and housing information, obtaining an order of protection, and filing for divorce or legal separation.

The Brewster Center and Tucson Centers for Women and Children both provide many services to victims of DV. The Brewster Center has two shelters, a 24 hour crisis line, counseling services for DV victims, victim advocacy, as well as provides community education through their outreach program. Tucson Centers for Women and Children offers a 24 hour crisis line as well, with emergency shelters for women and children, and transitional housing. They also have many outreach programs and support groups available for victims.

Summary

DV is a tremendous problem facing many women in our society today. During pregnancy many women may experience increased DV, or perhaps encounter DV for the
first time. It is imperative for HCPs to routinely screen women for DV as they present to prenatal visits during their pregnancy. Through identification and recognition of DV women can be provided with support and interventions to meet their personal needs.
CHAPTER II: REVIEW OF THE LITERATURE

Introduction

This chapter provides overviews of extant literature relevant to DV during pregnancy: 1) trends of domestic violence during pregnancy, 2) effective techniques for screening women during pregnancy for domestic violence, and 3) interventions for pregnant women at risk for new or ongoing violence. Recommendations for best practice for screening pregnant women for DV are based on the literature and evidence reviewed in this chapter.

Trends of Domestic Violence During Pregnancy

There is considerable evidence that DV may actually increase during pregnancy. Examples of available evidence and research are presented to support the contention that DV during pregnancy is not uncommon and that the consequences may be serious for both the women and their babies.

Gazmararian, Petersen, Spitz, Goodwin, Saltzman, and Marks (2000) reviewed the literature and current knowledge to determine the relationship between violence and reproductive health, as well as to make suggestions for future research. The researchers found that there is a great opportunity for HCPs to screen for DV during the reproductive years because most women visit their providers frequently during this time period (Gazmararian et al., 2000). Reported rates of DV during pregnancy were found to range from 4% to 8% (Gazmararian et al). It was also suggested that DV was possibly more common than routinely screened pregnancy conditions, such as preeclampsia and gestational diabetes (Gazmararian et al). Low infant birth weight and mean birth weight
were the only pregnancy outcomes related to the presence of DV during pregnancy (Gazmararian et al.). For future practice and research, Gazmararian et al. (2000) suggested assessing for DV at multiple visits during the pregnancy, as well as at least once during later pregnancy because repeated inquiries contribute to higher rates of DV disclosure.

Yost, Bloom, McIntire, and Leveno (2005) conducted a prospective study to determine if there was an increased risk of adverse outcomes of pregnancy in women reporting DV during their pregnancy. A sample of 16,041 women was recruited for participation from a labor and delivery unit in Dallas County, Texas, as they presented for delivery. The women were interviewed using questions that address “whether a family member physically **H**urt her, **I**nsulted her or talked down to her, **T**hreatened her with harm, or **S**creamed or cursed at her during this pregnancy” (Yost et al., p.62). This questionnaire is represented as the acronym HITS (Yost et al., p.62). An affirmative (“yes”) answer to any of the four questions was an indicator of DV. A subsample of 949 women (6%) was identified as having experienced some type of DV during her pregnancy. Physical abuse was reported at a higher rate among African American and younger women (Yost et al.). All women experiencing DV were given a phone number to a twenty-four hour violence intervention center (Yost et al.). No data was provided by the researchers regarding the use of the violence intervention center by study participants who screened positive for domestic violence.

Yost, Bloom, McIntire, and Leveno (2005) found an increase in low birth weight infants in women reporting verbal abuse during pregnancy (7.6%), compared to women
with low birth weight, but who denied DV (5.1%) (Yost et al). The incidence of neonatal deaths was increased (7 times greater) in women reporting physical abuse (1.5%), compared with women who denied abuse (0.2%). However, the researchers found that women declining to participate in the survey had almost a 3-fold increase of low birth weight infants (12.8%) as compared to the women reporting no abuse (5.1%) (Yost et al). Women declining to participate were more likely to have had little or no prenatal care, an increase in the occurrence of placental abruption, a delivery considered preterm, infants with lower birth weights, and infants who were admitted to the neonatal intensive care unit (Yost et al). The researchers concluded that women who did not participate or who could not answer the survey were at an increased risk for an adverse outcome in their pregnancy. These women’s increased risk for adverse pregnancy outcomes may also be attributed to the fact that they were less likely to have received prenatal care during their pregnancies. It was speculated that these women may have declined participation if they were experiencing DV “because they were fearful of retaliation” (Yost et al, p. 64).

Effective Techniques for Screening Women for Domestic Violence

The American College of Obstetricians and Gynecologists (ACOG) and the Center for Disease Control and Prevention (CDC) provide recommendations for healthcare providers for screening for domestic violence. Both of these organizations recommend routine screening of pregnant women at the first prenatal visit, at least once during each trimester, and at their postpartum visit (ACOG, 2007; CDC, 2007). Non-pregnant women should be routinely screened at family planning, obstetrical/gynecological, and preconception visits (ACOG, 2007; CDC, 2007).
Renker and Tonkin (2006) studied perceptions about experiences with prenatal DV screening among 519 postpartum women from two hospitals: 244 from Hospital A and 275 from Hospital B. Participants were randomly selected to participate in audio- and video-enhanced anonymous computer interviews (Renker & Tonkin). Data was collected using the *Abuse Assessment Screen* developed by the Nursing Research Consortium on Violence and Abuse, and the *Women’s Experiences With Battering Scale*, which was developed by Smith, Earp, and DeVellis (Renker & Tonkin). The question, “Do you feel that you were emotionally abused during your pregnancy?” and the *Women’s Experiences With Battering Scale* were both used to identify women who encountered emotional or psychological abuse (Renker & Tonkin). The researchers developed additional questions which addressed if the women had been screened during their pregnancies for DV, their response to the DV screening, and their awareness of laws requiring reporting of DV by healthcare providers (Renker & Tonkin). Of the 60.1% of women who were screened by a healthcare provider during their pregnancy for DV, only 38.7% of those individuals were screened by their prenatal care provider; the screening of the remaining women occurred at visits to triage areas, the emergency room, and upon their admission for labor and delivery (Renker & Tonkin). Ninety-seven percent of women screened by their healthcare providers found no offense or embarrassment in the screening (Renker & Tonkin).

Renker and Tonkin found the disclosure rate of women who were abused during their pregnancy and screened for DV by their provider was only 16.7%, however 43.9% of abused women who denied being victimized by DV during pregnancy “would have
changed their response if they had known that violence disclosure was not reportable in their state unless the victim was seriously injured or was wounded with a lethal weapon” (Renker & Tonkin, p.348). This research first illustrates that pregnant women accept and find no offense in being screened for DV by their healthcare providers. Secondly, this study also shows that women are often reluctant to disclose abuse or violence to their healthcare provider for fear that it will be reported. This suggests that, healthcare providers should make a point of familiarizing themselves with their respective local and state reporting laws for DV and share this information with their patients during the screening process.

Williamson, Coonrod, Bay, Brady, Partap, and Lone Wolf (2004) performed a cross-sectional survey of Arizona physicians to determine their use and comfort level with screening for DV. Of the 14,999 practicing physicians in Arizona, a stratified probability sample of 2,244 physicians received the questionnaire (Williamson et al., 2004). The physician sample population was comprised of physicians from 13 different specialty areas including: “anesthesiology and pain control, emergency medicine, family practice, general practice, internal medicine, medicine subspecialty, obstetrics/gynecology, obstetrics/gynecology subspecialty, physical medicine/rehabilitation, psychiatry, general surgery, orthopedic surgery, and surgical subspecialty” (Williamson et al., 2004, p.1050).

Brief 5 minute questionnaires assessed the physicians’ use of DV screening in their practice setting, as well as their preferred method to learn about DV screening. Physicians were also questioned regarding personal barriers to screening that they have
encountered during their practice. A total of 976 physicians returned questionnaires and were included in the data analysis (Williamson, Coonrod, Bay, Brady, Partap, & Lone Wolf, 2004). Of the responding physicians, only 22% screened their women patients on a regular basis, while 27% occasionally screened their patients, and 51% did not screen their patients (Williams et al., 2004). Only 27% of non-pregnant females were screened for DV by their obstetricians and gynecologists, while 39% of pregnant women were screened (Williams et al., 2004). However, reported rates of screening for DV and awareness of services for DV victims were highest among subspecialty physicians, including: obstetrics/gynecology, psychiatry, and emergency medicine, as well as family physicians (Williams et al., 2004).

The researchers assessed the willingness of the physicians to utilize both DV screening tools and materials in their offices. “82.6% of the respondents reported that they were willing to use DV materials in their practice, 76.5% were comfortable with using a screening tool” (Williamson, Coonrod, Bay, Brady, Partap, & Lone Wolf, 2004, p.1052).

The research results illustrate the need for improved routine DV screening by physicians of their women patients. It also identified areas where physicians need more training, as in providing care for and making referrals to resources for DV victims. One question the research raises is why routine DV screening rates are low, when a majority of physicians reported that they were willing to use a DV screening tool in their practice to screen patients.
Wiist and McFarlane (1999) evaluated the effectiveness of a routine abuse assessment protocol in prenatal clinics. The March of Dimes protocol which incorporates the Abuse Assessment Screen was implemented in 2 public health department clinics that provided prenatal care. A third public health clinic was chosen as a comparison clinic; however the protocol was not implemented at this location. Chart audits were performed and examined abuse assessment 15 months prior to protocol implementation, and again at 3 and 12 months post protocol implementation. Chart auditors determined if a completed Abuse Assessment screen was in the chart, documentation of identified abuse, documentation of referrals provided, and whether or not the HCP made a referral (Wiist & McFarlane, 1999).

Wiist and McFarlane found that prior to implementation of the abuse assessment protocol there was no universal DV screening and no referral documentation in charts (1999). At the 2 clinics where the protocol was initiated, after implementation, screening for DV increased 88%, and DV detection increased from 0.8% to 7% (Wiist & McFarlane). The number of referrals for abused women also increased post protocol to 67% at 3 month chart audit, and 53% at 12 month chart audit (Wiist & McFarlane). Overall, the researchers found that by implementing an abuse assessment protocol the number of women screened and referred for DV increased, and there was an increase in documentation of assessments and referrals in the patient’s chart.

Interventions for Pregnant Women at Risk for New or Ongoing Violence

McFarlane, Groff, O’Brien, and Watson performed a clinical trial to assess women’s safety behaviors, their use of available community resources, and the extent of
violence they encountered after implementation of two DV interventions (2006). A sample of 360 women, ages 18 to 45 were chosen from two public health primary care clinics and two Women, Infants, and Children (WIC) clinics. (McFarlane, Groff, O’Brien, & Watson, 2006). Two different types of abuse intervention were tested by the researchers; the first intervention was an abuse assessment and a referral card, while the second intervention was an abuse assessment, a referral card, and nurse case management (McFarlane et al). The referral card provided the women with information for local shelters, legal advice, counseling services, and police assistance, as well as a safety plan. Women receiving nurse case management in addition to the referral card were provided with supportive care, anticipatory guidance, and guided referrals (McFarlane et al). There was an increase in the number of safety behaviors adopted by women in each of the groups, as well as a significant decrease in the frequency, severity, and type of violence that the women encountered (McFarlane et al). The women in both intervention groups also decreased their use of available community services following the interventions, one possible explanation for this finding is that the women were able to disclose their abuse to a nurse and had support from the research nurses during each 6 month follow-up study visit (McFarlane et al). This research shows that through the use of abuse assessment and referrals there is a great opportunity for HCPs to prevent future occurrences of DV encounters.

Espinosa and Osborne (2002) discuss the three levels of DV interventions. The goal of primary intervention is to increase public awareness of DV and to decrease societal influences that lead to violence (Espinosa & Osborne). Examples of primary
interventions include: political activism and participation in DV coalitions by the HCP, providing women with safe options for family planning and childcare, and by encouraging the media to portray healthy images of women (Espinosa & Osborne). Public education serves to increase DV awareness and to decrease the negative stigma associated with being a DV victim. Secondary interventions focus on DV screening and treatment for women disclosing DV. The Abuse Assessment Screen (AAS) is a tool that allows providers to openly address DV with their patients (Espinosa & Osborne). When a woman discloses DV it is imperative for the HCP to provide her with nonjudgmental support. By providing nonjudgmental support, the HCP is able to offer information about local DV resources and options, and lets the woman make her own informed decision about her path of treatment (Espinosa & Osborne). The implementation of tertiary interventions occurs once DV has been disclosed. Tertiary interventions aim to ensure the woman’s safety, and that of her unborn child (Espinosa & Osborne). Tertiary interventions include proper documentation of DV in the chart, providing referrals to local resources, such as agencies with 24 hour DV hotlines, DV shelters and transitional housing, counseling services, and DV advocacy programs (Espinosa & Osborne).

Summary

A great deal of literature has been written about the incidence of DV and efforts to screen for DV have increased in recent. The Abuse Assessment Screen has been proven an effective tool for HCPs to aid in screening for DV during prenatal visits. The implementation of DV screening protocols in prenatal clinics increases the number women who are screened and referred for DV services. There are interventions available
for DV victims, however there are very limited reports evaluating the effectiveness of interventions for women in DV situations.
CHAPTER III: PROPOSAL FOR BEST PRACTICE

Introduction

The purpose of this chapter is to present evidence based recommendations for best practice for screening pregnant women for DV in the primary care setting. Through implementation of best practice, HCPs will have the necessary tools for screening pregnant women for DV as they present at routine prenatal visits. The goals are 1) HCPs will routinely screen pregnant women for DV at their prenatal visits, resulting in an increase in the number of pregnant women being screened for DV, and 2) the HCP will be able to provide appropriate interventions and resources to women who are victims of DV.

Patient Participation

Patients to be included in the DV screening are those women aged 18 years and older, presenting to the site to receive prenatal care.

Screeners and Screening Location

The primary HCP screening for DV during routine prenatal care visits would be the intake nurses. Ideally, the nurse practitioner or physician would screen the patient for DV while they were speaking with the woman and performing her physical exam. However, often times the women is not alone during this time, she may be accompanied by her partner and even children. When screening for DV, the HCP must ensure the screening is performed in a private setting to maintain confidentiality and safety (McFarlane, Parker, & Cross, 2001).
The screening location would be the intake room. In this location the nurse can ensure privacy and confidentiality because the patient and the nurse are alone.

Screening Tools

There will be two tools for screening used by the nurses, as well as a question to address emotional abuse. The first tool is the *Abuse Assessment Screen* (AAS). The AAS was developed in 1991 by the Nursing Research Consortium on Violence and Abuse as a means for the HCP to address DV in a manner that was direct and straightforward (Soeken, McFarlane, Parker, & Lominack, 2003). The AAS has been tested for both content validity and effectiveness (Soeken, McFarlane, Parker, & Lominack). This 4-item self-report questionnaire is comprised of 3 *Yes/No* questions that assess the woman for DV during the past year and in the current pregnancy, as well as forced sexual encounters. A body map is also provided for victims to identify areas of injury and threats of injury. The woman places a number 1 through 6

\[ 1 = \text{threats of abuse including use of weapon}, \ 2 = \text{slapping, pushing; no injuries and/or lasting pain}, \ 3 = \text{punching, kicking, bruises, cuts and/or continuing pain}, \ 4 = \text{beating up, severe contusions, burns, broken bones}, \ 5 = \text{head injury, internal injury, permanent injury}, \ 6 = \text{use of weapon; wound from weapon} \]

on the body map locating the area of threat or injury (McFarlane, Parker, & Cross, 2001). Since the ultimate goal is the safety of the woman and her unborn child, if the woman indicates that she is currently experiencing DV, then the intake nurse would also administer the Danger Assessment (DA), in an effort to prevent such outcomes as Laci Peterson’s.
Campbell developed *The Danger Assessment* (DA) in 1986 as a tool for identification of women experiencing DV who were most likely to encounter extreme danger (John Hopkins University, School of Nursing, 2007). The DA, is a 14-item self-report questionnaire listing risk factors most commonly associated with women experiencing DV, who later became homicide victims (McFarlane, Parker, & Cross, 2001). The women answer each question with a *Yes/No*. Through utilization of the DA the safety of the current relationship and woman’s danger level can be objectively evaluated (McFarlane, Parker, & Cross, 2001). There is no scoring tool for the DA, the HCP reviews the woman’s answers and identifies areas of concerns. The woman and the HCP can then develop a safety plan to best suit the woman’s safety needs.

The AAS and DA do not address emotional abuse, which is a form of DV the woman may experience. In addition to the previous assessment tools, the HCP provider would also assess for emotional abuse using the following screening question: “Does your partner ever criticize you, call you names, become jealous of your activities with other friends and family members, or accuse you of being unfaithful?” The response to this question would be used in addition to the other responses to determine the presence of DV.

**Summary**

Through the use of the AAS, the emotional abuse screening question, and the DA, the intake nurse will screen all pregnant women aged 18 years and older presenting for prenatal care visits for DV in the privacy of the intake room.
CHAPTER IV: PROPOSAL FOR IMPLEMENTATION AND EVALUATION

Introduction

The purpose of this chapter is to discuss the steps required to prepare for and implement the recommended best practice in a primary care setting. Then the author will discuss how to evaluate the success of utilizing the DV screening tools.

Project Coordinator

The coordinator and individual responsible for ensuring proper implementation and evaluation of the recommended best practice will be the site’s nurse practitioner (NP).

Training & Resources for Staff

The coordinator will schedule informational training sessions for all healthcare providers and staff at the site. The coordinator will hold training sessions as follows:

Healthcare provider training: 4-6 hours, content to include discussion of DV definitions and dynamics, rationale for screening women for DV during pregnancy, importance of provider in screening and providing resources, and description of the proposed plan. An individual from the Brewster Center’s Community Education Center and one from the Tucson Center for Women and Children would be scheduled to speak regarding available community resources for pregnant women experiencing DV. The Brewster Center volunteer would also help conduct the general DV awareness session.

Staff training: 2 hours, to review the importance of screening for DV during pregnancy, training in administering the AAS, emotional abuse screening question, and the DA, as well as how/when to notify the NP or physician of a patient experiencing DV.
To address the health and wellness of the staff, the number of a counselor at the Brewster Center would be provided. During such training sessions individuals may discover they are victims of DV or have unresolved feelings regarding previous experiences with DV. These individuals may find it necessary to discuss and resolve their own feelings before participating in screening for DV.

Screening

Before each woman is seen by the NP or physician for her scheduled prenatal care visit, the intake nurse assesses her vital signs and any complaints she may have. During this time the intake nurse would also assess the woman for DV using the AAS, the emotional abuse screening question, and DA if the woman discloses DV. The nurse would use the Domestic Violence Screening Decision Tree to aid in screening the woman for DV (Figure 1).
Upon calling the woman to the intake room, the nurse would ask anyone accompanying the woman to wait in the waiting room because this part of the visit is the portion conducted while the patient is alone. Acknowledge and reassure the accompanying individual that they will be allowed to accompany the woman when she sees the NP or physician. By conducting a private interview, the nurse is able to ensure privacy. To ensure confidentiality, the nurse should let the woman know that any information she shares is kept between her and the NP and/or physician; no information will be shared with her partner or members of her family.
The nurse would tell the patient that the medical and nursing staff is concerned for the safety and well-being of all of their patients, and they routinely ask questions regarding each woman’s safety. To administer the AAS, the nurse would sit down with the woman where she can make eye contact with her, and in a manner allowing the woman to read the questions. The nurse would then ask the woman each question. When it is time for the woman to identify abuse on the body map, the woman should indicate and draw this herself. The HCP would then ask the emotional abuse screening question: “Does your partner ever criticize you, call you names, become jealous of your activities with other friends and family members, or accuse you of being unfaithful?” When the woman denies DV, no further action is taken. When the woman discloses DV to the nurse, the nurse would administer the DA to the woman, assessing for her safety. As with the AAS, the nurse would read each of the questions to the woman and she would respond with a yes or no answer. Documentation of the DV assessments would be kept in the chart for future reference for all women. DV screening of all patients would occur at each visit, and interventions provided for women disclosing DV would be evaluated at follow-up visits.

Notification of HCP

Once a woman has disclosed DV and a DA has been completed, the NP or physician would be asked to join them in the intake room. At this time the HCPs would initiate appropriate interventions.

Interventions & Resources for Patients
The original intervention is screening the pregnant woman for DV during her pregnancy. If the HCP does not take advantage of the opportunity to assess for DV at this time, the patient may never be assessed and DV may go undetected.

The interventions the HCP takes upon initial DV disclosure were developed with the assistance of Teresa Wilson, MS, APRNC, CNS, the Perinatal Clinical Nurse Specialist at Carondelet’s St. Joseph’s Hospital in Tucson, Arizona. Teresa has over 15 years of experience working with survivors of DV. In 1994 she became a core team member of the newly organized Continuous Quality Improvement (CQI) team at Carondelet St. Mary’s Hospital in Tucson, AZ, whose primary goal was to develop a DV policy and procedure for the Carondelet Health Network facilities in southern Arizona; the policy has since become a community and national model for HCPs and organizations such as the National Family Violence Prevention Fund. She has also served as a member of the Tucson Domestic Violence Community Collaboration for Healthcare group, which aimed to create a consistent, state-of-the-art response by the local healthcare community to DV. Teresa has served as an educator and played a key role in training of over 400 Carondelet associates, mostly nurses, in an 8-hour DV training course.

Initially, upon patient disclosure of DV there are four steps that the HCP should take:

1) Reassure the patient of continued confidentiality and validate her feelings

(Carondelet Health Network, 1998; Wilson, personal communication, October 5, 2007).
2) Assure the patient that she is not responsible for the DV; she is the victim (Wilson, personal communication, October 5, 2007; Dienemann, Campbell, Wiederhorn, Laughon, & Jordan, 2003).

3) Warn the woman that she is at increased risk for further DV (Carondelet Health Network, 1998; Wilson, personal communication, October 5, 2007).

4) Provide the woman with local resource numbers and assure her that she has many options (Dienemann et al., 2003).

The HCP and pregnant woman would then decide if it was safe for her to take a shoe card and the *Domestic Violence Survivor’s Guide*. If a patient finds herself in a situation that is unsafe to take these materials, the HCP should help the woman to memorize the phone number to one of the local agencies or shelters for DV victims, such as the Brewster Center. The interventions provided by the HCP should be documented in the patient’s chart. In the primary care setting the patient is given the referral information to the DV agencies and shelters and the woman herself must make the call to initiate contact.

The HCP should discuss the importance of developing a safety/escape plan with the woman. Due to increased vulnerability and danger that a woman may experience at the time she leaves a partner who is violent towards her, it is important for her to receive assistance from an agency specializing in DV.

Costs

Insurance would cover the cost of screening for DV because the screening would take place at each scheduled prenatal visit. Resource materials, for example, shoe cards
and Domestic Violence Survivor Guides are available free of charge from local agencies. The only costs to be encountered by the site are for printing screening tools.

**Barriers**

Potential barriers to screening for DV do exist. Personal beliefs of the staff members and their experiences with DV may deter them from wanting to participate in screening. HCPs may have the attitude that the screening will be offensive to the women. Time constraints of the scheduled office visit, and the potential for a longer visit if DV is disclosed.

The training provided to the staff is aimed at educating them about DV. Through training and DV education, as well as discussion of personal feelings with DV hopefully the barriers will be reduced. It only takes a few minutes to administer the AAS and ask the emotional abuse screening question, and once the staff is used to this added piece as part of the intake routine the flow of the scheduled appointments should go smoothly without much change in time.

**Evaluation**

A chart audit would be conducted to look for documentation of DV screening at 3 months, 6 months, and 12 months. The chart audit is to ensure that DV screening by the HCP is being completed, as well as proper documentation of the screen and interventions if required. The importance of looking at three points in time is to monitor the continued use of screening after initial implementation.

**Summary**
Through proper staff education and training, pregnant women presenting for prenatal care would be screened for DV using the AAS, emotional abuse screening question, and the DA. Upon disclosure of DV the HCP would: reassure and validate the woman’s feelings, assure the woman that she is the victim, warns the woman of her increased risk for further DV, and provide the woman with options and the numbers to local agencies who provide assistance to victims of DV. At the woman’s next appointment the HCP would reassess the woman for DV and evaluate the interventions provided at the previous visit.

Conclusions

DV is a tremendous problem facing many women in our society today. During pregnancy many women may experience increased DV, or perhaps encounter DV for the first time. It is imperative for HCPs to routinely screen women for DV as they present to prenatal visits during their pregnancy. By implementing a DV screening tool and protocol into practice at routine prenatal visits more women can effectively be screened for DV, and those women identified as victims can receive assistance through referrals to appropriate DV victim services.
APPENDIX A

ABUSE ASSESSMENT SCREEN
ABUSE ASSESSMENT SCREEN

1. **WITHIN THE LAST YEAR**, have you been hit, slapped, kicked, or otherwise physically hurt by someone?  
   - YES  
   - NO
   
   If YES, by whom? ____________________________  
   Total number of times ________________________

2. **SINCE YOU'VE BEEN PREGNANT**, have you been hit, slapped, kicked, or otherwise physically hurt by someone?  
   - YES  
   - NO
   
   If YES, by whom? ____________________________  
   Total number of times ________________________

**MARK THE AREA OF INJURY ON THE BODY MAP. SCORE EACH INCIDENT ACCORDING TO THE FOLLOWING SCALE:**

1 = Threats of abuse including use of a weapon

2 = Slapping, pushing; no injuries and/or lasting pain

3 = Punching, kicking, bruises, cuts and/or continuing pain

4 = Beating up, severe contusions, burns, broken bones

5 = Head injury, internal injury, permanent injury

6 = Use of weapon; wound from weapon

If any of the descriptions for the higher number apply, use the higher number.

3. **WITHIN THE LAST YEAR**, has anyone forced you to have sexual activities?  
   - YES  
   - NO
   
   If YES, by whom? ____________________________  
   Total number of times ________________________

*Developed by the Nursing Research Consortium on Violence and Abuse. Readers are encouraged to reproduce and use this assessment tool.*

(McFarlane, Parker, & Cross, 2001)
APPENDIX B

DANGER ASSESSMENT
DANGER ASSESSMENT

Several risk factors have been associated with homicides (murders) of both batterers and battered women in research that has been conducted after the killings have taken place. We cannot predict what will happen in your case, but we would like you to be aware of the danger of homicide in situations of severe battering and for you to see how many of the risk factors apply to your situation. (The “he” in the question refers to your husband, partner, ex-husband, ex-partner or whoever is currently physically hurting you).

Please check YES or NO for each question below.

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1. Has the physical violence increased in frequency over the past year?</td>
</tr>
<tr>
<td></td>
<td>2. Has the physical violence increased in severity over the past year and/or has a weapon or threat with a weapon been used?</td>
</tr>
<tr>
<td></td>
<td>3. Does he ever try to choke you?</td>
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<tr>
<td></td>
<td>4. Is there a gun in the house?</td>
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<tr>
<td></td>
<td>5. Has he ever forced you into sex when you did not wish to do so?</td>
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<tr>
<td></td>
<td>6. Does he use drugs? By drugs I mean uppers or amphetamines, speed, angel dust, cocaine, crack, street drugs, heroin, or mixtures.</td>
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<tr>
<td></td>
<td>7. Does he threaten to kill you and/or do you believe he is capable of killing you?</td>
</tr>
<tr>
<td></td>
<td>8. Is he drunk every day or almost every day (in terms of quantity of alcohol)?</td>
</tr>
</tbody>
</table>
|     | 9. Does he control most/all of your daily activities? For instance, does he tell you with whom you can be friends, how much money you can take with you shopping or when you can take the car?
   (If he tries, but you do not let him, check here:____) |
|     | 10. Have you ever been beaten by him while you were pregnant?
   (If never pregnant by him, check here:____) |
|     | 11. Is he violently and constantly jealous of you? (For instance, does he say, “If I can’t have you, no one can”?) |
|     | 12. Have you ever threatened or tried to commit suicide? |
|     | 13. Has he ever threatened or tried to commit suicide? |
|     | 14. Is he violent outside of the home? |

TOTAL YES ANSWERS

Thank you. Please talk to your nurse, advocate or counselor about what the Danger Assessment means in terms of your situation.

From Campbell, 1986

(McFarlane, Parker, & Cross, 2001)
REFERENCES


Wilson, T. A. (2007, October). Screening and intervention for domestic violence/abuse, and how to locate resources. Seminar and PowerPoint presentation presented for nurses at St. Joseph’s Hospital, Tucson, AZ.