Irish College of General Practitioners

Domestic Violence During Pregnancy – GP Survey Report

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Executive Summary

Aims and objectives of study

This survey was conducted as part of a project whose aim was to raise awareness and increase the recognition of domestic violence against women during pregnancy at primary care level.

Specifically, the objectives of this study were:

- To assess the awareness levels of GPs regarding the prevalence of domestic violence during pregnancy
- To assess current practice amongst GPs with regard to identifying domestic violence during pregnancy
- To identify GP knowledge gaps and related learning needs in relation to domestic violence during pregnancy
- To establish GP attitudes and barriers to identifying and discussing with pregnant patients domestic violence during pregnancy.

Methods

A project advisory group was convened to oversee this quantitative research. Data collection was through the use of postal questionnaires. A questionnaire was developed in view of the literature and with the input of Cosc and the HSE.

A total of 530 completed surveys were included in the final analysis, a response rate of 17.6% of the ICGP membership. Of these respondents, 57% (n=300) were female and 43% (n=226) were male.

Key findings

- Of those surveyed, 62.7% (n=331) had never asked a pregnant woman about domestic violence and 98.9% of respondents do not routinely ask all pregnant women about domestic violence.
- Almost 20% of GPs had treated between one and five women who disclosed instances of domestic abuse during their pregnancy, either spontaneously or as a result of GP questioning.
- Over half of respondents had never had a pregnant woman disclose an instance of domestic abuse during a consultation.
- All respondents, to whom a disclosure of violence had ever been made, took some form of appropriate action.
- Just over half of respondents noted improved outcomes for their patient following intervention, while 47.3% noted no change in their patient's circumstances. A small number of respondents (6) noted a worsening in their patient's circumstances following intervention.
- The majority of respondents (84%) had completed no training or education in managing domestic violence at undergraduate level, during the course of their GP training (57%) or during their continuing medical education (CME) (76%).
- Approximately 65% of respondents were unaware of any guidance document for GPs on the subject of domestic violence.

- The vast majority of respondents indicated that they would welcome further education in the area of domestic violence during pregnancy. While all defined subject areas were seen as extremely relevant to respondents, the most commonly selected were 'appropriate referral options for women who disclose', 'how to respond to disclosures of domestic violence during pregnancy' and 'legal issues and reporting requirements'.
- A large portion (63.5%) of respondents agreed that additional resources would be helpful for improved management of cases in general practice.

Conclusion

This survey provides some insight into the awareness, recognition and current practice of GPs in Ireland towards the identification and management of domestic violence during pregnancy. It also outlines necessary education requirements from a GP perspective in the topic area.

Concrete recommendations are made specifically related to guideline awareness and education based on the key findings, which suggest a need for:

- Increased GP clinical knowledge of domestic violence during pregnancy.
- Improved GPs' confidence in addressing domestic violence during pregnancy with their patients.
- Further promotion of the ICGP Domestic Violence: a guide for general practice Quick Reference Guide (2014).
- Further education on, but not limited to:

Signs and symptoms of domestic violence during pregnancy.

Appropriate referral options for women who disclose.

How to respond to a disclosure of domestic violence during pregnancy.

Legal issues and reporting requirements.

Introduction

Domestic violence, or intimate partner violence (IPV) as it is also known, is a complex and serious health and human rights issue which occurs globally across all educational attainment, socioeconomic, religious and cultural demographics (WHO, 2012). More commonly inflicted upon women by a male partner, one in three women experience physical, sexual, psychological, economic or verbal abuse by an intimate partner at some time in their life (Johnson et al, 2003; WHO, 2013).

In Ireland the most commonly accepted definition of domestic violence is outlined in the Report of the Task Force on Violence Against Women (1997) which states:

"Domestic Violence refers to the use of physical or emotional force or threat of physical force, including sexual violence, in close adult relationships [...] It can also involve emotional abuse; the destruction of property; isolation from friends, family and other potential sources of support; threats to others including children; stalking; and control over access to money, personal items, food, transportation and the telephone".

Pregnancy is considered to be a critical period during which domestic violence can begin, or escalate, due to a woman's increased physical and mental vulnerability (Jeanjot, Barlow and Rozenberg, 2008). Pregnancy can have an impact on intimate relationships be it financially, sexually and/or emotionally. Estimates of the prevalence of domestic violence during pregnancy vary, however it is thought that up to 30% of intimate violence first begins during this time (HSE, 2010; Taillieu and Brownridge, 2010). Of note, migrant women, women with substance abuse issues, and young women and adolescent girls are considered to be at a higher risk of abuse during pregnancy (Espinosa and Osborne, 2002; Stewart et al, 2013). Some women who are subjected to domestic violence before pregnancy have identified how the rate and severity of violence within their intimate relationship increased dramatically during pregnancy (Karmaliani et al, 2008; Talilleu and Brownridge, 2010). Contrastingly, instances of domestic violence may decrease during pregnancy, and escalate again in the post-partum period (Martin et al, 2001; Charles and Perreira, 2007; Taillieu and Brownridge, 2010). In an Irish context, one study undertaken in The Rotunda Hospital Dublin in 2000 found that one in eight respondents had experienced abuse during the course of their most recent pregnancy (O'Donnell et al, 2000).

Domestic violence during pregnancy not only detrimentally impacts on a woman's health; it can also have a negative impact on the health of the unborn child. Numerous health consequences of violence during pregnancy include increased incidence of miscarriage, infection, haemorrhaging, uterine rupture, premature birth, low birth weight of the baby and neonatal death (Anderson, Marshak and Hebbeler, 2002; Huth-Bocks, Levendosky and Bogat, 2003; O'Reilly, Beale and Gillies, 2010). The psychological impact of domestic violence during pregnancy includes depression, anxiety, post-traumatic stress disorder, substance misuse and suicidal ideation (Coid et al, 2003; Ramsey et al, 2012). Research suggests that women experiencing abuse may present late for prenatal care during pregnancy and have little contact with health care professionals during the post-natal period (Viellas et al, 2013). The influence of domestic violence, particularly severe long-term abuse, can have an enduring impact on victims, with physical and psychological co-morbidities diagnosed long after violence desists (Heise and Moreno, 2002; WHO, 2012).

Domestic violence is a hidden and stigmatised health issue. Instances of violence are thought to be vastly under-reported, as women who are affected are often reluctant

to disclose their experiences and are unsure of how to best seek help (Gracia and Herrero, 2006; Overstreet and Quinn, 2013). General practitioners (GPs) play an essential role in early identification and the referral of patients experiencing the emotional and physical effects of domestic violence. Women experiencing domestic violence are more likely to present to their GP more so than any other healthcare professional for help and support (Hegarty and Taft, 2001). Pregnancy presents an opportunity for general practitioners to routinely consult with women during pregnancy and the post-partum period, increasing the possibility of early detection and intervention. However, recognising possible signs and symptoms and responding appropriately can be challenging for GPs. Oftentimes, abused women are likely to present with health concerns not directly associated with visible injuries such as welts, bruises, cuts or fractures (Campbell, 2002). Instead, women who experience abuse commonly attend complaining of headache, insomnia, depression, anxiety or gastrointestinal and gynaecological related issues (Sugg, 2015).

Domestic violence is a complex social phenomenon and as such devising clear screening criteria can be challenging (O' Doherty et al, 2015). The World Health Organisation (WHO) identifies the primary care setting as an important centre for early detection and intervention for domestic violence. In 2013, WHO published clinical and policy guidelines for GPs responding to intimate partner violence and sexual violence against women, which recommend that women should be assessed for signs and symptoms of domestic abuse (WHO, 2013). While routine inquiry using simple, non-judgemental questioning is an important aspect of early detection (Jeanjot, Barlow and Rozenberg, 2008), there is no international consensus on whether screening/routine inquiry or selective questioning should be employed as the preferred approach to detecting domestic violence. Screening/routine inquiry is defined as asking the question/set of questions of all women on at least one occasion. Selective questioning is a practice whereby a practitioner asks the question of a woman (s)he has concerns about, or at a particular time in a woman's life or at presentation of a certain type of injury or illness (Taket et al, 2003). At least two randomised controlled trials (Feder et al, 2009; McMillan et al, 2009), a systematic review (Feder et al, 2011) and a recent Cochrane review (O' Doherty et al, 2015) do not support universal screening because, while it may increase identification and referrals to support services, it has not been found to improve outcomes. A systematic review concludes that there is insufficient evidence that screening for domestic violence during pregnancy results in improved outcomes for women (O'Reilly, Beale and Gillies, 2010). The ICGP Quality in Practice Guidelines recommends that GPs and practice nurses use their clinical judgement as to when it is appropriate to ask (Kenny and ní Riain, 2014).

The majority of women do not object to being asked about domestic violence, once it is approached in a non-judgemental, non-directive, safe and confidential environment (Gielen et al, 2000, Bradley et al. 2002; Ramsey et al, 2002; Feder et al, 2006). Feder et al's 2006 study on abused women's expectations and experiences when engaging with health care professionals found that women regarded what was appropriate or inappropriate to ask depended on the circumstances of the conversation, their readiness to deal with the abuse and their relationship with the professional making the inquiry. It is important to recognise that some women may find it objectionable to be asked about domestic violence when presenting to their GP with an 'unrelated' health concern (Davidson et al, 2001; Richardson

et al, 2002). Although the majority of GPs consider domestic violence to be a serious issue, real and perceived barriers to routine inquiry have been identified. Sprague et al (2012) identified 22 studies that surveyed health care clinicians about obstacles to screening for domestic violence. The most common barriers identified were time limitations (cited in 82% of studies) and a lack of knowledge (68%). A reluctance to ask about abuse and a lack of confidence in how to respond in an appropriate manner are frequently identified as primary concerns (Ramsey et al, 2012). Other barriers to routine inquiry include a lack of awareness of the prevalence of domestic violence, discomfort with the topic, differing language and cultural practices, a sense of powerlessness when dealing with complex family matters, fear of misdiagnosis and a lack of privacy in consultations[1] (Waalen et al, 2000; Kearns et al, 2008; Sprague et al, 2012; Hegarty et al, 2013; Mørk, Andersen and Taket, 2014). Limited access to relevant resources also play a vital role in recognising, responding to and supporting victims of domestic abuse (Hamburger and Phelan, 2004; Sprague et al, 2012; Kenny and ní Riain, 2014; Zaher et al, 2014). Responding to domestic abuse when both partners are patients of the general practitioner or practice can also be extremely difficult to negotiate (Ferris et al, 1997). In addition, research suggests that some health care clinicians do not consider screening for domestic violence to be part of their role (Sprague et al, 2012). With this in mind, studies have noted a poor standard of response by healthcare professionals when instances of domestic violence have been disclosed, including the inappropriate documentation of abuse in medical records (Richardson et al, 2002).

Interventions by general practitioners mainly entail providing relevant contact information, helping to devise a safety plan, and referring patients forward to support services and agencies such as refuges or counselling (Jewkes, 2002). Education on key skills such as appropriate "clinical skills, documentation and provision of referral" has been found to have a positive impact on the attitudes and beliefs of health care practitioners and increase the identification of cases of domestic violence (WHO, 2013). Training has also been found to increase physician's self-efficacy in treating victims of domestic violence (Zaher et al, 2014). Effective training can have a positive impact on clinician confidence and can increase general practitioner competence when dealing with cases. GP knowledge can also have an educational effect on women who are experiencing violence; oftentimes victims may be unaware of the necessity of having a safety plan in place and of the impact domestic violence can have on their long term health (Wong et al, 2008). Information resources on domestic violence, particularly visible formats such as posters, leaflets, and small cards with relevant contact numbers in general practice waiting areas, toilets and consultation rooms are not only necessary for patient awareness, but are useful prompts and reminders for general practitioners to raise the issue during consultations with women.

The international literature on the subject of domestic violence during pregnancy is extensive however there is a dearth of information in the subject area of general practice particularly in an Irish context. This study aims to contribute to the knowledge base by assessing GP awareness and increasing the recognition of domestic violence during pregnancy at primary care level, given the key role that GPs play as the first point or only of contact for medical advice and support by women experiencing partner violence (Feder et al, 2011).

1 Lack of privacy in consultations refers to persons accompanying the patient rather than unsuitable consulting rooms.

Methodology

Aim and objectives

This survey was conducted as part of a project whose aim was to raise awareness and increase the recognition of domestic violence against women during pregnancy at primary care level.

Specifically, the objectives of this study were:

- To assess the awareness levels of GPs regarding the prevalence of domestic violence during pregnancy
- To assess current practice amongst GPs with regard to identifying domestic violence during pregnancy
- To identify GP knowledge gaps and related learning needs in relation to domestic violence during pregnancy
- To establish GP attitudes and barriers to identifying and discussing with pregnant patients domestic violence during pregnancy.

Study design

The study consisted of a quantitative survey of GPs. A questionnaire was developed in view of the literature and with the input of Cosc and the HSE National Social Inclusion Office.

Postal questionnaires were sent to 3,007 ICGP members in the Republic of Ireland, excluding retired GPs and trainees. Alongside the questionnaire an information sheet was provided which informed interested participants of the purpose of the study. Return freepost envelopes were included in study packs to encourage response. A postal reminder was sent two weeks following the initial posting. Return of the completed questionnaires was taken as consent.

The final questionnaire consisted of 19 questions. GPs were asked about their experience in asking pregnant women about domestic violence, sought information on actions taken following a disclosure of abuse and awareness of support services available, and queried further education requirements. GP and practice demographics were collected at the conclusion of the survey. The questionnaire is included in Appendix 1.

Data analysis

A total of 530 completed surveys were included in the final analysis, a response rate of 17.6%. Quantitative data were entered into the Statistical Package for the Social Sciences version 22 (SPSS) for analysis. Frequency distributions, descriptive statistics and cross-tabulations were generated to establish the extent to which key objectives of the study had been achieved.

Ethical considerations

The return of completed questionnaires by participants to the research team was taken as evidence of consent. No identifying information was recorded on questionnaires resulting in the questionnaires being totally anonymous. No references are made to individual participants to ensure privacy. Data were stored in accordance with the Data Protection (Amendment) Act 2003.

Findings

Demographics and respondent profile

This section briefly sets out the demographics of the GPs who completed the survey in addition to providing some further information about the respondents. A total of 530 completed surveys were included in the final dataset.

Of these respondents, 57% (n=300) were female and 43% (n=226) were male. ICGP membership statistics show that 45% of the total population of GPs in practice in 2015 were females.

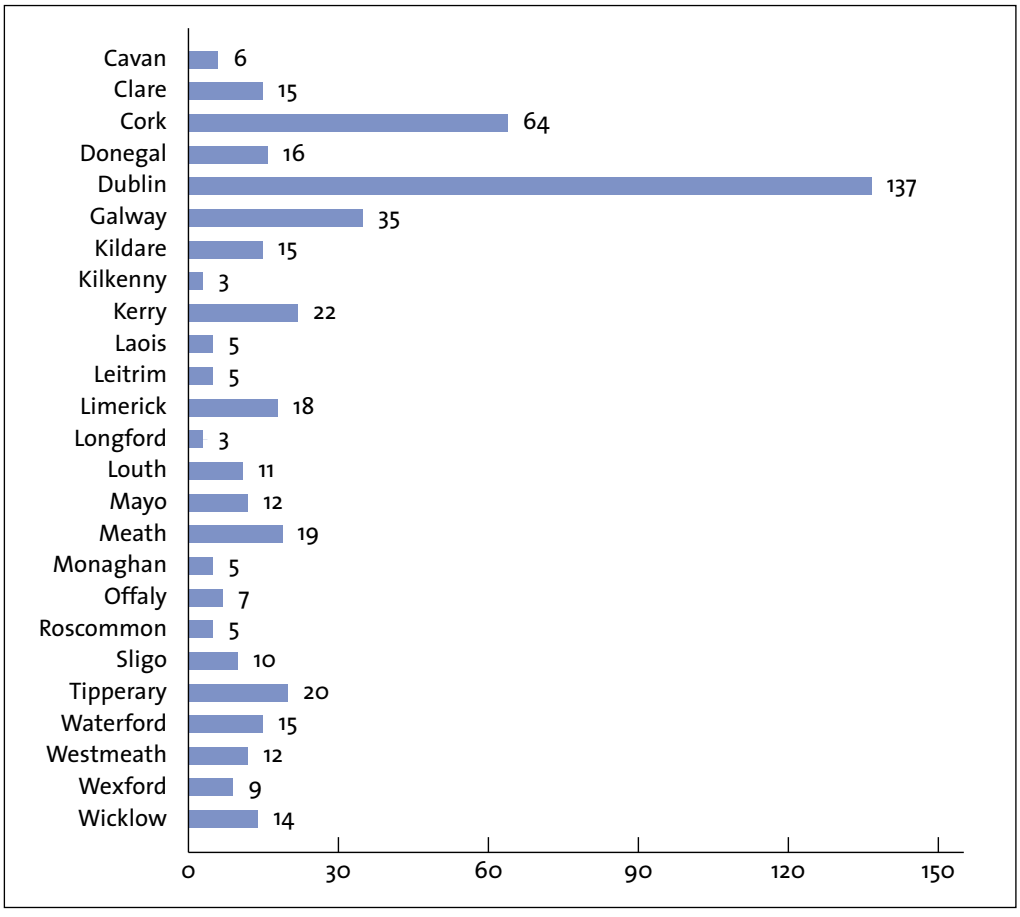
Male respondents were asked whether there was at least one female GP working in their practice. In 77% (n=179) of such cases, a female GP was in situ in their practice.

Just over 22% (n=117) of respondents were over 30 years in general practice, 34.4% (n=181) were between 15-30 years, 29.5% (n=155) were between five and <15 years and 13.9% (n=73) were less than five years in practice. This is consistent with previous data (Daly and Collins, 2007).

Single handed practices comprised 32.6% (n=158) of the respondents, which is consistent with the overall ICGP membership population (ICGP, 2015).

All counties in the Republic of Ireland were represented. Of the counties in which the GP practices were located, those identified most frequently were Dublin (28.1%), Cork (13.1%) and Galway (7.2%) (Figure 1).

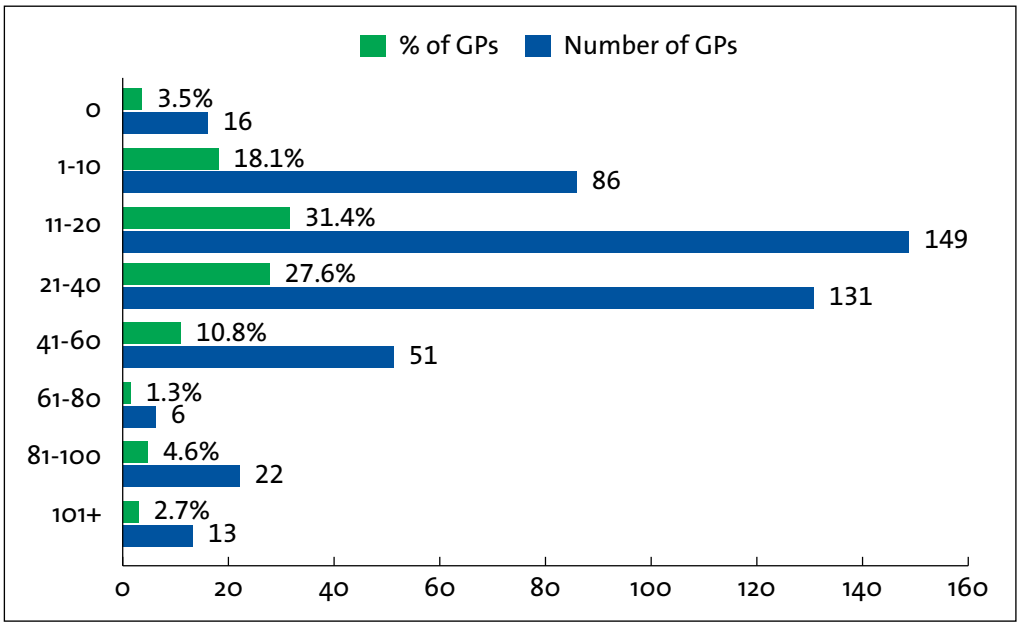
Fig. 1. County of practice



GP views and experience

Approximately 18% of respondents had 1-10 pregnant women attend for antenatal care in the previous 12 months (Figure 2); 31% (n=149) had 11-20 women, 28% (n=131) had 21-40 women, 11% (n=51) had 41-60 women, and 8.6% (n=59) had between 61 and 200 women. Just over 3% (n=16) of respondents did not consult with any patients for antenatal care during this period.

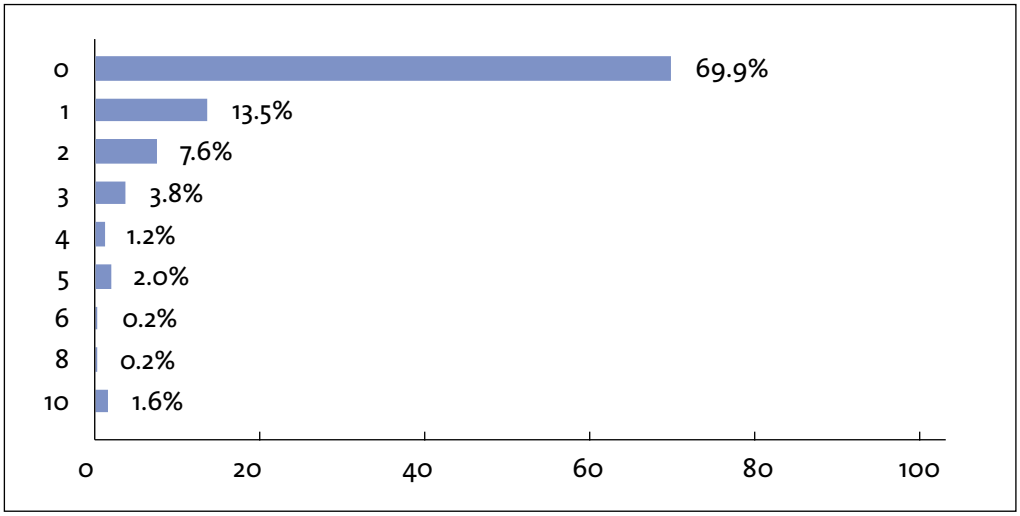
Fig 2: Number of pregnant women in attendance for antenatal care in the past year



Of those surveyed, 62.7% (n=331) had never asked a pregnant woman about domestic violence; while the vast majority (98.9%) of respondents never routinely ask all pregnant women about domestic violence.

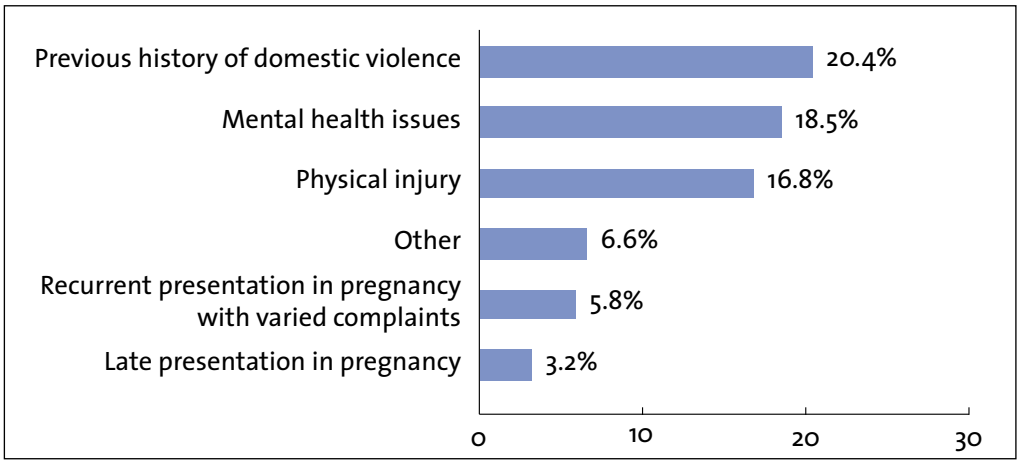
Within the past year, approximately 70% (n=351) of respondents had not asked any pregnant women about domestic violence while nearly 25% (n=125) of respondents had asked between one and three pregnant women (Figure 3).

Fig. 3: Number of pregnant women asked about domestic violence in the past year (%)



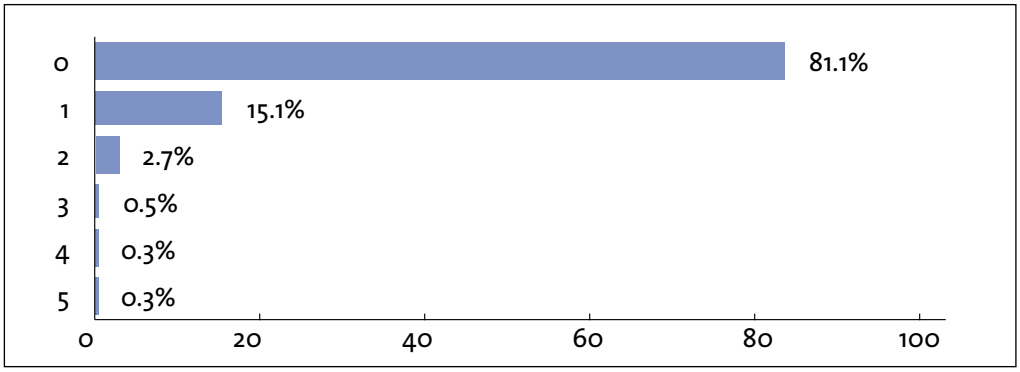
GPs were provided with a list of presenting complaints and asked to choose as many that applied, if relevant, to identify why they initially asked a pregnant patient about domestic violence (Figure 4). In one fifth of cases (n=108), a patient's previous history of domestic violence was the initial reason for asking. 'Mental health issues' (n=98) and presenting with physical injuries (n=89) were the second and third most common reasons for asking. Among 'other' reasons identified (6.6%) were knowledge of a patient's relationship issues (n=5), concerned third parties (including family members), informing of possible abuse (n=4), patients presenting with alcohol or drug addiction (n=3), spontaneous patient disclosure (n=3), knowledge of a patient's partner (n=2) and an instance of statutory rape (n=1).

Fig. 4: Of pregnant women asked, what prompted GPs to address domestic violence (%)



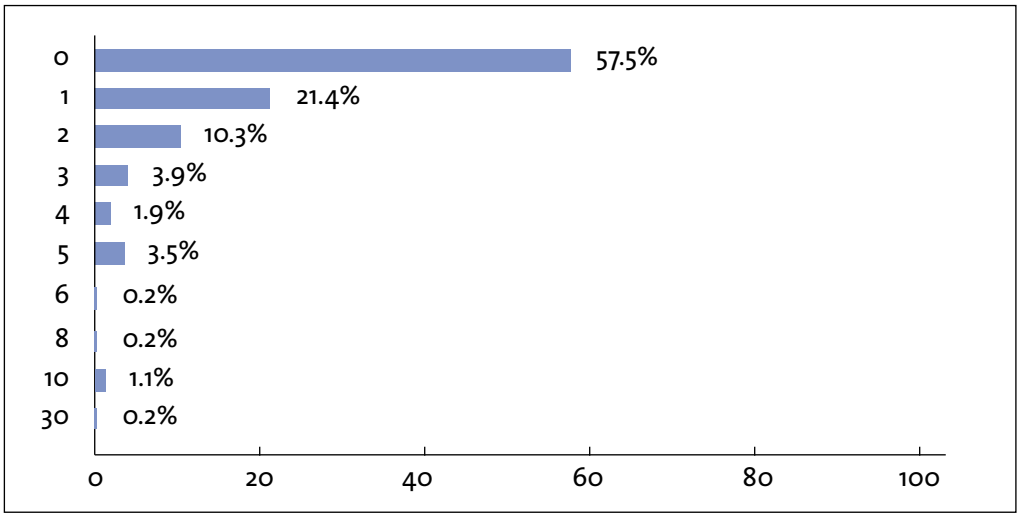
Almost 20% (n=75) of GPs had treated between one and five women who disclosed instances of domestic abuse during their pregnancy, either spontaneously or as a result of GP questioning, in the most recent twelve months (Figure 5). More than 80% of respondents (n=322) had experienced no such disclosures in that time.

Fig. 5: Number of women who disclosed domestic abuse during pregnancy in the past year (%)



Just over 31% (n=138) of respondents had 1-2 patients and 9% (n=40) had 3-5 patients disclose to them over the course of their time working in general practice (Figure 6). Six respondents had between six and 10 women identify instances of abuse during their pregnancies, while one had 30 women. Over half of respondents (57.5%, n= 252) had never had a pregnant woman disclose an instance of domestic abuse during a consultation.

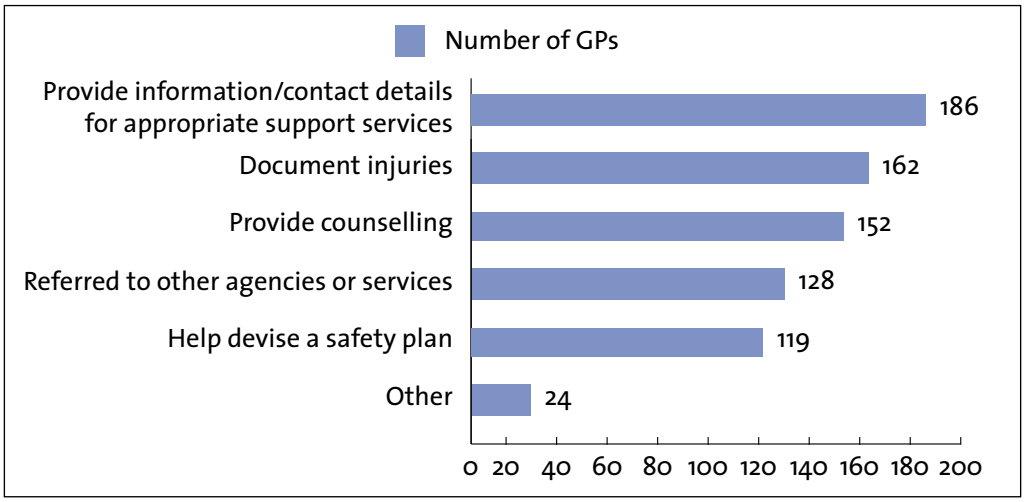
Fig. 6: Percentage of women who ever disclosed domestic abuse during pregnancy (%)



Respondents to whom a disclosure was ever made were asked to identify the actions they took following the disclosure (Figure 7). A predefined list of actions was provided and respondents were offered the opportunity to select all actions which applied to them. All respondents, to whom a disclosure of violence had ever been made, took some form of appropriate action. The most common course of action was to supply the patient with information about and contact details for relevant support services (n=186); other actions included documenting injuries (n=162), providing counselling (n=152), referring the patient to other agencies/services (n=128) and helping the patient to devise a safety plan (n=119).

Of the respondents who offered insight (n=24) on other actions they undertook following the most recent disclosure, some advised their patient to contact the Gardaí, discuss their circumstances with their families, and to return for regular antenatal check-ups.

Fig. 7: Actions taken by GPs after most recent disclosure

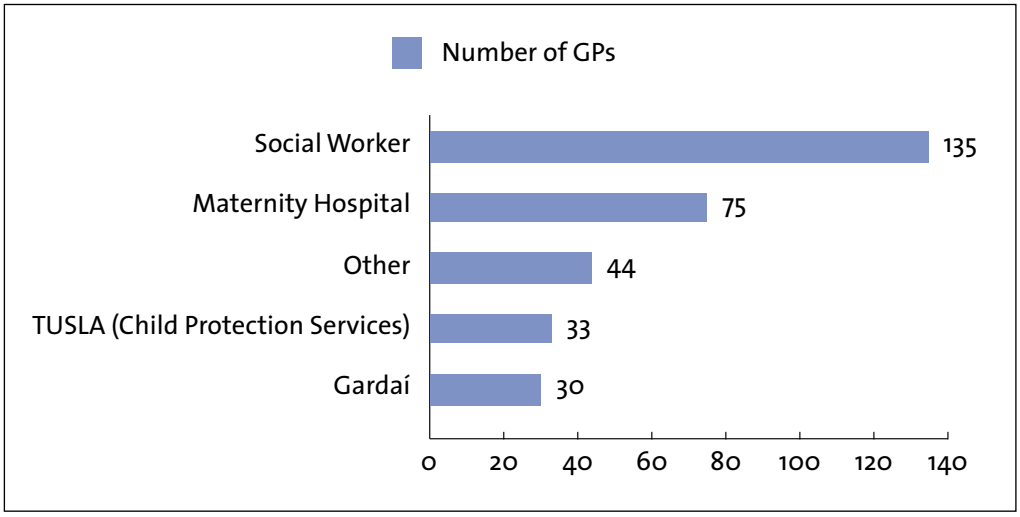


Respondents to whom a disclosure was ever made were asked to identify if they ever made contact with agencies/services following a disclosure (Figure 8). A predefined list of agencies/services was provided and respondents were offered

the opportunity to select all that applied to them. One hundred and thirty five respondents contacted a social worker following a disclosure, while 75 made contact with the relevant maternity hospital, 33 with Child Protection Services (TUSLA) and 30 with Gardaí (Figure 8).

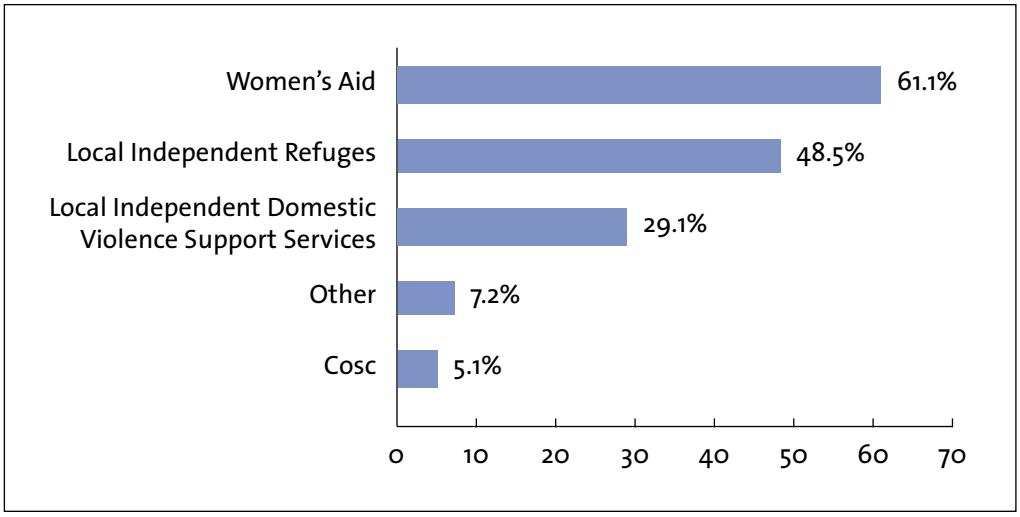
Of the respondents who selected 'other', nine made contact with a 'women's refuge', three with 'liaison nurse/midwife in local hospital', three with a mental health service, one with a public health nurse, and one made contact with an 'immigrant support group'.

Fig. 8: Ever made contact with agencies/services when instance of domestic violence during pregnancy disclosed



All GPs were asked to identify, from a pre-defined list, the support services they were familiar with which are available to women experiencing domestic violence. Women's Aid was the most commonly known support service, with local independent refuges the second most common.

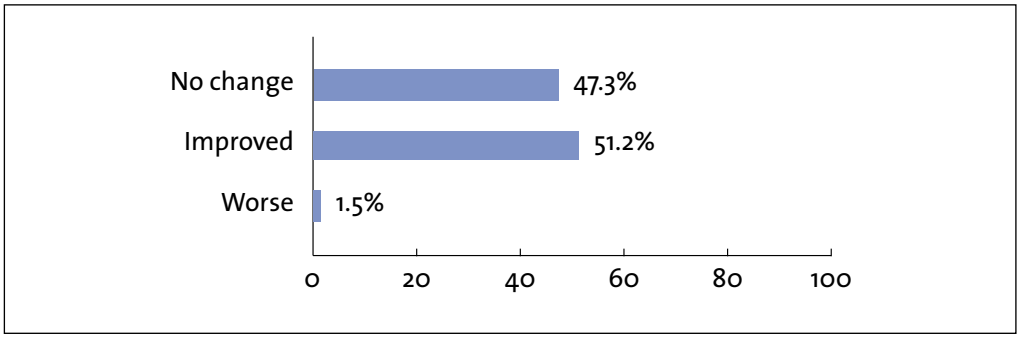
Fig. 9: GP awareness of support services available (%)



The majority of respondents had two differing views on the most common results from intervention for the victim following a disclosure of domestic violence (Figure

10). Just over half (n=196) noted improved outcomes for their patient, while 47.3% (n=181) noted no change in their patient's circumstances. Six respondents noted a worsening in their patient's circumstances following an intervention.

Fig. 10: Usual outcome from intervention for the victim (%)



The main barrier identified by respondents in asking about domestic violence during pregnancy was discomfort in asking; closely followed by lack of GP knowledge and lack of time in consultations.

Fig. 11: The main barrier to GPs asking about domestic violence (%)

Respondents were asked to rate four statements on a five point Likert scale in order of 'strongly agree' to 'strongly disagree' (Table 1). Just over 99% agreed that GPs should ask a pregnant woman about domestic violence if they suspect their patient is experiencing it.

Over half of respondents (52.3%) disagreed with the statement that GPs should have primary responsibility for dealing with domestic violence during pregnancy, while 26.3% indicated that they were unsure.

Just over 41% of respondents were unsure of the statement that maternity hospitals should have primary responsibility for dealing with pregnant women who are experiencing domestic violence; while 32% disagreed with this statement.

Only 19.6% of respondents agreed that a GP should ask all pregnant women about domestic violence. Over 46% disagreed with this statement.

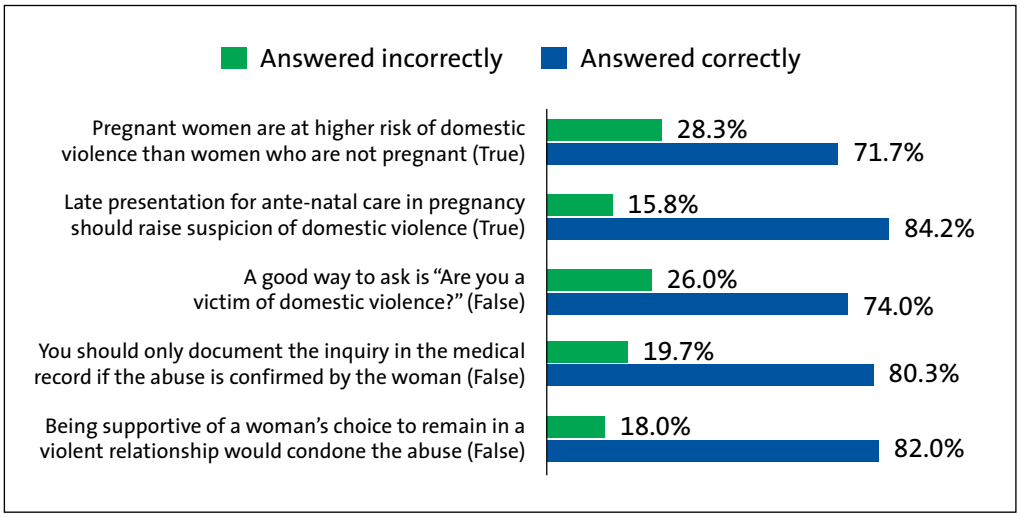
Table 1: Domestic violence during pregnancy – the role of the GP (%)

	Strongly disagree	Disagree	Unsure	Agree	Strongly agree
Maternity hospitals should have primary responsibility for dealing with domestic violence during pregnancy.	5.2	26.8	41.5	16.8	9.7
A GP should ask a pregnant woman about domestic violence if he/she suspects they are experiencing it.	0.4	0.2	0.4	31.5	67.6
A GP should ask all pregnant women about domestic violence.	8.4	38.1	33.9	15.2	4.4
GPs should have primary responsibility for dealing with domestic violence during pregnancy.	15.5	36.8	26.3	16.8	4.6

GP knowledge about domestic violence during pregnancy was assessed using five statements, with the responses 'true' or 'false' (Figure 12). Overall, 72.5% of respondents answered all five questions correctly.

Just under 72% of respondents were correct in stating that pregnant women are at a higher risk of domestic violence than those not pregnant. Approximately 84% of respondents were correct in their opinion that late ante-natal presentation should raise suspicion of domestic violence. Seventy-four percent of respondents positively indicated that asking a patient "are you a victim of domestic violence?" was an inappropriate approach to take. Over 80% of respondents correctly selected 'false' responses for the final two statements regarding documenting inquiries in medical records and condoning abuse.

Fig. 12: The percentage of GPs who correctly answered statements related to domestic violence



The majority (84%) of respondents completed no training or education in managing domestic violence whilst studying in an undergraduate setting. Of the GPs who completed training or education in this area in an undergraduate setting, a mean of 3.77 hours was recorded. Just over 57% of respondents completed no training or

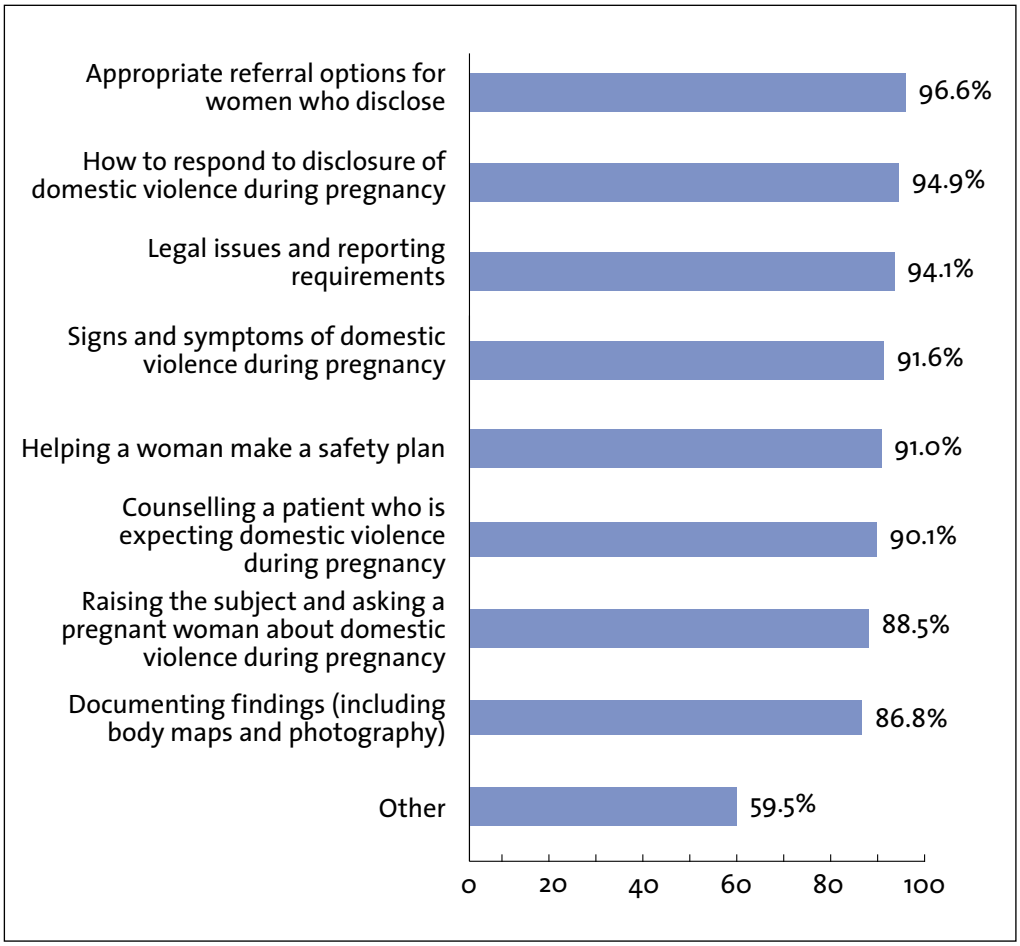
education during their GP training. Of those who did, the mean was 3.02 in the GP training setting. Approximately 76% of respondents had completed no continuous medical education (CME) hours in the area of domestic violence. Of those who did, the mean number of hours in the CME setting was 3.08 hours. Across all training opportunities the number of hours ranges from 0 to 75 with a mean for all GPs who responded of 2.06.

Approximately 65% of respondents were unaware of any guidance document for GPs on the subject of domestic violence.

Of the respondents who offered insight on the specific guidance documents they were aware of, the most common version mentioned was the ICGP '*Domestic Violence*: A Guide for General Practice' and other ICGP related documents. Other sources mentioned were RCGP Ireland, Women's Aid, Safe Ireland and the *Society of Obstetricians and Gynaecologists of Canada* (*SOGC*).

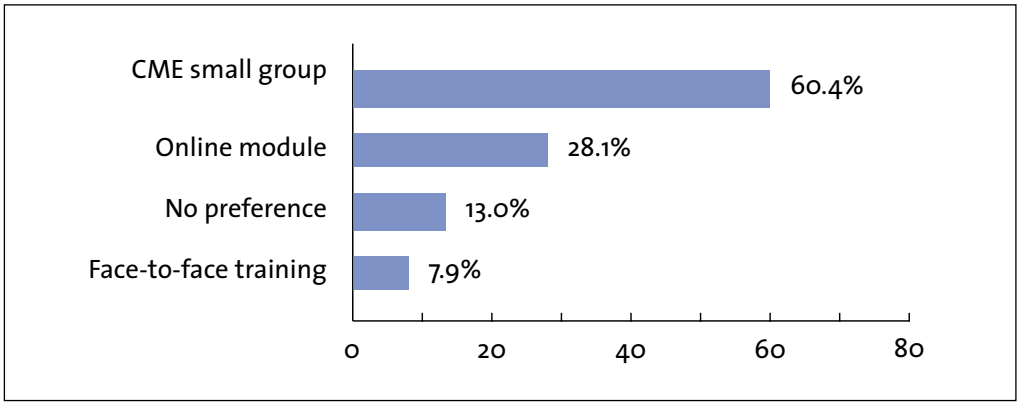
The vast majority of respondents indicated that they would welcome further education in the area of domestic violence during pregnancy. As shown in Figure13, all subject topics were ranked highly. The top three areas of interest were 'appropriate referral options for women who disclose', 'how to respond to disclosures of domestic violence during pregnancy' and 'legal issues and reporting requirements'. Additional subject areas highlighted as relevant were the "care of other children in the home" and "family support".

Fig. 13: Areas of interest for further education - %



When asked to select their preferred formats to receive additional domestic violence related education, the CME small group network (60.4%) and via an online module (28.1%) were the most commonly selected formats (Figure.14).

Fig. 14: Education format preference (%)



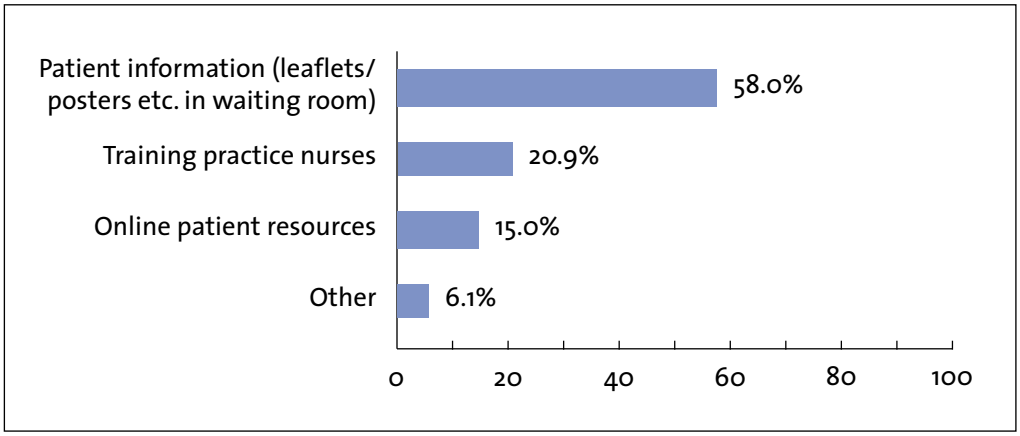
Time constraints and lack of relevance to their practice were identified as the main reasons why some respondents indicated that they were not interested in receiving further education on domestic violence during pregnancy. One GP offered further insight on their reason for not engaging in further education, stating "I feel competent dealing with it".

Over half (52.5%, n=275) of respondents indicated that they did not have any domestic violence patient education or resource materials, including posters or brochures, available for patients in their practice waiting room. A little over 18% (n=96) were unsure if these materials were available. Approximately 30% (n=153) of respondents had some form of domestic violence material available in their practice.

The majority of respondents indicated that they would display posters (80.7%, n=389) and leaflets (91.5%, n=460) in their practices if they were provided.

A large portion (63.5%) of respondents agreed that additional resources would be helpful to improve the management of cases in general practice - information materials (58%), training of practice nurses to support patients experiencing domestic violence (20.9%) and online patient resources (15%) were identified as potential helpful supports.

Fig. 15: Helpful supports in managing domestic violence in practice (%)



Discussion

This survey yields some important information with regard to awareness, recognition and the current practice of GPs in Ireland towards the identification and management of domestic violence during pregnancy. It also outlines necessary learning requirements from a GP perspective in this topic area.

The response rate, although consistent with other GP surveys (VanGeest, Johnson and Welch, 2007, Byrne et al, 2010; O'Shea and Collins, 2016), may be a limiting factor in this study. GP survey response rates are routinely lower than those from the general population, and it is thought that GPs who felt the survey was not relevant to them (e.g. no experience in the topic area) or were time poor were more likely not to reply (O'Brien et al, 2014). However, the profile of those respondents who did reply is broadly consistent with national GP data. More female GPs (57%) responded than male (43%). This may be explained by the likelihood that female GPs in mixed practices may be specifically requested by pregnant patients who are attending for antenatal care. In addition, this topic falls within women's health, and female GPs are more likely to undertake women's health work within the practice and, therefore, may be more likely to respond to this study. .

The vast majority of GPs do not routinely ask their pregnant patients about domestic violence, which is acceptable as routine inquiry of all pregnant women is not considered compulsory in general practice (Boyle and Jones, 2006). Screening women for domestic violence via routine inquiry does not guarantee the reporting of harm due to a range of reasons (MacMillan et al, 2009), however research suggests that appropriate training and resources are essential to support GPs in instances of case-based inquiry (Spangaro, Zwi and Poulos, 2009; O'Campo et al, 2011; Stöckl et al, 2013).

Nearly 30% of GPs indicated that they are uncomfortable asking women about domestic violence (Boyle and Jones, 2006), indicating a need to further explore GPs perceived uneasiness around this subject area and to address it via relevant education programmes.

Lack of GP clinical knowledge on the topic, e.g. signs and symptoms, was identified as the second most common barrier to asking women about domestic violence, which clearly demonstrates GPs' current perception of their overall ability to sufficiently engage with this topic. The findings suggest that GPs' knowledge of domestic violence during pregnancy would be substantially improved through further education. Overall, findings suggest that many GPs have received limited training hours on how to deal with domestic violence cases during their undergraduate years, subsequent training and CME. This shortfall in GP training and CME is a clear obstacle for GPs which should be addressed. This education should emphasise that while any woman might experience domestic violence, vulnerable groups of women including migrant women and women with substance abuse issues are at a higher risk than others during pregnancy (Espinosa and Osborne, 2002; Kenny and ní Riain, 2014). Interestingly, GPs indicated a preference for training in this area to be part of small group CME meetings.

Twenty-three percent of GPs cited lack of knowledge as a barrier to asking about domestic violence. However, in the knowledge test over 70% of GPs answered all five questions correctly. Some GPs may have sufficient knowledge but a perceived lack of knowledge may prevent inquiry. This lack of confidence in dealing with

this issue should be challenged and explored in education sessions on this topic. Approximately 29% cited feeling uncomfortable about asking about domestic violence as a barrier to asking about domestic violence. This attitude should also be explored in related education sessions. Another commonly cited barrier was lack of time. A substantial number of GPs reported time constraints due to heavy workloads as a barrier in inquiring about domestic violence, which is consistent with surveys of GPs both nationally and internationally (Rose et al, 2011).

GP consultations are short and multiple problems are often addressed during consultations. Education programmes on domestic violence may need to challenge GPs' attitude that asking about domestic violence will be time consuming. It would be beneficial to explore optimal approaches to enquiring about domestic violence quickly, and improving GP confidence in their ability to ask about domestic violence during a consultation.

International literature shows that GPs are reluctant to ask women about domestic violence and in this study, almost two-thirds of GPs had never asked a pregnant woman about domestic violence. As was evident in the findings, few GPs had managed a case of disclosure, which is predictable when taking into consideration the lack of inquiry and the knowledge that a high proportion of women do not spontaneously disclose instances of domestic abuse during consultations. On the rare occasion that GPs did become aware of domestic violence, they took action and in all cases that action was appropriate.

There is no international consensus on the effectiveness of screening women and further rigorous research is necessary to conclude that pregnant women are more likely to disclose abuse when screened during antenatal appointments (O'Doherty et al, 2015). However, despite the lack of clear guidelines in this area, training to build confidence in discussing the domestic violence and knowing how to respond is a distinct necessity.

GP personal beliefs were identified by some GPs as a barrier to inquiring. Implicit bias, including cultural and religious views, has been sometimes cited as directly affecting professional behaviour when engaging with patients across a range of sensitive topics including domestic abuse (Chapman, Kaatz and Carnes, 2013). Private consultations with possible victims are fundamentally necessary, particularly in cases where partners may commonly be in attendance.

For the purpose of this study, improvement from an intervention following disclosure of domestic violence might relate to progresses in physical and mental health, and quality of life (O'Doherty et al, 2015). Slightly more than half of GPs (51.2%) thought that a woman's life improved following a disclosure of abuse; notably less that the 72.5% of GPs who believed that the outcome for their patient was improved once in cases were elder abuse and neglect were identified (O'Brien et al, 2014). Considering that just under half of GPs who responded to this survey believed that a woman's life did not improve following a disclosure, this demonstrates an attitude that GP inquiry may not have any positive impact for their patients experiencing domestic violence during pregnancy. Uncertainty about the beneficial outcome of the disclosure of instances of abuse has been previously recorded (Ramsey et al, 2012; O'Doherty et al, 2015), however Rhodes (2006) found that inquiry about and disclosures of intimate partner violence were associated with higher patient satisfaction with care. This is an area which should be explored further and integrated into GP training.

Nearly two thirds of respondents were unaware of the guidance documents for primary care clinicians on domestic violence, which is consistent with the proportion of those who were unaware of it in the 2011 ICGP survey on the update of ICGP clinical guidelines (ICGP, 2011). That survey found that awareness of guidelines about specific diseases in general practice was higher than awareness of similar guidelines on less detectable illness and health issues (ICGP, 2011). Research suggests that GPs frequently do not adhere to guidelines or guidance documents due to multiple factors including guidance overload, overly detailed documents and a lack of practical implementation of guidelines due to the complexities of individual patient needs (Austad et al, 2015). However, some GPs surveyed for this report were unaware of the full range of support services available, identifying a need for further education in this area.

A high proportion of GPs who responded to this survey suggested that they would display posters and other information resources in their practices if provided. Providing GPs with such resources may be beneficial to patients. However, it is important to take into consideration that any information in those resources should be specific rather than general so as to best pin point referral pathways and access to local services. Furthermore practices may have individual policies on the amount of information and literature they display in their waiting areas, which might impede the impact of such resources if they were supplied in bulk. The health awareness messages GPs offer in consultations and display in waiting rooms may have a greater impact if each focuses on one aspect of national, multi-media campaigns.

Recommendations and Conclusion

The ICGP and relevant parties are considering these findings and what actions need to be taken from this report. The following recommendations are proposed:

Guideline awareness

- The ICGP should continue to promote and circulate the ICGP Domestic Violence: A guide for general practice (2014), which was devised to enable GPs to identify best practice related to domestic violence presentation in the clinical setting.
- Implementation of the National Strategy on Domestic, Sexual and Gender-based Violence 2016-2021 should incorporate training for GPs in their roles as front-line health professionals.
- GPs vary in their management of domestic violence in practice. National interagency (e.g. primary care staff, social workers, maternity hospitals and *Garda* Síochána) guidelines should be developed on how to appropriately deal with disclosures so as to utilise the wide range of multidisciplinary supports and services available.

Education and Resources

- Funding should be provided for continuing research into related topic areas.
- Adequate funding should also be made available to educate GPs and practice nurses on prioritised subject areas including appropriate referral options for women, how to respond to disclosures of domestic violence during pregnancy and legal issues and reporting requirements.
- Education programmes should include training to impart knowledge, challenge attitudes and teach skills.
- GPs must be provided with localised, specific information on the resources and supports available for their patients experiencing domestic violence.

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Appendix 1

Domestic Violence (Intimate Partner Violence) during Pregnancy

- Thank you for taking the time to complete this questionnaire.
- **Definition:** The World Health Organisation defines Domestic Violence as "any behaviour within an intimate relationship that causes physical, psychological or sexual harm to those in that relationship".
- **Note:** The term Domestic Violence (also commonly known as Intimate Partner Violence) will be used throughout this questionnaire.

1. **How many pregnant women have attended you for antenatal care in the past year?** _____
2. **a). Have you ever asked a pregnant woman about domestic violence?**
   Yes ❑ 1 No ❑ 2
   b). Do you routinely ask all pregnant women about domestic violence?
   Yes ❑ 1 No ❑ 2
3. **In the past year how many pregnant women have you asked about domestic violence?** (Approximate estimation please) _____
4. **Of the pregnant women you have asked about domestic violence, what prompted you to address it?**

	Tick all that apply
Physical injury	❑ 1
Previous history of domestic violence	❑ 2
Recurrent presentation in pregnancy with varied complaints	❑ 3
Mental health issues	❑ 4
Late presentation in pregnancy	❑ 5
Other (please specify here):	❑ 6

5. **In your recollection, how many women have disclosed instances of domestic abuse to you during pregnancy (either spontaneously or as a result of your questioning)?**
   a). In the past year _____ **b).** Ever _____
6. **Thinking of the most recent case, either disclosed voluntarily or as a result of questioning, what actions did you take?**

	Tick all that apply
Provide counselling	❑ 1
Provide information/contact details for appropriate support services	❑ 2
Help devise a safety plan	❑ 3
Document injuries	❑ 4
Referred to other agencies or services	❑ 5
Not applicable	❑ 6
Other (please specify here):	❑ 7

7. **Have you ever made contact with any of the following agencies/services when an instance of domestic violence in pregnancy was disclosed to you?** (Tick all that apply)
Maternity hospital ❑ 1 Social worker ❑ 2 TUSLA (Child Protection Services) ❑ 3
Gardaí ❑ 4 Not applicable ❑ 5 Other ❑ 6 (please specify)_____

8. **Are you aware of any of the following support services available to women experiencing domestic violence?** (Tick all that apply)
COSC ❑ 1 Women's Aid ❑ 2 Local Independent Refuges ❑ 3
Local Independent domestic violence support services ❑ 4
Other ❑ 5 (please specify)_____

9. **In your experience what is the most usual outcome from intervention for the victim following disclosure of domestic violence?**
No change ❑ 1 Improved ❑ 2 Worse ❑ 3

10. **In your experience what do you think are the main barriers to GPs asking about domestic violence during pregnancy? Please rank the top 3 barriers only** (with 1 being the most significant barrier etc.):

	Rank your top 3
Lack of GP knowledge	___
GPs don't have the necessary training	___
GPs feel uncomfortable asking	___
Lack of GP time	___
Lack of resources	___
Lack of support services	___
Lack of privacy	___
Language barriers	___
Cultural barriers	___
GP's personal beliefs	___

11. **Please indicate if you agree or disagree with each of the following statements:**

	Strongly agree	Agree	Unsure	Disagree	Strongly disagree
GPs should have primary responsibility for dealing with domestic violence during pregnancy.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5
A GP should ask all pregnant women about domestic violence.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5
A GP should ask a pregnant woman about domestic violence if he/she suspects they are experiencing it.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5
Maternity hospitals should have primary responsibility for dealing with domestic violence during pregnancy.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5

12. Please answer true or false to the following items:

	True	False
Pregnant women are at higher risk of domestic violence than women who are not pregnant	❑ 1	❑ 2
Late presentation for ante-natal care in pregnancy should raise suspicion of domestic violence	❑ 1	❑ 2
A good way to ask is "Are you a victim of domestic violence?"	❑ 1	❑ 2
You should only document the inquiry in the medical record if the abuse is confirmed by the woman	❑ 1	❑ 2
Being supportive of a woman's choice to remain in a violent relationship would condone the abuse	❑ 1	❑ 2

13. How many hours of education/training have you undertaken in managing domestic violence?
In undergraduate setting ____hrs In GP training ____hrs In CME ____hrs

14. Are you aware of any guidance document for GPs on Domestic Violence?
Yes ❑ 1 No ❑ 2 If yes, which one? _____

15. Would you welcome further education on any of the following:

	Yes	No	If yes, please rank your top 3
Signs and symptoms of domestic violence during pregnancy	❑ 1	❑ 2	___
Raising the subject and asking a pregnant woman about domestic violence during pregnancy	❑ 1	❑ 2	___
How to respond to disclosure of domestic violence during pregnancy	❑ 1	❑ 2	___
Counselling a patient who is experiencing domestic violence during pregnancy	❑ 1	❑ 2	___
Helping a woman make a safety plan	❑ 1	❑ 2	___
Documenting findings (including body maps and photography)	❑ 1	❑ 2	___
Appropriate referral options for women who disclose	❑ 1	❑ 2	___
Legal issues and reporting requirements	❑ 1	❑ 2	___
Other (please specify):	❑ 1	❑ 2	___

16. In what format would you like to receive this education?
On-line module ❑ 1 Face-to-face training ❑ 2 CME small group ❑ 3
No preference ❑ 4

17. If no to all in Q15 please indicate why not (tick all that apply):
Time constraints ❑ 1 Lack of relevance to my practice ❑ 2
I have already attended a course ❑ 3
Other ❑ 4 (please specify) _____

18. a). Would additional resources be helpful in managing domestic violence in your practice?
Yes ❑ 1 No ❑ 2 Unsure ❑ 3

b). If yes, what one support would be the most helpful in managing domestic violence in your practice?
Patient information (leaflets/posters etc. in waiting room) ❑ 1
Online patient resources ❑ 2 Training practice nurses ❑ 3
Other ❑ 4 (please specify) _____

19. Please answer the following questions on you and your practice:
a). Your sex: Male ❑ 1 Female ❑ 2

b). If you are a male GP, is there at least one female GP working in your practice? Yes ❑ 1 No ❑ 2

c). Years working in general practice? <5 ❑ 1 5-<15 ❑ 2 15-<30 ❑ 3 ≥30 ❑ 4

d). Total number of doctors (including yourself) in your practice:
Full time ___ Part time ___

e). County or Dublin postal district of your practice? _____

f). Are there domestic violence patient education or resource materials (posters, brochures, etc.) available in your practice waiting room?
Yes ❑ 1 No ❑ 2 Unsure ❑ 3

g). Would you display the following if provided? Posters: Yes ❑ 1 No ❑ 2
Leaflets: Yes ❑ 1 No ❑ 2

THANK YOU FOR PARTICIPATING IN THIS SURVEY.

PLEASE RETURN IT IN THE FREEPOST ENVELOPE PROVIDED TO:

The Irish College Of General Practitioners, 4–5 Lincoln Place, FREEPOST, Dublin 2

For access to Domestic Violence Guidelines please visit:

www.icgp.ie/QIPDomesticViolence

www.cosc.ie

The Irish College of General Practitioners (ICGP) is the professional body for general practice in Ireland. The College was founded in 1984 and is based in Lincoln Place, Dublin 2. The College's primary aim is to serve the patient and the general practitioner by encouraging and maintaining the highest standards of general medical practice. It is the representative organisation on education, training and standards in general practice.

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