

Title: Development of an Evidence-based Domestic Violence Guideline: Supporting Perinatal Women-Centered Care in Japan

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Summary

Objective:

to develop evidenced-based women centered care clinical guideline designed to assist midwives and other health care providers in Japanese hospitals, clinics, and midwifery offices, in identifying and supporting potential or actual perinatal victims of domestic violence(DV).

Design :

systematic review and critical appraisal of extant research; structured assessment of clinical guideline development.

Method:

Systematic and comprehensive literature search. Appraisal of Guidelines for Research & Evaluation (AGREE) was used to assess the guideline development for purposes of assuring methodological quality.

Findings:

Electronic searches of medical and nursing databases between February and December 2003 retrieved 2,392 articles. Selected as

evidence were 157 articles yielding 28 recommendations aligned to clinical assessment questions.

Key conclusions:

Using expert consensus and external reviews, recommendations were generated that provided the at-risk perinatal group with the best practice available possible to prevent further harm.

Implications for practice:

The evidenced-base clinical guideline fosters a supportive environment for DV education for health care providers, and to improve clinic access for at-risk perinatal women. DV information and a negotiated midwife-client safety plan can be initiated for potential or actual DV victims and is achieved through understanding the risks of the woman and her fetus or infant, while respecting the woman's intention.

Key words: Domestic violence, Evidence-based guidelines, Women-centered perinatal care, Japan

Introduction

Background

It has been at least 10 years since the UN General Assembly (Office of the United Nations High Commissioner for Human Rights, 1993) and the 1995 4th World Conference Women Beijing Declaration (United Nations Develop Programmes, 1995) identified domestic violence (DV) as a global concern. In Japan, the Gender Equality Bureau of the Cabinet Office's (1999) intimate partner violence study found that one in three women had experienced emotional abuse and one in 20 women had experienced life-threatening physical abuse by their intimate partners such as husbands and lovers. Based on these findings, the government enacted legislation for the prevention of spousal violence and the protection of victims in October 2001. The DV prevention act, "Law For The Prevention Of Spousal Violence And The Protection Of Victims", defined 'violence' as 'physical abuse'.(see Appendix 1 for additional DV definition) However, psychological abuse was also defined as violence in this law when the abuse leads to post-traumatic stress disorder (PTSD) as defined in the criminal law. The law clearly stated that DV is a violation of the basic human rights of women and defined the DV responsibility of the state and local governments. Spousal violence counseling and support centers were charged with managing both physical and psychological abuse.

The enactment of the law seemed to facilitate both public understanding of the issue, and the detection and protection of victims. However, there were not enough support centers and shelters available, and the law did not cover violence

from an intimate partner outside marriage. In addition, DV was still identified as a social problem rather than as a medical problem. In 2004, the government responded to those issues and revised the law. The latest report by the Gender Equality Bureau (2003) indicated that 3.6% of women were physically abused by their partner, which is comparable to the finding in 1999. Unfortunately, it suggests that there has been no reduction in the number of victims.

The Bureau of Citizens and Cultural Affairs of the Tokyo Metropolitan Government interviewed victims of DV and discovered cases in which violence began or escalated during pregnancy (Bureau 1998). Kataoka (2004) surveyed pregnant women living in large cities in Japan and found that approximately 24% were at risk of becoming DV victims and that approximately 5% were at serious risk

DV has a serious impact not only on women's physical health, for example injury from physical abuse, but also on their mental and emotional health, such as depression, anxiety, and PTSD (Jones et al., 2001; Walling et al, 1994). Violence during pregnancy impacts both maternal and fetal health, and may be related to child abuse after birth (Rumm, 2000). Therefore support is particularly necessary for women during pregnancy, or in the perinatal period. Because pregnant women regularly attend health clinics, healthcare providers have an opportunity to detect and assist victims of DV (Tinkler & Quinney, 1998).

The law states that the role of health practitioners is to report the incidence of DV and to provide adequate information to the victims. Adequate information and clinical guidelines supporting the educational process must emerge from

evidence-based health care. Of the clinical guidelines we located in a literature search, only two, both located in North America, had been developed using evidence-based medicine: the United States Preventive Services Task Force (2004), and the Canadian Task Force on Preventive Health Care (2001). To date, no similar group in Japan has published guidelines that provide healthcare givers with concrete evidence based information.

Our goal was to develop an evidenced-base guideline, that provides midwives with practical guidance on identifying victims, provides adequate support for their recovery, and indicates ways of collaborating with other organizations with the aim of improving the quality of care for victims of DV in Japan..

Women-centered care

When there is DV in a household, women feel deprived of power, control and self-esteem, and in order for the woman to regain her sense of power and to recuperate her mental, physical, psychological, and/or social health, it is important to provide healthcare and welfare in accordance with the principles that mitigate oppression and fosters empowerment. Women-centered care is a philosophical and practical approach toward that end.

Women-centered care (Hills & Mullett 2002) emphasizes the significance of social, cultural, and political influences of women on their health. Its goal is the general well-being of women. A women-centered approach ensures the right of women to aspire to the well-being of their preference, and supports women in achieving their full potential. Supporting the principle of women-centered care are

the concepts of, respect, security, free will, and empowerment. Respect is primary; it is important to respect and treat women as equals. Respect gives women free-will and facilitates their decision making, which in turn leads to empowerment and thus autonomy. There are four directives shaping the DV clinical guideline and providing direction for caregivers' basic attitude in providing women-centered care: (a) treat women with respect and dignity as individuals; (b) provide care in a non-threatening manner, (c) work in collaboration as equal partners and (d) give priority to the woman's preference over that of the caregiver. Caregivers should consider that care, which is good for victims of DV, is care that is good for everyone. We developed the guideline to assist perinatal and postnatal women at risk: (a) history of DV, (b) currently a victim, and (c) women who were not yet aware of being victims of DV and are therefore "latent". Hence this guideline covers the process of identifying perinatal victims of DV and the strategies for providing adequate resources. It does not cover therapeutic interventions such as how to conduct counseling. Prospective users of this guideline are midwives and other healthcare providers who provide perinatal care.

Methods

The guideline development was part of a larger project that included developing a culturally sensitive DV screening tool for this target group (Kataoka et al 2004). However, given the differences in foci of the component parts of the project we chose to provide separate reports on our outcomes (Hegyvary, 2005). The clinical

guideline is intended to provide direction for using the screening tool. We established rigour through an established critical appraisal process of the literature and a well developed assessment method of the guideline construction process by a third party.

To guide our critical appraisal we used Nakayama's (2004) chapter, "Process of guideline development for healthcare", which is in accordance with the basic practice of EBM. Our research team conducted the comprehensive literature survey and review, and identified evidence of adequate support systems for DV victims, their effective detection, protection, and safety planning.

Establishing a quality database demanded rigour and systematic procedures. We proceeded in three steps: literature search, exclusion of irrelevant articles, and critical review.

Literature Search. We conducted an extensive literature search to capture relevant studies relating to our project of screening tool development (Nakayama, 2004) and guideline development. Our DV project literature search was previously described by Kataoka et al (2004):

"Searches of the relevant databases for guidelines, primary studies and reviews used the search terms "domestic violence", "spouse abuse", "partner abuse", "battered women", and relevant Mesh (medical subject headings) terms.

For guidelines developed by other groups, we search the National Guideline Clearinghouse database, Centers for Disease Control & Prevention Guidelines database, and Medline through HSTAT (Health Services/Technology Assessment

Text) systems, as well as the lists in “Primary Care-Clinical Practice Guidelines” hosted by the UCSF Department of Medicine.

The Cochran Library and ACP Journal Club were searched for systematic Reviews (with or without meta-analysis). The concerns and references of Clinical Evidence and Up To Date were searched for information relevant to DV, as were the databases of the Joanna Briggs Institute, which produces systematic reviews and guidelines on nursing, and CINAHL. For relevant Japanese literature, we searched the Clinical Guideline List of Toho University Medical Center, and the Scientific Research Database of the Ministry of Health, Labor and Welfare.

For eligible primary studies, we searched PubMed, CINAHL, the Cochrane Library and the Ichushi-Web, the online database of Japanese medical literature, from the very first records of each database until February 2003. In addition; we manually searched the reference lists of relevant studies identified, as well as master theses and dissertations in Japan. The search strategy yielded a total of 2392 articles”. (78-9)

Exclusion of irrelevant publications. Publications relevant to perinatal domestic violence were selected, giving a total of 655 including those obtained from a pilot search. One reviewer critiqued the title and abstract of each article to exclude from further analysis: (a) those studies that did not comply with the scope of the guideline; (b) studies that focused on the perpetrator of DV, children or the elderly; and (c) qualitative research, which was excluded because the critical analysis process and units of analysis were not parallel. Remaining for critical

appraisal were 545 publications.

Critical Appraisal of the Literature. For the third step, two reviewers critically appraised the 545 publications. Both the quality of the evidenced and the level of evidence were to be determined. Five evaluation systems were used depending on the needs of the evaluation process. Although the systems are closely aligned and historically the authors have collaborated, we found that in some cases one system worked the better than the others.

To evaluate the quality of each article, two types of evaluation sheets were prepared. One type was developed to evaluate studies with a clear research design, based on work done by the Evidence-Based Medicine Working Group (2001) and the other type were the worksheets of the Japanese version (Public Health Resource Unit, 2002) of the Critical Appraisal Skills Programme (CASP), which provided guiding questions for critical evaluation.. The level of evidence, based on the criteria of evidence level presented by the Oxford Centre for Evidence-based Medicine (2001) that speaks to the ranking of validity, with random control trials as the highest level, was determined from the results of the critical appraisal. From this rigorous review 157 articles met the criteria.

In addition, the research team, using the Oxford Centre scheme (2001), developed an evaluation sheet for each of the five focus areas: diagnosis, prognosis, therapy/prevention, etiology/harm, and overview. These areas served to organize the selected studies. (Retrieved April 24, 2006, from http://www.cebm.net/levels_of_evidence.asp.) Incorporation of research into this

guideline was determined by its quality and evidence level; the decision to incorporate was reached by consensus.

Recommendation Grade

After articles were evaluated based on their level of evidenced, we organized the articles based on the strength of evidence and the area of clinical concern. Thus, clinical questions were derived from EBM and categorized according to the evidence level and those meeting the highest standard were used to develop the highest grade - A recommendation or imperative. The standard of recommendation grades (Table 1) was based on the standard Infectious Disease Society of America (IDSA) evidence-grading system (Kish 2001), and the consensus of the members of the research team. When the evidence level was unclear, the grade of recommendation was determined according to the considerations identified by the Canadian Task Force on Preventive Health Care (2003) (Table 2), which takes into account various risk issues.

Assessment of the Guideline Development

In keeping with the women-centered care philosophy, we used the Appraisal of Guidelines for Research & Evaluation (AGREE) (AGREE Collaboration, 2001), to assess the process of the guideline development, for purposes of improving the methodological quality. A group of 22 stakeholders: clinical epidemiologists, representatives of feminist groups, DV survivors, therapists, DV consultants, physicians, midwives, nurses, public health nurses, lawyers etc, each received an

assessment packet. They were asked to provide opinions and/or comments on regarding the six domains relevant to the guideline development: (1) scope and purpose; (2) stakeholder involvement; (3) rigour of development; (4) clarity and presentation; (5) applicability to clinical area; and (6) editorial independence (conflict of interest reduction). Results were obtained from 16 (80%) of the assessors.

We calculated a standard score for each of the six domains. A high degree of agreement, 96% was obtained for scope and purpose (domain 1) and 88% for rigour of developmental (domain 3). A moderate level of 68% was reached for clarity and presentation (domain 4), 62% for stakeholder involvement (domain 2); and 57% for independence of editing (domain 6). The lowest level of agreement of 38% was for applicability (domain 5). We modified the guideline based upon this feedback.

Results

The first version of the guideline was completed 18 months later in July 2004. Linking of evidenced based research with the clinical questions that formed the guideline was achieved through two processes. Clinical questions were derived based on the review of the literature and feedback from the panel of stakeholders and clinical experts. The research committee arranged the questions into a logical order and through consensus grouped the relevant research articles according to the clinical question. We then formulated 28 recommendations grouped according to each clinical question (Appendix 2) and imperative level. The clinical questions and related research are presented in Appendix 3. Thus, the

guideline was organized based on the evaluation of selected literature and presents care-practice that is currently considered to be the most effective. Clinical questions are also posed that agencies can use to assess their own DV programme. A summary flowchart of support is shown in the Figure. The guideline is intended for immediate clinical use by caregivers. It is cultural sensitive for Japanese women in the clinical setting.

Dissemination Strategies

This guideline will be made available to the public to facilitate understanding of the issues of DV. It will be disseminated through hospitals, clinics and birth centers, the nonprofit organization Center of the Education and Support for Health and Security of Women, feminist and/or consumer groups. After the guideline is publicized through these channels, public opinion will be canvassed, as well as that from healthcare providers involved in perinatal care. For our next steps we think it is also important to further develop this screening tool to suit women from an Asian culture and must be tested for its efficacy at model institutions. As their social situation changes, the circumstances and support required by women also change. Accordingly, this guideline needs to be revised every 3 years by the working group, and evaluated by the third parties. The revision would lend itself to the iterative and inclusional process of action-research.

Then, intervention studies are necessary to measure outcomes based on 1) how many women will have developed a safety plan for themselves, 2) the extent to which available resources for women have increased, 3) how many women have been able to become independent from DV shelter support and 4) comparisons of

changes in their quality of life before and after interventions.

The guideline is designed to educate the public as well as health care professionals regarding the importance of early detection of DV. Although it is widely recognized (Ramsay et al, 2002, Zink et al, 2006) that screening is not yet strongly linked to DV reduction we understand that women's decisions to leave the abusing partner is often a long and complicated process and therefore our women-centered care screening program is intended to support DV victims leading to the appropriate support for women that includes a high regard for their own decision making.

Conclusion

Although circumstances surrounding DV, such as frequency of DV or support systems, vary from one country to another, DV is a common health issue despite cultural differences. Women-centered care is considered a universal supporting concept. We developed a clinical guideline for midwives and physicians who care for perinatal women outpatient settings. The development of the guideline followed high standards of rigour using a systematic critical appraisal process of evidenced based medicine. The relevance and validity of the guideline development was strengthened through an established process for external review by stakeholders. Furthermore, the guideline in content and process is firmly based on the principle of women-centered care.

The guideline is designed to achieve early detection of DV victims leading to the

appropriate support for women that includes a high regard for their own decision making.

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Table 1. Standards for Recommendation Grades¹

Grades	Definition	Rationale
A	Strongly recommended	Good evidence to recommend clinical preventive action.
B	Recommended	Fair evidence to recommend clinical preventive action.
C	May be recommended depending on circumstances	Equivocal evidence or not enough to recommend clinical preventive action; harm is no greater than desired effect of the preventive action.
D	Not recommended	Fair evidence to recommend against the clinical preventive action. Harm is greater than desired effect of the action.
E	Must be avoided	Good evidence to recommend against clinical preventive action. Evidence supports the absence of desired effects or harm of the action.

¹from: Infectious Disease Society of America (Kish 2001)

Table 2. Guiding Factors for Decision-Making When Evidence is Unclear¹

Increase patient involvement in decision-making
Minimize harm
Advocate major change only on strong proof of need
Avoid unnecessary labelling
Avoid expensive manoeuvres of unclear benefit
Focus on conditions with a high burden of illness
Be attentive to special needs of high-risk groups

¹ from Canadian Task Force on Preventive Health Care (2003)

Appendix 1. Definition of Domestic Violence

DV refers to a pattern of violence inflicted on a woman, usually by her intimate partner. Intimate partner includes men in relationship with the woman either currently or in the past, such as boyfriend, ex-boyfriend, husband or separated husband. The pattern of DV can include physical, psychological or sexual abuse. DV is considered to be actions that threaten the safety and dignity of women. Here, DV, violence and abuse are used interchangeably.

A 'victim of DV' refers to all women (excluding children) who are recipients of violence from their intimate partners. Victims are not necessarily aware that they are being abused. Battered women and survivors will also be used interchangeably.

Physical, Psychological and Sexual Abuse

Physical abuse is when physical power that may injure the woman is used to control her. It can include scratching, pushing, hitting, flinging, grappling, biting, pulling hair, slapping, punching, and burning.

Psychological abuse includes a range of actions that cause or potentially cause emotional harm or pain, such as verbal insults, control of behavior, isolation, neglect and threats.

Sexual abuse occurs when women are deprived of their choice about sexual behavior (e.g. being forced to have unwanted sex, to watch pornography, or to have an unwanted abortion). It can also include refusal to use contraception despite requests.

Appendix 2. Excerpts from the guideline according to each clinical question and recommendation level

No.	CQ (Clinical Question)	Answer	Recommendation ¹
I. Healthcare provider as support			
1	Is educational intervention necessary for healthcare providers?	Yes.	A
2	Should healthcare providers improve their medical facilities to support DV victims?	Yes. They should be more accessible and comfortable to DV victims.	C
II. DV screening			
3	Is DV screening necessary during perinatal care?	Yes.	B
4	Should the target for screening be focused on women with particular signs of DV?	No, it should not be limited to those with DV risks, signs or symptoms.	D
5	What are the appropriate settings for DV screening?	Wherever the privacy of the woman is secured, and without the presence of her family, husband or intimate partners.	A
6	What kind of attitudes should healthcare providers take towards DV victims?	Respect, empathy and supportive.	A
7	Which DV screening tools are known to be effective?	Abuse Assessment Screen” (AAS), “Partner Violence Screen” (PVS), and “Violence Against Women Screen” (VAWS) – Any one of these tools should be used for screening.	B
8	How should DV screening be conducted?	By self-administered questionnaire.	B
9	What is the appropriate timing and frequency for DV screening?	DV screening should be done more than once	C
		DV screening should take place during pregnancy but may also be considered after childbirth.	C
III. Identifying the risk factors			
10	What are the appropriate indicative risk factors?	Alcohol abuse, drug abuse, unemployment of	C

		the partner as well as previous experience of childbirth may be indicative of DV risk.	
IV. Identifying the clinical symptoms			
11	Should miscarriage and elective abortion be considered as clinical symptoms of DV?	Experience of either of these more than once must be paid special attention.	A
12	What kind of physical injuries are to be considered as clinical symptoms of DV?	Physical injuries on head, neck and face.	C
13	What conditional changes in pregnant women need special attention?	Anomalous weight changes (i.e. excessive weight gain or loss) may need special attention.	C
14	What psychological conditions of pregnant women require attention?	PTSD and depression may be indicative of DV and need special attention. Similarly, fear of sexual intercourse and decreased sexual desire may require special attention.	B C
15	Should delayed presentation to prenatal care be considered as a clinical symptom of DV?	Yes.	B
16	Can past DV experience be considered as a clinical symptom of DV?	Yes.	C
17	Is low birth weight of the newborn a clinical symptom of DV?	Yes.	A
18	Should fetal distress and death be considered as clinical symptoms of DV?	Yes.	A
V. Does the woman consent to assistance?			
19	Is consent of the woman required before discussing DV with her?	Yes.	A
20	Should the woman's decision be confirmed before support is offered?	The woman must be asked if she is willing to seek support.	A
VI. Safety assessment			
21	Should the safety of the woman and children be assessed?	Yes.	B
22	What scale is to be used for the risk assessment?	The "Danger Assessment Scale" (DAS) should be	B

		used.	
VII. Safety planning			
23	Should referrals be made to police or DV support centers?	Yes, with the woman's consent if the woman and children are at high risk of their life.	A
24	Is safety planning necessary to ensure the safety of the woman?	Yes, and support for the planning must be offered.	A
VIII. Providing information on useful social resources			
25	Is it necessary to provide the women with information on social resources and with support for utilizing them?	Yes.	A
26	What discretion must be used when providing information for the women?	Information must be provided for the woman while ensuring her safety e.g. in a manner the abuser would not notice.	A
IX. Follow-up and documentation			
27	How long should the woman be followed up?	As long as necessary through the perinatal and postpartum periods.	B
28	What precautions should be taken with the documentation of DV?	Speech should be recorded only with the woman's consent. The information must be stored with care and under no circumstance be disclosed to anyone else. Healthcare providers should be aware of necessary precautions for handling personal information.	A

¹ Recommendation grade based on the Infectious Disease Society of America model

Appendix 3. References used, their relationship to the clinical questions and level of evidence

CQ 1. Is educational intervention necessary for health care providers?

Ramsay J, Richardson J, Carter YH et al 2002 Should health professionals screen women for domestic violence? Systematic review. BMJ 325:314-318 [CQ 1, 3, 19-28 level 1a]

Campbell JC, Coben JH, McLoughlin E et al 2001 An evaluation of a system-change training model to improve emergency department response to battered women. Acad Emerg Med 8:131-138 [CQ 1 level 1b]

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their effectiveness in identifying and treating wife abuse. Med Care 32:1163-1172
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CQ 2. Should health care providers improve their medical facilities to support DV victims?

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CQ 3. Is DV screening necessary during perinatal care?

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CQ 3-9: DV Screening

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CQ: Does the woman consent to assistance? [19-20]; Safety assessment [21-22]; Safety planning [23-24]; Providing information on useful social resources [25-26]; Follow-up and documentation [27-28]

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CQ 19. Is consent of the woman reequired before discussing DV with her?

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CQ 22. What scale is to be used for the risk assessment?

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QC 24. Is safety planning necessary to ensure the safety of the woman?

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¹ Questions that are grouped (e.g. 11-18) are listed according to the beginning number (e.g 11). References are organized alphabetically by question.

Figure. Flowchart of Women-centered Care Guideline for Domestic Violence Support

