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The impact of domestic violence upon default from colposcopy services

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4 Discussion

4.1 Recruitment

Participants for this trial were recruited from Western Hospital, Sunshine. Sunshine Hospital catchment extends from the inner Western Suburbs of Melbourne and surrounding areas. Approximately 738,000 people live in Western Health's catchment area (Western Health, 2010). Sunshine Hospital is located in St Albans, an inner Western Suburb of Melbourne about 17 kilometres from Melbourne's CBD. According to St Albans demographics local statistics the median age is 36 and less than 35% of people living in St Albans were born in Australia and less than 25% speak English as their first language. Unemployment is over 11% and almost 30% of homes in St Albans are rented (St Albans demographics, 2011). These statistics are typical for Melbourne's inner Western Suburbs.

Recruitment was undertaken at Sunshine Hospital Women's Clinic outpatient department. Women attending appointments for colposcopy services were invited to participate.

Of the 581 women approached to participate in the trial, consent was obtained from 574 women (99%), following initial recruitment one woman withdrew whilst completing the questionnaire and another woman gave ambiguous responses to IPV and her data was excluded. In six cases a partner came into the room during the process of completing the questionnaire and in case of a possible risk to the safety of the participant recruitment activity was ceased. In these cases ascertainment of IPV was not able to be determined.

Overall recruitment was high due to many contributing factors. The questionnaire used was very short and did not take up a lot of the participant's time. Women were also advised at the time of recruitment that following completion of the confidential questionnaire they would not be required to do anything further and the questionnaire was completed in the time that the women were waiting to be called into the room for their colposcopy appointment visit. During this waiting time many women feel very nervous as they pass the time before they go in for what is often an invasive procedure. Many welcomed a conversation with the researcher to help them feel calm before they entered the room with the treating doctor.

The questions were read to the participants by the researcher or with the assistance of a medical interpreter. Following completion of the questionnaire, the researcher escorted the participants into the treatment room. They were then welcomed by the Consultant Gynaecologist who continued to do the colposcopy consultation, where I was the nurse chaperone/assistant during the procedure. I felt very comfortable talking to the patients because I was familiar with approaching them and had experience as a gynaecology nurse in Women's Clinic, Sunshine Hospital for many years.

The interviews were conducted in a private room with 2 exits in the case of threatening disclosure of violence. All women who made a disclosure of domestic violence were offered referral to ongoing counselling and social support services. If the patient gave consent, information in relation to IPV was also disclosed to the woman's attending doctor. However if the women wished this information to remain confidential, this information was not disclosed. All women were offered the opportunity to have the information disclosed to the hospital social support services.

The hospital appointment system was then accessed and information on all appointments specific to the participant and her colposcopy appointments were extracted and other women's health appointments were extracted over a 36 month follow up period.

A final important factor resulting in a high recruitment rate was the fact that very few partners attend colposcopy outpatient appointments compared to other clinical services such as antenatal clinic visits. Those partners that did attend usually chose to wait in the waiting room when the patient was called.

4.2Prevalence

The prevalence of IPV in the clinic population was high with a disclosure in one third of the cohort. In half of these, the violence was unilaterally directed by the male partner towards the women, but in the remaining cases, violence was bi-directional. In only 1.9% of the cohort was the woman the sole perpetrator of violence. The high prevalence of exposure to domestic violence suggests that screening in this population is warranted.

In three studies conducted in clinical settings, IPV prevalence was high. In a trial conducted in an emergency department with almost 1,500 participants, IPV prevalence was as high as 18% (Mathew., A. E., Marsh, B., Smith, L.S & Houry, D. 2012).

Another study conducted in an antenatal clinic with HIV positive women, disclosure was as high as 32% (Ezaenochie, Olagbuji, Ande, Kubeyinje & Okonofue, 2011). A study conducted in fracture clinic exposed IPV prevalence persisted at 32% (Bhandari et al., 2011).

Although statistics vary, when a screening tool is used, disclosure for IPV in a clinical setting is high.

4.3 Association of IPV

In the present study, we found that women exposed to violence were slightly younger than those who were not, however, the difference of two years is of doubtful clinical significance. However, they were also more likely to be current smokers. Numerous studies have reported an association between IPV and cigarette smoking. One of the largest studies involved a survey in the United States of 13,494 adults which reported a 2 to 4 fold increase in risk of smoking in women exposed to family violence (Felitti et al., 1998). The finding is relevant in the context of the colposcopy clinic, as there is evidence that toxins within cigarettes are excreted within the cervical mucus and may influence the ability of the immune system to overcome localised human papilloma virus infection and may interfere with the regression of low grade lesions on the cervix (Karlsson, 2009).

Women exposed to violence were more likely to be depressed as measured by the Beck Depression Inventory. This finding has also been reported elsewhere (Lester & Wilson, 1999). In a study of 65 women living in sanctuary houses as a result of violence who were screened with the Beck Depression Inventory (Beck, Ward & Mendelson, 1961), every woman interviewed was found to score above the cut off recommended for treatment. Women were also found to have high rates of menstrual irregularities, genital tract infections and premenstrual syndrome symptomatology (Lester & Wilson, 1999).

Perhaps the most important association was between the observation of housing instability and default from the first clinic attendance. A recent Indian study of 2435 women which focussed on the interplay of life factors involved in women's reproductive health experiences, documented a link between violence and homelessness (Fung-Kee_Fung, Howlett & Olivarer, 2010). An Australian study of teenage mothers

also reported an association between IPV, homelessness and sexually transmitted infections (Siemieniuk, Krentz, Gish & Gill, 2010).

Housing instability can result in women moving address and missing hospital appointments that are routinely sent through the postal service. This can lead to higher rates of primary default from care.

These linkages and associations may explain why women exposed to IPV have poorer healthcare outcomes compared to other subgroups of women. Researchers have previously explored reasons for default at colposcopy clinics and reported that the routinely collected demographic variables did not identify a subgroup of women at risk for default (Quinlivan & Evans, 2005). However, these routine variables do not include IPV and housing stability, which would need to be captured using a specific screening protocol in colposcopy clinics.

4.4 Default and loss to follow up from colposcopy

The present study indicates that exposure to domestic violence is a significant independent association of recurrent default from colposcopy services. It is also associated with significantly higher rates of loss to follow up. This association persisted in multivariate analysis.

High rates of default from care and loss to follow up are reported widely in the literature in relation to colposcopy and antenatal clinical services (Quinlivan and Evans, 2001; Balasubramani, Orbell, Haggart, Brown & Tidy, 2008; Audi & Segall-Correa, 2008; Miller, Siejak & Schroedar, 1997). Default from care adds considerable cost to the public health system and can result in longer waiting periods for access to care. Despite various interventions that have been trialled in the research literature such as reminder

letters, text messages, partial and full booking of lists, default remains a clinical problem (Balasubramani et al., 2008; Lester & Wilson, 1999).

Many organisations have developed strategies to reduce default from colposcopy services (Balasubramani et al., 2008; Millier et al., 1997; Fung-Kee_Fung et al., 2010). However, a large postal survey in the UK found that default was hard to predict using standard demographic variables, although an intention to attend the clinical service three weeks before the appointment date was associated with a higher rate of attendance.

One study reported that smoking and distance to the hospital were associated with higher default rates (Balasubramani et al., 2008). Of note, this study did not identify domestic violence status or undertake multivariate analysis. In our study, smoking was not a significant association of persistent default in multivariate analysis.

Other organisations have used evidence-based guidelines to develop service protocols designed to improve care outcomes and minimise default (Fung-Kee_Fung et al., 2010). These processes have not relied upon close examination of the individual features and social circumstances of the attending patients. Their long term efficacy remains unclear.

The problem may be a general one with default in attending for care, rather than a specific type of care. In a qualitative study in HIV positive patients who were exposed to IPV, women reported how domestic violence diminished their ability to obtain regular care (Siemieniuk et al., 2010). The study reported that “Abused women were reluctant to keep appointments if they were afraid of their partners, if they were depressed, feeling ill or ‘too worn down’, or if they were ashamed of being abused (Siemieniuk et al., 2010).” In a Brazilian study, exposure to IPV was associated with self reported difficulty in attending for antenatal care (Audi et al., 2008).

We conclude that exposure to IPV may be a barrier to women's access to colposcopy and completion of programs of care. This failure may result in suboptimal healthcare outcomes and further aggravate the damage done to women. It may be necessary for clinical services to screen for domestic violence and to provide flexibility for these vulnerable women to access care beyond rigid appointment systems. Strategies that direct default strategies in a targeted manner are more likely to be effective than non directed strategies.

Housing instability and depression were also independent associations of default in the multivariate analysis. This finding is consistent with several pre-existing studies (Hasker et al., 2008; Jakubowiak, Bogorodskaya, Borisov, Damilova, Kourbatova, 2007; House, 1989; Kerins, McKee & Bennett, 2010).

4.5 Default and loss to follow up from women's health clinics

The present study indicates that exposure to domestic violence is a significant independent association of recurrent default from women's health clinic services. Despite various interventions that have been trialled in the research literature such as reminder letters, text messages, partial and full booking of lists, default remains a clinical problem (Balasubramani et al., 2008; Lester & Wilson, 1999). Exposure to IPV may be a barrier to women's access to women's health services and completion of care. This failure may result in suboptimal healthcare outcomes. It may be necessary for clinical services to screen for domestic violence and to provide flexibility for these vulnerable women to access care beyond rigid appointment systems. Strategies that direct default strategies in a targeted manner are more likely to be effective than non directed strategies. Unstable housing was also a significant independent association of

default from other women's health clinics (Hasker et al., 2008; Jakubowiak et al., 2007).

4.6 What we have learnt from this thesis

The prevalence of IPV in the colposcopy clinic population was high with a positive disclosure in one third of the cohort. In half of these, the violence was unilaterally directed by the male partner to the women, but in the remaining cases, violence was bi-directional. In only 1.9% of cases was the woman the sole perpetrator of violence. The prevalence suggests that screening in this population is warranted. Those at higher risk of IPV are more likely have been exposed during childhood and it is therefore accepted as normal and disclosure is not common.

Without screening, women exposed to IPV may be at increased risk of developing other health problems including precancerous or cancerous lesions of the cervix. There is evidence that they are at increased risk of acquiring sexually transmitted infections (Coker et al., 2004). It has been reported that in a teenage pregnancy population that teenagers exposed to domestic violence were at 7 fold risk of having an abnormal Pap smear compared to those pregnant teenagers not exposed to IPV (Quinlivan and Evans, 2001). Women exposed to violence were also more likely to report being sad or depressed (Valentine, Rodriguez, Lapeyrouse & Zang, 2011; Koopman et al., 2007; Dutton, Kaltman, Goodman, Weinfurt & Vankos, 2005). Women exposed to violence were slightly younger than those who were not, however, the difference of 2 years is of doubtful clinical significance. However, they were also more likely to be current smokers.

Women exposed to IPV were more likely to be lost to follow up in a colposcopy outpatient setting therefore leaving them more at risk of cervical cancer. Exposed

women are also less likely to be compliant in attending other women's health clinic appointments. It is reasonable to assume that some of the poorer health outcomes seen in women who have been affected by IPV are due to noncompliance in outpatients attendance as a result of exposure to IPV.

4.7 Where to from here?

Routine screening tools should be used as a fundamental part of all women's health outpatient appointment settings. Medical and nursing staff should receive adequate training in screening of IPV as studies suggest that they are then significantly more likely to screen for IPV (Frank, Elon, Seltzman, Houry, McMahon & Doyle, 2006). It may be necessary for clinical services to provide flexibility for these vulnerable patients to access care. Patients that have been identified as having exposure to IPV could be offered a referral to a social work/mental health worker who is equipped in offering support and implementing appropriate intervention and future prevention strategies.

Part of the consultation should address the need to complete care, individualised strategies to promote compliance should be crafted by the clinician and woman. This could include additional contact numbers being provided by the women to the clinician of "safe" contacts who would be contacted if default occurs to assist the patient to attend for care. If patients have unstable housing or are homeless then referral to social work supports may assist in obtaining "safe" addresses of friends for mail may be helpful. If patients have depressive symptoms then patients may default from care.

No single strategy is likely to be effective, but simply undertaking a discussion on default and how to minimize it may reinforce the message of the importance of completing care especially when dealing with premalignant conditions.

Medical organisations should have a strategy in dealing with patients that have been identified as having IPV exposure. Attendance should be monitored and effective strategies to reduce default should be assessed.

