

Australian Domestic & Family Violence CLEARINGHOUSE

ISSUES PAPER 6

Violence against women in pregnancy and after childbirth:

Current knowledge and issues in health care responses

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She was seven months pregnant, she was beaten from top to toe...with one of those meat [steels] that butchers sharpen their knives with ... How she wasn't killed I don't know. He got in too ... she was going to testify ... [but] she discharged herself and went with him.

Just being pregnant. I'd never specifically went myself, it was only when I was allowed to go to the doctors when I was pregnant.

Introduction and overview

As the quote above illustrates, pregnancy may be one of the few times when chronically abused women are permitted to go to the doctor. As almost all Australian women have regular contact with the health system when they are pregnant and for up to a year afterwards, it is a unique opportunity for beneficial intervention in the lives of women who are victimised. It is vitally important that the Australian health system, and birthing services in particular, are safe, confidential places where women receive effective support and high quality care if they

disclose abuse. How prepared the Australian health system is to respond to these challenges is the focus of this paper.

The first section of the paper reviews the current evidence in Australia and overseas which suggests that between four to eight or nine in every hundred pregnant women are abused during their pregnancy and/or after the birth. It also shows that when women are abused, they are less likely to have planned the pregnancy or to want it. Further, evidence from overseas indicates that there is a significant proportion of abused women among those seeking to terminate their pregnancies.

The second section identifies which Australian women are more at risk than others and how common consequences of abuse, such as stress, drug and alcohol abuse, smoking, eating disorders and/or injuries, further damage their health in pregnancy, and jeopardise their birth outcomes and their babies. There is a particular focus on abuse by intimate partners, a term interchangeable with domestic violence in the overall paper. Evidence from both overseas and Australia is included but Australian studies are highlighted.

The third section of the paper discusses the controversy around the development of universal screening programs for abuse and other psychosocial issues in pregnancy. It outlines how screening developed as a biomedical test and the principles surrounding whether screening should or should not be implemented. It is argued that we do not have the evidence to recommend partner abuse screening as policy at present. The paper also argues that the term 'screening' and screening methods are inappropriate for complex psychosocial issues such as partner abuse.

The final section outlines the preconditions required within the Australian health system prior to implementing the policy goal of routine inquiry about abuse in pregnancy. These preconditions include thorough, sustainable training for all care providers in contact with pregnant women and those who have recently delivered. Implications for abused women of the 'shared care' model (where women are booked in for birthing care as public patients, but



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where some or all of their antenatal care is provided in the community) are also considered. The paper argues that quality of care for abused women includes the need for effective forms of coordination between hospitals and community-based services (e.g. General Practitioners) in order to ensure women's safety and confidentiality. The paper argues such measures should be the paramount consideration in any health service response to violence against pregnant and postpartum women and that, until such preconditions are met, universal screening or routine inquiry policies should not be recommended, as we cannot guarantee that we do no harm. The paper continues with a brief review of current evaluations of interventions outside the health system and urges the development of stronger links between health services and the broader community response to violence against women.

The paper is illustrated with quotations from research about GP care for women abused by their partners (Head and Taft, 1995).

The wider context of violence against women and the health system

In its many forms, from deliberate abortion of female fetuses and female infanticide to female genital mutilation, child sexual abuse and rape, through partner abuse to elder abuse, violence against women has grave health consequences for women, their families and communities. US academic Ann Flitcraft wrote about the gendered risk of violence that:

The epidemiology of rape, physical and sexual assaults in marital cohabiting and dating relationships and long-term effects of childhood sexual abuse reveals women's vulnerability to abuse across the lifespan (Flitcraft, 1992, p.3194).

In Australia and overseas, national and international government and health provider associations have developed policies about violence against women or domestic violence (Australian Medical Association, 1998; Office for the Status of Women, 1997; Schenker, 1996). In May 1996, the 49th World Health Assembly, followed closely by the World Health Organisation and the UN Population Fund, declared violence against women a public health issue (WHO, 1997; Hedin, 2000). The 43rd session of the UN Commission on the Status of Women recognised that violence against women is escalating in all cultures, societies and socio-economic groups and consequently the prevalence of mental disorders in women throughout their life cycle is on the rise (WHO, 2000).

Violence against women as a public health issue was highlighted in the early work of pro-feminist medical researchers in the United States. They found that hospital responses to women abused by intimate

partners could revictimise them, if the form of violence was identified at all (Stark et al., 1979). Evan Stark, Ann Flitcraft and William Frazier found that the number of victimised women was ten times higher than that identified by hospital staff, and condemned the fact that:

At first, single episodes of injury are seen as legitimate medical problems. But as it becomes clear that neither the women presenting with these injuries nor the injuries, on an aggregate, are responding to treatment, these women's problems are reinterpreted as symptoms of particular social or psychopathologies, for example, alcoholism or depression. Because it is now the women who are seen as owning the problems, they (e.g., rather than their assailants) become the object of medical management.'

(Stark and Flitcraft 1996, pp. 15-16)

Women's satisfaction with medical responses to their disclosures of abuse was explored in the earliest domestic violence phone surveys conducted in Australia in the 1980s (Women's Policy Coordination Unit, 1985; Queensland Domestic Violence Taskforce, 1988). They found many abused women turned to their GPs if they disclosed to anyone, but that many were not satisfied with the responses. Both reports recommended the urgent provision of training for health professionals, so that doctors in particular would be better informed and feel more confident to respond supportively. Both in Australia and overseas, undergraduate medical and nursing courses have since attempted to incorporate education about violence against women (Committee on Wife Assault, 1990; Hendricks-Matthews, 1992; Hoff and Ross, 1995; Kassebaum, 1995; Schoonmaker and Shull, 1994; Alpert, 1995; Ambuel, 1996; Brandt Jr, 1997; Tomaszewski and Ollie, 1993).

In response to women's needs and concerns, accreditation and continuing education programs for Australian general practitioners (GPs) are paying more attention to improving GP communication and counselling skills and increasing understanding of the health effects of violence. The Royal Australian College of General Practice (RACGP) has developed and updated a continuing medical education program and manual for GPs on Violence Against Women (RACGP Training Program, 1999; Women and Violence Project RACGP, 1998).

While all this is excellent progress towards achieving better-qualified doctors, significant problems remain. These include:

- Undergraduate training about violence against women is a very small, introductory segment of medical training
- Training for GPs about violence against women is in its infancy
- Participation in continuing training is voluntary

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- GPs have not been trained to handle the tensions in identifying and managing victims, abusers and their children
- There is little research or evidence underpinning what doctors should be taught – what is good practice?
- The training is not yet adequately evaluated, especially from the victimised women’s point of view
- There is a lack of proper infrastructure and support for doctors to undertake this task

These are significant problems that have yet to be addressed (Head and Taft, 1995; Taft, 2000). In the meantime, pregnant, victimised women will continue to present troubling and unresolved symptoms to their family doctors and antenatal clinics.

In the US, a special edition of the *Maternal and Child Health Journal*, reporting the discussions and recommendations from a 1999 national Conference on Violence and Reproductive Health, summarised the ways in which violence affects women’s reproductive health. Including the possibility of forced sex, women may be unable to:

- Control or negotiate satisfactory or consistent contraceptive use
- Protect themselves against infection from HIV or STDs
- Plan a pregnancy
- Remain free from assault during pregnancy
- Access health care, including screening or antenatal care (Spitz and Marks, 2000)

Based on findings from interviews with pregnant abused women, Campbell, Oliver and Bullock (1993) proposed four categories of abuse which might explain the differing rationales for violence from abusive partners:

- 1 Jealousy toward the unborn child
- 2 Anger toward the unborn child

- 3 Pregnancy specific violence, not directed to the child
- 4 ‘Business as usual’.

The Women’s Safety Survey, an Australian national population prevalence study of violence against women, found a common experience of victimised women to be their abuse during pregnancy (Australian Bureau of Statistics, 1996).

How widespread is abuse in pregnancy and who is affected?

Dilemmas in measuring intimate violence and abuse

Before considering the prevalence of abuse in pregnancy and after birth, it is important to understand the broader problems associated with the measurement of domestic violence and abuse against women. Researchers originate from different disciplines and theoretical backgrounds, so they differ in their definitions of abuse among couples and the tools with which they measure the problem. Others have thoroughly and critically reviewed these issues (Hegarty and Roberts, 1998; Domestic Violence and Incest Resource Centre, 1998; Ferrante et al., 1996). A special edition of *Violence Against Women* (Vol. 6, 2000) was devoted to the measurement and surveillance of violence against women (Campbell, 2000; DeKeseredy, 2000; Davis, 1988; Bachman, 2000; Gordon, 2000; Schwartz, 2000; Gelles, 2000).

Fundamentally, scholars can either limit their measures to physical violence or legal definitions, including physical and sexual violence alone, or they can expand their definitions to include other experiences reported by women, such as emotional abuse and harassment (Hegarty et al., 1999). Additionally, questions can inquire about individual actions, such as slapping or stalking and ask about severity, frequency, motives and outcomes. Whether they are asked in person, on a self-report questionnaire or over the telephone, all affect the prevalence rates uncovered. Non-English-speaking women are often excluded because of language problems and the cost of interpreters. Lastly, researchers will not approach women if their partners will not leave their side, so that they do not jeopardise their safety.

This places in context the complex challenges involved with the measurement of violence around pregnancy, challenges which are extremely pertinent when considering the arguments for screening. Studies in pregnancy can ask about various times of abuse: abuse over the lifetime of a woman, in a previous relationship or pregnancy, or about abuse in the current pregnancy or after the birth (Murphy et al., 2001). This can cause uncertainty about

whether the abuse is specifically pregnancy related. Sometimes it is unclear whether violence occurred years before (and is ongoing violence) or it began in the months before the pregnancy and is pregnancy-related (Ballard et al., 1998). Is the perpetrator a current or a previous partner, the father of the child or another family member or person? Prevalence rates can also vary depending on in which period the data is gathered, as abused women often attend in the last few months of pregnancy. Such methodological differences can limit the results, under-estimate the overall prevalence and result in difficulties in comparing studies.

The prevalence of violence in pregnancy

A recent significant overseas review of fourteen studies of the prevalence of violence against pregnant women (including Webster's 1994 Australian study described in detail below) clearly illustrates the different outcomes according to the measures used, the population studied, the periods observed and the study methods (Gazmararian et al., 1996). The authors found prevalence rates of violence against pregnant women of between 0.9 per cent and 20.1 per cent, depending on whether the study was population- or clinic-based, what form of abuse was measured, who perpetrated it, and the population characteristics of the women (such as their age, ethnicity or socio-economic status). Eight of the eleven studies, using data from one-off in-person interviews and similar measures, found rates of between 3.9 per cent and 8.3 per cent. One study of 548 Canadian women (Stewart and Cecutti, 1993) found that the rate of abuse (6.6 per cent) did not vary over five different antenatal sites, but that 60 women (10.9 per cent) were abused before the pregnancy, suggesting prior abuse as a clear risk for abuse during pregnancy. In this sample, 23 of the 36 women abused in the current pregnancy (63.9 per cent) reported that the level of abuse had risen, 11 (30.6 per cent) that it was as much as before and only 2 (5.6 per cent) that it was less than before. Five women (13.9 per cent) were abused for the first time during the pregnancy (Stewart and Cecutti, 1993).

Australian data on the prevalence and nature of violence against pregnant women

In 1996, the Australian Bureau of Statistics conducted a national population study of violence against women, the Women's Safety Survey. It reported data on over 6000 Australian women physically or sexually abused or threatened in ways prosecutable under Australian criminal law. The survey found that 1.9 per cent of women had experienced sexual violence during the past twelve months and that 18 per cent had experienced sexual violence

in their lifetime, but they were not asked about any pregnancy outcome. Twenty-three per cent, or one in four or five Australian women, had experienced violence from a male partner during their lifetime. This rate was higher (42 per cent) among separated or divorced women, compared with the 8 per cent of those in current relationships. Within the previous twelve months, 2.6 per cent of women had been abused by male partners, although the rate was higher (7.3 per cent) in younger women. Just under half of the abused women (46 per cent) experienced abuse in pregnancy, 20 per cent for the first time (Australian Bureau of Statistics, 1996).

Prior to the ABS study, Webster and her colleagues in Brisbane found that almost a third (29.7 per cent) of over 1000 women presenting to an antenatal clinic had ever experienced abuse (Webster et al., 1994). Eighty per cent of the abusers were intimate male partners or ex-partners. Five point eight per cent of the women had experienced abuse in the current pregnancy; this rose to 8.9 per cent at 36 weeks when late-presenting women arrived. Fifty-two (18.3 per cent) said they were abused for the first time when they were pregnant in this current or a previous pregnancy. Fourteen of these women stated that the abuse had increased since the pregnancy was confirmed. The authors were shocked at the high rate of abuse among the 103 teenagers over 16 (44 per cent) and the severity of the abuse, described below, that some women suffered.

- 23.5% said they were pushed, shoved or slapped
- 13.2% said that they were kicked, bitten or hit with a fist
- 5.8% reported serious threats to their life
- 5.6% that they were choked or strangled
- 5.3% were sexually abused
- 3.7% that they were hurt with a knife or gun
- 4.7% ticked all categories

A third had sought treatment related to injuries from the abuse during the pregnancy. Over ten per cent (113) of the sample was Aboriginal/Islander and, without analysing the groups separately, it is unclear what role Aboriginality played.

In this study, single or de-facto, separated or divorced women, those on home duties, and women with lower levels of education were more likely to experience abuse across all three categories of severity. Markers of risk such as youth, marital status, education and low income have been found across many other studies (Goodwin et al., 2000; Stewart and Cecutti, 1993; Hedin et al., 1999; Martin et al., 2001).

Recent evidence has emerged overseas of a signifi-

cant proportion of abused women with unintended and rape-related pregnancies and among women seeking abortion. Some of this evidence is specific to the makeup and culture of the United States. However, it raises important questions about the possible scope of similar problems of the relationship of partner abuse to unintended and unwanted pregnancies in Australia.

Violence against women and unintended, unwanted and rape-related pregnancies and abortion

Australian studies have highlighted the high risk of abuse among teenage and young women (Australian Bureau of Statistics, 1996; Webster et al., 1994). A recent study in Chicago found that African-American teenage girls who experienced partner abuse had their birth control methods sabotaged by boyfriends verbally or physically in proportion to the severity of the violence they were suffering. The study investigated how intimate male partners of young Black women limited their agency, by putting pressure on, or coercing them over, decisions to become pregnant or to study or work (Centre for Impact Research, 2000).

A US national women's study conducted three waves of telephone interviews (one per year) of more than 3000 women over 18 to investigate rape-related pregnancies and their perpetrators. Thirteen point six per cent of women reported lifetime prevalence of rape (non-consensual oral, anal or vaginal penetration) and five in every hundred women reported rape-related pregnancy. While for 58.8 per cent of women the pregnancy was the result of a single rape, in 41.2 per cent of cases, repetitive rape was involved (Holmes et al., 1996). Twenty-nine point four per cent of the perpetrators were boyfriends, 17.6 per cent husbands and the next most frequent categories were friends or other relatives, emphasising the vulnerability of women to males close to them. Almost half of the first rapes and rape-related pregnancies occurred when women were less than 18 years old. Women kept the baby in 32.3 per cent of cases; 50 per cent underwent abortions; and 5.9 per cent placed the infant for adoption. Eleven point eight per cent resulted in spontaneous abortion (Holmes et al., 1996). There is no equivalent Australian analysis linking rape to unintended pregnancies, abuse or abortion although the Australian Longitudinal Women's Health Study (Women's Health Australia) has the capacity to do so.

In the United States, the Pregnancy Risk Assessment Monitoring System (PRAMS) routinely surveys women in 14 states after their recent delivery. This large-scale population study of almost forty thousand women who had delivered in the last two to six months, found that violence was linked to pregnancy planning (Goodwin et al., 2000). The

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women's former or current intimate partners inflicted 75 per cent of the physical violence, the only form inquired about. Women with unwanted or mistimed pregnancies reported higher rates of physical violence at any time during the twelve months before conception (12.6 per cent) or during pregnancy (15.3 per cent) than women with intended pregnancies. Overall, women with unwanted pregnancies had two and a half times the risk of experiencing physical violence than did women with intended pregnancies. The overall prevalence of abuse around the time of pregnancy (12 months before and during the pregnancy) was 8.8 per cent.

In relation to the timing of abuse, this study found that 3.2 per cent of women reported abuse only during the 12 months before the pregnancy, 1.5 per cent only during the pregnancy and 4.1 per cent during both time periods. This suggests that about half experienced abuse throughout both periods, similar to Stewart and Cecutti's (1993) finding of prior abuse as a risk factor for abuse during pregnancy. Women with intended pregnancies reported less abuse at each period. Violence was four times higher among women whose partners did not want the pregnancy. Similar to the Australian studies, it was higher among younger women, those with less education, on benefits, who had delayed antenatal care and those who smoked. However, it is important to note that maternal characteristics modified the effects. Similar to late attendance for antenatal care, pregnancy intendedness as a risk marker for abuse is more significant in women with higher socio-economic status, as younger, poorer women already have many risk markers for violence (Goodwin et al., 2000).

The links between child and adult abuse and pregnancy

There are strong, well documented links between childhood victimisation and later victimisation in adulthood (WHO, 2000; Australian Bureau of Statistics, 1996). Child rape (or incest) under 16 years or severe beatings by parents or carers are associated with an almost four times greater risk of partner abuse in adulthood or almost three times greater risk of adult rape (Coid et al. 2001). Childhood victimisation (as well as inducing coexisting mental health problems), can result in

difficult sexual and interpersonal relationships and unsafe sex behaviours (WHO, 2000). Interestingly, one in five unintended first pregnancies are associated with the woman's experience of abuse and household dysfunction during childhood. The greater a woman's childhood history of abuse and dysfunction, the greater is her risk of unintended pregnancy (Dietz et al. 1999). Another area which is slowly emerging and for which we need further understanding in Australia is the link between partner abuse, forced sex, contraception, pregnancy and women's decisions to continue or terminate a pregnancy. New evidence overseas suggests that abused women will seek to abort unintended or unwanted pregnancies.

Abuse and abortion

PRAMS, (outlined above) was limited to women with pregnancies resulting in live births. A recent study of 486 women over 18 seeking abortions in an urban US abortion outpatient clinic asked women about any physical abuse over the previous year and/or any inflicted in this pregnancy (Glander et al., 1998). Thirty-nine and a half per cent had a history of some form of abuse. Abused women were significantly less likely to inform the partner of the pregnancy, to have the partner support the decision to abort or to involve him in the process. The timing of the pregnancy was the most common reason for termination. While this did not differ significantly between the abused and non-abused groups, relationship issues did significantly affect the abused women's decisions to abort more than those of the non-abused women. There are limitations to this and other studies linking abuse and abortions and the real prevalence of abuse among women seeking terminations requires more study as it may be higher (Hedin and Janson, 2000; Webster et al., 1996). While there is evidence of high abuse levels among women with unintended and unwanted pregnancies, we need further understanding of the role the abuse and the perpetrator played in these pregnancies.

To summarise, both in Australia and overseas, intimate male partners, or others close to pregnant women, abuse approximately four to nine of every hundred women during pregnancy. Abuse can continue after the baby is born. Younger women, particularly teenagers, single, separated and divorced women, Aboriginal women and those with low socio-economic status, women with unintended or unwanted pregnancies and who attend late for antenatal care appear to be at greater risk. Because many of the pregnancies can be unwanted, a higher proportion of abused than non-abused women seek to terminate their pregnancies and this should be investigated among Australian abortion services. Abused women may be over-represented among those with miscarriages. Previous abuse is also a warning sign of abuse during the pregnancy,

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although some women are abused for the first time during the pregnancy and violence can commence or continue after delivery. The abuse can impact adversely on both the woman and her current and previous children. If she was abused herself as a child, the detrimental effects of violence can compound and extend into adulthood and beyond into the next generation.

What are the dangers to the mothers' and children's health and wellbeing from this form of abuse?

The studies by Webster et al. and others demonstrated that severe violence can be inflicted on pregnant women. The violence may commence or escalate and the patterns may alter in pregnancy, with some women having multiple injury sites (such as head, limbs and neck) while others have the violence targeted to their abdomen (Stewart and Cecutti, 1993; Parker et al., 1994). However, some women experience decreased violence during pregnancy and attempt to remain pregnant to protect themselves (Mezey and Bewley, 1997).

In general, abused women are at greater risk than other women of physical injury (or homicide), gynaecological problems, complications in pregnancy and childbirth, depression, anxiety, chronic somatic disorders, sexually transmitted diseases (STDs) and HIV infections and eating disorders. This can lead to their increased use of health services and resources (Eisenstat and Bancroft, 1999; Sasseti, 1993). Women who are abused in pregnancy are more likely to smoke, use drugs and antidepressants, have a poor diet, poorer levels of support, higher miscarriage rates and to make more use of social workers (Webster et al., 1994; Stewart and Cecutti, 1993).

Roberts and colleagues in Brisbane found women who have experienced abuse have significantly greater risks of serious mental disorder and harmful drug and alcohol abuse than non-abused women. Women, who were doubly abused, in both child and adulthood, were at significantly greater risk than those abused as adults only (Roberts et al., 1998). The relationship between violence and depression and anxiety in women is well documented. In severe cases, this extends to suicidal behaviour. An

evidence-based review of Women's Mental Health for the World Health Organisation outlines how violence, by forcing submission and enforcing a sense of subordination, engenders a sense of defeat, loss of self esteem and diminishes women's coping capacity.

He'd go off to work each day and come home and say, what have you done all day? You know, because I'm still in my dressing gown and ragged and grey and the house is a mess. The baby was spotless but the house was a mess ... So he started bagging me generally. The relationship became probably very much abusive while I was depressed. I mean I got bagged for it, told I was hopeless.

Several overseas studies have suggested that abuse could induce preterm births and affect babies' birth weight. While older women have an elevated risk of preterm birth (Verkerk et al., 1994) younger and teenage pregnant women have higher rates of partner abuse (Stewart and Cecutti, 1993). Adult pregnant women suffer greater severity of abuse than do younger women (Parker et al., 1994).

Violence and birth outcomes

In 1996, Webster and colleagues examined the relationship of abuse to birth outcomes in the same group of women from their previous study (Webster et al., 1996). The 10 per cent of Aboriginal and Torres Strait Islander (ATSI) women are more visible in this study. ATSI women have double the number of foetal death and low birth weight infants compared with non-Indigenous Australian women (Plunkett et al., 1996). ATSI women also have considerably higher rates of death associated with partner abuse (Mouzos, 1999).

The more severe the abuse, the higher were the rates of smoking, alcohol abuse and parity (numbers of births) among the abused women. When controlling for factors such as smoking, marital status, age and employment, which might also affect the birth outcome, they found no differences between abused or non-abused women's babies' gestation at delivery, length of stay in hospital or in the intensive care nursery (Webster et al., 1996). They also found an association with asthma and epilepsy not previously mentioned in other studies. When all the different factors, including Aboriginality, were included there was no difference in average birth weight between the two groups, a similar result to that found by Campbell et al. (1999).

However, a new meta-analysis of eight studies has challenged the finding that there is no difference in birth weight between the babies of abused and non-abused women (Murphy et al., 2001). Murphy and colleagues combined the data from eight studies of

women who reported physical, sexual or emotional abuse during pregnancy and found that they were 30 per cent more likely than non-abused women to give birth to a baby with low birth-weight. This finding accords with another systematic review of violence and adverse pregnancy outcomes (Petersen et al., 1997). It is wise, however, considering the acknowledged problems with measurement, to recognise the inconclusive nature of these findings. We should recognise that the health risks associated with abuse – such as stress, smoking, poor weight gain, drug and alcohol abuse – are both risk markers and/or consequences of violence. All these factors will contribute to the likelihood of a poor birth outcome, particularly low birth weight.

Well, I couldn't eat properly. My weight went down to 6 stone (from 9 stone 2), I just couldn't eat and swallow any food ... I was just sitting, sitting, sitting, my head was throbbing, like there was a ton of bricks on it, and what I did, I still cannot believe that now, that I walked about twenty kilometres three times a week, just to survive.

Violence and adolescents

Webster and colleagues' study (1994) first highlighted the risk for Australian adolescent girls (over 16) for abuse in pregnancy. Overseas studies (with limitations) have highlighted how dating partners and others close to them can harm pregnant adolescents and the consequent serious health damage to young women and their children (Wiemann et al., 2000; Covington et al., 2000). Silverman and colleagues (2001) found 18-20 per cent of US girls in years 9-12 had experienced dating violence and also had higher risks of unhealthy weight control behaviours, substance abuse, sexual risk behaviours, pregnancy and thoughts of, or attempted, suicide.

I had tried to take my life, seriously... I found that the constant anger from the moment I opened my eyes, all day, every day, whenever he walked in the door, was just so terrible. It was a battering.

Quinlivan and Evans (2001) in Western Australia investigated the risks to 537 pregnant adolescent Australian girls (aged 12-17). Aboriginal girls made up approximately 25 per cent of the sample. Unfortunately the authors do not report what form of domestic violence was being measured, who inquired about it and the relationship of the perpetrators to the girls or to the pregnancy. They explored abuse in the current pregnancy and/or the 6 months leading up to it. There were no differences between the abused and non-abused group in terms of age, height, weight or Aboriginality. They did find

significantly more abused girls had un- or semi-planned pregnancies and presented later for antenatal care, although there was no difference in gestational age at which the pregnancy was diagnosed. Whilst the rate of drug consumption (smoking, alcohol and non-prescription drugs) was high in both groups, it was significantly higher among abused teenagers. Amphetamines and solvents were abused almost solely among the victimised group. Young, pregnant and abused teenagers had significantly higher rates of social isolation and homelessness and fathers of the baby no longer involved with the mother. Ninety per cent of the girls had a major psychosocial disorder. While there were no differences in newborn weight, length or head circumference, abused girls and their babies had more neonatal and post-partum morbidity. It would have been helpful if the study reported an analysis of the two cohorts of Aboriginal and non-Aboriginal girls separately to see what contribution this made to the differences. Their experience of colonial oppression has exacerbated the high rates of partner and substance abuse, injury and deaths among Aboriginal women and communities. It is important that special care and attention is paid to the experiences of Aboriginal and Torres Strait Islander pregnant women and their babies.

Quinliven and Evans (2001) found higher rates of genital tract infection, Pap smear abnormalities and anaemia among the abused girls when compared to the non-abused. A US study comparing abused and non-abused pregnant Hispanic women found higher rates of sexually related vaginal infection (Bacterial Vaginosis and Chlamydia trachomatis) among abused women. These often-undetected sexually transmitted diseases are known to contribute to preterm births (King et al., 2000).

Homicide

Campbell et al (1993) suggest that violence during pregnancy is indicative of a more severe form of partner abuse and can become lethal. There is a growing recognition that the most severe outcome of abuse in pregnancy is pregnancy related mortality. In the US (and UK), retrospective analyses of mortality data have revealed the hidden proportion of pregnant women murdered by partners or others close to them (Parsons and Harper, 1999; Horon and Cheng, 2001; Frye, 2001). There is no analysis of this kind yet in Australia.

The impact of violence on children and young people

Exposure to violence between parents results in higher levels of physical and psychosomatic disorders, behavioural problems, post-traumatic stress and poor educational achievements in children and young people in both Australian and overseas

studies (Laing, 2000; James, 1994; Mathias et al. 1995; McCloskey et al., 1995; Fantuzzo and Mohr, 1999). Despite the limitations of research to date, there is evidence that the children of victims are not only at risk of abuse, but those who are exposed to violence suffer similar psychological and physical illness to children who are directly abused (Fantuzzo and Mohr, 1999; Laing, 2000).

He wasn't walking until 18 months. He wasn't doing normal things like other little babies were doing. He wasn't allowed onto the floor

It got to the stage where we were fighting and this is the time where [he] grabbed the chair and smashed it right next to the baby and he did that on purpose to scare me and it did hit the baby

My little one was put behind the tyre in a capsule so I couldn't leave, when she was a baby

And they don't even ask, how are these scars on the face ... why did you have X-ray on your daughter's leg ... the X-ray's done and I'm thinking that I am going to get back to that house with my child, she was eighteen months then and I'm thinking I'm in that house and these two children see me being throttled in the house

In summary, the adverse effects on health caused by partner abuse/domestic violence have been well documented. Women who are abused will develop coping strategies, which often include smoking and drug and alcohol abuse. Due to the accumulated stress, smoking, eating and sleeping disorders may result in poor weight gain during pregnancy. All these, together with poor or late access to antenatal care will compound the risks to the woman's pregnancy and her capacity to manage her own health, the pregnancy and the delivery. It may contribute to poor birth outcomes such as low birth-weight or pre-term birth and neonatal complications for the baby. In the worst-case scenario, pregnant women may be murdered, although the prevalence of this form of homicide is unknown in Australia. The children of abused women, whether abused directly or exposed to violence in their families, suffer disproportionately from both physical and psychological illness, behavioural and learning disorders.

Is screening the best way to respond?

The first and currently most popular intervention policy in the US health sector (and in some Australian states) is screening, either for psychosocial problems in general or for partner abuse in particular. The aim of screening is to enable women to disclose to health providers in order to refer them to help from specialist community based domestic violence services, police, legal and financial services. At present the majority of women do not disclose, and if they do their abuse is likely to have reached a serious level (Hegarty and Taft, 2001). If women receive an unsupportive or judgmental response from a health care provider it can discourage them from seeking further help for a long time (Keys Young, 1998). This section examines the cost/benefits of the current screening policies in Australia and overseas to women abused by partners and will examine women's own attitudes to it.

Why women don't disclose to health providers

The ABS study revealed that women disclosed to few, if any, people about their abuse. If they told any health professional, it was their GP (Australian Bureau of Statistics, 1996). There are many well-documented barriers to women's disclosures about their abuse to health care providers (Hegarty and Taft, 2001; Waalen et al., 2000; Rodriguez et al., 2001), which include:

- Shame and/or embarrassment
- Fear of the abuser and retribution
- Belief the abuse is normal and common among couples
- Fear of judgmental attitudes
- Belief or hope he will change (when the baby comes)
- Her partner is present
- The abuse is her responsibility, no-one else can help

Gerbert and colleagues have described the 'dance of disclosure', or ways in which women may suggest, hint or deny abuse because of the 'quagmire' of legitimate fears and reasons which prevent them from telling their carers (Gerbert et al., 1999; Gerbert et al., 1996). Women can give out many hints to health professionals:

I think when you go to a GP you send out all the little signals, waiting for, listen, something's happening here, for them

almost to take over and help you, but you can't actually walk in and say, look, this has happened to me and I need help. It's really hard to say that. And it's almost like, constantly, I'm really tired, I'm not coping real well ... but I'm OK and it's like you're sending out the signals but nobody picks them up

Recognition of barriers to disclosure, and of the harm to which both abused women and children are vulnerable, have led many, both in Australia and overseas, to call for routine 'screening' of women for partner abuse and other psychosocial issues (Family Violence Prevention Fund, 1999; Lapp, 2000; Thompson and Krugman, 2001; Webster et al., 2000). The term 'psychosocial' incorporates a multitude of problems, such as social isolation and homelessness, postnatal depression, drug and alcohol abuse, childhood sexual abuse or partner abuse. These problems have many different causes and solutions. They can exist separately or be entangled in the same woman's complex history. There are many questions about the accuracy of screening tests as they can lead to labelling women, which may be accompanied by stigmatisation and costs to women. In addition, there are serious reservations about how well prepared the staff and services are to respond. Several scholars have begun to question the wisdom of calling for universal screening of psychosocial issues, and partner abuse specifically, without the evidence that we will do no harm (Lawler, 1998; Taft, 2001; Marchant et al., 2001).

What is 'screening' and how should we assess it?

Screening is a scientific and biomedical term, which can be defined as:

The systematic, population-wide application of a test to identify symptom-free individuals considered to be at sufficient risk of a specific disease or disorder to benefit from further investigation or direct preventative action. (Wald, 1994 cited in Lawler, 1996).

There are specific scientific principles guiding whether screening should be applied, listed in the Table below.

The disease

It must be an important health problem

The natural history of the disease must be understood

There should be a recognisable or early symptomatic stage

The screening test

There must be a test or examination of reasonable sensitivity and specificity

Screening must be continuous

The test must be acceptable to the population screened

Intervention or follow-up

Facilities must exist for assessment and treatment

There must be an accepted form of treatment

There must be an agreed policy on whom to treat

Economy

The cost of screening patients (including diagnosis and treatment) must be economically balanced in relation to possible expenditure on medical care as a whole

(Lawler, 1998)

Violence as 'disease'

While the consequences of violence against women may be diseases such as STDs and mental disorders, violence is not a medical but a social problem (notwithstanding its recognition both nationally and internationally by health organisations as a serious health issue). Hence the use of a biomedical term such as 'screening' is both misleading and undesirable, as the 'treatment' is not within the medical profession's remit, but located more broadly in the entire community. Further, the natural history of intimate partner abuse is poorly understood although there are common patterns, such as the 'cycle of abuse', which affects about 60 per cent of victims (Walker, 1983). The common 'symptoms' or warning signs of partner abuse in the early stages are complex and multi-faceted, in comparison to the often clearer symptoms of serious disease.

The screening test

There are two important features of a screening test. The first is how effective it is at avoiding false-positives – that is, telling someone they have a disease when they don't. The second is how successful it is at avoiding false negatives – identifying a person as without the disease when they have it. The degree to which a test avoids false positives is called its sensitivity and to which it avoids false negatives is called its specificity. The screening tools or tests applied to identify diseases are tested rigorously to find out if they will avoid these errors. Most tests are biomedical, via fluid samples, X-ray and/or lab testing and are vital with

life-threatening illnesses to guide appropriate treatment. Unlike domestic violence, they are usually applied to identify an illness the person is unaware of, such as cancer. Most victims do not have to be told they are abused.

Research measurement tools for psychosocial issues such as postnatal depression, drug and alcohol abuse or partner abuse are different and have many layers of carefully tested questions to increase their accuracy. They are inappropriate for regular use in antenatal clinic or GP visits as they take a long time to administer. Is there a sensitive and specific screening tool for violence against women, or domestic violence? Certainly there are many scholars trying to find one set of questions, which can be used continuously in health care settings – one both rigorous (that accurately identifies all women who are abused) and pragmatic (quick/short) to use (Koziol-McLain et al., 2001; McFarlane and Gondolf, 1998; Norton et al., 1995; Feldhaus et al., 1997).

NSW and Queensland health services have been piloting screening programs in antenatal and emergency departments. The domestic violence 'screening tools' used are different from each other. The Queensland measurement tool does not refer to partners at all, but asks about fear of anyone at home (Queensland DVI, 2000). The New South Wales tool was adapted from the short, but popular Abuse Assessment Screen (McFarlane et al., 1992), and only asks about physical abuse by partners (Irwin and Waugh, 2001). This raises a number of important questions. Are they missing women who are controlled by partners' threats, humiliation and denigration? What is being measured in a (usually much shorter) screening tool and who is counted as 'an abused woman'? Should all women who answer 'yes' to any of these questions be defined as abused? If a woman says 'no', is she a 'false negative' or choosing not to disclose, and what are the implications of this? These factors have an important bearing on the reported prevalence rates in different health settings, on what is taught to health professionals and on the form any intervention should take. The brevity and scope of short screens cast serious doubt about the sensitivity and specificity of 'tools' and whether such strategies should be pursued.

Women will respond differently to direct inquiry, depending on their level of trust in their carer, their level of fear and the relative comfort and familiarity of the different settings of a hospital antenatal clinic or general practice. Women do disclose more readily if they are being asked regularly throughout their pregnancy (Norton et al., 1995). It is seriously doubtful whether any one form of words will be more or less comfortable or even desirable for every practitioner and appropriate to every culture, age and class of woman. If we value women's agency in knowing when it is safe and right for them to disclose; if we recognise that providers can have different sexes,

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cultures and personalities and consequently their own ways of inquiring sensitively; if we teach them to listen sensitively to women's cues and unique circumstances and leave them to inquire in their own ways, we may be more successful in offering women a better quality of care (Taft, 2001).

Is screening acceptable to women?

Screening in health services can mean anything from routine questions of all women over a certain age about previous or current violence at routine women's health checkups, or during one-off or all consultations, or in a first or at every antenatal visit. When studies ask about screening, it is not always clear what they mean, making it unclear what women's preferences and options might be. As the studies below demonstrate, women's answers depend on what they are being asked and their abuse status.

The first evidence of the broad acceptability of routine inquiry resulted from an often-quoted small study of 164 primary care patients and 27 physicians, who were surveyed about attitudes to inquiry about domestic violence. Seventy eight per cent of the patients favoured routine physical abuse inquiry and only 68 per cent favoured routine sexual abuse inquiry. However, only 7 per cent of patients were actually ever asked about physical abuse and 6 per cent about sexual abuse. Ninety per cent thought doctors could help with the problems, but there is no indication of how many patients were abused and, if they were, whether their opinion of routine inquiry was different from those who were not abused. Only a third of the doctors felt that questions should be asked routinely. Two thirds never asked routinely although 81 per cent felt that they could help (Friedman et al., 1992).

More recently, two studies asked specifically about attitudes to being screened and did discriminate among abused and non-abused women (Gielen et al., 2000; Stenson et al., 2001). Gielen and colleagues compared 240 randomly selected non-abused women from a US health maintenance organisation with 202 who disclosed physical abuse. Overall, when asked whether health care providers should routinely screen all women for physical and sexual abuse at all visits, only 54.5 per cent of abused women and 41.5 per cent of non-abused women agreed. While most (86 per cent) thought screening

would make it easier for women to get help, 11 per cent thought they would lose their health insurance. Abused women were 1.7 times more likely to think routine screening would insult non-abused women, and 1.5 times more likely to believe it would put women more at risk from their abuser. However, while the support for screening is low at just over 50 per cent, abused women were 1.5 times more likely to support such a policy.

In contrast, Stenson and colleagues asked 879 pregnant women attending a Swedish antenatal clinic who had been screened at several visits to describe how they felt when being asked questions from the Abuse Assessment Screen (Stenson et al., 2001). They coded the answers into four exclusive categories and compared women who had disclosed to those who had not. Women who had not disclosed were significantly more likely to find the questions acceptable (82 per cent) than those who disclosed abuse (71.7 per cent). Significantly more who had disclosed (13.9 per cent) found them both acceptable and unacceptable/disagreeable than those who hadn't (2.7 per cent). Almost double the victimised women (4.8 per cent) found them unacceptable/disagreeable compared with 2.7 per cent of those who did not disclose. The authors note the more equivocal findings of women who disclosed and express regret they could not distinguish those abused currently from those abused in the past to explore whether there are differences between those women.

The costs of screening for women

These studies suggest that routine screening is supported in principle by a majority of women, but that there are many qualifications, especially from women who disclose abuse when they are asked more discriminating questions. The question about whether we should ask routinely seems predicated on the quality and safety of the health system response. We cannot assume that, because many women have never been asked (Mazza et al., 1996; Hegarty and Roberts, 1998), they necessarily want to be asked routinely, whatever response the health provider makes.

Newer concepts of screening come with more of the baggage of surveillance and state and professional control over families and individuals which have been radically and effectively critiqued by Foucault (1973) amongst others. A careful balance must be struck between the rights of individual citizens and the population health responsibilities of government and its agencies. Such tensions are found in the debates about screening for domestic violence in general practice. The major reason for inquiring about violence is the potential to reach women early and offer them the information, support and options for intervening or stopping it. Early intervention offers the potential to help children and men also, when services have the expertise to provide best

practice responses. However, without expertise and good practice, identifying and ‘diagnosing’ victims can have detrimental effects. This can occur when screening is implemented before doctors have the confidence and expertise to respond (Cole, 1999). Poor responses, still visible in current practice, can have negative consequences for the victims, such as revictimisation, stigmatisation or feelings of hopelessness (Head and Taft, 1995; Taft, 2000).

So I kept going back and of course I was branded a neurotic woman

Every two weeks I'd be at the doctors ... I just felt that it was someone impartial that would listen. But he wasn't impartial at all. He didn't care

There are further considerations. If women are assigned diagnoses of psychological illness as a result of domestic violence, their abuser can use this in courts as a reason to gain custody of the children. When doctors report children at risk from the abuser, women can be blamed by child protection agencies for not protecting their children from him and their children could be taken away. In the US, abuse identified in a woman's records can detrimentally affect her health insurance (Heise et al., 1999) or put a woman at risk if there is no protocol over file management and the abuser sees the files (Cole, 1999).

Is screening an adequate intervention?

Two pilot screening studies have now been completed in Queensland and NSW. Neither followed up to evaluate the long-term impact of the screening process on the lives of abused women (Irwin and Waugh, 2001; Queensland Health DVI, 2000). Screening forms in Queensland varied from asking about physical abuse, humiliation or fear-inducing behaviour over the last twelve months to asking in the emergency department solely about whether anyone made a woman afraid. The form goes on to ask if women want help. It also asks permission to send the information to their GP. The NSW screen asked about physical abuse, fear and safety then also offered help at the time.

In NSW, only 24 per cent of women were screened due to the lack of privacy to ask questions, the limited time to do so with heavy workplace demands, staff discomfort with asking personal questions and uncertainty about what to do if women did disclose. The providers who undertook training, similar to the RACGP finding, had a sound knowledge of the indicators and effects of domestic violence but were under-confident about how to respond (Women and Violence Project RACGP, 1996). The NSW report recommended sustainable training, an improved environment for screening and the implementation

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of protocols. Sixty-seven per cent of women asked thought it most appropriate for their GPs to inquire, with the majority saying it was ‘OK’ or feeling relieved about being asked. Reservations about inquiry, confidentiality and disclosure were greater in rural communities. Eleven per cent (106) said they had been physically abused or were fearful of partners. Twelve (11 per cent) did not feel safe to go home and 32 (30 per cent) accepted some help. The evaluation suggests a considerable level of abuse, but staff unprepared and under-confident about their ability to help.

In Queensland, stage 2 of their screening initiative has been completed. Screening rates were higher in Queensland (82 per cent) than NSW, with the highest rates achieved in antenatal clinics (89.2 per cent). Rates of screening and disclosures varied substantially from the emergency departments (23 per cent of all women screened and 8.5 per cent disclosure) through gynaecology (45 per cent screened and 12.4 per cent disclosure) to antenatal clinics (89.2 per cent screened and 6.8 per cent disclosure). Over the two stages of this pilot, between 10-14 per cent of women who disclosed, accepted help, but none in either emergency or gynaecology departments. This was a source of frustration for staff. Forty-four women who had screened positive were surveyed about this when they returned to the hospital at their 36-week visit. Fear, hope of change, shame and self-blame were common reasons women gave for not accepting help from health staff or that the situation may have resolved itself. Some suggested that women were not ready for change and some women wanted help for their partners also. Women said they received and valued help from friends and family, counselling and groupwork, police, legal and welfare assistance. The report's authors noted that it was difficult to ascertain anything about client satisfaction with screening but more about their satisfaction with other agencies' services.

Few studies have documented the steps following disclosure of abuse, including treatment, support and referrals to other agencies. Indeed, links between the health care setting and other services need to be investigated to ensure clients are experiencing a supportive and smooth transition between agencies

(Queensland Health DVI, 2000, p. 39)

The Queensland Domestic Violence Initiative has progressed the development and implementation of

screening for domestic violence and in doing so, has developed protocols and processes which will be invaluable for those wishing to implement routine inquiry in the same or in a different manner. They have argued that the process of disclosure and inquiry itself is a beneficial intervention. However, there is little thorough evidence to support this. Project staff are now developing mechanisms to negotiate with GP divisions about training and to investigate what happened when they informed GPs about women's abuse status. This information will be important for the development of quality care for pregnant women who disclose in the hospital setting. Despite the limitations of both pilot studies, both reports have recommended increases in screening in both states.

Strengthening effective responses in the health system

Screening policies focus on increasing the numbers of disclosures. This emphasis may be at the cost of ensuring quality of care, especially the care and support women are able to receive from the provider to whom they disclose. Women who are abused want sensitive, supportive and well informed health care providers (Head and Taft, 1995). One of the greatest barriers to women's disclosure is the fact that health professionals don't ask and are reluctant to screen (Parsons et al., 1995; Chamberlain and Perham-Hester, 2000). The reasons they don't ask are complex and include many personal and professional barriers. Staff can hold prejudicial beliefs about abuse, who is vulnerable to it and who perpetrates it. They may hold other inaccurate beliefs. One major reason is their lack of effective training (Head and Taft, 1995; Hegarty and Taft, 2001; Ferris, 1994; Sugg and Inui, 1992).

Why health providers don't want to ask

The barriers for doctors can include that they may:

- not recognise non-physical symptoms
- fear offending patients
- not know how common domestic violence is
- believe if they do not see it, it is not a problem, so do not ask
- not have the time
- not understand the consequences
- experience identification with patients
- have experienced violence themselves as victims or abusers
- not believe that the man could be an abuser

- feel powerless
- be ignorant of community domestic violence agencies
- and in the case of some male GPs, think that their gender is a barrier

(Taft A, 2000)

Many doctors believe that they should inquire, have a growing belief that it is their professional responsibility to do so, but most still do not and if they do, believe they don't detect sufficient numbers (Ferris, 1994). This can be a source of distress and feelings of powerlessness, particularly for concerned GPs (Taft, 2000). Even after training, the Australian state screening pilot evaluations found that many health personnel are still reluctant to inquire (Queensland Health DVI, 2000; Irwin and Waugh, 2001). More importantly, sustaining the learning from education and training and building expertise is difficult at present, particularly in busy emergency departments.

In America, it appears that those doctors who either ask or respond are only doing so with certain women. PRAMS, the large sentinel surveillance system described earlier, found that pregnant women with more risk markers for abuse (young, poorly educated, those on welfare and non-white) discussed abuse with their health providers. However, women who were abused were only likely to discuss abuse with providers in 52 per cent of cases. While this varied from state to state, providers were only discussing physical abuse with certain women and not always with those who were abused (Durant et al., 2000). Similarly, in Australia, Hegarty (1998) found that those few women who were asked about abuse by their GPs were older and had experienced severe, combined abuse.

Problems within current management of partner abuse by health professionals

Before routine inquiry about abuse with all women is implemented, we need to ensure that the system in place responds to the very real need of women for safety and confidentiality and that women can trust that if they disclose, the health provider will respond with sensitivity and informed support. Recent research with family doctors found that:

- Some doctors will undertake or prescribe couple counselling when there is violence, despite this being contra-indicated (Ferris et al., 1999; Ferris et al., 1997; Taft, 2000).
- Some will break confidentiality by talking to abusers or other family members from concern for the victim, which can result in further violence (Taft, 2000; Bowker and Maurer, 1987).

- Others will advise leaving before the woman is ready or able to leave and will be frustrated with ‘non-compliance’ when she returns and hasn’t done so.
- Many GPs are unaware of the links between domestic violence and child abuse, of the impact of domestic violence on children, and of how to manage this issue
- The impact of having to manage many increasingly complex psychosocial issues with inadequate training, counselling expertise, supervision or debriefing is impacting adversely on GPs themselves, particularly female GPs, who see more cases
- There are inadequate case management strategies developed for general practice, especially in group practices
- There are no adequate guidelines or processes between general practice and the wider family violence system (Taft, 2000).

While family doctors play a vital role in the care of pregnant and abused women, they are one part of the wider health system and whole of community response. Health provider inquiry and confidence to respond depends on effective training and institutional support. In the UK, Davidson et al. (2000) recently conducted a systematic review of the evidence for which domestic violence interventions work in health systems, in the context of the possible introduction of screening policies. They concluded that there have been no systematic evaluations and therefore there are serious limitations about what could be achieved in the UK health care setting. They noted the problems of staff time and workload, lack of sustainable, or any, staff training, lack of privacy for women and the problems when partners are present. They suggested that more testing should be undertaken before any programs are implemented and recommended short-term changes such as reviewing provisions for confidentiality, privacy, time, links to child protection and weekend provision of support for victims who disclose, prior to any major policy shifts (Davidson et al., 2000).

Similarly, a comprehensive US five-city investigation to analyse impediments to physicians identifying and managing violence in families found that:

- despite each city’s health institutions recognising the seriousness of the problem, there were no overall management responses
- existing programs were driven by charismatic leaders who developed and drove programs, which withered after they left
- health service providers who worked consistently with the problems reported being marginalised

by colleagues and facing serious economic, social and psychological disincentives to family violence work

- access to the health care system overall was inadequate for those from lower socio-economic groups
- although still inadequate, the child abuse system was the best developed, having arisen from within the health care system. However, health services were reluctant partners in addressing violence against women, because change for battered women had been initiated by the women’s movement
- there was little effective coordination among agencies responsible for addressing family violence, and
- primary prevention of family violence was only addressed by advocacy groups (Cohen et al., 1997)

Some of these conclusions, for example the reluctance of health services to be involved with perceived feminist services such as rape crisis or domestic violence services, are relevant in the Australian context.

Marchant et al. (2001) also conducted an audit of U.K. maternity services’ current policy and practices for addressing domestic violence and found great variation across the country. Only 12 per cent of 183 National Health Service Trusts had written policies and 30 per cent had agreed practices. The authors highlighted that certain common practices such as encouraging the involvement of partners and the use of hand-held records could make disclosure and safety difficult for some abused women. They also lamented the lack of national guidelines around safety and confidentiality to inform best practice. They expressed concern that, despite the close relationship between child abuse and domestic violence, there are inadequate guidelines, support and collaborative practices between the two systems for referrals and support for midwives. There was, they emphasised, a lack of evidence for the risks or benefits to women of routine questioning. They suggested trials should be conducted to provide evidence to inform recommendations about screening. The screening evaluations in two Australian states highlighted the similar limitations existing in our own system about the benefits versus risks to women.

The dilemmas in the ‘shared care’ birthing system with partner abuse

Pregnant women in Australia have many choices of models of care from which they can choose. Models of ‘shared care’ are becoming increasingly popular in Australia. In Victoria, shared care has been defined as ‘care in which women are booked for intrapartum

... change in professional practice will take many years and should commence in undergraduate education and continue throughout accreditation and continuing education.

care as public patients, with some or all antenatal care undertaken by care providers in the community' (Brown et al., 1999, p. 18). Almost half of Victorian pregnant women (46 per cent) are now receiving either shared or combined care (Brown et al., 2001). Similar to screening policies, shared care provision in Victoria was thought to be the desirable option and to be the desired choice of most women. It was assumed that shared care provision would increase women's rates of satisfaction with birthing services. On the contrary, the routine 1994 Survey of Recent Mothers in Victoria found that shared care was the least popular model of care for birthing women (Brown et al., 1999). This was also the case with women from culturally and linguistically diverse backgrounds (Small et al., 1998). The Review of Shared Care found that the model had not been adequately implemented and evaluated and that communication and protocols between general practice and hospitals needed to be improved. In the most recent Victorian Survey of Recent Mothers, women's satisfaction with this model has improved (Brown et al., 2001). Many of Davidson et al.'s findings about hand held files and the encouragement of partners to participate more fully in birthing need to be considered in shared care organisation so that the safety and confidentiality of abused women is paramount.

Challenges in improving GP management of partner abuse

Many of the community care providers are GPs. GPs are family doctors who not only see women, but also their abusive partners and their children, so potentially they could offer assistance to all family members. However, as the evidence above suggests, GPs are untrained, under-confident and poorly networked into the broader family violence response system. A recent formative evaluation of innovative GP training about partner abuse, which included working with abusers and children, found increased confidence and knowledge about resources but limited changes in the attitudes and practice of those GPs who chose to participate (Taft, 2000). This is echoed in the RACGP's own training evaluations and overseas evaluations of undergraduate medical education about the issue (Women and Violence Project RACGP, 1996; Short et al., 1997).

In America, a recent trial of GP training provided high-level evidence of mixed results. Thompson and

colleagues conducted a randomised trial of the identification and management of domestic violence in five primary care clinics of a health maintenance organisation, which manage 84,000 patients over age 20 (Thompson et al., 2000). Their training for physicians, nurses and assistants from adult care teams in Puget Sound, was randomised into control and intervention clinics, where the intervention group participated in a year-long intervention to improve practice. This included half-day training sessions, additional training for leaders, a bimonthly newsletter, clinical rounds, system support and feedback of results. The group tested staff knowledge, attitudes and beliefs at baseline, 8-9 and 21-23 months. Medical records were abstracted at baseline and nine months after the project began, to investigate rates of inquiry, case finding at specific visits and assessment of victim management plans.

This substantial effort resulted in some significant changes in staff attitudes and beliefs (about their own efficacy, safety, and fear of offending). While the changes were small, they were sustained to the 23rd month. Similar to an Australian evaluation of training (Taft, 2000), they were unable to alter perceptions that the task is emotionally draining. Audit of the medical records shows increases in inquiry and disclosure due largely to the use of a questionnaire at physical examinations. Overall their case finding (asking when symptoms are present) increased by 30 per cent. Although this was not statistically significant, it may well have been a practical improvement. The authors suggest that an audit of records is unreliable to capture the extent of behaviour change and queried the cost-benefit of the intervention. They did not survey the patients. The results suggest that change in professional practice will take many years and should commence in undergraduate education and continue throughout accreditation and continuing education.

Challenges in improving the hospital practice around partner abuse

In the US, which has a substantially different system from our own, with less primary care physicians (GPs) and more use of hospitals, there has been greater focus on hospital protocol development. Guidelines and examples of good practice protocols have recently been published, setting out the core components for protocols as including:

- definitions of domestic violence that include heterosexual and gay and lesbian people
- facts versus myths about domestic violence
- common indicators of physical and non-physical abuse
- culturally sensitive sample assessment questions and techniques

- a legal overview of health professionals' legal reporting responsibilities and pertinent criminal and domestic violence legislation
- advocacy with the police and court systems
- forensic evidence collection, including the use of photographic/body map documentation
- medical record documentation
- reviews of safety issues for patients and staff
- community referrals including batterer referrals and
- a selected bibliography (Sheridan and Taylor, 1993).

The authors recognise that protocols themselves are never sufficient and very thorough policies, procedures and problem solving are outlined. In a recent book, Stark and Flitcraft outline the need for vigilance about battering and abuse in many medical and health settings, including mental health services. They add that discharge planning is a very important area when women have been abused. This would have implications for the early discharge planning in birthing services when women have been identified as abused. They emphasise strongly the need to retain a broad perspective on the gendered nature of battering and the need for increased equality and empowerment of women (Stark and Flitcraft, 1996).

In order for routine inquiry (or screening) to be effective in health care settings, current evidence suggests that quality care after pregnant women disclose, requires:

- sustainable, effective training for health care providers;
- a safe physical and emotional environment;
- a gendered perspective; and
- the effective implementation of protocols and procedures in all ante, intra and postpartum services.

These quality control measures should be implemented prior to routine inquiry and regularly monitored and evaluated to ensure the safety, confidentiality and enhanced wellbeing of women and children.

What's effective outside the health system?

Health care providers need to be reassured that if they encourage women to disclose they can refer confidently to community-based services which will provide effective help. Women want help for themselves, their children and sometimes for their

Most health providers are unaware of, and not effectively integrated with, those community-based domestic violence services that can offer support to women and children who are abused by the men in their families.

partners. Recent editions of these Issues Papers have reviewed current Australian interventions in criminal justice (Holder, 2001), individual and groupwork approaches with women (Laing, 2001) and working with children and young people exposed to violence (Laing, 2000). Many male behaviour change groups have sprung up around Australia and accreditation and standards of practice support some. These have been evaluated here and overseas, but their effectiveness for all men who abuse remains controversial (Frances, 1996; Frances, 1998; Keys Young, 1999; Gondolf, 2000). However, most health care providers are unfamiliar with these services, unsure how to access them and unaware of the special referral processes necessary to support abused women or monitor men who abuse. These services are not specific to pregnant or postpartum women.

Over the last twenty years, substantial community intervention trials in the US have been conducted to intervene with low-income pregnant women to see whether child abuse, juvenile delinquency, repeat pregnancies and postnatal depression can be decreased among families at risk. In the journal 'The Future of Children', Gomby et al. (1999) reviewed the range of parenting education and home-visiting programs which offer support to low-income and at risk women and their children. While advising caution about the limited achievements, they also suggest that they show promise. This is similar to the conclusion reached in a UK review of trials of home visiting to prevent child injuries (Roberts et al., 1996).

One large randomised trial of nurse home visitation during and after birth until the child was two aimed to reduce child abuse and increase family planning. This showed some gains for the low-income mothers who received the nurse home visits. However, the 15-year follow-up showed that, while the intervention effects were sustained, the intervention was ineffective when chronic domestic violence was present. It was unclear whether the nurses had any domestic violence training, but was considered highly unlikely (Olds et al., 1997; Eckenrode et al., 2000).

Promising multi-strategy programs such as these are targeted to strengthening the resiliency and wellbeing of women and children. In an Irish study, first time mothers achieved better health practices for themselves and their infants in a community

mothers' program in Dublin, suggesting that peer mothering programs may be helpful (Johnson et al., 1993). McFarlane and her colleagues have evaluated this strategy with abused pregnant women. They tested several interventions to reduce or prevent abuse with a predominantly low-income Hispanic population in antenatal clinics in Texas (McFarlane and Gondolf, 1998; McFarlane et al., 1998; McFarlane et al., 1997; McFarlane and Wiist, 1997). The area of Texas where McFarlane's research was conducted provided refuges, but had no outreach or advocacy services for abused women. One hundred and thirty two pregnant women in public antenatal clinics (roughly equal Hispanic, Black and White women) who had experienced prior or current abuse, or were afraid of their partner, were compared with a control group of 67 abused women who had delivered their babies. Staff discussed partners' actions and women's safety behaviours with the intervention groups three times throughout the pregnancy (McFarlane et al., 1998). Each discussion lasted about 20 minutes. Women from intervention and control groups were given a wallet-sized card with community resources on it. Safety behaviours increased significantly over the duration of the pregnancy, increasing each visit across all three intervention ethnic groups. However, overall use of resources and the police was not related to the presence or absence of the intervention but to the severity of the abuse (McFarlane et al., 1997; McFarlane et al., 1998).

The Mentor Mother study in Texas, USA, combined advocacy for 329 pregnant abused women with home visiting and sought to improve women's safety and wellbeing. However, this intervention ceased at birth, a time when pressures on both partners from the new baby increase. This US study, which compared giving identified abused women printed information, hospital-based counselling or Mentor Mothers, found that the initial benefit of Mentor Mothers was not sustained 6, 12 and 18 months after birth, when the intervention ceased at birth (McFarlane and Wiist, 1997).

Most health providers are unaware of, and not effectively integrated with, those community-based domestic violence services that can offer support to women and children who are abused by the men in their families. There is evidence that general interventions with pregnant women at risk are effective in increasing the health and wellbeing of women and children. These should be adapted and trialed in Australia to see whether they are effective with women who are abused. More broadly, there is considerable work required to integrate case management practices between birthing services and the domestic violence service system.

Conclusion

Violence against pregnant and postpartum women is prevalent and endured by between 4 per cent to 9 per cent of pregnant women across many developed countries. The prevalence is probably much greater in disadvantaged communities. There is evidence of increased prevalence of abuse among women with unwanted or unplanned pregnancies and women seeking abortions. There is also alarming evidence emerging about the prevalence of pregnant homicide victims. It is clear that low income, unmarried, separated or divorced and poorly educated women are more at risk than others, but health care providers should be vigilant with any woman who attends late for antenatal care and with those with unwanted pregnancies. As Aboriginal and Torres Strait Islander women have many of these characteristics, overlaid with disadvantages from colonial oppression, there is an increased risk of partner violence and they may be at particular risk of violence in pregnancy.

Women who are abused often suffer mental illness, alcohol and drug abuse, high rates of smoking, poor diet, eating disorders and STDs as a consequence of the abuse. Not only are there adverse effects on women's health, but abuse can also result in serious peri and neonatal problems, more commonly low birth weight or preterm birth among their babies. Abuse adversely affects children at all stages in their lives psychologically, physically and emotionally and these can all accumulate if the abuse continues. Abuse can seriously affect women's capacity to parent effectively and there are strong links between domestic violence and child abuse.

Health services, especially birthing services, have a unique opportunity to intervene beneficially. Intervention involves inquiry about abuse in pregnant women and support to assist women to access the services they need to stop abuse and strengthen their health and wellbeing and that of their children.

Routine inquiry in birthing services is a vital goal to reduce violence against pregnant and postpartum women. At present, however, the majority of health providers and health services are ill equipped to respond to this very demanding task. Similarly to the UK, a baseline survey in Australia of the preparedness of maternity services to respond would offer a starting point from which to develop enhanced provision at local and state levels and better coordinated services across the country. There is considerable risk that if undue emphasis is placed on increasing disclosure rates, by screening in services where effective provision is not in place to ensure safety and confidentiality, women may experience harm. The popularity of shared care as a birthing model of choice for many Australian women places additional importance on improving its

effectiveness. We must ensure that any enhanced communication between GPs and hospitals incorporates the conditions required to protect the safety and confidentiality of women experiencing violence. Lastly, health services are critically important links in the overall community response to violence against women and need to be welcomed and supported to play a more effective role.

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