Domestic violence in pregnancy: midwives and routine questioning

The Confidential enquiry into maternal and child health (CEMACH) (2004) set the standard for maternity care to protect women from domestic violence. Twelve women who were murdered by their partner and 43 further deaths from disclosure with no appropriate referrals prompted the routine enquiry for domestic violence to be initiated in 2000. The death rate from domestic violence had marginally decreased slightly in the latest report from The Centre for Maternal and Child Enquiries (CMACE) (2011) with 11 women murdered by their partner and 34 further deaths from disclosure with no referrals. The aim of this article is to review the current literature in order to explore evidence that questions the confidence of midwives when asking about domestic violence in pregnancy. The article aims to highlight the concerns that midwives face when confronted with a positive disclosure of domestic violence, and to provide a flow chart to aid in referral.

BACKGROUND
Reports from CEMACH (2004) show that at least one million women in the United Kingdom will experience domestic violence at some time in their lives, and that many will endure domestic violence at least 30 times before seeking help. This figure includes 30 per cent of women who will suffer from abuse starting, changing in intensity or method (for example: psychological, sexual or physical abuse) and continuing during pregnancy (CEMACH 2004).

Midwives have been expected to routinely ask about domestic violence since 2000, as a result of recommendations from the Department of Health (DH) (2000), advising that routine questioning for domestic violence should be introduced for all women, and to include the development of local strategies for referral to multidisciplinary teams. Of 391 women identified in the report who had died from domestic violence-related incidents, 12 were murdered by their partner and 43 voluntarily disclosed domestic violence to the healthcare professional, as none were directly asked about domestic violence. Half of the women who were murdered continued to receive midwifery-led care with no referrals made.

Routine questioning for domestic violence is generally accepted by women (DH 2000), but reports show that it is more likely that women will disclose
domestic violence if directly asked. Evidence from the DH has shown that women who suffer from domestic abuse rarely disclose the information to their midwife for fear of intimidation, embarrassment or further abuse (DH 2000; Nasir and Hyder 2003). Those who do are in need of support, understanding and trust from their midwife (National Institute of Health and Care Excellence (NICE) 2008). As domestic violence is known to increase during pregnancy (Royal College of Midwives (RCM) 1999), women need to know that midwives are confident and equipped to deal with and support disclosure when it occurs. However, the reports show that midwives are not confident to support them (Bacchus et al. 2003).

The CMACE report (2011) showed a small improvement in figures for domestic violence-related maternal deaths occurring between 2006-2008, stating that 34 of the women who had died had again voluntarily disclosed domestic violence to their healthcare professional, and a further 11 were murdered by their partner. These figures suggest that routine questioning does improve domestic violence disclosure. However, as women continue to voluntarily disclose domestic violence, we need to explore whether midwives are confident to ask the question about domestic violence and what concerns they have when confronted with a positive disclosure.

**METHODS**

Primary research articles were included in the literature review as they addressed the feelings, stereotypes and attitudes of midwives towards routine questioning and domestic violence education. Semi-structured questionnaires and interview articles were also included as they investigated concerns and barriers that midwives faced. The articles had been granted ethical approval and had been peer reviewed to assess the credibility of each article. The topics of interest extracted from the data included barriers and concerns faced by midwives when asking the routine question enquiring about domestic violence; how to ask the question; education; lack of confidence when addressing domestic violence; and how to deal with positive disclosure.

**FINDINGS**

Eight studies were included that used semi-structured interviews and questionnaires to record data from midwives who expressed views and concerns relating to domestic violence and education. The interviews were conducted before and after domestic violence education to reflect the effectiveness and quality of programmes offered to midwives. The studies reflected demographic differences between midwives in Northern Ireland, Leeds and London and included 865 hospital- and community midwives, including age ranges of 25-40 and 40-55.

Ninety two per cent of the midwives questioned within the studies agreed that they had a major part to play in screening for domestic violence; however only 28 per cent reported that they had raised the issue when they had performed booking appointments.

The main area for concern was the midwives’ lack of confidence when dealing with positive disclosure

Throughout the articles, recurring themes arose as barriers or areas that caused concern for midwives, when asking about domestic violence. The findings were that:

- midwives reported a lack of confidence and how to ask about domestic violence due to insufficient education, and a lack of knowledge around the subject
- there were concerns around partner presence and lack of confidential/private areas to ask about domestic violence. Some midwives raised fears regarding aggression from partners, and did not feel that it was their place to deal with this and so often would make no provision to remove women to ask, if partners were present.
- concern was raised regarding ‘opening a can of worms’ for fear of exposing further problems (Bacchus et al. 2002; Gielen et al. 2000; Wathen et al. 2008).
- language barriers and time restraints were also raised as problem areas, as time to provide interpreters for the questioning of domestic violence would itself bring pressures to practice (Protheroe et al. 2003).

The studies showed the main area for concern was the midwives’ lack of confidence when dealing with positive disclosure, and the uncertainties of referral procedures.

**WHAT CAN BE DONE**

At present there appear to be many interventions and contact points for midwives to access but no solid domestic violence policy or guideline to follow. The introduction of a national guideline for...
Flow Chart 1

1. Appoint domestic violence midwife/construct domestic violence policy
2. Set up pregnancy wellbeing clinics
3. Routine questioning by midwife
   - Negative disclosure. Ensure woman is aware that disclosure can be made at any time
     - Repeat questioning at 28 weeks
       - Negative disclosure
       - Positive disclosure
       - Repeat questioning at 34 weeks
         - Negative disclosure
         - Positive disclosure
         - Repeat questioning at five day postnatal visit
           - Negative disclosure
           - Positive disclosure
           - Ensure woman is aware of contact points should her situation change, leaflets/contact numbers
   - Positive disclosure
     - Refer to pregnancy wellbeing clinic/specialist midwife, provide appointment time for woman
     - Individualised support dependent on needs. Referral to safeguarding, drug/alcohol support, counselling including/excluding partner. Support for women wishing to leave relationships/referrals to safe housing
     - Further appointments/counselling sessions, support as needed
DOMESTIC VIOLENCE IN PREGNANCY

Domestic violence referral may provide the support for midwives to have the confidence to perform routine questioning effectively. The introduction of education including simulation of how to ask the question, may be beneficial in building confidence for midwives to perform the routine enquiry, as would the provision of leaflets for non-English speaking women, containing information in the five most common foreign languages spoken in Britain.

Midwives are aware that screening and intervention for domestic violence are an important part of midwifery practice, relying on timely referrals for individualised support through specialist midwives and safeguarding teams. Therefore the appointment of a specialist domestic violence midwife solely to formulate referral policies and to manage and discretely work within pregnancy wellbeing clinics may provide midwives with the referral pathway they need to have the confidence to support these women.

The introduction of a flow chart to aid midwives in the referral process (See previous page, 29) will ensure that women who give positive disclosure will leave the clinic with an appointment to see a specialist midwife. The clinic itself will be an ordinary looking clinic to outsiders, held within an already functioning midwifery unit, which will not raise suspicion with the perpetrator and will allow women to receive support individualised to their circumstances. This may be: counselling for the woman; for her and her partner; drug and alcohol support for her or her partner; or assistance to leave violent or abusive relationships. The woman may be removed from the room for safe questioning with a simple request to go to another room for height or weight measurement, where the specialist midwife would see her briefly first.

It appears from the reports that midwives lack confidence when addressing domestic violence and require more intense education.

One study addressed the issue of the impact of domestic violence education on midwives and showed that it improved awareness and knowledge but had no impact on midwives’ practice (Protheroe et al 2003). There is up-to-date evidence based education in place for newly qualified- and student midwives; however there is no recent research which examines whether it has made an impact on midwives’ attitudes and midwifery practice relating to domestic violence. Therefore there is a clear need for further research into this area examining the impact of routine questioning and the confidence of midwives. One report explored women’s views of routine enquiry and showed that the barriers identified were evident in practice. As domestic violence in pregnancy impacts on both the woman and the fetus, it is essential that measures are implemented to assist midwives to feel confident when asking about and referring cases of domestic violence in pregnancy, and to ensure that women are given the opportunity to disclose domestic violence through confident effective questioning.

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REFERENCES


