

# The role of a midwife in domestic violence cases



## **Domestic violence and public health – The role of the midwife.**

Why is domestic violence a public health issue for midwives?

The latest triennial maternal mortality report (CEMACH, 2004) reveals that for the years 2000-2002 eleven new mothers were murdered, within six weeks of giving birth, by their partners. The report highlights that domestic violence is a risk factor for maternal death from all causes. In this report 14 percent of all the women who died had declared that they were subjected to domestic violence. This translates to 51 women in England, Wales and Northern Ireland over the three year period. If progress is to be made in reducing maternal mortality careful note needs to be taken of all the risk factors. Risk assessment is currently a means by which the type of care received by the woman in pregnancy and labour is determined. This midwifery role is already well established for antenatal and intrapartum care.

### Epidemiology

Domestic violence has a high prevalence. Crime figures for a single day, 28th September 2000, were obtained and publicised from British police forces. On that day there were 1 300 calls to the police reporting domestic violence. Extrapolating from this there is an incidence of domestic violence every six to 20 seconds. Most of the victims are women. According to Home office figures two women die in Britain each week from violence by either their current or their previous partner (Mirrlees-Black, 1999). A study in London found in a sample of women on antenatal and postnatal wards a 23% lifetime experience of domestic violence. Three percent of these women

were encountering domestic violence in the present pregnancy (Bacchus, 2004).

### The impact of domestic violence

What constitutes domestic violence varies tremendously. It does not have to be physical violence. This is problematic. Collection of statistics is hampered by the blurring of the boundaries between the abuse severity. Whilst it can be argued that no level of abuse is acceptable some distinction needs to be drawn. Pregnancy may act as a trigger for domestic violence; it may start at this time or change in nature sometimes becoming mental rather than physical but sometimes being more focussed on blows to the abdomen. The puerperium is a time of particular vulnerability (CEMACH, 2004).

The high prevalence of domestic violence impacts economically on society. The costs of dealing with 100, 000 women seeking medical help annually due to domestic violence and the fact that of applications for shelter on account of homelessness 17 per cent are caused by domestic violence may be costing London alone approximately £250 million each year. Support systems are overstretched; there are 7 000 women and children looking for places of safety every day (Seymour, 2001).

Physical violence to a pregnant woman increases the risk of miscarriage, premature labour, low birth weight and intrauterine fetal death. Domestic violence may increase the likelihood of a pregnant woman smoking, drinking alcohol or taking drugs with deleterious effects on the pregnancy and fetus. Domestic violence is associated with depression and suicide attempts.

Trauma to the abdomen incurs risk of life threatening placental abruption,

rupture of the uterus or other internal organs in addition to the fetal risks. Women incurring domestic violence are less likely to be able to access antenatal care, many book late and a significant proportion not at all. They have problems accessing care and often default on visits, change addresses and have no reliable means of being contacted. Often the partner will exercise stifling control over them and accompany them during visits to the midwife, answer questions for them and remain present during examinations (Mezey, 2002).

#### Initiatives to address the problem

The Department of Health's National Service Framework (2004) for Children, Young people and Maternity Services states the importance of identifying victims of domestic violence and includes pointers for recognition and action during pregnancy and recommends that staff should be aware of the importance of these aspects. Some emphasis is put on the supportiveness of the environment and the sensitivity of the enquiry about the abuse.

The Government has looked closely at the issue of domestic violence (The Government's Proposals on Domestic Violence, 2003). Parliament has legislated via the Domestic Violence, Crime and Victims Act 2004. This has extended police powers of arrest for common assault under the Police and Criminal Evidence Act 1984. This has had some effect with dawn raids to intercept offenders (Bird, 2004). Dimond (2005) argues that to really tackle the issue of domestic violence people in general must become involved and this includes health care providers. It is already the case that following an assault which leads to miscarriage the offender can be charged under s. 58 of the Offences against the Person Act 1861 (Bristol Evening Post, 2004).

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Where the assault leads to premature delivery from which the child dies the charge is one of manslaughter. The Home Office is taking the lead on behalf of the Government on this issue. Specialist domestic violence courts are planned. In Leeds it is piloting a Domestic Violence Cluster Court. The aim is to make the process of dealing with the perpetrators faster and to make custodial sentences longer. In 2000, the Department of Health advocated routine questioning of pregnant women about domestic violence. The Royal College of Obstetricians and Gynaecologists, the Royal College of Midwives and NICE all requested that this should happen. In a position paper in 1999 the Royal College of Midwives recommended that abuse be recognised and documented and also that such women should be given information to choose for themselves what to do.

It is recognised that it is important for a woman to be able to find the help that she needs when she is ready (Smith, 2005). Whilst the woman can be assured of confidentiality it is important that the extent and limitations of this are made clear. For instance if she already has children and there is a risk that they may suffer domestic violence then confidentiality will have to be broken. If there is a real danger to the fetus once it is born then again the confidentiality between the woman and the midwife will have to be broken. Up until the moment of birth the fetus does not have any right of its own in law.

In Wales and in Bristol there have been significant projects to screening pregnant women for domestic violence and following through the positive answers. There have also been initiatives in Leeds and also in London. A study done in Bristol (Salmon 2004) and funded by the Department of Health <https://assignbuster.com/the-role-of-a-midwife-in-domestic-violence-cases/>

showed that where midwives were trained to ask about domestic violence more women disclosed it. Midwives wanted further training and without this only 10% of midwives would ask about domestic violence by choice.

Midwifery training in asking the question increased midwives' confidence in this area(Baird, 2005). The Bristol research was important to determine the impact of the routine questioning about domestic violence on midwifery education. The multi-agency involvement of the work and education was apparent. A vitally important aspect of the work on disclosure was talking to the woman alone, specifically without the presence of her partner (Merchant, 2001). The question is unlikely to be of benefit if the woman is not asked alone or if there is no effective follow up (Ward and Spence, 2001).

Sometimes the only time the abusive partner will allow the woman to be alone is when she goes to the toilet. Therefore posters must be available in this location detailing contact numbers of women's refuges, social services, victim support etc. Information can also be pre-printed on maternity records so that if a partner sees it it is obviously not aimed specifically at that woman and she is then not likely to suffer further abuse on account of him seeing the information. Another aspect, which might be considered, is to have in the women's toilet a poster indicating that if the woman is being abused she may mark her routine urine container in some way that alerts the midwife but no one else that she is in danger from domestic violence. Women from ethnic minorities where English is not spoken by the woman pose particular difficulties. It is important to use an interpreter who is not a family member.

The Bristol study was a pilot to inform about education needs of midwives when asking about domestic violence. It was not designed as a study to gather evidence about whether it is effective to promote disclosure and whether subsequent information and support giving is beneficial in reducing the problem.

London based initiatives

Mezey studied 892 pregnant women at St George's Hospital, south London. Midwives were trained to ask the question about domestic violence. Women were more likely to admit to domestic violence when directly questioned about it. Women's fears of loss of confidentiality or that their children might be removed from them hampered disclosure. Some midwives found asking the question was distressing and some feared reprisal from the woman's partner. It was clear from the study that midwives cannot tackle this problem alone. Considerable back up from other agencies is vital and all agencies must work together.

The strengths of the work and initiatives so far include the understanding and acceptance that whilst midwives play a pivotal role in this opportunity to screen women for domestic violence they cannot tackle the problem alone. It is accepted that training of midwives can enhance the percentage of women abused who disclose this. Other strategies around enhancing disclosure also have a positive effect.

To be critical the major weakness of the initiatives is that they are not of proven benefit. Statistics are always going to be difficult to collect in this area. Concentrating on this problem may be detracting from other important

midwifery aspects and studies have not addressed this aspect. Training given to midwives has not been universal and the wider aspects of continuing professional development and training of other members of the multi disciplinary team have not been set up. Just admitting to domestic violence does not mean that the woman's life is going to improve. To bring the problem out into the open may upset the woman's family and result in isolating her from them both physically and emotionally and in some situations may do more harm than good. A targeted approach needs to be fostered and work needs to be done to evaluate how we can spot the domestic violence cases where intervention would really make a difference. It is doubted whether this is a midwifery role since skills within the field of criminology would seem appropriate.

What improvements could be made?

A recommendation of the 2000-2002 maternal mortality report (CEMACH, 2004) is that midwives require adequate training both pre registration and as continuing professional development to ensure that they can effectively assess women who suffer domestic violence.

A further recommendation is that all pregnant women should be asked if they suffer domestic violence presently or previously (but that the question be deferred until midwives have received the relevant training and multidisciplinary support services are in place).

Asking about domestic abuse is generally done poorly in social history taking (Foy, 2000). The most difficult part seems to be the midwife asking the question about domestic violence (Scobie and McGuire, 1999; Price and



Baird, 2003; Mezey et al, 2003). The default position would seem to be that they midwife is reluctant to ask and the patient feels unable to talk about it (Ashton, 2004).

The educational aspect is important. Both theory and practical skills are involved. The work around domestic violence is multidisciplinary and multi-agency and clearly this needs to be reflected in the midwife education and continuing professional development courses (Baird, 2005). There needs to direction from the nursing and Midwifery Council and the Royal College of Midwives about what the training will consist of and what comprises the required level of competency.

Education should be of proven benefit to practice.

The reluctance to answer the question is not supported by women being offended; generally they accept it (Price, 2004). Approximately 90% of women asked are in favour of being asked (Leeds Inter-Agency Project, 2005).

On average a woman will suffer domestic violence 35 times before she contacts the police. This is of concern and highlights the degree to which women are trapped in the violent situation. Factors within themselves, for instance fears of reprisals from the partner, compounded with a lack of confidence in the police, social services and the legal system contribute to this problem. Pressure cannot be put on the woman to leave the violent situation (Bewley C and Gibb, 2001). Initiatives aimed at these problems are needed.

How midwives can be involved in this public health initiative

Thirty percent of domestic violence towards women starts whilst they are pregnant (CEMACH, 2004). Asking all pregnant women about domestic violence as a routine question has advantages over asking only a selected group, for instance; it helps with the changing attitude to domestic violence; it helps women feel they are not being picked on and it is less likely to jeopardise the safety of an abused woman (Tacket, 2004).

The key areas of involvement of midwives to best support these women include;

- Asking all women directly whether they have been domestically abused and facilitating disclosure
- Documentation and allocating those with positive responses to high dependency care
- Giving information to affected women thereby enabling them to access specialised help
- Supporting women when they are making a change away from the violent situation
- Inter-agency working (Hepburn M McCartney, 1997)

Peer review

Midwives do agree with the concept of questioning pregnant women about domestic violence and approximately 80% also agree that it should be the midwife who does this (Price, 2004). However in clinical practice only about 60% are happy about asking the woman this question (Price, 2004). The reasons the midwives gave for these problems were practicalities such as a

lack of time or lack of staff or difficulty getting privacy with the woman and personal problems with asking the question (Leeds Inter-Agency project, 2005).

## Conclusion

With the increased awareness and increased stance of non-acceptability of domestic violence it is to be hoped that people in general will have a common awareness about how they can seek help. Pregnancy is still going to be a vulnerable time from the point of view of the physical stage of mother and fetus and the fact that such a high percentage of abuse situations develop during pregnancy. Midwives are therefore still going to be pivotal in this area. Another important aspect from the midwifery point of view is that a woman may be better motivated to make a change to her situation whilst she is pregnant. Perhaps the role of the midwife in aspiring to solve the problem of domestic violence will be moving away from just asking the question and giving information (since women will largely already have this knowledge) towards encouraging the woman to make a change that really is for the better. It should be recognised at this stage in time that greater challenges lie ahead and we should plan for them now.

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