Australian Joint Domestic Violence & Sexual Assault Conference

Surfers Paradise
September 2001

"To screen or Not to Screen that is the Question?"

(The case for Opportunistic Screening)

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OUTLINE OF PRESENTATION

This paper will present the results of the Hume Region Maternity Psychosocial Risk Assessment Project. This project is at the end of its 2nd year and involves the integrated opportunistic screening of maternity clients across acute and primary health service sectors throughout the Hume Region of Victoria.

In particular this paper will focus on:

1. Providing an overview of the Hume Region Maternity Psychosocial Risk Assessment Project:
   - 1.1 The aims of the project
   - 1.2 The background to the project
   - 1.3 Identifying the catalysts for change
   - 1.4 The elements of the Tool itself
   - 1.5 Implementation of the project and associated challenges

2. Presentation of the Raw Clinical Data available to date, with particular emphasis on the longitudinal domestic violence data.

3.The impact of opportunistic screening on:

- Patients, their care and their views.
- Health Service Providers (Acute and Primary).
- Professional communication and networks

1. OVERVIEW OF THE HUME REGION MATERNITY PSYCHOSOCIAL RISK ASSESSMENT PROJECT:

1.1 AIMS OF THE PROJECT:

The aims of the HRMPRAT were to:

- Improve the identification and management of mothers, babies and families in psychosocially at risk situations, particularly

- Improve communication between service providers caring for the woman during the maternity episode of care.

1.2 BACKGROUND TO THE PROJECT:

The Hume Health Region of Victoria extends from Wodonga in the North East to Shepparton and its catchment in the West and to Broadford (the Melbourne metropolitan fringe) in the south. Its demography is diverse and it's population concentration ranges from rural remote and sparsely populated, in the Alpine region to rural city size in Shepparton and Wodonga . It covers approximately 250,000 square kilometers.
Sites involved in this project, funded by the Victorian Department of Human services, with a collective annual birth rates of 3,170 per annum are as follows:

- Wodonga Regional Health Service (1500 births pa)
- Goulburn Valley Health- Shepparton (900 births pa)
- Wangaratta District base Hospital (450 births pa)
- Seymour District Health Service (240 births pa)
- Alpine Health (80 births pa)

Total Birth Rate for the above 3,170 pa

Prior to August 2000 women would be "booked in" antenatally using a standard Medical/Surgical Obstetric History Sheet. In some organisations this process would take as little as ten minutes. It was a time to talk at the woman, not to engage the woman. There was little opportunity to listen to the woman or her concerns at this time.

Certainly within this very medical model of care, emphasis was placed on the physical health of the mother and her baby, pelvic capacity, foetal dimensions and presentation and preparation for breast feeding, not on establishing the mother's psychosocial wellness or adaptation to pregnancy.

So……..how did "the can of worms" present itself

1.3 THE CATALYSTS FOR CHANGE:

1998 Victorian Data revealed the following:

Perinatal Data

- 11.9% of all births at Wodonga Regional health Service (WRHS) were to single mothers (State Average was 12.5%)
- 6.3% of all births were to teenage mothers (state average was

- The casemix imperative that discharge following normal vaginal delivery be achieved within three days post delivery.

Local data revealed the following:

- A retrospective audit of 50 records was conducted in 1997, at the Wodonga Regional Health Service, to identify patient referral needs. This audit demonstrated that only 2% (n=1)of the audited patients received a referral to social work, however 12%(n=6) of that sample had indications for social work referral.

- For the 6 month period 9/98- 3/99 only 3.7%(n=28) of **all** antenatal women(n=750), received a referral to social work.

- Perceptions by clinical staff that we were clearly "missing something"

- Increased workload and system stress arising from the amalgamation and integration of birthing services across the Border, resulting in the clear need to look for new ways to manage a new service, rather than being encumbered with baggage and inefficiencies from 2 sites.

These audits clearly demonstrated that referral on the grounds of psychosocial need was inadequate, and that a better method of client assessment and referral was required.

These results were followed by a successful submission for funding to the Department of Human Services, Victoria, to develop and trial a revised assessment system for women that would improve the identification and management of those clients psychosocially "at risk".

1.4 THE TOOL ITSELF (COMPONENTS):

The Tool consists of the following components:

- A Patient Questionnaire, completed at home prior to antenatal presentation.
- a Standard Medical /Obstetric Assessment (antenatally and postnatally).
- The Qld D.V. Initiative Questions (asked antenatally, postnatally prior to discharge from hospital and postpartum at 3-4/12 by the M&CHN)
- The Maternity Social Support Scale(MSSS -RWH Brisbane)-this is a self assessment of the supports

30 mins

- The Edinburgh Postnatal Depression Score(EPDS) administered antenatally and at 6/52 postnatally
- A summary Sheet that identifies all the risk factors for the episode and that is forwarded to the Social Worker and the GP following antenatal assessment, and postnatally, and also to the M&CHN postnatally. The woman consents to her information being forwarded on to her GP and the M&CHN.

1.5 IMPLEMENTATION OF THE PROJECT:

Participation in the Project by the women was consensual.

The First Version of the Antenatal Risk assessment Tool, was piloted on 60 patients in 1998, followed by refinement and a randomized control trial on 100 patients in 1999. Patient satisfaction with the assessment process was high. Ethics approval was obtained from the Department of Human Services Victoria in late 1999 and the current version of the Tool (as outlined in the previous slide), was implemented across the project sites, commencing in August 2000. Project roll out continues across the health sector, including primary health, until the end of September 2001.

2. SO WHAT DOES THE RAW DATA REVEAL:

The outline of the results for the Hume Region as per the bar graphs is as follows (at time of preparation of presentation):

Antenatal:

Total Cohort : n = 587

Risk Factors demonstrated in order of prevalence (%):

- Recent Stressful Life event 24%
- Presented with Antenatal Depression(EPDS) 16%
- Past History of Psychiatric or psychological intervention 14%
- Limited Supports (as per MSSS) 13%
- Past History of Postnatal depression 8%
- Current History of Substance Abuse (self or partner in last 12/12) 6%
- History of Childhood Abuse 6%
- Domestic Violence Disclosure 1.8% (n=11)

with the pilot study the demonstrated a 2% identification rate)

- Social Work Offer accepted 18%

Postnatal prior to Discharge from Hospital:

Total Cohort: n = 485

Risk Factors demonstrated in order of Prevalence (%):

Birth Not According to Plan	23%
Problems with the Baby (incl Breast feeding)	18%
Late Birth Complications	9%
Domestic Violence	4%
Dissatisfied with Care	4%
Social Work consult offered	11%
Social Work Consult accepted	9%

Post Discharge Assessment for DV and PND (by M&CHN) at 6-8/52 :

Scores are presented as a percentage of the available post discharge cohort:

- **PND** scores using the EPDS:
- Total Cohort: n = 327 (including non project women)
  - Score < 9 = 85 %
  - Score >9 = 15%

Using one of the larger sites cohorts, where the EPDS had been separated between project and non project women, the data revealed that 63%, or n=33, of high scoring EPDS women (that is with Edinburgh's of 10 and above) had not participated in the project. The most common reasons cited in high scoring women were:

- Birth not according to plan
- Dissatisfied with care
- Problems with the baby

- **Domestic Violence:**
- Total Cohort: n = 136
  - Disclosure Rate = 3% of new disclosures.

NB As these were all new disclosures, it could be extrapolated from the 50% increase in disclosure rate from the antenatal to postnatalassessment, that the real disclosure rate is possibly as high as 6%. This figure of course does not relate to the incidence of Domestic Violence, simply the

3. THE IMPACT OF "OPENING THE CAN OF WORMS"

- **Improving continuity of Care for Women** across their maternity episode, by the implementation of a clinically useful vehicle of communication (The HRMPRAT):

  89% (n =57), found the information contained in the Summary sheet Clinically Useful

  97% (n =59), stated that they felt the assessment was thorough

- **Improving communication flow across the various service sectors,** health service providers (Medical Practitioners, Nurses, and Social Workers) were very satisfied with the Tool and the process in this regard:

  91% (n= 56), stated that that the Tool assisted with improving communication between health professionals

- **Improved Awareness of Issues such as Domestic Violence amongst Acute Health Staff:**

  91% (n=55), now support the practice of opportunistic screening for women in the maternity episode.

  It is to be noted that the whole concept of midwives and M&CHN's questioning women about DV was the most contentious part of the project at it's inception.

- **Improved Linkages and Networking with the Primary Health Sector, particularly in relation to DV.**
  This occurred via:

  1. Substantial education across the Hume Region provided

2. Support from the Hume Region Domestic Violence Network, (known as Womens Health Goulburn North East), at the various local sites and regionally.

3. Inclusion in the Regional and Local Domestic Violence Networks.

   This was without a doubt the most useful contact and information source that we could have had…as we were indeed "the new kids on the block" in the DV arena…and we knew it !

- **Improved Understanding of Professional Role Boundary Issues**, and how to access the appropriate level of assistance for a Family in need and ourselves. Basically what we learned was that we weren't expected to be all things to all people in this regard, and that help was out there.

- **The Women Loved It:**

  - 99% (N=94) were satisfied with their booking in assessment

  - 98% (n = 91) were happy with the fact that summary information on their assessment and care had been sent to their GP and the M&CHN with their consent.

  - Regarding the womens level of comfort with the assessment process they responded as follows:

    - 100% (n = 89) felt that the questions were asked professionally and tactfully
    - 100% (n= 83) felt the midwife was supportive in her line of questioning…and only
    - 5%, that is 4 patients, (n = 82) felt that the questions were invasive

4. CONCLUSION

the way, about their relationships both past and present…good and bad.

We all felt most privileged that the women shared some of their most personal information with us. Indeed we agreed that the assessment we were now using was enriching us as professionals, through exposure to a whole new dimension of practice, one in which we had a place….. and one in which we could actually participate proactively….a new experience for Acute Health Professionals.

We would like to take this opportunity to Thank all who have helped us along the way, but most particularly to the DV Outreach workers in the Hume Region, and to the Goulburn North East Womens Health Domestic Violence Resource Co-ordinators, Jo Loiterton and Kylie Stevens for their ongoing support of our project and our unquenchable thirst for knowledge.

Thank You.