

A Quality Improvement Project on Improving Risk Assessment of Domestic Violence and Abuse at Southwark Perinatal Service

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Introduction

- Southwark Perinatal Service provides specialist mental health care to a caseload of around 75 women in Southwark who are pregnant or up to one year post-partum and experiencing moderate to severe mental illness.
- Domestic violence and abuse (DVA) includes psychological, emotional and economic abuse, as well as physical and sexual abuse, and the perpetrator may be a partner, ex-partner or family member¹.
- 1 in 4 patients in contact with mental health services are likely to be current or recent victims of DVA² and perinatal patients are especially vulnerable.
- The rise in cases of DVA during the COVID-19 epidemic is a public health crisis, with women and children at disproportionately increased risk of harm³, and there was a serious incident of DVA within Southwark Perinatal Service during government-imposed lockdown.
- NICE guidance states that the assessment of a suspected mental health problem in pregnancy and the postnatal period should include risk assessment of DVA⁴, but this is not always clearly documented.

Aims

The overall aim of the project was to improve the risk assessment of DVA of patients under Southwark Perinatal Service.

- 100%** of initial assessments should have both a **Risk Assessment Tool** and **Child Need and Risk Screen** completed on electronic Patient Journey System (ePJS), as outlined by the Trust's Operational Policy⁵.
- 100%** of **Risk Assessment Tools** should include documentation on the **presence or absence of current or recent DVA**.
 - If DVA is present, **100%** should state a **specific plan** around DVA.
- The **Child Need and Risk Screen** includes a tick box asking whether there is "any report of domestic violence within this family?" (Yes/No).
 - If DVA is present, **100%** should include a comment on both the **impact on children** and **actions taken**.

Methods

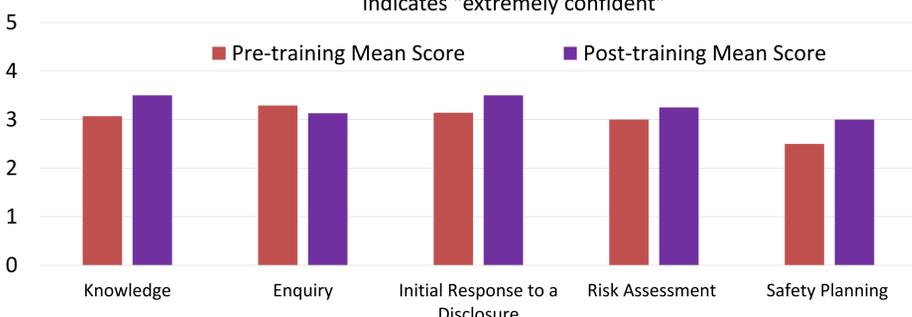
- Risk Assessment Tools and Child Need and Risk Screens on ePJS were screened for all initial assessments conducted by clinicians at Southwark Perinatal Service in the six weeks prior to the interventions, from 23/03/20 - 01/05/20 (n=14), and then for the six weeks following the interventions, from 15/06/20 - 24/07/20 (n=15).
- A one hour virtual training session on DVA was delivered to a total of 14 clinicians on 09/06/20. To increase the number of attendees, clinicians were invited from both Southwark Perinatal Service and the equivalent service in Lambeth.
- Prior to this training, an online anonymous survey was sent to clinicians at Southwark and Lambeth Perinatal Services, asking them to rate their confidence in the following five domains out of 5, where a score of 1 indicates "not at all confident" and 5 indicates "extremely confident": knowledge of DVA; enquiry into DVA; initial response to a disclosure of DVA; risk assessment of DVA; and safety planning with a victim of DVA. These five domains were covered in the training session, and the same online survey was sent to all attendees to reassess their confidence in these domains following the training.
- The training presentation slides and a single summary sheet of key points were then emailed to all clinicians at Southwark Perinatal Service.
- To aid sustainability, these documents were also uploaded to the Southwark Perinatal Service Microsoft Teams group, which is readily accessible to all clinicians, and will be included in the induction bundle for new staff.

Results

Online surveys

- 14 clinicians completed the pre-training survey, 14 attended the training session, eight of whom completed the post-training survey.
- Confidence improved for four of the five domains (see Figure 1), other than for enquiry about DVA, with the mean score falling slightly from 3.29 to 3.13.

Figure 1. Clinicians' confidence in five domains of assessing DVA, pre-training and post-training, where a score of 1 indicates "not at all confident" and a score of 5 indicates "extremely confident"



Results

Risk Assessment Tool

- Of the 14 initial assessments completed pre-intervention, 11 (**78.6%**) had a Risk Assessment Tool and this improved slightly to 13 out of 15 (**86.7%**) post-intervention.
- Pre-intervention, seven of the 11 (**63.6%**) completed Risk Assessment Tools included documentation on the presence or absence of DVA, and only two of the four (**50%**) identified DVA cases had specific plans documented, such as referral to a DVA charity (see Figure 2). In two DVA cases, the perpetrators were ex-partners, in one case it was the current partner, and in the final case the perpetrators were the current partner and a family member.
- Following the intervention, this worsened to only seven out of 13 (**53.8%**) Risk Assessment Tools including documentation on DVA. Neither of the two identified DVA cases, one of which was Honour-based Violence (HBV) and the other was abuse from a family member, had specific plans documented (see Figure 3).

Figure 2. PRE-INTERVENTION

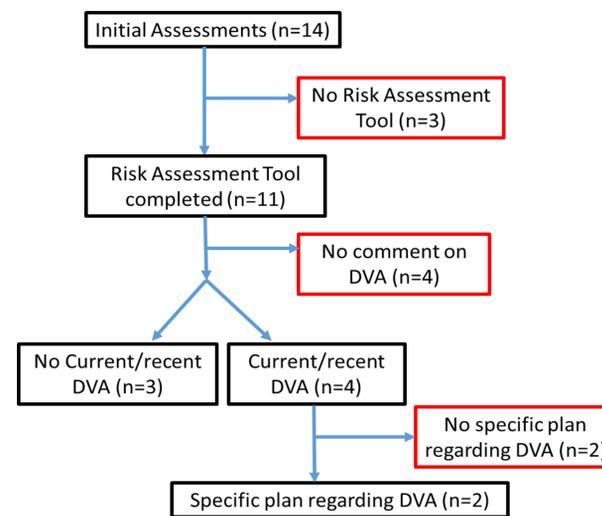
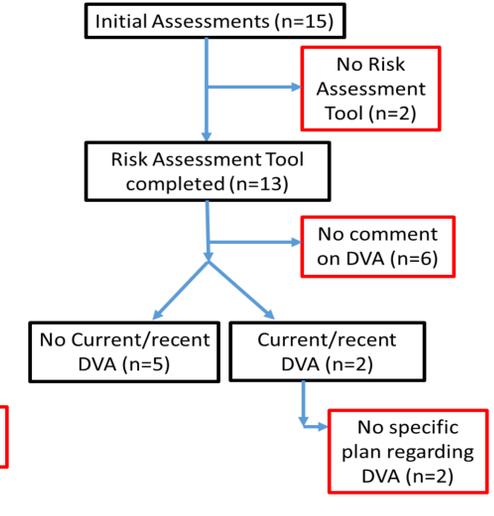


Figure 3. POST-INTERVENTION



Child Need and Risk Screen

- Of the 14 initial assessments completed pre-intervention, 12 (**85.7%**) had a Child Need and Risk Screen and this improved only slightly to 13 out of 15 (**86.7%**) post-intervention.
- Pre-intervention, there were four identified cases of DVA, which were the same cases identified by screening the Risk Assessment Tools for this cohort. Whilst all four (**100%**) stated the actions taken, such as referral to Child Safeguarding or Children's Social Services, only three of the four (**75%**) commented on the impact upon the children, for example, direct or indirect harms.
- Post-intervention, there were no identified cases of DVA, despite two cases (HBV and DVA from a family member) being identified by screening the Risk Assessment Tools for this cohort.

Discussion

The aims of the project were not met as the two ePJS risk tools were not always completed for initial assessments, and those that were did not always document DVA risk and specific plans. In contrast, the online surveys showed a small improvement in clinicians' confidence across four of the five domains of DVA assessment, aside from enquiry into DVA, and this should be a focus for further training sessions, for example with role-play demonstrations. This discrepancy may be due to the small sample sizes, which is a major limitation of this project, as well as high staff turnover. Of note, the training was delivered to both Lambeth and Southwark clinicians, whereas only Southwark risk tools were screened, and over only six week periods. A strength of this project is its sustainability; the training material is now easily accessible by clinicians and is part of the induction bundle for new staff.

The two ePJS risk tools could be improved upon; documentation around DVA was entered in various sections of the Risk Assessment Tool, which could lead to information being missed, and there is no section on "Risk from Others". A tick-box regarding DVA, with a prompt to remind clinicians of its definition and forms and requesting further details and a plan, would be helpful, given its high prevalence and associated risks. However, the tick-box question in the Child Need and Risk Screen ("Is there any report of domestic violence within this family?") may be over-simplistic, as the case of HBV and the case of DVA from a family member were missed by clinicians completing this risk tool, and it fails to consider the risks to children from other forms of DVA, aside from physical violence.

Conclusions

- Whilst clinicians reported improved confidence in risk assessing DVA following the interventions, this was not reflected on review of ePJS risk tools. This may in part be due to high staff turnover as well as small sample sizes, with data collection restricted to the Southwark team over six weeks.
- Further training on DVA will be delivered on a regular basis and outcomes reassessed. This training should focus on enquiry into DVA and DVA from family members, including HBV.
- The Risk Assessment Tool and Child Need and Risk Screen on ePJS must be improved in order to ensure clarity and consistency of documentation around DVA, its impact and specific planning.

References

- Home Office. *Information for Local Areas on the change to the Definition of Domestic Violence and Abuse*. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/142701/guide-on-definition-of-dv.pdf (accessed 24/09/2020).
- Yapp et al., LARA-VP: A resource to help mental health professionals identify and respond to Domestic Violence and Abuse (DVA). King's College London, 2018.
- Chandan JS, Taylor J, Bradbury-Jones C, Nirantharakumar K, Kane E, Bandyopadhyay S. COVID-19: a public health approach to manage domestic violence is needed. *The Lancet Public Health*. 2020 Jun 1;5(6):e309.
- National Institute for Health and Care Excellence. *Antenatal and postnatal mental health: clinical management and service guidance Clinical guideline [CG192]*. <https://www.nice.org.uk/guidance/cg192/chapter/1-Recommendations#assessment-and-care-planning-in-pregnancy-and-the-postnatal-period> (accessed 24/09/2020).
- Community Perinatal Mental Health Team Operational Policy, Version 6. South London and Maudsley NHS Foundation Trust (February 2019).