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## **NCT Policy Briefing:**

### **Domestic abuse during pregnancy and the postnatal period**

**This briefing sets out NCT policy on domestic abuse against women during pregnancy and the postnatal period. Domestic abuse is defined and its incidence during pregnancy and after birth is examined, including the physical and psychological impacts for women and infants. The indicators of domestic abuse are outlined and the NHS policy of routine enquiry about domestic abuse by health professionals. The briefing also discusses the knowledge, training and support systems necessary to enable professionals working with families during the perinatal period to identify and respond appropriately to suspected or known cases of domestic abuse. Separate *NCT Internal Policy and Good Practice Guidance on Domestic Abuse* sets out internal NCT policy on identification of and response to domestic abuse, providing guidance to NCT specialist workers, students and volunteers providing parent support.**

#### **NCT policy**

- 1. It is important that all those working with families during the perinatal period are aware of the incidence of domestic abuse during pregnancy and afterwards, as a significant number of their clients will be affected by the issue. Health professionals must have an understanding that domestic abuse can take a number of forms, including physical, sexual, psychological, emotional and financial abuse and honour based violence, and that abuse can be perpetrated by partners or ex-partners, and family members.**
- 2. Health professionals should be aware that women from all backgrounds, social classes and ethnic groups can be affected by domestic abuse. Whilst it is not possible to draw assumptions about women who may or may not experience abuse, health professionals must understand that some women have particular vulnerabilities and face additional constraints that can make it more difficult for them to access appropriate support or leave a violent relationship.**

- 3. The costs and consequences of domestic abuse have a significant impact on the health and well-being of women, babies and families, and on wider society. Domestic abuse presents a major public health concern and the health sector has an important role to play in addressing domestic abuse. Health professionals are in an ideal position to identify and offer support to women affected by abuse and must consider it their responsibility to do so, in a sensitive and appropriate manner.**
- 4. Systems and structures should be in place to maximise the opportunities for domestic abuse to be identified during pregnancy and responded to sensitively and effectively. This includes training of health professionals on domestic abuse and follow-up support, development and dissemination of appropriate guidance and procedures, and development of multi-agency working and agreed systems for referrals from the maternity team to specialist providers of domestic abuse support services, social services, housing, and other necessary agencies. Health professionals and others who deliver perinatal services should be aware of signs that a woman may be at risk, have the skills to raise the issue with her in a safe setting, and be able to refer her to appropriate source of specialist help. Midwives should routinely enquire about domestic abuse during antenatal appointments when they have received appropriate training and the necessary support systems are in place.**
- 5. Women from communities known to practice Female Genital Mutilation (FGM) should be routinely screened for FGM in the antenatal period by midwives and other health professionals working with pregnant women. Health professionals should receive training to support identification of women affected by FGM and to ensure appropriate and sensitive response. They should be aware of the cultural groups in which FGM is practiced, understand the implications of FGM for pregnancy and childbirth, and follow good practice guidance for care during pregnancy and labour. Health professionals must also have awareness of the law in relation to FGM and child protection issues for female children born to women affected by FGM.**
- 6. Women from ethnic minorities and women who do not speak English fluently need support to facilitate safe disclosure of domestic abuse. This should include the opportunity to develop trusting relationships with a known carer and access to appropriate interpreting services provided by female interpreters. Staff need to be aware of the cultural norms and particular sensitivities within different minority communities, whilst communicating clearly that domestic abuse is unacceptable.**
- 7. Training for staff and record keeping systems should give high priority to confidentiality and safeguarding and protection issues, in order for women to feel confident to disclose abuse and to ensure the safety of women, their children and vulnerable adults.**

## **Introduction and background**

It is common for domestic abuse to begin or escalate during pregnancy and the postnatal period, so women are particularly vulnerable to abuse at this time.<sup>2,3,4</sup> Domestic abuse is widespread, affecting one in four women in England and Wales during their lifetime,<sup>5</sup> and despite common misconceptions, women from all backgrounds can experience domestic abuse. The impacts of domestic abuse are considerable and far-reaching and the issue presents a major public health concern.<sup>2,6</sup>

In recent years there has been increased recognition and moves to address the role that the health sector must play in responding to the issue of domestic abuse.<sup>7,6,8</sup> The most recent measure taken has been the introduction across the UK of routine enquiry about domestic abuse by health professionals,

in the antenatal period.<sup>9,10,11,12</sup> Professionals working with families during the perinatal period are in an ideal position to identify and offer appropriate support to women affected by abuse and must consider it their responsibility to do so. The appropriate ways for professionals working with families to do this, and the necessary service developments to support them in this role, are discussed in this briefing.

- 1. It is important that all those working with families during the perinatal period are aware of the incidence of domestic abuse during pregnancy and afterwards, as a significant number of their clients will be affected by the issue. Health professionals must have an understanding that domestic abuse can take a number of forms, including physical, sexual, psychological, emotional and financial abuse and honour based violence, and that abuse can be perpetrated by partners or ex-partners, and family members.**

### *1.1 What is domestic abuse?*

Increasingly the term 'domestic abuse' is used in place of 'domestic violence' or 'intimate partner violence', to emphasise that there are many forms of abuse (including emotional abuse), not only physical violence. Domestic abuse can be defined as;

*'an incident of threatening behaviour, violence or abuse (psychological, physical, sexual, financial or emotional) between adults who are or have been intimate partners or family members, regardless of gender or sexuality'.<sup>5</sup>*

Domestic abuse can include:<sup>13,14</sup>

- physical violence, including hitting, kicking and beating
- psychological violence, including intimidation, humiliation and belittling
- forced intercourse and other forms of sexual abuse and coercion
- controlling behaviours, including isolation from family and friends, monitoring of movements, financial control and restricting access to information and services
- forms of honour based violence (see 1.2)

Domestic abuse may occur as a single event but is more commonly ongoing, escalating in severity and frequency over time.<sup>2,3</sup> Abuse can continue when partners have separated and the time when a woman tells her partner that she is leaving him, or attempts to leave him, is the most dangerous period, when most murders and severe injuries take place.<sup>15,2,16,17</sup> Domestic abuse can occur within both heterosexual and same-sex relationships<sup>18</sup> and can be perpetrated by both men and women. However, the majority of domestic abuse is committed by men against women.<sup>19,3</sup> Crime figures for England and Wales in 2007-2008 show that 85% of domestic violence victims are female.<sup>20</sup> In comparison with male victims, women are more likely to be injured or killed and to experience repeat assault or frightening threats.<sup>17,21</sup> For these reasons and the association between domestic abuse and pregnancy and the postnatal period, this briefing focuses on domestic abuse against women. The importance of support for men experiencing domestic abuse is recognised, and therefore links to information and support providers on domestic abuse committed against men are included in section 8.5.

### *1.2 What is honour based violence?*

'Honour based violence' is a term for forms of violence that take place in certain cultures, mostly against women, related to cultural notions of perceived immoral behaviour, honour and shame.

In relation to honour based violence, the *DH Responding to Domestic Abuse Handbook for Health Professionals* explains that;

*'Domestic abuse may take on different forms within specific communities. For example, women and girls may even be killed for their actual or perceived immoral behaviour in some communities. This is sometimes termed an 'honour killing', whereby the family or community try to restore their honour and respect by killing the woman or girl concerned. Immoral behaviour may take the form of perceived or actual infidelity, refusing to submit to marriage, separating, flirting with men or 'allowing' herself to be raped'.<sup>2</sup>*

Honour based violence is usually perpetrated by family or community members and can take on the following forms:<sup>5</sup>

- female genital mutilation (FGM) (see sections 5 and 8.6)
- forced marriage
- other types of honour based violence, such as murder or attempted murder associated with behaviour perceived to bring shame upon the family or community.

### *1.3 Prevalence of abuse during pregnancy*

One in four women will experience domestic abuse in their lifetime and in England and Wales on average two women are killed each week by a current or former partner.<sup>5</sup> It is common for abuse to begin or escalate during pregnancy.<sup>3,4,2</sup> Around 30% of all domestic violence is thought to begin during pregnancy<sup>22</sup> although some women report a decrease in violence by abusive partners whilst pregnant.<sup>16,23</sup> Sometimes abuse during pregnancy is a continuation of violence that preceded the pregnancy.<sup>23,16</sup> There is also some evidence to suggest that the postnatal period is the time that women may be most vulnerable to abuse.<sup>24,25</sup>

Statistics on the prevalence of abuse during pregnancy vary significantly between studies, affected by research methods, the populations studied, time periods observed and definitions used. Yet the actual incidence of abuse is likely to be higher than reported prevalence because underreporting of domestic abuse is common due to the personal nature and stigma of domestic abuse, feelings of shame or fear of retaliation. Women who experience abuse tend to access antenatal care later or less regularly than other women and are often accompanied by their partner, limiting their opportunities for disclosure.<sup>26,27,28</sup> A review of studies examining the prevalence of domestic abuse during pregnancy in the US and Canada reports a range of 0.9% to 19%.<sup>29</sup> Studies undertaken in England of domestic abuse during pregnancy report prevalence rates between 3.4% and 5.8%.<sup>24,30,31,32</sup> This suggests that the prevalence of domestic abuse during pregnancy is as common as obstetric complications such as gestational diabetes, twins or placenta praevia.<sup>33</sup>

The impact of domestic abuse during pregnancy and the postnatal period has been highlighted by the UK Confidential Enquiries into Maternal Deaths.<sup>34,26,27,22</sup> In 2003-05, 14 percent of all women who died had reported that they were subject to domestic abuse, and at least 19 women were murdered during pregnancy or the year after giving birth: the majority by their partner.<sup>27</sup>

### *1.4 Why is an increase in abuse associated with pregnancy and childbirth?*

Abuse can never be justified and while changes associated with pregnancy are not responsible for causing abuse, there are factors which may explain why women are more vulnerable to abuse at this time.

Abusers tend to be jealous and insecure individuals and pregnancy can trigger increased jealousy and possessiveness by abusers, as well as accusations of infidelity and questioning of the child's paternity.<sup>33,16,23</sup> A common explanation for abuse during pregnancy is the perpetrator's jealousy and resentment towards the unborn child. Abusers may resent the 'intrusion' of the baby which they feel threatened by and angry towards, particularly if they feel that they are no longer the woman's centre of attention.<sup>23,33,35,36</sup> This is exacerbated by how the woman may appear preoccupied with the baby and

therefore less emotionally available to her partner.<sup>33,16</sup> The increased contact with friends and family that often accompanies pregnancy, as well as the attention the woman receives from antenatal care providers, can cause increased anger, jealousy and resentment.<sup>16,33,36</sup> Some women who have been abused by a partner whilst pregnant also attribute violence to the pregnancy being unwanted by their partner.<sup>16,23</sup>

Given the controlling nature of domestic abuse, abusers are likely to feel threatened by a loss of power and control as their partner's body changes during pregnancy; changes which symbolize the woman's autonomy and independence.<sup>33,16</sup> In addition, pregnancy interferes with the couple's usual routine and the daily roles and tasks that the woman can perform.<sup>23</sup> Reduced sexual activity during pregnancy and the postnatal period can also trigger anger and violence.<sup>23,16</sup> Violence has also been found to be associated with stress associated with financial worries, with abuse following requests for money by women (who are often financially dependent on their partners).<sup>16</sup> Pregnancy can also be associated with an increase in violence when the pregnancy and concerns about bringing a child up in an abusive relationship act as an impetus for women to try to leave their partner, which can trigger additional abuse.<sup>2,16,17,15</sup>

**2. Health professionals should be aware that women from all backgrounds, social classes and ethnic groups can be affected by domestic abuse. Whilst it is not possible to draw assumptions about women who may or may not experience abuse, health professionals must understand that some women have particular vulnerabilities and face additional constraints that can make it more difficult for them to access appropriate support or leave a violent relationship.**

### *2.1 Vulnerability to domestic abuse of particular groups*

Women from all backgrounds, social classes and ethnic groups can experience domestic abuse. In general, there is no evidence to suggest that prevalence of domestic abuse varies by socio-economic class,<sup>37,6</sup> or ethnicity.<sup>38</sup> However, some specific groups of women are more vulnerable to abuse. A number of studies show that young women or mothers are more likely to experience domestic abuse.<sup>34,39,4,25,40,17</sup> Women who abuse drugs and alcohol, or have a partner who abuses drugs or alcohol, are also more at risk.<sup>16,39,4,25,41,24,17</sup> Additionally, refugees and asylum seekers are particularly likely to have experienced rape, torture and other forms of sexual abuse,<sup>42</sup> as well as sex workers or women who have been trafficked into the UK for prostitution.<sup>27</sup>

The British Crime Survey shows that there is no variation in the overall prevalence of domestic abuse by ethnicity,<sup>38</sup> but there are specific cultural forms of domestic abuse, such as female genital mutilation (FGM), 'honour based violence' and forced marriage, which women from specific cultures or ethnic groups are more vulnerable to.<sup>2,5</sup> There is also some evidence to suggest that women from some Asian cultures may be more likely to experience domestic abuse by in-laws, or experience family collusion over abuse they have experienced, possibly due to perceptions of 'honour'.<sup>43,2,34,44,27,45,46,47</sup> Honour based violence, forced marriage and family collusion over abuse may cause or contribute to deaths during or soon after pregnancy.<sup>34,27</sup>

### *2.2 Women who have additional needs and constraints*

The effects of domestic abuse can be devastating. While many of the effects are common to all women, some women are less well resourced, informed about their rights and options or supported by extended family and friends. These factors can make it harder to leave violent relationships or to access appropriate support.<sup>6,44</sup>

Disabled women are particularly likely to face barriers to leaving a violent partner, and there is also some evidence to suggest that women with disabilities are at increased risk of abuse.<sup>48,17</sup> Women with disabilities can experience abuse by a designated carer, and may have the added worries of losing a home that has been specifically adapted to their needs, or losing support or independence and having to turn to institutional care.<sup>2,48</sup>

Women living in small towns or rural areas may feel particularly restricted by fears of gossiping in the community and 'everyone knowing', at the same time as having less access than women in larger towns and cities to a refuge and other support services.<sup>49</sup> There are also issues particular to middle class women. Domestic abuse may be more likely to remain hidden when taking place in a large house or wealthy neighbourhood. Middle class women may fear that they will not be believed due to the misconception that 'it doesn't happen to women like that', and particularly if their partner is a respected professional.<sup>2</sup> Additionally, women in a same-sex relationship may face additional barriers to disclosing abuse or accessing appropriate support, including fears of being discriminated against because of their sexuality, mistaken assumptions about abuse in same-sex relationships or fear that their partner will be able to access women-only services to trace them.<sup>18,2</sup>

Women from ethnic minorities, who may have particular needs and for whom there is also a lack of specialist services, including translation services, may also experience greater difficulties and constraints.<sup>43,44,45,46,47,50</sup> Cultural or religious beliefs and expectations and the related stigma and shame associated with failed marriages in some cultures can influence whether women remain in abusive relationships or are able to disclose abuse and access sources of support.<sup>43,44,45,47,46,50,2</sup> This can also be affected by experiences, or fear, of racism and prejudices by service providers.<sup>2,44,51</sup> Traveller women may have particularly difficulties accessing services due to difficulties posed by living in a mobile community, and fear of prejudice and discrimination or concerns about their community's reaction if the police become involved.<sup>2,49</sup> Language difficulties for women who do not speak English fluently are discussed in section 6.

Women who have uncertain or limited leave to remain in the UK are more likely to have fewer options and sources of support available to them, or may be more hesitant to report abuse due to fear of losing their right to stay in the UK.<sup>44,52,53,46,47</sup> Partners may use this threat as part of abuse.<sup>2,54</sup> A condition attached to the stay of individuals with uncertain residence status or limited leave to remain is that they have 'no recourse to public funds.' This means they cannot access emergency accommodation or any other welfare benefits such as housing benefits and income support, nor work, which can leave them either trapped with a violent partner or destitute. The rule applies to women entering the UK on the basis of marriage for an initial two-year period, as well as some economic migrants and failed asylum seekers.<sup>52,53,46</sup> A new scheme to support domestic violence victims who are in this situation is due to be announced by the Westminster government shortly.<sup>20</sup> Women who do have definite leave to remain, but who originally entered the UK as a result of marriage, may experience increased pressure from the family to remain in the relationship.<sup>44</sup>

**3. The costs and consequences of domestic abuse have a significant impact on the health and well-being of women, babies, families and on wider society. Domestic abuse presents a major public health concern and the health sector has an important role to play in addressing domestic abuse. Health professionals are in an ideal position to identify and offer support to women affected by abuse and must consider it their responsibility to do so, in a sensitive and appropriate manner.**

*3.1 Physical consequences of domestic abuse*

Domestic abuse is associated with a range of short and long-term physical and psychological consequences.<sup>13,2,14</sup> These include injury, gynaecological disorders, unwanted pregnancy, sexually

transmitted infection, and emotional and psychosocial disorders.<sup>14,2</sup> Domestic abuse can be fatal, due to murder or manslaughter, suicide or behavioural risk factors associated with suffering abuse.<sup>2,14,27</sup>

Domestic abuse during pregnancy involves additional risks, including miscarriage, prematurity, low birth weight or injury to babies, poor maternal mental health, maternal death, foetal death, uterine rupture and haemorrhage.<sup>2,3,27,55,41,56,57</sup> Violence directed towards the abdomen, breasts and genitals is common,<sup>6,16,57,23,33</sup> suggesting that the unborn child is also a target for abuse and a focus of the man's anger.<sup>33,23</sup>

In addition to direct harm, the risk of poorer outcomes during pregnancy is heightened as abuse acts as a barrier to women attending for antenatal care. Contact for women experiencing abuse tends to be later and less regular.<sup>26,27,28</sup> This is because abusive partners prevent women from accessing care due to the increased likelihood of abuse being detected in pregnancy, as a result of the contact with health professionals and the physical examinations women undergo during pregnancy checks.<sup>27,6,55,56,33</sup>

### *3.2 Psychological consequences of domestic abuse*

Domestic abuse has considerable psychological effects. Women experiencing abuse can suffer depression, anxiety and post traumatic stress, including flash backs. Experiencing domestic abuse is also linked to alcohol and drug abuse,<sup>2,40,14,58</sup> self-harm<sup>2,14</sup> and eating disorders.<sup>2,40</sup> In pregnant women, these behaviours can contribute to poor birth outcomes.<sup>40</sup> Abused women are also more at risk of suicide.<sup>2,14</sup> The CEMACH enquiry into maternal deaths in the UK, 2003-05, found that 42% of the women who died of suicide were 'living with domestic abuse'.<sup>27</sup>

Living in an abusive relationship has a profound effect upon a woman's self-esteem.<sup>33,23,16,36</sup> Psychological abuse and controlling behaviour by abusers, including intimidating, possessive and humiliating behaviour, seek to undermine a woman's confidence, reducing her certainty and control over what is happening.<sup>33,36</sup> Abusers frequently follow acts of physical abuse with expressions of remorse, love and promises to change, increasing the woman's uncertainty.<sup>33,36</sup> Women may feel ashamed of experiencing abuse, burdened by the perceived need for secrecy, and feel a sense of responsibility for the behaviour of their partner.<sup>2,14,16,33</sup> Abusers often seek to isolate women from their family, friends and other sources of support and escape, thus increasing their dependence. To outsiders the abuser may seem incapable of violence.<sup>33,36</sup> These factors can make it hard for a woman to disclose abuse, seek help or leave an abusive partner.<sup>33,2,36</sup>

### *3.3 Consequences of domestic abuse for babies and children*

Domestic abuse during pregnancy and birth is associated with a range of negative consequences for babies and children, in addition to the physical risks to the unborn child (listed in section 3.1).

Exposure to domestic abuse can have long-term physical, psychological, behavioural and developmental impacts for babies and children.<sup>2,20,40,15</sup> It is estimated that babies and children are present during 90% of domestic violence incidents.<sup>59</sup> In addition to the psychological harm and distress that witnessing domestic abuse and growing up in an environment of fear can have on infants, they can physically be harmed by being caught in the cross fire.<sup>2,15</sup> Furthermore, in households where there is domestic abuse, abusive partners are also more likely to abuse the children.<sup>2,20,15</sup>

The psychological impacts that domestic abuse has upon women, such as depression, can have significant implications for women's relationship with their baby or child, and for the infant's psychological well-being. Research shows that women affected by domestic abuse are more likely to score lower on assessments of maternal attachment during pregnancy and postnatally, are at greater risk of postnatal depression, and are more likely to have negative perceptions of their infants and of themselves as mothers.<sup>60,61,58</sup> Infants whose mothers experience domestic abuse are also more likely

to develop insecure attachments.<sup>62</sup> They can also suffer considerable psychological trauma and are more likely to show posttraumatic-stress symptoms, such as hyperarousal, increased fear and aggression.<sup>63</sup>

Given the significant impact of domestic abuse upon children, the Adoption and Children Act 2002 identifies living with or witnessing domestic violence as a potential source of 'significant harm' for children and domestic abuse therefore necessitates consideration of child protection issues.<sup>2,64</sup>

### *3.4 Other costs of domestic abuse*

The total financial costs of domestic abuse in England and Wales, including personal costs to victims and those of the state (of the legal, healthcare, social and housing services and impacts on economic output), are an estimated £23 billion a year.<sup>65</sup> The cost to the healthcare systems of treating abuse-related physical injuries and mental health problems is £1.4 billion a year.<sup>65</sup>

### *3.4 Indicators and risk factors for domestic abuse*

The *CEMACH enquiry into maternal deaths in the UK, 2003-05* lists the following indicators of and risk factors for domestic abuse during pregnancy:<sup>27</sup>

- late booking and/or poor or non attendance for antenatal care
- repeat attendance at antenatal clinics, GP's surgery or Emergency Departments for minor injuries or trivial or non existent complaints or unexplained admissions
- non-compliance with treatment regimens/ early self discharge from hospital
- repeat presentation with depression, anxiety, self-harm and psychosomatic symptoms
- injuries that are untended and of several different ages, especially to the neck, head, breasts, abdomen and genitals
- minimalisation of signs of abuse on the body
- sexually transmitted diseases and frequent vaginal or urinary tract infections and pelvic pain or unexplained vaginal bleeding
- poor obstetric history including: repeated miscarriage or terminations of pregnancy, stillbirth, or preterm labour, or preterm birth, intrauterine growth retardation/low birth weight, unwanted or unplanned pregnancy
- the constant presence of an overbearing or domineering partner who may answer all questions for their partner and be unwilling to leave the room
- the woman appears evasive or reluctant to speak or disagree in front of her partner.

Demonstrating the extent of the progress that is needed within the health service to effectively identify and support women who experience abuse, the CEMACH enquiry of maternal deaths in the UK in 2003-05 found that all of the 19 women who were murdered had at least two of these identifiable risk factors and in many cases visible symptoms. Yet these were not acted upon by healthcare professionals and it is thought that none of these women were referred for help or advice.<sup>27</sup>

### *3.5 The role of the health sector in identification and response to domestic abuse*

Health professionals are often the first point of contact for women who have experienced abuse and pregnancy offers considerable opportunity to identify and support these women.<sup>2,8,64</sup> Midwives, GPs and health visitors see women routinely and have the opportunity to create safe and private opportunities for women to disclose and receive support in relation to abuse.<sup>64,8</sup> The Royal College of Midwives (RCM) states that; 'the midwife is ideally placed to identify ongoing abuse and to offer care, support and information to women'.<sup>66</sup>

This role of the health sector in responding to domestic abuse is set out in the *National Service Framework (NSF) for Children, Young People and Maternity Services in England* (2004) that states all NHS maternity care providers and Primary Care Trusts should ensure that:<sup>7</sup>

- ‘All pregnant women are offered a supportive environment and the opportunity to disclose domestic violence; and local support services and networks are developed and midwives and other health professionals involved are trained to respond appropriately.’
- ‘Maternity service staff are aware of the importance of domestic violence in their practice and are competent in recognising the symptoms and presentations. They are able to make a sensitive enquiry if concerned<sup>1</sup> and can provide basic information about, or referral to, local services as required.’
- ‘As part of the local inter-agency domestic violence strategy, joint working arrangements are in place between maternity services and local agencies with responsibility for dealing with domestic violence; information about these services is made available to all pregnant women whether they are affected by violence or not and, if they are, irrespective of whether they choose to disclose it.’
- ‘Maternity and social services have joint working arrangements in place to respond to concerns about the welfare of an unborn baby and its future, due to the impact of the mother’s needs and circumstances.’

The NSF acknowledges, however, that inter-agency collaboration to enable referrals and support women affected by abuse; ‘is underdeveloped and needs addressing.’<sup>7</sup>

**4. Systems and structures should be in place to maximise the opportunities for domestic abuse to be identified during pregnancy and responded to sensitively and effectively. This includes training of health professionals on domestic abuse and follow-up support, development and dissemination of appropriate guidance and procedures, and development of multi-agency working and agreed systems for referrals from the maternity team to specialist providers of domestic abuse support services, social services, housing, and other necessary agencies. Health professionals and others who deliver perinatal services should be aware of signs that a woman may be at risk, have the skills to raise the issue with her in a safe setting, and be able to refer her to appropriate source of specialist help. Midwives should routinely enquire about domestic abuse during antenatal appointments when they have received appropriate training and the necessary support systems are in place.**

*4.1 Routine enquiry about domestic abuse by midwives*

In recent years throughout the UK, midwives have begun to ask all women about domestic abuse during antenatal care as a matter of routine (known as routine enquiry). In England, in 2004 the DH announced that routine enquiry was to be introduced and since 2007 it has been rolled out to pregnant women during antenatal visits.<sup>5,9</sup> In Wales, routine enquiry has also been introduced, following the establishment in 2004 of an All Wales Midwifery and Health Visitors and Networking Group, to review current practice and the evidence base for routine enquiry and domestic abuse care. The group developed an *Antenatal Routine Enquiry Into Domestic Abuse Care Pathway*, for use by midwives and health visitors, and in 2006 published a training pack to support its implementation.<sup>10,67</sup> The pathway has also been extended into Accident and Emergency (A&E) services.<sup>45</sup> In Scotland, routine enquiry is recommended as part of the information recording within the Scottish Woman-held Maternity Record<sup>68,11</sup> In 2008 instructions and guidance was issued to Scottish Health Boards on the development of 3 year gender-based violence action plans which must address implementation of

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<sup>1</sup> Since publication of the NSF routine enquiry by midwives about domestic abuse has been rolled out throughout the NHS: see section 4.3.

routine enquiry, not only in maternity services but also in addiction and mental health services, A& E, primary care and sexual and reproductive health services.<sup>69</sup> In Northern Ireland routine enquiry by midwives was introduced in 2006-07.<sup>12</sup>

To support routine enquiry it is recommended that women are seen alone at least once during the antenatal period to facilitate more easy disclosure.<sup>2,27,70</sup> Routine enquiry is supported by the RCM<sup>66</sup> and the CEMACH maternal death enquiry 'once multi-agency support services are in place' and 'accompanied by the development of local strategies for referral to a local multidisciplinary support network to whom the woman can be referred if necessary'.<sup>27</sup>

The impact of the introduction of routine enquiry and changes in practice have not yet been evaluated but research shows that routine enquiry is acceptable to the majority of women when it is explained that all women are asked about domestic abuse.<sup>71,3,72</sup> Research also shows that those who have experienced abuse find it difficult to raise the issue themselves so enquiry is welcomed, providing that it takes place by a trained and understanding midwife in a safe and private environment.<sup>73,3,2</sup> The DH recommends that midwives enquire whilst taking a social history and asking about other factors that have a negative impact on women's health. However, it is important that staff 'never ask about domestic abuse when anybody else is present' (except a professional interpreter).<sup>2</sup> Carrying out routine screening in this way avoids stigmatising women and reduces embarrassment and fears of being judged, therefore making it easier for women to disclose abuse and receive support.<sup>3,64,73,2</sup>

Routine enquiry was introduced in the England following a successful pilot at North Bristol NHS Trust.<sup>9,74,75</sup> The roll out at the trust followed a training programme for midwives supplemented by important follow up support, advice and leadership. The training was evaluated positively by midwives and outcomes included increased awareness, knowledge and confidence in dealing with the issue. Midwives also showed positive attitudes towards enquiry. At six months after the introduction, while the majority of midwives were routinely asking about domestic abuse only 50% of the time, disclosure rates or documented incidents of 'cause for concern' had increased almost six-fold.<sup>75</sup> A six-fold increase in disclosure of abuse was also found by a similar intervention study at Guy's and St. Thomas's Hospitals, London.<sup>73</sup>

#### *4.2 The need for training of health professionals to support routine enquiry*

The DH *Responding to Domestic Abuse Handbook for Health Professionals* states that 'all staff who have contact with patients should be trained in domestic abuse issues', which should; 'start at undergraduate level and continue in specialist training and continuous professional development programmes'.<sup>2</sup> The Bristol pilot project evaluated routine enquiry by midwives as successful when introduced following a training programme for midwives which includes opportunities to develop practical skills in routine enquiry.<sup>75</sup> The report recommended that the training programme should be extended to include regular updates for midwives, improved procedures for formal record keeping and increased awareness of and provision for the specific needs of ethnic and minority groups.<sup>75</sup> It is also important that midwives are well informed and knowledgeable about local resources, to help them to respond to disclosure and make appropriate referrals.<sup>8</sup>

The need for training and ongoing support for health professionals in relation to domestic abuse is shown by studies of factors preventing health professionals from enquiring about domestic abuse, undertaken amongst staff who had not received specific training. Barriers to enquiry included staff lacking confidence, feeling fearful of offending women, having insufficient knowledge, and feeling unable to support abused women, as well as negative assumptions, attitudes and beliefs about abuse.<sup>76,77,78</sup> A lack of awareness of domestic abuse during pregnancy, the common misconception that pregnancy offers protection from abuse, and the idealised image of pregnancy and the nuclear family are additional factors that contribute to poor detection and appropriate intervention by health professionals.<sup>33</sup> Midwives may also have fears about their own safety when working in a violent

situation, and midwives who have personal experience of domestic abuse may find addressing domestic abuse personally difficult.<sup>73,35,76</sup>

#### 4.3 *Appropriate and sensitive responses to domestic abuse*

The DH *Responding to Domestic Abuse Handbook for Health Professionals* makes it clear that health professionals should; ‘never assume that someone else will take care of domestic abuse issues.’ It states that the role of the health professional should be limited to:<sup>2</sup>

- focusing on the woman’s safety and that of her children, if she has any;
- giving her information and referring her to relevant agencies;
- making it easy for a woman to talk about her experiences;
- supporting and reassuring her;
- being non-judgemental;
- ensuring confidentiality and if there is a need to share information with other agencies (see section 8)
- attending to all the woman’s health needs.

A lack of knowledge and understanding of domestic abuse amongst health professionals means that responses to abuse are not always appropriate and women are not treated with necessary sensitivity and understanding.<sup>3,79,77</sup> A common mistake is to advise or assume that a woman can and should simply leave their abusive partner, or to blame or judge her for not doing so.<sup>35,79</sup> On this issue the DH advises health professionals to: ‘support the woman in whatever decision she makes’ even though; ‘You might not understand her decision’.<sup>2</sup>

The reasons some women stay with or return to an abusive partner are varied and complex.<sup>36</sup> The time when a woman either tells her partner that she is leaving him, or attempts to leave him, is the most dangerous time. To prevent women from leaving or to punish them for initiating separation it is common for abusers to escalate violence, and the risk of murder is greatest at this time.<sup>2,16</sup> Professionals working with families also need to be aware that leaving a violent partner does not necessarily end the abuse. Abusers can be very persistent in tracking women down and using various ways to continue to intimidate and control. However, it should also be remembered that sometimes women still love their abuser, believe he can change or want their children to grow up with their father.<sup>2</sup> Additionally, the psychological impacts of abuse and way that abusers commonly isolate women from sources of support can have a profound affect on a woman’s ability to act autonomously from her partner, and financial constraints often act as a barrier to women making a clean break.<sup>33,36,2</sup> Whilst for some women pregnancy can be a factor that motivates them to leave their partner, pregnancy and the postnatal period are also times when women can feel particularly emotionally dependent on their partners, so other women may be reluctant to leave at this time.<sup>80</sup> Overall it is important that midwives are not prescriptive in their approach, providing information rather than advice to women, whilst offering women the opportunity to talk to someone who is caring and understanding.<sup>10,71</sup>

Health professionals working with women with a history of abuse, and particularly sexual abuse, also need to bear in mind that these women may experience pregnancy and childbirth as threatening to their physical integrity.<sup>80</sup> Physical examinations in particular, especially if undertaken by male practitioners, can be particularly difficult, and may trigger flashbacks or cause women to remember past experiences.<sup>80</sup> It is also important to be sensitive to how women who have been abused are less likely to have planned their pregnancy, because it is common for abusive partners to inflict sexual abuse and coercion and to control a woman’s reproduction and contraceptive use.<sup>40,29,16,33</sup> They are also likely to have mixed, complex and sometimes conflicting feelings about having a baby. So it is important for care givers to be sensitive to women’s experiences and to recognise that pregnancy is not always welcomed or experienced in a positive way by all women.

#### 4.4 Limitations of routine enquiry

Even when routine enquiry is introduced, and with adequate training and support mechanisms, it does have limitations. The Bristol pilot found that the most significant barrier to routine enquiry was the presence of a family member during the appointment, followed by a lack of privacy, time and resources. Additional barriers include lone working and the potential threat of violence, and staff shortages.<sup>75,81,73</sup>

Opportunities for routine enquiry are reduced by the late and infrequent contact with maternity services that is common for women who experience domestic abuse. Yet even when it is possible to ask a woman about abuse there are factors which prevent disclosure or effective identification and response. Women may be reluctant to disclose abuse due to fears of resultant violence by their partner, of being judged, or of her child being taken away.<sup>33</sup> To offer women support in relation to domestic abuse, in addition to routine enquiry: 'information about local sources of help and emergency help lines such as those provided by Women's Aid should be displayed in suitable places in antenatal clinics, for example in the women's toilets or printed as a routine at the bottom of hand-held maternity notes or cooperation cards.'<sup>27</sup>

**5. Women from communities known to practice Female Genital Mutilation (FGM) should be routinely screened for FGM in the antenatal period by midwives and other health professionals working with pregnant women. Health professionals should receive training to support identification of women affected by FGM and to ensure appropriate and sensitive response. They should be aware of the cultural groups in which FGM is practiced, understand the implications of FGM for pregnancy and childbirth, and follow good practice guidance for care during pregnancy and labour. Health professionals must also have awareness of the law in relation to FGM and child protection issues for female children born to women affected by FGM.**

##### 5.1 Screening and care for women affected by female genital mutilation

The NICE *Antenatal Care Guideline* recommends that: 'pregnant women who have had female genital mutilation should be identified early in antenatal care through sensitive enquiry. Antenatal examination will then allow planning of intrapartum care.'<sup>72</sup> This is of great importance because FGM has considerable long-term health risks, and complications for pregnancy and labour with implications for both the mother and baby. Women who have undergone FGM therefore have specific obstetric needs during pregnancy and labour. For women who have undergone the most severe form of FGM, a procedure is needed in the antenatal period or during labour to open the woman's scar tissue to allow the baby to be born safely.<sup>82</sup> Guidance for midwives and other health professionals on identifying and caring for women affected by FGM is available from the RCN<sup>82</sup> and the RCM.<sup>83</sup>

It is important that health professionals receive training to enable them to effectively and sensitively identify and care for women affected by FGM. Professionals should be sensitive to how women who have undergone FGM may not understand the term 'female genital mutilation' or may find it offensive. They may instead use the terms 'female circumcision' or 'cutting'. Women with FGM may also be unlikely to identify it as a form of abuse or violence. While some women who have undergone FGM may benefit from specialist FGM support services, unlike domestic abuse, FGM presents a medical issue during pregnancy and labour requiring careful obstetric management rather than an ongoing abuse issue requiring professionals to ask and refer for domestic abuse support.

Training for professionals should also cover the legal aspects of FGM, including the responsibilities health professionals have regarding child protection and FGM. FGM is illegal in the UK but the

children of women who have undergone FGM are potentially at risk of being subjected to FGM. FGM is therefore a child protection issue, but the position for the woman is different from the position of other victims of domestic abuse, as she herself may be under suspicion as a potential perpetrator of abuse if she has a girl child. Health professionals who believe that an adult has undergone FGM have a duty under the Child Protection Act (1989) to consider the risks to their children and inform social services or the police.<sup>82</sup>

For further information, guidance and links to support services in relation to FGM see section 8.6.

**6. Women from ethnic minorities and women who do not speak English fluently need support to facilitate safe disclosure of domestic abuse. This should include the opportunity to develop trusting relationships with a known carer and access to appropriate interpreting services provided by female interpreters. Staff need to be aware of the cultural norms and particular sensitivities within different minority communities, whilst communicating clearly that domestic abuse is unacceptable.**

*6.1 Specific needs and considerations for ethnic minority women*

For women who don't speak English fluently, language difficulties can act as a barrier to disclosing abuse or accessing services. The DH recommends that 'All staff should have access to professional interpreters.'<sup>2</sup> The importance of this is shown by findings from the the CEMACH maternal death enquiry 2003-04. Five of the nineteen women murdered during pregnancy or the year following birth did not speak English and during appointments their partners who went on to murder them acted as a translator, preventing the women from seeking help. Partners or family members should therefore not be used as translators.<sup>27</sup> Additionally, as recommended by the RCM, interpreters should be female.<sup>66</sup>

Research shows that women from ethnic minorities sometimes prefer a health professional or translator of the same ethnicity or background, which can help with cultural understanding and language issues.<sup>51</sup> However, some women may prefer someone who is not of the same culture or ethnicity, due to fear that they may know or be related to someone they know and information will be passed on about their situation.<sup>44,43</sup> This fear of 'gossiping' within the community is particularly relevant to some ethnic minority groups due to cultural perceptions of 'honour' and 'shame'.<sup>43,44</sup> To increase women's confidence and ability to disclose abuse, women should therefore be assured of confidentiality (within the limits of confidentiality) and be offered the opportunity to decline the use of a particular midwife or translator that they are not comfortable with.<sup>43</sup>

A lack of, or inappropriate, translation services represent a barrier to routine enquiry for women who do not speak English. Yet it has also been suggested that routine enquiry may not be appropriate for women from ethnic minorities in certain circumstances, because guidance supporting routine enquiry does not address specific issues particular to ethnic minority women.<sup>43</sup> For midwives to be able to effectively identify cases of abuse and support women from ethnic minorities, they need cultural awareness, including knowledge of specific cultural forms of domestic abuse. They also need an understanding of the additional constraints and pressures that ethnic minority women can face which can make it harder to disclose or escape abuse (see section 2.2).<sup>43</sup> To address these issues, as well as translation services being readily available, health service providers should ensure that materials about domestic abuse and information about specialist services for BME women are available in a range of languages, to pass to women and allow referrals to specialist services.<sup>75</sup> Some information about specialist support services for women from ethnic minorities is included in the contacts section of the *DH Responding to Domestic Abuse Handbook for Health Professionals*. Additionally midwives should have specific information about local services and support groups.<sup>2</sup>

## **7. Training for staff and record keeping systems should give high priority to confidentiality and safeguarding and protection issues, in order for women to feel confident to disclose abuse and to ensure the safety of women, their children and vulnerable adults.**

### *7.1 Confidentiality, safeguarding and protection*

Ensuring confidentiality and women's safety by preventing abusive partners, and other individuals, from accessing records relating to domestic abuse is an essential part of effective service provision for women affected by domestic abuse. On this issue the DH recommends that; 'domestic abuse should be recorded separately from the main patient record' and health professionals should; 'ensure that the record can only be accessed by those directly involved in the woman's care. Domestic abuse should never be recorded in hand-held notes, such as maternity notes.'<sup>2</sup> Additionally the RCM recommends that; 'midwives should be vigilant about keeping information confidential from the abuser and disclose only with the permission of the woman, on a need-to-know basis.'<sup>66</sup> However, there are exceptions to this rule and limits to confidentiality. In the interest of safeguarding and protecting children and vulnerable adults, and women experiencing abuse if there are immediate concerns for her life, it can be necessary to share information without a woman's permission with the relevant agencies (such as social or child protection services or the police)..

The DH makes it clear that 'safeguarding and protection should always take precedence over confidentiality'<sup>2</sup>, such as in relation to child protection if exposure to domestic abuse is judged to place children at significant risk of harm. In these instances health professionals should follow normal child protection procedures, referring to social services if necessary, and providing support and protection to the abused mother so that she is able to protect her children.<sup>2</sup> In relation to safeguarding and protection of vulnerable adults, a vulnerable adult is defined as someone: 'who is or may be in need of community care services by reason of mental or other disability, of age or illness; and who is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation' (Department of Health, 2000).<sup>84</sup> Women who experience domestic abuse are not routinely classified as vulnerable adults, yet vulnerable adults can also experience domestic abuse or be at risk of significant harm if a parent or carer etc is being abused. If a vulnerable adult is experiencing abuse, procedures for both safeguarding vulnerable adults and response to domestic abuse must be followed.

To provide further clarification to health professionals on confidentiality and safeguarding and protection issues, all PCTs should have documentation, confidentiality and information procedures in place.<sup>2</sup>

### *7.2 Note-taking*

In addition to the confidentiality issues associated with notekeeping The DH recommends that health professionals should; 'keep detailed, accurate and clear notes to indicate the harm that domestic abuse has caused. Comprehensive note taking is important because medical records can provide evidence to bring abusers to justice, as well as influence housing and immigration decisions.'<sup>2</sup> According to Nursing and Midwifery Council Guidelines for records and record keeping, midwives do not need a woman's permission to record a disclosure of domestic abuse or the findings of an examination, although it should be made clear to the woman that midwives have a duty to keep a record of disclosure and injuries.<sup>2</sup>

## **8. Further sources of information and support:**

### *8.1 Guidance for NCT specialist workers, students and volunteers providing parent support:*

- NCT (2009) Domestic abuse during pregnancy and the postnatal period: NCT internal policy and good practice guidance for NCT specialist workers, students and volunteers.<sup>1</sup>

### 8.2 Guidance for health professionals on domestic abuse:

- Department of Health (2005) *Responding to domestic abuse: a handbook for health professionals*.<sup>2</sup>
- Scottish Executive (2003) *Responding to domestic abuse: guidance for health care workers in NHS Scotland*.<sup>85</sup>
- All Wales Midwifery and Health Visitors and Networking Group (2006) *All Wales Antenatal Routine Enquiry Into Domestic Abuse Care Pathway Training Pack*.<sup>67</sup>
- Department of Health and North Bristol NHS Trust (Website) *Domestic Violence in Pregnancy: Guide for Midwives and Health Professionals*.<sup>86</sup>
- Royal College of Midwives (2006) *Domestic abuse: pregnancy, birth and the puerperium. Position statement no 11*.<sup>66</sup>

### 8.3 Domestic abuse information and support services for women:

If you need any further information the following two websites offer information, resources and research and policy work for women affected by domestic abuse, professionals and the general public. They also provide information about national and local support services (including refuges, counselling, and legal and economic information or support) for women affected by domestic abuse, including specialist services for women from different ethnic minorities and for lesbian, bisexual or transsexual women. Both organizations work across the whole of the UK:

- **Women's Aid:** <http://www.womensaid.org.uk/>
- **Refuge:** <http://www.refuge.org.uk/>

In partnership these organisations run the **free 24 hour National Domestic Violence Helpline: 0808 2000 247**

At the following page you can search for local support services by region in the UK:

[http://www.womensaid.org.uk/landing\\_page.asp?section=000100010024&sectionTitle=Find+a+local+service](http://www.womensaid.org.uk/landing_page.asp?section=000100010024&sectionTitle=Find+a+local+service)

Please be aware that women may worry about accessing information via websites due to the fear that abusive partners are able to monitor the websites they access. Both of the websites above provide guidance to women about deleting their internet history, but it is not always possible to completely cover tracks online. So the safest option is for women to access the internet outside of the home on a computer that is not used by their partner.

### 8.4 Other useful organisations

- **Samaritans (UK):** [www.samaritans.org](http://www.samaritans.org)  
**24 hour telephone line: 08457 90 90 90**
- **NSPCC (UK):** [www.nspcc.org.uk](http://www.nspcc.org.uk)  
**24 hour free Child Protection Helpline: 08000 800 5000**

### 8.5 Information and support services for male victims of domestic abuse

Further information about domestic abuse committed against males and support services for male victims of domestic abuse is available from:

- **Men's Advice line:** <http://www.mensadvice.org.uk>  
**Freephone telephone line for male victims of domestic abuse:** 0808 801 0327

#### 8.6 Female genital mutilation information, guidance and support services:

- Royal College of Nursing (RCN) (2006) *Female Genital Mutilation: An RCN educational resource for nursing and midwifery staff* (2006).<sup>82</sup>
- Royal College of Midwives (RCM) (1998) *Position Paper No.21 Female Genital Mutilation (Female Circumcision)*.<sup>83</sup>
- FORWARD (Foundation for Women's Health Research and Development) An African women's organisation based in London offering information, support, guidance and training in relation to FGM: [www.forwarduk.org.uk](http://www.forwarduk.org.uk)

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The NCT wants all parents to have an experience of pregnancy, birth and early parenthood that enriches their lives and gives them confidence in being a parent.

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