



A five year follow up study of the Bristol Pregnancy and Domestic Violence Programme (BPDVP) to promote routine antenatal enquiry for domestic violence at North Bristol NHS Trust

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Final Report

A Five Year Follow up Study of the 'Bristol Pregnancy Domestic Violence Programme' and Introduction of Routine Antenatal Enquiry

Final Report for Avon Primary Care
Research Collaborative

Final Report

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Acknowledgements

We are very grateful to a wide range of people who contributed their knowledge, time and attention to this evaluation. In particular, we would like to thank the community midwifery staff at North Bristol NHS Trust, who completed the midwifery surveys, contributed to the focus group discussions and distributed the acceptability survey. This evaluation would not have been possible without the assistance and commitment of the Community Midwifery Matron, Linda Hicken, who supported the field work. Thanks also go to health and social services managers and policy developers who agreed to be interviewed.

Thanks also go to the local women's services, Next Link Bristol and Bristol Freedom Programme for their support and agreement to support the recruitment of women to take part in the study.

We would also like to acknowledge the contribution of the steering group members: Ann Remmers (North Bristol NHS Trust), Paul White (UWE), Lesley Welch (Safer Bristol), Donna Sealey (NHS Bristol Public Health Directorate), Amy Campbell (NHS Bristol Public Health Directorate), Ruth Dawes (NHS Bristol Public Health Directorate), and Professor Sheila Hunt (Cardiff University).

Finally, enormous thanks must go to the maternity service users who agreed to complete the survey and who gave up their personal time to participate in an interview; their contribution to the evaluation is crucial to the ongoing improvement of maternity care.

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April 2011

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Main cover image: "domestic violence, young mother fleeing" from Jim Varney/Science Photo Library. Thanks also to Midirs for the use of their photographs.

ISBN: 978-1-86043-460-0

Published by the University of the West of England, Bristol

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Chapter One Introduction

In 2004 the Department of Health funded a study exploring the impact of the Bristol Pregnancy and Domestic Violence Programme on the introduction of antenatal enquiry for domestic violence. The University of the West of England and North Bristol NHS Trust undertook this study. The aim of the programme was to equip midwives to confidently routinely enquire about domestic violence during the antenatal period. The evaluation found that the training impacted positively on participants in relation to increased levels of knowledge and awareness of domestic violence. Importantly it also improved midwives' confidence in directly asking about domestic violence in their everyday contact with women. Women had increased opportunities to disclose experiences of abuse and this led to an increase in the numbers of women who were formally recorded as 'cause for concern' as a result of domestic violence. Following this study, the researchers developed a comprehensive teaching pack, which was identified in the DH (2005) publication, 'Responding to Domestic Violence: A handbook for health professionals' as best practice. Subsequently the teaching pack was made available nationally to support acute and primary trusts in the introduction of antenatal enquiry into domestic violence throughout England and Wales (Salmon et al 2004). It has also been adopted by practitioners internationally from as far afield as Japan, Australia, USA and Norway. Five years on, it is important to establish the degree to which the programme continues to be effective. Questions are posed about the degree to which routine enquiry is embedded within midwifery practice and women's expectations of care and, the broader implications of its introduction on policy and practice development.

The study

The purpose of this follow up study is to inform future policy and practice and build on the evidence surrounding the impact of antenatal enquiry for domestic violence on women's care experiences. The objectives of the study were to:

- assess the acceptability, experience and consequences of routine antenatal domestic violence enquiry from the perspective of women using maternity services
- understand the experience of referral and support for women who positively disclose domestic violence

- analyse the degree to which changes identified at practitioner level in 2004 (in relation to knowledge, attitudes and efficacy) have been maintained since the introduction of the programme
- explore possible changes in rates of positive disclosure since the introduction of routine enquiry
- analyse the impact on midwifery practice and identify the longer term issues for service development

Content of the report

This report presents the findings of fieldwork with women, midwives and stakeholders involved in antenatal care and safeguarding as service users, practitioners and policy makers. Chapter two outlines the national policy context, the original project structure and summarises the main findings from the 2004 evaluation. The methods used to carry out the evaluation are described in chapter three. Chapter four focuses on the findings from women, in particular women's views on being asked about abuse. Particular attention is also given to understanding the experiences of those who positively disclosed abuse during contact with the maternity services. Chapter five reports on the quantitative findings from midwives, establishing the degree to which practitioners have retained and built on their original exposure to the BPDVP. Qualitative findings analyse the experiences of everyday practice including any barriers to asking; coping with disclosure and issues surrounding information sharing with other professional groups. The final findings outlined in chapter six document the views of stakeholders including those who are responsible for the strategic direction and management of the midwifery service. In addition, reflections are included from stakeholders from children's safeguarding services exploring the consequences for collaborative working of increasing numbers of women positively disclosing abuse during pregnancy. Discussion and recommendations are outlined in the final chapter.

Chapter Two The Context

Definitions

Domestic violence and abuse can take many forms including physical, psychological, emotional and sexual violence, restriction of movements, isolation, deprivation and financial control. Recently, a term more commonly used instead of domestic violence is domestic abuse, which is perceived to enable a better understanding of the impact of non-physical violence (Department of Health (DH) 2010). It is also considered to encompass cultural concerns such as forced marriage, female genital mutilation and cutting and honour crimes (Centre for Maternal and Child Enquiries (CMACE) 2011). For the purpose of this report the words violence and abuse may be used interchangeably, especially when respondents are cited.

The policy context and professional response to abuse

There has been a growing awareness for the need of health professionals to become more proactive around domestic violence. This includes the development of an enhanced knowledge and understanding of the consequences of abuse and its overall impact on health. However, there continues to be reluctance on behalf of some health professionals to embrace enquiry into domestic violence and abuse, possibly because they lack the confidence and knowledge to do so (DH 2005, 2010; Lewis 2007). Clinicians may remain unclear about their role in addressing domestic violence and find it difficult to listen or understand a woman's experience on disclosure. Some report having difficulty empathising with a victim's powerlessness (DH 2010). Women will rarely voluntarily disclose information about their abusive experiences to health professionals. However, the use of brief questioning by professionals is known to lead to higher rates of disclosure (Bacchus 2002; Bacchus et al 2007). Research has also shown that women support routine questioning if asked in a sensitive manner and by a well trained professional (Bacchus et al 2002).

It has been suggested that until recently the proactive identification of abuse within health services has been poor (DH 2010). As a result many health care organisations have published guidelines promoting the introduction of routine enquiry, (Royal College of Nursing 2000; DH 2005; Royal College of Midwives 2006). The

Royal Colleges have also issued guidance and policies tackling domestic violence highlighting professional bodies' expectations of health professional's role in challenging domestic violence (British Medical Association 1998; The Royal College of Nursing 1998; Royal College of Midwives 2006). The Department of Health supports an interagency approach to addressing domestic violence and issued clear guidance to all health professionals advocating that the health service is in a unique position to help and support women and children who suffer from abuse. Virtually every woman in the UK will access healthcare at some point in her life (DH 2005). While national policy supports routine enquiry, to date little research has been carried out to assess its overall effectiveness or indeed its broader implications for health service development.

It is now recognised that there are vast financial implications to local communities each year in terms of dealing with domestic abuse, this includes health, criminal justice system, social services and policing. Figures first published by Walby in 2004, highlighted the cost to England and Wales alone, which was estimated to be £5.7 billion a year, with the cost to the NHS for physical injuries was estimated to be £1.2 billion (Walby 2004; Walby and Allen 2004). The NHS has a particular contribution to make in domestic violence, not only because of the impact on victim's health, but also because the NHS may be the first point of contact for many women. It is therefore vital health professionals offer continued support to women who are surviving in an abusive relationship. It has been argued that some health professionals continue to be reluctant to take up routine enquiry because of a lack of confidence, knowledge or support to undertake this role (DH 2010). The Bristol Pregnancy and Domestic Violence Programme (BPDVP) Evaluation clearly demonstrated that for routine enquiry to be effective and responsive, staff required education, training and support (Salmon et al 2004).

While there continues to be debate about whether pregnancy acts as a trigger for domestic violence or exacerbates existing violence (DH 2005; Helton, McFarlane & Anderson 1987), what is certain is that abuse can have grave consequences leading to recurrent miscarriage, low birth weight, fetal injury, stillbirth and maternal death (Helton et al 1987; Bullock & McFarlane 1989; Mc Farlane et al 1992, 1996; Hunt and Martin 2001; Valladares et al 2002; Neggers et al 2004; Kady et al 2005; Faramrzi et al 2005). It is difficult to estimate the

exact prevalence of domestic violence during pregnancy, as women may be reluctant to disclose their experiences. However, it is thought that for almost 30% of women who suffer from domestic violence in their lifetime, the first incidence of violence occurred during pregnancy (Helton, McFarlane & Anderson 1987). Reported prevalence of violence in pregnancy ranges from 0.9 per cent to 20 per cent (Gazmararian et al 1996; Radford and Hester 2006). However, Taillieu and Brownridge (2010) recently suggest that the majority of international studies have found prevalence rates of between 3.9% and 8.3%.

The recent Centre for Maternal and Child Enquires Report (CMACE) (2011) analysing maternal deaths thought to be unrelated to their pregnancy, suggests that of the 50 deaths between 2006-2008, 34 of those who died from any cause had features of domestic abuse. The perpetrator of domestic violence in most cases is often the woman's partner; this was reflected in the 11 murders considered. Seven of the women were murdered by their partners, another died in a house fire thought to have been started by her partner.

Lessons from the enquiry suggest and recommend:

- that routine enquiry 'asking the question about domestic abuse' should be made either 'when taking a social history at booking' or at 'another point during a woman's antenatal period'.
- all women should be seen alone at least once during the antenatal period to facilitate disclosure of domestic abuse.
- health service providers and purchasers should have clear policies on the use of interpretation services that ensure non English speaking women and children are able to disclose abuse.

When routine enquiry is introduced, this must be accompanied by safe and appropriate methods of recording and referral pathways to local multidisciplinary support networks must be evident (Bacchus et al 2004; Salmon et al 2005; Bacchus et al 2007; Price et al 2007; Baird 2010; DH 2010; Torres-Vitolas et al 2010).

Domestic violence and UK statistics

- Domestic violence continues to claim the lives of around two women a week and touch millions of more people (Home Office 2008; DH 2010).
- 28% of women aged 16–59 have experienced domestic violence (Walker et al British Crime Survey 2008–2009).
- The British Crime Survey self-completed questionnaire indicates that around 10,000 women are sexually assaulted and 2,000 women are raped each week (Walker et al British Crime Survey 2008–2009).
- In a recent study of 13–17 years of age in an intimate relationship, one in six girls said they had been hit by their boyfriends and one in sixteen had been raped (Barter et al 2009).
- Nearly three quarters of children on the at risk register live in households where violence occurs (Department of Health 2002).
- The Centre for Maternal and Child Enquires (CMACE) highlighted that 34 of the women who died during the years 2006–2008 had features of domestic abuse. For 11 women; the abuse was fatal and the cause of their death (CMACE 2011).

The Bristol Pregnancy and Domestic Violence Programme (BPDVP) 2004

In light of this evidence, the Bristol Pregnancy and Domestic Violence Programme (BPDVP) was introduced into North Bristol NHS Trust with the overall aim to equip a group of community midwives with both the knowledge and confidence to effectively enquire about domestic violence in the antenatal period. The programme consisted of in-service education and follow-up support arrangements. The study underpinning this work sought to evaluate the impact of the programme, including the recommendations to build upon and sustain education within the field of domestic violence and pregnancy. This work was funded by the Department of Health; it commenced in March 2003 and was completed in March 2004.

Chapter Three Research Methods

The aim of the evaluation

Consistent with the project aims, this evaluation set out to assess the impacts of the Bristol Pregnancy and Domestic Violence Programme at five years follow up. The methodological approach adopted for the evaluation included multiple professional and user perspectives and both process and outcome measures. It is important that the investigation is rigorous, whilst taking into account the context of the subject being studied. Allowing for synergy between the two elements of education and practice it was possible to create a more sensitive relationship between an overall evaluation of an educational programme and ongoing practice (Pawson and Tilley 1997).

The objectives were to:

- assess the acceptability, experience and consequences of routine antenatal domestic violence enquiry for pregnant women
- understand the experiences of referral and support for women who positively disclose domestic violence
- establish the degree to which changes identified at practitioner level (in relation to knowledge, attitudes and efficacy) have been maintained since programme introduction in 2004
- assess changes in rates of positive disclosure since the introduction of routine enquiry
- establish the impact of these developments on midwifery, health and social care provision from the perspective of multi-disciplinary stakeholders

The purpose of the follow up study is to inform future practice and help build a body of evaluation nationally, that analyses the impact of high quality education on antenatal enquiry for domestic violence, the outcomes for women and the implications for service development. The data was collected between May 2010 and March 2011 from a range of perspectives, at different organisational levels and included quantitative and qualitative approaches. Participants included midwives, maternity service users and key stakeholders across health and social care.

Sampling

Participants were recruited through a number of approaches. Midwives from the original study within North Bristol NHS Trust were contacted

through Trust managers and seventy two were invited to take part, six were subsequently excluded due to long term ill health and fifty eight midwives completed the survey. Of these, a purposive sample of eleven took part in two focus groups. The final sample included original community midwives who took part in 2004 and all those who had been recruited or had transferred into North Bristol Trust since. Women attending twelve community bases for antenatal care across the North of the City of Bristol between September 2010 and January 2011 were asked if they would like to complete the survey which focused on the acceptability of enquiry. The clinics represented communities with diverse cultural, social and ethnic minority populations. Identification was possible through the Joint Strategic Needs Assessment of health and wellbeing in Bristol, (2008/2009) of communities with higher levels of black and ethnic minority populations; social and rented housing; unemployment and teenage pregnancy, to support a comprehensive and inclusive approach. In total, 300 surveys were distributed to the clinics, with 236 women completing the survey, a response rate of 79%. Recruitment of women who had experienced domestic violence was much more difficult and took place through local voluntary agencies and local programmes aimed at supporting women who had experienced domestic violence. Local stakeholders were identified from within the health service that had regular and direct contact with midwives enquiring about violence. In addition two stakeholders were social work professionals working for children and young people's services. In total seven respondents took part.

Impact evaluation, data collection

The methodological approach adopted for the study included multiple professional perspectives and the views and experiences of women. It was therefore appropriate to employ a mixed methods approach to data collection that included both process and outcome measures.

Community midwife questionnaire

This aspect of the impact evaluation focused on assessing whether the self reported changes in attitudes, behaviour and efficacy were maintained by the community midwives who took part in the original study. A 54-item questionnaire was completed, where possible questions were those utilised in the original survey (see attached) and using similar

measurement scales. Areas that were covered in the questionnaire included: demographic/professional information including numbers of years post qualification, professional experience, educational background, knowledge of and attitudes to domestic violence, levels of confidence in asking about violence and perceptions of potential barriers.

Data monitoring for positive disclosures

Data was collected to assess possible changes in disclosure since the completion of the original study. All the Maternity Trust records were examined in relation to "cause for concern forms". Community midwives complete these when women positively disclose violence within a home setting; they also highlight referral pathways and some clinical outcomes.

Pregnant women's acceptability questionnaire

Post card questionnaires were administered to 300 women over a period of nine months. The survey assessed women's views of the acceptability and impact of routine enquiry on their experiences of midwifery care. Biographical data was also collected including marital status, ethnicity, and stage of pregnancy, home situation, income and levels of support.

Process evaluation, data collection

There were several elements to the process evaluation, which sought to understand the influences, views and experiences of midwives and pregnant users of the service in relation to routine enquiry for domestic abuse. This was to establish the degree to which the initial Bristol Domestic Violence Programme was successful in its attempts to change practice and integrate routine enquiry into midwifery practice. In addition, it was possible to explore with other stakeholders the impact on other local services of heightened awareness and identification of domestic violence.

Community midwife focus group interviews

Attendance at area midwifery meetings allowed the researcher to explain the study to the midwives, provide information sheets and contact details for participation. Eleven midwives took part in the focus group discussions: ten of the midwives were based in the community and one midwife was the based in the antenatal ward in the hospital. The aim of discussion was to obtain

the overall views of midwives with regard to the introduction and ongoing implementation of routine enquiry. It was also possible to analyse the experiences of community midwives, identifying opportunities and barriers to practice.

Service user's experiences of services

These one to one interviews aimed to understand the views and experiences of women who had positively disclosed violence during their contact with maternity services. Biographical information was recorded, women were asked to reflect on their experiences of the maternity services after disclosure, including the degree to which they felt able to respond honestly when asked directly about abuse. Reflections were also sought on how practitioners had shared information with other agencies, the degree to which the care they received was joined up and suggestions for future service improvement.

Interviews with stakeholders

Telephone and face to face interviews were carried out with six stakeholders from within health and children and young people's services and the Third sector. The interview aimed to understand from a managerial and strategic perspective the degree to which this aspect of domestic abuse work was an organisational priority. In addition, issues surrounding ongoing training and support and areas of future service development were discussed. Interviews with stakeholders from non-health sectors explored the impact on their services of midwives routinely enquiring, the increased numbers of disclosures and partnership working.

Data analysis

From the community midwife questionnaire, it was possible to collect data as post intervention comparison. All measures were subject to descriptive statistics. The longitudinal data (encompassing the 2004 data) relating to knowledge, confidence and efficacy were analysed using standard analytical techniques for categorical data. Quantitative data from the self-completion post card was also subject to descriptive statistics assessing acceptability, levels and outcomes of enquiry. Comparisons were also made between levels of disclosure during the original study and 18 months following on from the intervention to assess levels of sustainability from data collected through routine monitoring. A research team member, Paul White, Head of the Statistical Support Unit for Research at the

University of The West of England provided the necessary guidance and support in the use of the appropriate statistical analyses.

Qualitative data collected from the interviews and questionnaires was analysed to identify the key emergent themes (Strauss and Corbin 1998) to assist in the identification of factors that have contributed to or hindered the successful introduction of routine enquiry. NVivo 8 was employed as a qualitative data management package to support consistent treatment of the data.

Ethical considerations

All those asked to participate in the research were given information sheets that provided a summary and 14 days to consider participation. DH (2005) guidance was addressed throughout the process including informed consent; voluntary participation, confidentiality and anonymity. Particular attention was paid to issues of safeguarding, in accordance with the NMC Code of Professional Conduct (2008). Particular attention was paid to information about child protection issues and the right to withdraw. In addition, the researchers recognised that these may be highly sensitive interviews and provision was made for additional support for any issues subsequently women wished to discuss through the participating voluntary organisations. The interviews with the women took place within the premises of Next Link and the freedom programme or in one instance in the woman's home where her support worker was also present during the interview. All the data collected was anonymised and pseudonyms were used in the qualitative data.

Ethical review and approval was awarded through the LREC and the UWE, Bristol Research Ethics Committee. In accordance with ethical principles pseudonyms have been used to protect the identity of the participants.

Chapter Four Findings women's experiences

Profile of survey respondents

Women across a range of communities were asked to complete the survey, this included women who did not speak English or spoke English as an additional language. The survey was translated into Polish and Somalian. Unfortunately, although the survey was available in these additional languages none were completed. In total 300 women were approached to complete questionnaires, with 236 agreeing to take part. The majority of the women who completed the postcard questionnaire were white British (79.1%) but also included a significant number of women from other cultural groups as demonstrated in Table 1.

Women lived in a range of circumstances, with approximately 59.0% of the pregnant women living in privately owned accommodations. 41.1% were tenants, living with friends, in temporary accommodation or other (Table 2).

Table 3 depicts at what stage of their pregnancy they were asked about domestic abuse. The table indicates that a large proportion of the women (48.7%) were asked by a midwife between the weeks of 8 to 16 gestation, with a large percentage of women, (30.9%), being asked at the booking visit.

Levels of enquiry and women's perceptions of why they were asked

Women responded to whether during their pregnancy a midwife had asked about domestic abuse: 79.0% (95% confidence interval ranges from 73.17% to 84.02%) of the respondents reported that they had been asked about domestic violence during their pregnancy and 21.0% had not. In addition, in an open-ended question, women were asked to explain the reasons why midwives asked about domestic violence, a total of 230 women responded. Reasons women gave were connected to protection of the mother or child (13%); concerns over safety (25%); concerns over the health of the mother and baby (22%). Women identified these concerns as concerns relating to miscarriage; stress; depression and harm to the baby. Nineteen of the women who gave this answer made a direct link between domestic violence and pregnancy, suggesting that domestic violence started in pregnancy, intensified or pregnancy in itself made women more vulnerable to violence.

Table 1 Ethnicity of sample

	Frequency	Percent	Valid Percent
White British	186	78.8	79.1
White Other	20	8.5	8.5
Black (British, African, Caribbean)	12	5.1	5.1
Asian (British, Bangladesh, Indian, Pakistani)	8	3.4	3.4
Other	2	0.8	0.9
Mixed ethnicity	7	3.0	3.0
Total	235	99.6	100.0
Missing data	1	0.4	

Table 2 Accommodation of sample

	Frequency	Percent	Valid Percent
Private owned	135	57.2	59.0
Private rented	55	23.3	24.0
Council	22	9.3	9.6
Temporary accommodation	5	2.1	2.2
Friends	2	0.8	0.9
Others	10	4.2	4.4
Total	229	97.0	100.0
Missing	7	3.0	

Table 3 Stage of pregnancy when women were asked by the midwife about domestic violence

Weeks pregnant	Frequency	Percent
4-8	14	7.9
8-12	73	30.9
12-16	38	17.8
16-20	10	3.3
20-24	2	0.8
24-28	0	0
28-32	0	0
32-36	2	1.1
36-40	2	1.1

11% stated that the reason for asking was so that help and support could be provided for women who were at risk. A dominant concern about asking about violence is that women may be fearful of disclosing abuse because of the potential involvement of child protection services. Twenty-five (11%) of all responses made reference to the monitoring aspects of midwives enquiring and 2% highlighted that domestic violence was a crime and should be treated as such. Respondents felt it was important midwives

gave women an opportunity to talk about issues they would not normally share (6%). This characterised the possibility of prevention of and referral to an appropriate agencies and in some instances, an end to women’s victimisation (10%).

Disclosure of abuse from survey data

Response from the survey data signified that four of the 236 respondents were experiencing domestic abuse during their current pregnancy. Of the four women who were experiencing domestic abuse, only two had discussed the violence with the midwife.

Acceptability of routine enquiry

To establish the degree to which women have found enquiry acceptable, a set of statements were developed. Each question was on a five point Likert scale from strongly agree to strongly disagree, which women were asked to respond to. The results are summarised in Table 4.

Importantly, the key findings in the table above demonstrate that 94.4% of the women felt comfortable with a midwife asking about domestic violence (95% confidence interval ranges from 90.69% to 97.01%). 96.6% also think it is appropriate for a midwife to ask about domestic abuse (95% confidence interval [93.38%; 98.51%]). 95.3% also understand

the reasons why the midwife should ask about domestic violence (95% confidence interval for this percentage ranges from 91.71% to 97.62).

Interviews with survivors of domestic violence and abuse

Domestic abuse, pregnancy and the experience of using maternity services

The aim of the interviews with service users who were known to have experienced abuse during their relationships was to qualitatively explore their experiences of maternity services, to explore their views of routine antenatal enquiry and professionals’ responses to a positive disclosure. Women were recruited from two local services helping women in abusive relationships, Next Link and the Bristol Freedom Programme. Next Link provides specialist domestic abuse services to women and children including a dedicated Black, Minority Ethnic, South Asian and Somali service. Other services include safe houses, children’s services, resettlement and crisis intervention. The Bristol Freedom Programme is a 12-week programme that provides information and understanding for women who currently are or have previously experienced domestic violence and abuse. Seven interviews were conducted with women who had experience of local maternity services.

Table 4 Percentage responses to acceptability of routine enquiry

How much do you agree with following statements?	Strongly Agree %	Agree %	Neither %	Disagree %	Strongly Disagree %	Non-response %
I feel comfortable with a midwife asking about domestic violence	50	44	4	1	1	0
I understand the reasons why the midwife asks about domestic violence	60	34	4	1	0	1
I do not think it is the role of the midwife to ask about domestic violence	1	2	8	38	50	1
I think domestic violence is too sensitive and embarrassing to discuss with the midwife	0	3	9	45	42	1
I think that women who are experiencing domestic violence would benefit from telling a midwife	48	43	5	3	1	0
I think midwives should be able to offer advice and support to a woman experiencing domestic violence	58	37	2	2	1	0
I think it is appropriate for a midwife to ask about domestic violence	57	39	3	0	0	1

Profile of interview participants

Seven women were interviewed. The age of the women ranged from twenty four to thirty eight years of age. All the women had accessed the maternity services at North Bristol NHS Trust, since the introduction of routine enquiry. Women’s ethnic backgrounds were: White British, Black British and European. All the women had children. One woman was still with her abusive partner. The remaining six had separated from their partner. Two of the women were pregnant at the time of the interviews. Four of the participants were not in paid employment. Participant biographical information is summarised in Table 5.

Conducting the interviews

The interviews were mostly conducted at the premises of voluntary agencies. One interview was conducted in the woman’s home, but at the time of the interview the woman was separated from her partner. The researchers were aware that the interviews had the potential to stir some difficult, painful feelings and memories. Therefore, prior to conducting the interviews, attention was given to explaining issues of consent; possible withdrawal from the interview at the respondent’s request and the support mechanisms available post interview. The women were aware that they could invite their support worker to accompany them to the interview; only one participant took up this request. All the participants were able to access the many support mechanisms that were already available within Next Link and through the Freedom Programme facilitators. Details of local and national support systems were also available. Consistent with the values of the organisations we were working with, all the women received a £10.00 high street voucher for their time.

Data collection was conducted using semi-structured interviews. Questions centred on: biographical information; the role of health professionals in enquiry; responses to positive disclosure and possible improvements in care. Two of the researchers were involved in conducting the one to one interviews, which took between 45 minutes and an hour. All interviews were audio- recorded verbatim with consent.

Data analysis

All interviews were transcribed by the researcher conducting the interview and imported to specialist software package NVivo 8. The main objective of the analysis was to identify recurrent and significant themes that could be seen as dominant ‘patterns’ in the data. All the names used in the findings section of this report are pseudonyms to maintain anonymity and protect confidentiality. The following themes emerged from the data:

- types of abuse experienced during pregnancy
- Service users views of enquiry about domestic abuse
- experiences of maternity services, perceptions of trust and the issue of keeping silent

The primary purpose of the interviews was to ascertain the women’s views and thoughts around the role of the midwife in routine antenatal enquiry. However, some of the women wanted to talk to the researchers about some of the abusive behaviours they had experienced during pregnancy.

Experiences of abuse during pregnancy

The women reported a range of abusive behaviours, including emotional, controlling and physical violence. All of the participants interviewed, reported being bombarded with

Table 5 Participant biographical information

Name	Age	Ethnicity	Occupational Status	Children and ages	Status of living arrangements
Amelia	28	Black European	Hairdresser	1 child, 4 months	Separated from partner
Wendy	38	White British	PA	1 child, 4 years	Separated from partner
Nancy	34	White British	Full-time mother	1 child, 2 years	Separated from partner
Theresa	33	White British	Full-time mother	3 children, 9 & 5 years, 23 months	Separated from partner
Debbie	24	White British	Full-time Mother	2 children, 7 & 4 years, currently 32 weeks pregnant	Separated from partner
Nasreen	32	British Asian	Computer programmer	2 children, 11 years & 22 months, 3 months pregnant	Still in the relationship
Louise	24	White British	Full-time mother	1 child, 20 months	Separated from partner

verbal and frightening abuse. This caused them to be fearful of their partner's behaviour, even if they were not physically abusive. Theresa eloquently describes this fear in the following quote:

most nights you feel like you are just living on edge, you don't know what mood he is going to come home in and then you are just fearful of what mood he is going to come home in. I don't know, just living in fear actually and I think I prepared myself sometimes as well for it to happen. So I was ready for it to happen (Theresa).

Such findings support previous research that has suggested that women suffering violence pre - pregnancy report the violence becoming more psychological and sexual abuse (O'Campo et al 1994; Martin et al 2004). Two of the participants did not experience any form of physical violence during their pregnancy. They did, however, experience extreme verbal abuse and physical threats.

There is some evidence that an unwanted pregnancy by a male partner may trigger violence and abuse in a relationship (Bacchus et al 2006). Stewart and Cecutti (1993) reported that women with an unplanned pregnancy were almost three times more likely to experience violence compared to women with a planned pregnancy. One participant attributed the start of abusive behaviour by her partner to an unplanned pregnancy. Amelia had not experienced any form of abuse in the relationship previously. During the pregnancy, her partner became extremely abusive and aggressive towards her. The abuse included threats to kill her and the unborn baby if she did not agree to have a termination of pregnancy. She sought safety with friends and a woman's refuge:

Yes, he was very abusive to me he told me that he would kill me and my baby if I did not get rid of it, he told me he would find me and get a knife and kill the baby if I did not get rid of it (Amelia)

Amelia had been brought to the UK from Europe by her boyfriend four years earlier and had no family in the UK. She was twenty-eight years of age at the time of the interview, her baby was four months old and she admitted to feeling very isolated, vulnerable and remained fearful of her partner eventually finding her. She felt that her vulnerability was heightened because English was not her first language. Nasreen who aged thirty two and was pregnant with her third baby at the time of the interview highlighted how she had experienced an increase verbal abuse during her pregnancy:

The abuse is worse in pregnancy, he is more verbally abusive when I am pregnant, he makes extra demands on me in terms of looking after the house, he shouts at me and treats me like slave (Nasreen).

For some of the participants, the controlling behaviour during the pregnancy by their partner was difficult to come to terms with:

He was not really physically violent during pregnancy, he occasionally pushed or shoved me out the way, but he became more controlling, he would tell me what to wear, I was usually only allowed to wear jogging bottoms. I was not allowed to dye my hair and he wanted me to stay in the house all the time, he did not like me going out to meet my family or friends (Debbie).

Women's views on antenatal enquiry

All the participants' interviewed believed that it was acceptable for midwives to ask about domestic abuse. It was also very clear that the participants understood why midwives asked pregnant women about abuse. Although this remains an area which is under researched in the UK, of those studies that have explored women's views of routine enquiry or screening for domestic abuse in the antenatal period have demonstrated that the majority of women are in favour of being asked about domestic abuse (Webster et al 2001; Bacchus et al 2002). However, it is considered that in reality very few women when visiting either a primary or tertiary unit will be routinely asked about violence and abuse (DH 2005, 2010). Affirmation of the midwives' role is described in the following extract:

I understand why midwives ask about domestic violence, I do not have a problem with them asking me. I believe that midwife should ask about the relationship questions. Midwives have asked me about domestic violence in my last two pregnancies, and I feel it was a good thing (Amelia).

One of the participants reported that she had not been previously asked about domestic abuse during her first two pregnancies. However, at the time of this interview she was currently 32 weeks pregnant and had been asked about abuse by her current midwife. Debbie acknowledged she would have disclosed about the abuse in her previous pregnancies if she had been asked:

I would have disclosed to a midwife if they had asked, but they did not ask in my first two pregnancies, although I think initially I was not aware that what I was experiencing was domestic violence as it was just psychological and controlling

behaviour. It took me a few years to realise that what I was experiencing was domestic violence, yeah how stupid was I? (Debbie)

Experiences of maternity services, perceptions of trust and the issue of keeping silent

Fear of disclosure

Three of the participant disclosed that they were cautious about opening up to the midwife during pregnancy. In some situations they had concealed the ongoing abuse. The reasons for this can be very complex, but appeared to be associated with conflicting feelings, recognising that the behaviour of their partner was wrong, but hoping he would change and sometimes seeing themselves as part of the problem. Nevertheless, they did acknowledge that they would have welcomed discussing the abuse with the midwife, but often felt fearful to do so. They worried about not being believed, embarrassed and fearful of the outcome of such a disclosure. One participant reported that she was fearful of Social Services finding out about the abuse:

I did not tell the midwife, not because I did not want too, but because of social services, I did not want her to tell social services. Most people are scared of social services, especially if they have got kids. In a domestic relationship most people don't like social services so they will just suffer because they don't want social services involved (Theresa).

Feeling comfortable to disclose

However, some of the participants trusted the midwife and felt comfortable enough to be able to disclose about the violence in the relationship. Amelia was very positive about the help the midwife had given her through the pregnancy, acknowledging how much support the midwife had provided:

I was able to trust them enough to tell them. I was not embarrassed by being asked. I know they ask because they care Yes the midwife was so helpful, as soon as I told her about the violence and threats she helped me, even helping me fill out the necessary forms. She came to visit me in the refuge when I was no longer staying at my friend's house. She even arranged for the interpreter to be there for my scan appointment. I felt I could trust her (Amelia).

Some of the women who were experiencing abuse during pregnancy deliberated about how they felt when they had not been asked whether they were experiencing violence in their

relationship. They felt it was important that the midwife ask the question, as they clearly found it difficult to broach the subject. This can be due to shame and embarrassment of being in a violent relationship.

Keeping the secret

There was a real distinction between those women who had been asked and those who had not. Nancy reported that she was never asked about domestic violence during either of her two pregnancies, but wished she had been. She had found it was very difficult to open up to the midwife about the abuse without the midwife introducing the topic first:

They never actually asked me and I wish they had and offered me some help. You feel you are the only person going through life living with violence (Nancy).

Another participant reported similarly that her midwife had not asked her directly about domestic violence in her pregnancy, although she had considered telling the midwife about the abuse:

Sometimes I thought that if only I had the chance to talk to her, it would have been nice just to have a talk with someone. I didn't expect her to take action or for it to go further with the information. I just need somebody to talk too, really because at that time I was still trying keep my marriage going for the sake of my baby (Wendy).

This clearly identifies that some women may find it difficult to broach the subject without being directly asked. Several of the participants highlighted how supportive the midwife had been when they disclosed the abuse. Amelia discussed how supportive the midwife had been when she disclosed about the abuse in the relationship.

The midwife was very understanding, when I told her about the violence, she told me about the different agencies which could help me. She also helped me to fill in all the paperwork to apply for funding as they were all in English (Amelia).

Another participant Debbie was not asked about domestic violence until her third pregnancy. However, when asked directly by the midwife during her third pregnancy she was able to be honest in her reply. The midwife was very helpful, providing her with her advice, recommending that Debbie also share this information with her GP and health visitor:

I did not want to tell my GP about the violence, however, the midwife advised me to talk to my

GP and my health visitor. They both knew I was suffering from depression and the midwife thought it may help explain my depression. (Debbie).

All the women interviewed had experienced various forms of violence and abuse during their pregnancy, which had short and long term health outcomes for the women. Although the results are based on a small sample and were restricted to one Trust, when put alongside the service user's survey results, the evidence would seem to suggest that some women do not mind being asked about domestic abuse and in fact, find questioning acceptable. They believed a health care setting is a safe environment to open up about abuse. They also have a belief that midwives can be trusted and can offer them some support. Of course it is important to realise that some women may choose not to disclose about the abuse at the initial time of asking. However, by midwives raising the subject, asking about abuse may be enough to raise the woman's awareness, also signifying that she can disclose about abuse at a later appointment if she wishes. The findings from the interviews support the findings from Bacchus et al (2007) that the most helpful way to enquire about domestic abuse is for clinicians to assume a non-judgemental positive approach to questioning. Women may find it difficult to bring up the topic of domestic abuse; therefore direct questioning is needed to make sure that women are afforded the opportunity to access support and help.

Chapter Five Findings from midwives

There are extensive findings associated with the follow up survey with midwives, focusing on midwives' perceptions of their role in antenatal enquiry; support; levels of disclosure; knowledge, attitudes and skills associated with domestic violence and potential barriers to enquiry. It is not possible to report all these findings here. However, a fuller version will be available via the University of West of England website. The focus of the reporting here is on the comparative data that explores the extent to which the progress made in 2004 has been maintained in 2010. The following data analysis is based on $n = 58$ questionnaires received from midwives in 2010 and the 2005 follow-up data is used as the comparator.

A profile of the midwives who took part in 2010

59% of the participating midwives have been qualified for more than 20 years and 60% work part-time. It is estimated that 73% of the 2010 respondents took part in the original study. Of those who responded, 27% hold a certificate, another 31% hold a diploma and a further 33% hold an honours degree. At least 45% of the respondents covered some form of domestic violence education in their pre-registration training. It is estimated that approximately 75% of the North Bristol Trust midwife population have attended update sessions as part of their mandatory update program either annually or biennially. Approximately 97% of the North

Bristol Trust midwife population self-report some level of professional experience in dealing with domestic violence with 7% reporting a great deal of experience, 37% reporting a moderate amount, and 53% reporting a minimal amount.

Comparing 2004 with 2010: Reflecting on Domestic Violence Training in 2003/04 and the impact practice

Participants were asked to reflect on the domestic violence training in 2003/2004 and the effect it had on improving knowledge of domestic abuse in general. Using a five point Likert Scale, respondents were asked to indicate from: a great deal; a moderate amount; minimal amount; not at all or unsure. Cross-tabulation in Table 6 indicates that there is no marked change in response profile between 2004 and 2010, suggesting improvements in knowledge have been maintained. A Likert Scale was chosen because it is a common method used to collect attitudinal data from a questionnaire (Burnard et al 2011).

Participants were also asked to report on the effect the training had on their knowledge of screening for domestic violence using the same Likert Scale. Inspection of Table 7 suggests there was a tendency towards an increase in knowledge of screening for domestic violence when comparing 2010 with 2005:

- 61.0% in 2010 reported "a great deal" compared with 42% in 2005 [and this difference is borderline statistically significant, $p = 0.059$]
- 2010 respondents were 2.1 times more likely

Table 6 Effect on general knowledge of domestic violence following training

		General knowledge				
		A Great Deal	Moderate amount	Minimal amount	Not at all	Total
2010 Cohort	Count	27	15	1	0	43
	Percentage	62.8	34.9	2.3	0	100
2005 Cohort	Count	37	32	0	2	71
	Percentage	52.1	45.1	0	2.8	100

Table 7 Effect on knowledge of screening following training

		Screening				
		A Great Deal	Moderate amount	Minimal amount	Not at all	Total
2010 Cohort	Count	26	15	2	0	43
	Percentage	60.5	34.9	4.7	0	100
2005 Cohort	Count	30	35	0	6	71
	Percentage	42.3	49.3	0	8.5	100

Table 8 **Effect on knowledge of asking following training**

		Knowledge asking				
		A Great Deal	Moderate amount	Minimal amount	Not at all	Total
2010 Cohort	Count	26	15	2	0	43
	Percentage	60.5	34.9	4.7	0	100
2005 Cohort	Count	26	32	0	13	71
	Percentage	36.6	45.1	0	18.3	100

Table 9 **Levels of confidence in asking about domestic violence following training**

		Confidence asking					
		A Great Deal	Moderate amount	Minimal amount	Not at all	Unsure	Total
2010 Cohort	Count	25	15	3	0	0	43
	Percentage	58.1	34.9	7	0	0	100
2005 Cohort	Count	26	26	0	18	1	71
	Percentage	36.6	36.6	0	25.4	1.4	100

Table 10 **Levels of knowledge in responding to domestic violence following training**

		Knowledge responding					
		A Great Deal	Moderate amount	Minimal amount	Not at all	Unsure	Total
2010 Cohort	Count	20	19	4	0	0	43
	Percentage	46.5	44.2	9.3	0	0	100
2005 Cohort	Count	15	45	0	10	1	71
	Percentage	21.1	63.4	0	14.1	1.4	100

to report “a great deal” than those in 2005 [odds ratio = 2.1, 95% confidence interval = 0.99 to 4.66]

It was important that participants felt knowledgeable in asking about domestic violence. Participants were asked the effect of the training on their knowledge of how to ask. Results in Table 8 suggest there is an increase in knowledge in enquiring about domestic violence when comparing 2010 with 2005:

- 61.0% in 2010 reported “a great deal” compared with 37% in 2005 [p = 0.013]
- 2010 respondents being 2.6 times more likely to report “a great deal” than those in 2005 [odds ratio = 2.6, 95% confidence interval = 1.22 to 5.77]
- 0% in 2010 reporting “Not at all” compared with 18.3% in 2005 [p = 0.003]

To establish good practice midwives have to feel confident in their abilities to ask about abuse. Table 9 indicates that across the cohort there was a tendency for an increase in confidence in asking about domestic violence when comparing 2010 with 2005:

- 0% in 2010 reporting “Not at all or unsure” compared with 26.8% in 2005 [p < 0.001]

- 2005 respondents being 14.9 times more likely to report “Not at all or unsure” compared with the 2010 respondents [odds ratio = 14.9, 95% confidence interval = 1.92 to 111.1]

Asking the question alone is not enough in itself; midwives need to feel knowledgeable and confident in their abilities to respond positively when women disclose abuse. Results detailed in Table 10 suggest across the cohort there was a tendency to an increase in knowledge of how to deal with responses when comparing 2010 with 2005:

- 46.5% in 2010 reported “a great deal” compared with 21% in 2005 [p = 0.004]
- 2010 respondents being 3.2 times more likely to report “a great deal” than those in 2005 [odds ratio = 3.2, 95% confidence interval = 1.42 to 7.42]
- 0% in 2010 reporting “Not at all or unsure” compared with 15.5% in 2005 [p = 0.007]

Results in Table 11 suggest across the cohort there was a tendency to an increase in confidence of how to deal with responses when comparing 2010 with 2005:

- 39.5% in 2010 reported “a great deal” compared with 21.1% in 2005 [p = 0.034]

- 2010 respondents being 2.4 times more likely to report “a great deal” than those in 2005 [odds ratio = 2.44, 95% confidence interval = 1.06 to 5.63]
- 0% in 2010 reported “Not at all or unsure” compared with 18.3% in 2005 [p = 0.003]

A key aspect of responding appropriately to positive disclosure is working collaboratively with other agencies. For this to happen successfully, practitioners need to have knowledge, and confidence to work with other agencies.

Inspection of Table 12 suggests across the cohort, there was a tendency to an increased knowledge of how to work with other agencies when comparing 2010 with 2005 with:

- 44.2 in 2010 reported “a great deal” compared with 19.7% in 2005 [p = 0.005]
- 2010 respondents being 3.2 times more likely

to report “a great deal” than those in 2005 [odds ratio = 3.22, 95% confidence interval = 1.39 to 7.46]

- 0% in 2010 reporting “Not at all or unsure” compared with 19.7% in 2005 [p = 0.002]

Inspection of Table 13 suggests that across the cohort there was a tendency to an increase in reported confidence of how to work with other agencies when comparing 2010 with 2005 0% in 2010 reporting “Not at all or unsure” compared with 29.6% in 2005 [p < 0.001].

In terms of midwives’ general perception of the overall impact of the training on practice, findings presented in Table 14 suggest across the cohort there was a tendency to an increase in positive impact on practice when comparing 2010 with 2005:

- 65.9% in 2010 reported “a great deal”

Table 11 Levels of confidence in responding to domestic violence following training

		Confidence responding					Total
		A Great Deal	Moderate amount	Minimal amount	Not at all	Unsure	
2010 Cohort	Count	17	21	5	0	0	43
	Percentage	39.5	48.8	11.6	0	0	100
2005 Cohort	Count	15	43	0	11	2	71
	Percentage	21.1	60.6	0	15.5	2.8	100

Table 12 Levels of knowledge in working with other agencies following training

		Knowledge agencies					Total
		A Great Deal	Moderate amount	Minimal amount	Not at all	Unsure	
2010 Cohort	Count	19	16	8	0	0	43
	Percentage	44.2	37.2	18.6	0	0	100
2005 Cohort	Count	14	43	0	13	1	71
	Percentage	19.7	60.6	0	18.3	1.4	100

Table 13 Levels of confidence in working with other agencies following training

		Confidence agencies					Total
		A Great Deal	Moderate amount	Minimal amount	Not at all	Unsure	
2010 Cohort	Count	15	21	7	0	0	43
	Percentage	34.9	48.8	16.3	0	0	100
2005 Cohort	Count	14	36	0	20	1	71
	Percentage	19.7	50.7	0	28.2	1.4	100

Table 14 Overall impact of the training on practice

		Impact 2003/04				Total
		A Great Deal	Moderate amount	Minimal amount	Not at all	
2010 Cohort	Count	29	14	1	0	44
	Percentage	65.9	31.8	2.3	0	100
2005 Cohort	Count	30	29	2	9	70
	Percentage	42.9	41.4	2.9	12.9	100

compared with 42.9% in 2005 [p = 0.016]

- 2010 respondents being 2.6 times more likely to report “a great deal” than those in 2005 [odds ratio = 2.58, 95% confidence interval = 1.18 to 5.64]

The numbers of times midwives have the opportunity to ask women about domestic violence are important to allow the identification of women at risk and offer appropriate support. The cross-tabulation in Table 15 is based on the percentage of times able to ask about domestic violence. The reported levels of being able to ask the question have increased when comparing 2010 data with 2005 data. In particular:

- In 2005 25.4% report that they are only able to ask up to 20% of the time whereas everybody in 2010 are able to enquire in more than 20% of cases (p < 0.001)
- In 2010 only 3.8% report being able to routinely enquire in up to 40% of cases compared with 45.1% in 2005 (p < 0.001)
- In 2010 41.5% of respondents claim to routinely enquire at least 80% of the time compared with only 12.7% in 2005 [p < 0.001]
- Respondents in 2010 are 4.89 times more likely to report being able to enquire in at least 80% of case than in 2005 [95% confidence interval, 2.0 to 11.9]

In summary, midwives are creating more opportunities to ask women about abuse than in 2005. However, there continues to be barriers to routine enquiry, indicated by significant number of times midwives were not able to ask.

Barriers

Q53 probed barriers to screening, and are summarised below in Table 16. More than of half of midwives believe that personal experience of domestic violence (79%), concern about ongoing relationships with women (55%) and any perceived lack of organisational support (60%) are not barriers to effective screening. Nearly all (95%) consider presence of partner to be a barrier and 84% believe language difficulties can also be a barrier. There is a wide range of opinions on barriers arising from personal safety and available resources to deal with a disclosure.

Table 15 Opportunities to ask women

		Routine ask					Total
		0 - 20%	21 - 40%	41 - 60%	61- 80%	81 - 100%	
2010 Cohort	Count	0	2	16	13	22	53
	Percentage	0	3.8	30.2	24.5	41.5	100
2005 Cohort	Count	18	14	12	18	9	71
	Percentage	25.4	19.7	16.9	25.4	12.7	100
Total	Count	18	16	28	31	31	124
	Percentage	14.5	12.9	22.6	25	25	100

Table 16 Percentafe distribution for barriers

Questions	Answers				
	A Great Deal	Moderate amount	Minimal amount	Not at all	Unsure
Lack of organisational support	3.6	10.9	25.5	60.0	0
Personal experience of DV	0	3.6	17.9	78.6	0
Concern about personal safety	0	16.1	39.3	44.6	0
Lack of resources	1.8	16.1	41.1	39.3	1.8
Concerns about ongoing relationship	3.6	10.7	30.4	55.4	0
Presence of partner	82.5	12.3	3.5	1.8	0
Language barriers	45.6	38.6	10.5	5.3	0

Chapter Six Findings from the focus groups

In total, fourteen midwives consented to participate in the focus group interviews. However, due to clinical commitments and unforeseen family commitments three midwives were unable to attend. The focus group interviews were held on two separate occasions with seven midwives invited to each day. The midwives who attended were all experienced, with ten of the midwives who had taken part in the 2005 study. On average, participants had been qualified for more than ten years. Two focus groups were held as it was considered unlikely that one focus group meeting would meet the needs of the research, as there is always the possibility that responses are particular to that one group (Bryman 2008). It was also considered that having two smaller groups would be more manageable in terms of data collection and facilitating group dynamics.

The main aim of the focus group interviews was to provide the midwives with space to freely discuss and express their thoughts and feelings regarding their role, in terms of routine enquiry for domestic violence. In particular, the interview allowed the researchers to build up a view of the interaction and discussion between the midwives. The project researchers, KB and DS attended both group meetings, with the purpose of guiding each of the sessions whilst attempting not to be intrusive. One of the researchers took notes during the discussions, identifying non-verbal cues, including body language. The second acted as a facilitator, encouraging all participants to contribute and guiding the flow of conversation using a semi-structured topic guide. The interviews took place at the University in a relaxed setting to encourage the sharing of views and perspectives. The interviews lasted for one hour. For the purpose of the data collection, the aim was to have an emphasis in the questioning on a fairly tightly defined topic (Bryman 2008), which was their experiences of asking women about domestic abuse during pregnancy. The focus group interview was considered appropriate as it allowed the midwives to discuss and debate their experiences in a relatively unstructured way. According to King and Horrocks (2010) focus group interviews, if facilitated correctly by the group facilitator, can reveal the social and cultural context of people's attitudes and understanding.

The focus group interviews allowed the participants to bring to the forefront several

issues and concerns in relation to asking women about domestic violence and the consequence of a positive disclosure. Another effect of the focus group approach is the opportunity it affords other members of the group to probe each other's reasons for holding a certain viewpoint (Bryman 2008). Most of the midwives knew each other and this offered a level of confidence in the group's ability to discuss and interact. According to King and Horrocks (2010) people that are known to each other, friends or colleagues' are usually the people that are used to discuss and explore issues of significance. The interviews (with the midwives' consent) were tape-recorded. Prior to each interview, confidentiality, consent and willingness to participate were confirmed with all the participants. Both groups demonstrated good interaction with each other, indicating respect for each other views and beliefs.

The main themes to emerge from the data included:

- Barriers and solutions to asking women about domestic abuse
- The role of the midwife in supporting women experiencing domestic abuse
- Confidence in asking women about domestic abuse and pregnancy
- Midwives' relationship with women
- Information sharing with other professional groups
- Support for the role and education
- Coping with disclosure

Barriers and solutions to asking women about domestic abuse

The midwives clearly articulated that there continues to be some barriers to routine enquiry into domestic violence. These included, continued presence of partners, women whose first language was not English and some organisational barriers such as lack of privacy and time. These were similar barriers to those identified in the original study.

However, midwives were committed and positive about routine enquiry, highlighting strategies employed to highlight practitioner's willingness to discuss abusive relationships with women. This included placing domestic violence posters around the clinics, often in the toilets, and advising women to place a blue sticker on the urine pot if she wanted to speak to the midwife about domestic abuse without her partner being present:

We all know that domestic violence exists because it is out there isn't it. We put posters in antenatal clinic; we've also got posters in the toilets and tell the women that they can talk to me about domestic violence. This hopefully tells them it is acceptable to talk to me about it isn't it? (midwife 4).

We've got the dot to stick on the urine pot when we collect the urine samples, the women can put the dot on the pot in the women's toilets (midwife 2).

I do that with mine as well, hopefully it lets the women know that we care (midwife 4).

The midwives expressed concern and frustration that they were often unable to enquire about domestic violence due the presence of a partner at all the antenatal appointments. It was not considered safe or good practice to ask women about domestic violence when they were accompanied by a partner:

I think midwives should only ask if the partner is not there (midwife 1).

Yes that is the main barrier if he's with her at every appointment; you know you have not asked her but what else can you do, as we never ask the question in front of the partner (midwife 6).

Several of the midwives reported developing strategies to cope with the continuous presence of a partner. This included purposely placing the weighing scales in a different room or requesting a urine sample and then accompanying women to the toilet, allowing the midwife to have a time alone with women. During this brief window of opportunity the community midwife would ask the woman about domestic violence. Although the midwives did acknowledge these approaches were far from ideal:

if they're with husbands I always try and get them on their own, sometimes the loo is the best, we don't have the scales in our sort of booking office so you know we'll take them off and do their weight and height but then seems a little bit like oh do you want to talk to me about anything? It always seems a little bit sort of rushed ... not rushed but sort of it's not ideal but it's better than nothing at all I suppose (midwife 8).

You get an idea if something wrong and yes certainly if I haven't had chance sort of up to a certain point then yes I'll make a point of putting the scales in our office and doing it that way (midwife 2).

All the midwives articulated that men being present during consultations continue to make it very difficult for midwives to ask women about domestic violence.

Non-English speaking women

Midwives identified challenges when women did not understand or speak English; this was a particular difficulty when midwives had not been given prior information about the woman. This made it impossible to predict a woman's language needs and organise appropriate interpreters. During the focus group interviews, the midwives, did acknowledge that language line was currently available for them to use for their consultations with women whose first language was not English, though this was viewed as an unsuitable way to ask women about domestic violence. The presence of an interpreter was viewed as the most acceptable mode of asking non-English speaking women about domestic violence. However, the midwives did voice concerns about using an interpreter who lived within the local community or knew the family, they all considered this as an unsuitable option. They also believed that partners, children or family members who often accompany the women to all her antenatal appointments, should not be utilised as an interpreter during the consultation.

You don't know who you're talking on the phone even on language line (midwife 2).

Yes and if you think, how practice has moved forward and the doors that have been opened for English speaking women, and how many of those have been able to disclose since this work started. However, there is probably a huge pool of non English speaking women that we are missing, we're only just getting a few and that's only the ones that we can link a language to, for example those women who are perhaps fairly good at English themselves, or some that are British born (midwife 5).

It was also considered by some of the midwives that it was inappropriate to use local community link workers from the local area, as there was a concern that the link workers were also known within the local community:

Yes it is hard isn't it when you're using interpreters. If you've got somebody who's from the local community, because we used to use people from their own local area in We used to have link workers who would come and interpret for you, they've got some down I know that ... and ... and they use them as well and because of the difficulty with language. However, there's no better response than asking the woman in her own language direct (midwife 6).

It worries me to use interpreters as often the interpreters come from the community they live in

so actually they end up not being honest because they do not trust them enough to tell them (midwife 3).

That's right and they quite often will say all the right answers in the right places but you can tell by their persona but they're thinking something else, there's something extra, and it worries me that we are not acting on it (midwife 8).

I think we are managing to reach some but it's still not. I feel we could do it better than we are (midwife 1).

Yes without a doubt, language is a barrier (midwife 2).

The group acknowledged that in many occasions' sisters, sister in-laws and partners also attend the visits acting as the translator during the antenatal and postnatal visits:

Yes using translators, I doubt very much they're going to open up to a question like that that's had to be translated to a third party and you know I'm more than aware that it may well be there's a higher risk in women who can't speak English or don't know how to access services, so I always feel very uncomfortable with that really (midwife 8).

I'm sure with the Somalian community yes because a lot of the link workers come into the clinic as they're part of the community so there's no way I think the women would disclose about domestic violence when we are using workers from their community (midwife 5).

The midwives also identified that more thought and planning needed to be considered when providing antenatal care to non English speaking women in terms of verbal communication but also in terms of written material:

I have a large Polish contingency in my area but I haven't got a domestic violence information sheet translated into Polish, which might help if that might open up the conversation and I would be able to give that to them at booking visit (midwife 2).

The midwives felt that more thought was required in terms of addressing the needs of this particular group of women in relation to domestic abuse. This included leaflets in a range of languages, an understanding specialist services available locally and the use and availability of trusted interpreters.

Confidence in asking women about domestic violence and pregnancy

All the midwives present during the focus group interviews reported feeling 'quite confident'

when asking women about domestic violence. They talked about it as being an integral part of their role, even feeling a sense of pride in the responsibility of providing support to women experiencing domestic violence:

Yes I think midwives take a bit of pride in it don't they, that we are going to be asking these questions and we're going to be able to help with it and providing the sort of support if they are going through that, so yes I don't think midwives do not ask only if the partner is not there yes, I agree ... I'd say generally it's if the partner's there (midwife 2).

Over the years since the introduction of routine enquiry they suggested that they had developed a lot more confidence in the role:

Yes midwives feel much more confident in asking now (midwife 5).

Midwives are now expected to ask women during the antenatal period about the wellbeing and their mental health. Some of the clinicians considered that this had provided them with a gateway into exploring further when women described themselves a feeling unhappy or depressed. Often discussing these feelings enabled midwives to understand not only the reasons causing mental illness but the relationships between mental health family life and sometimes abuse:

I mean we now have, another mechanism for asking, what I think sometimes previously the way it was done we may not get a clear answer when we ask the question but if the ice has been broken because we're not just asking about abuse, we're also asking the question about mental health and wellbeing, it's kind of tied in so well now, so naturally so there's an acceptability by women (midwife 6).

Midwives relationship with woman

Midwives were asked to reflect on the impact asking women about domestic had on their relationships with women. Most felt that asking about domestic abuse had not impacted upon the relationship.

I've always felt that by asking them in a manner that's acceptable and empathetic rather a direct question it actually can help to build some sort of trust. You know because generally oh someone cares and you know it might not happen that time but once they start to trust you they know they can ask so it is just one of those things between midwife and woman isn't it really? (midwife 4).

Some of the midwives believed that women found the questioning acceptable and that they

were neither surprised nor offended at being asked:

Perhaps if you're asking the question again at a later time in the pregnancy they may not have told you at 12 weeks but then may actually tell you at 36 because of the relationship that you have built up with them. You know it is going and it will intensify or maybe they just feel ready to tell you at 36 weeks, I don't know but we're if we're only asking once, if we've lost that opportunity because women will tell you they won't tell unless you ask but once you ask some of them feel they can't open up until they have build up a relationship with you (midwife 1).

They've got to know you by 36 weeks as well haven't they especially if it's a difficult pregnancy. They've seen you probably sort of eight or nine times by then. So if you ask them they may feel able to tell you (midwife 2).

I want to solve the problems of the world and then when she doesn't want to leave him you think, so yes, it can be quite stressful for the midwife as well sometimes (midwife 2).

No I go into mother hen role, which is why I get really uncomfortable because you know if she was your daughter! (midwife 8).

You don't want it to affect your relationship but I think as long as you ... no it's never affected mine, I think it's how you word it I think (midwife 1).

Coping with disclosure

Midwives who took part in focus groups were all confident about asking women about domestic abuse and viewed it as part of their role. However, there were still some anxieties about responding effectively to a positive disclosure particularly in relation to workload demands, time constraints and their own capacity to deal with a positive disclosure. Some minor frustrations were also articulated when the women decided to stay with the partner, although midwives did acknowledge that was always the woman's choice:

It becomes all consuming, I was going to case conferences and pretty much every month and that she was well known to social services, the health visitors also knew about her, the GPs knew about her but for continuity it was me who saw her all the time and it was really wearing. In the end, despite all the help offered, she chose him and the baby was taken into care (midwife 4).

Others felt that because of their focus on responding to women's needs, midwives often wanted to solve everyone's problems, and this

was not always possible, particularly in relation to complex and abusive family relationships. There was an emotional burden to this work that midwives acknowledged. Strategies developed included: talking it through with colleagues and relying on supportive relationships at home, though sometimes this was not enough and practitioners worried about women long after their shift was over. Nevertheless, caring for women involved listening to their stories, offering emotional support and to informing them about the resources available:

We're nurses, midwives, mothers and women, we want to solve everyone's problems we do, we want to go in and do the right thing. We want you do A, B, C, D and that's it and you can get really cross if they don't follow it, and it's only ... it's over the last few years you think I can't take on everybody's responsibilities, but I have learned that I can't be responsible for everybody so I think you do at some point have to learn to step back and think I've done everything I can, I've given all the information I need to give, everybody's there, I can't do any more because you would go mad (midwife 3).

While preparing themselves to expect a positive disclosure from some women, and being experienced, midwives reported still feeling shocked by the numbers of women experiencing abuse. Several midwives felt distressed listening to stories of abuse, though still valued the opportunity for the women to share their stories and confidences. Some of the group firmly believe that women want to tell someone about the abuse:

But it's the responses that you get that are ... that still I get blown out by, I just think they're in so many people that are affected (midwife 3).

And it's the shame somehow attached, there's the desire to seek help, I definitely feel that women do want to tell you about the violence, and therefore we should be able to offer them some support (midwife 9).

One midwife talked about how each disclosure had to be understood in an individual context, that one size response does not fit all. Just as maternity care should be individualised then so should how domestic violence responses:

I think if possible we should look to community responses. So I went to an awful lot of trouble, I mean that's the only thing to do isn't. We should try to find the right kind of support and give her some numbers that she could use, sometimes doing all this can often take an awfully long time. To support them I usually talk in terms of this isn't about removing anyone's children unless they are

being harmed, this isn't about sending the police round, this isn't about jumping in with both feet ... but giving them tools, giving them numbers to help them make a choice. In terms of information sharing, I make it very clear that I'm talking to my manager, talking to a supervisor, definitely talking to the colleagues. If it is safe, I will phone them up, giving them a contact numbers, finding out how they are, not leaving it for routine antenatal visits, I call them three days later or sooner if I need too. I have asked them if they would like me to come and visit you at home. As a team we tried to act proactively by doing this (midwife 1).

Chapter Seven Findings from stakeholders

In total, six stakeholders were recruited to the study. This included: a midwifery manager, a director of nursing services, a Trust lead for safe guarding, an PCT Associate director of public health (now NHS Bristol), and two social services area managers. The stakeholders were identified in terms of their role in service development, staff management and leadership.

During the semi-structured interviews, stakeholders were asked to think about the implications of the midwifery services undertaking routine antenatal enquiry; long term outcomes for women and families; implications for practice development and interagency working. Consideration was given to where domestic violence sits in overall service planning given Trusts ongoing priorities and its connection with other health and community service priorities. Lastly, the threats and opportunities for collaborative working were explored. The interviews lasted on average forty five to sixty minutes, they were tape recorded with consent and transcribed by the researchers. The data generated was content analysed for emergent themes. Themes to emerge from the data included: domestic violence as a health service priority; the role of the midwife in domestic violence enquiry; the overall implications for future service provision and the implications for multi-agency working.

Domestic Violence as a health service priority

The importance of health services, particularly, midwifery in supporting the survivors of abuse, was emphasised by all the stakeholders interviewed. Stakeholders recognised there were significant benefits for women and reinforced the importance of midwives supporting women who are experiencing domestic violence on an ongoing basis. Three interviewees suggested that enquiry was embedded in practice and women generally expected to be asked:

Women now expect to be asked about domestic violence, the service has really moved forward; I feel they are leading the way within the health services (Midwifery Manager).

It is very important that midwives continue to ask about women about domestic violence. They can make such a difference to a woman's life and her wellbeing, not only for herself but for her children's sake also (Associate Director of NHS Bristol).

Stakeholders perceived there had been significant changes in health professionals' attitudes to their role in addressing domestic abuse. This had resulted in a more responsive and proactive approach towards domestic violence with more emphasis on early intervention, rather than the consequences of attack. Several respondents suggested that the midwives at NBT had influenced the development of practice at a local and national level, something respondents were keen to maintain. The ability of organisations to maintain this level of innovation depended on the degree to which domestic abuse remained on health and Government agendas. While two respondents were optimistic making reference to the White Papers: Equity and excellence: Liberating the NHS and Healthy lives, healthy people, others were uncertain about the implications of a change in Government maintaining "everything is uncertain". There was a concern that financial constraints on the National Health Service would lead to competition intensifying around a number of service priorities:

The new Health White paper has mentioned domestic violence against women and children and hopefully this will keep its profile high, but the future is very uncertain at the moment (Associate Director of NHS Bristol).

One stakeholder suggested the way forward would be to link domestic violence and sexual violence agendas with other service priorities such as teenage pregnancy, alcohol and drug abuse and mental health as an mechanism for keeping domestic violence high on the agenda:

Bring together sexual and domestic violence, and then link it to other service priorities such as mental health, teenage pregnancy, alcohol and drug abuse as all these social issues are interlinked. Even though, I feel nothing else on the health agenda should be at the expense of domestic violence as it is important work, but perhaps we have to consider that this maybe a way of protecting it (Service Director).

Another stakeholder maintained that policy makers and service managers must be patient, as the long-term benefits of this work might not be realised until this generation of children have grown up:

We have to consider that we could not see the effect of all this work until children grow up. There is such a change in recognition and awareness that emotional abuse is damaging for women and her children, my goodness especially the children. By education, women will come to realise that

domestic violence does affect their children lives and taking them away from the violence will improve their overall wellbeing both in the short term and long term (Safe Guarding Lead).

The role of the midwife in domestic violence enquiry

There was a general consensus that the midwifery service had been instrumental in taking the lead in health at addressing domestic abuse:

I feel communication and information is now much better between the various agencies. Midwives no longer feel so isolated in this role (Midwifery Manager).

I am very impressed with how the midwives have lead the way in Bristol concerning health involvement – 5-6 years ago, health was being constantly being criticised for their lack of involvement with domestic violence agenda (Associate Director of NHS Bristol).

A midwifery manager highlighted that the introduction of routine enquiry had led to the realisation that a number of child protection cases may have previously gone unnoticed. There was a confidence that by asking about domestic violence, midwives were also able to identify other risk behaviours such as child protection, drug and alcohol use, mental health concerns and female genital mutilation. This is illustrated in the following extract:

The introduction of routine enquiry into domestic violence over the last four years has definitely led to an acknowledgment and realisation of large number of child protection issues which may not have been raised without asking about domestic violence. It is important to realise that this may have been missed without midwives asking about domestic violence. It has also raised other issues such as female genital mutilation, drug abuse; mental health concerns (Midwifery Manager).

It was also felt this work could only be continued with ongoing education, training and support for midwives. This was felt to be an essential element for the success and the continuation of the work:

Education and training are very important if we want staff to continue to ask about domestic violence, they need to know how to ask – how to respond and how to access help for the women – tools have to be designed – guidelines and policies must be there. The training should be mandatory – even if it with a short face-to-face session linked with safeguarding and perhaps a workbook –

online tool. But some of it has to be with face to face training. Sadly, acute Trusts will not always see this as a cost saving exercise (Service Director).

The overall safety of midwives was raised: while some voiced concerns about individual safety, there was a general feeling that midwives were skilled at assessing risk to themselves and their colleagues:

I have no major concerns around midwives' safety – midwives are aware that their safety is the absolute priority of the management and as a manager I would never expect any of the midwives to enter into a dangerous situation. They also have skills around conflict resolution and making dynamic risk assessments. Senior midwives have the skills and abilities to make good decisions around risk assessment. I would support any midwife who decided not to follow up a case where they felt their own safety was an issue (Midwifery Manager).

The overall implications for future service provision

In Bristol last year, the Primary Care Trust made domestic violence a health priority and this has resulted in the development of new posts. However, because of competing priorities and reductions in various health and provision budgets there was a general consensus from several of the stakeholders that there would be a requirement for everyone to work hard to keep it at the top of the local health agenda.

Last year Bristol PCT did prioritise domestic violence and it is important that this continues and that everyone continues to work hard to keep it at the top of the agenda (Service Director).

In the acute Trust, it was also felt necessary to consider employing a specialist midwife to lead on the complex cases as the introduction of routine enquiry has seen an increase in disclosure rates:

If we keep asking the question as we are doing them we will uncover more cases, I therefore feel there is a need for a named midwife with time allocation as part of her role to lead on the training, to support midwives and help with the completion of the necessary information sharing paperwork such as the Multi Agency Risk Assessment Conference (MARAC) and the Common Assessment Framework (CAF), and of course to be there to support women to access the right support agencies for her needs. Her role could also include safeguarding; there is a definite need to employ a lead midwife who will take a lead and manage this important role (Maternity Manager).

It was perceived this work needed to extend to other professional groups involved in the care of women and children. One manager suggested that this was not just a 'midwifery and health visiting issue' it was every health professional's business to enquire about a history of violence and provide support and advice to a woman and her children.

Midwives and indeed all health care professionals have to continue to ask women about domestic abuse, this work is important, we must not turn the clock back – if we ask the right question, you will get the right answer. We must work together to ensure that services continue – it is so important from an ethical stance that we continue to ask the question, however equally we must have the services to refer the identified women onto (Safeguarding Lead).

This is no longer just a midwifery matter, there are clear guidelines for other professional groups to follow, and they must take the lead from the midwives (Service Director).

The importance of multi-agency working

The importance of multi-agency working was a theme that was voiced by all the stakeholders interviewed. There was a strong conviction that responding to domestic abuse was not a one agency response and that every agency has an important role to perform to develop an acceptable response and support mechanism for women and children.

This work is just so important – we must continue this work around domestic violence. Encourage the NHS trusts and PCT to work closely together, continue to strengthen the links. I am hopefully that because Bristol and hopefully South Gloucester have adopted the Identification and Referral to Improve Safety (IRIS) model that this will continue and that GP commissioners will continue to adopt the IRIS project. We must build on the good work of the midwives and more recently the GPs (Service Director).

Nevertheless, social work professionals working for children and young people's services highlighted some of the ongoing tensions between agencies working in the field in relation to safeguarding. These were largely connected to perceived organisational differences in thresholds for services. For example where there was a positive disclosure during pregnancy for domestic abuse, social work assessment teams for children and families would not automatically intervene. Much more detail would be needed by these professionals to understand the context, intensity

and nature of the family relationships and the violence.

With reference, to the recent introduction of the Common Assessment Framework (CAF) it was suggested by the social work stakeholders that midwives might increasingly be required to accept responsibility as the lead professional in managing risks associated with domestic violence. For example, there may only be social work involvement when there were identified child protection concerns:

“when domestic violence is very entrenched, and the families are persistently very violent, so much so that their behaviours are so risky that there is an intervention connected to child protection” (Area Manager, for Children's and Young People's Services).

Through the CAF and Children in Need (CHIN) processes it was suggested that midwives may be able to respond to women through the level two specialist abuse services provided by the Third sector, rather than immediate referral to social work assessment teams. Social work professionals also identified the need for more professional education, to develop interprofessional awareness of each other's roles and organisational priorities. A failure to identify women's needs or appropriately refer through the processes highlighted meant that women could be denied services:

OK antenatal enquiry is fine as far as it goes, some of it is about shared knowledge, shared stuff; but the primary difficulty is that midwives have wider areas of responsibility and they need to fulfil those responsibilities. Midwives have new roles in CAF, which they have to fulfil. Safeguarding services have increasing referral rates and we cannot cover everything so something has to shift. There are new services in localities now and midwives should access them at a lower level through the third sector provision. More difficult is that people are denied access to a service through in-action because of the failure of professionals to make a CAF referral. This means that they are not presented at a CAF panel and they cannot access services (Hospital Team Manager, Children's and Young People's Services).

It was acknowledged that some midwives might need more in-depth education and training to understand how to assess the extent and intensity of violent relationships, as more accurate and detailed referrals would allow for a more individual and effective response when assessed through CAF panels. Some referrals from midwives were seen as lacking adequate

detail to make decisions over how to effectively allocate scarce resources associated with Tier Three services.

There was a social work perception that for those professionals who were not working in safeguarding on a daily basis, a completion of a cause for concern, CAF or CHIN referrals were seen as a way of resolving practitioners own anxieties about ongoing domestic violence, documentation and referral. For some, completing the paperwork may bring closure to difficult social situations that they felt that they were not trained to deal with on an ongoing basis. Supporting health professionals to understand and live with social aspects of risk was seen as essential if resources were to be allocated to those in most need or danger, and would meet client needs.

Chapter Eight Discussion

Women's acceptability about being asked about domestic abuse

Across all social backgrounds, almost all women (97%) agreed that it was appropriate for midwives to ask directly about abuse. This included women who had been subject to abuse during pregnancy. These findings support the research from Bacchus et al (2007). From a user perspective, the most helpful way to enquire about domestic abuse is for clinicians to assume a non-judgemental positive approach to questioning. Data presented here suggested women may find it difficult to bring up the topic of domestic violence; therefore direct questioning allows women the opportunity to open up about abuse and ask for support and help. Women had a comprehensive understanding of the reasons why midwives asked and made nuanced suggestions about the difficulties women experiencing abuse face in accessing help. The Department of Health Taskforce on the health aspects of violence against women and children (DH 2010) reported on the views of 211 women who had experienced abuse. Similar to this work, it was noted women do not mind being asked about abuse, as long as they had privacy to discuss the issue and staff were understanding and validating of their accounts (DH 2010).

For the 236 women who completed the survey only four, (1.7%) reported experiencing abuse during this pregnancy; two had not disclosed to their midwife, while of those interviewed, three out of the seven reported not having shared their experiences of abuse. This indicates domestic abuse continues to be under reported in this group. Reasons for this were sometimes connected to fears about safeguarding: the women were concerned that their children may be removed from the home if they disclosed to the midwife about domestic abuse occurring within the family. However, more in-depth research needs to explore in more detail women's concerns and how the barriers to disclosure can be overcome by health services.

Importantly, women believed that offering an opportunity to discuss abuse allowed for the possibility of prevention and referral to appropriate support services. For those who had suffered abuse, there was recognition that while women may not feel able to disclose to midwives in the initial stages of the relationship, in the longer term, when disclosure had occurred the outcomes had been very positive. Not least, the

midwife was someone to share their fears and concerns about the consequences of the violence for themselves, the pregnancy and their babies. Other outcomes included: referral to support services; antenatal support within refuges; access to interpreters; and safe information sharing with other primary health care team members. Some women were cautious about the monitoring aspects of the midwifery role reporting feeling fearful of sharing information about their abuse because of potential referral to social services, and the risk of their abusive partner finding out about their disclosure.

Midwives

This is the first UK based follow up study to have evaluated the outcomes of an educational domestic violence intervention five years on. Midwife outcomes focused on their abilities to ask women about abuse, feel supported and refer appropriately. Five years on, the statistical evidence presented here suggests that the skills, knowledge and confidence associated with antenatal enquiry for domestic violence developed through the 2004 BPDVP programme have been maintained, with support of mandatory training. However, midwives attitudes in relation to their role in domestic voice, had changed significantly with all (100%) of those surveyed now reporting that enquiry was a fundamental part of their role. Interviewees reported a strong sense of pride in supporting women and providing opportunities for women to appraise their abusive relationships and explore alternatives with advice from specialist domestic violence agencies.

While results suggest midwives had increased opportunity, improved confidence in asking women and responding to positive disclosure, a numbers of barriers were identified, similar to those in 2005. This included the continued presence of a partner; lack of appropriate interpretation services for Non English speaking clients, and a lack of privacy in some clinical areas. The midwives also expressed some anxieties around time constraints and their capacity to respond to a positive disclosure. This and other studies have clearly identified that the biggest barrier to routine enquiry about domestic abuse is the presence of a partner (Taket 2004; Salmon et al 2005; Lewis 2007, 2011). One of the biggest challenges facing the midwives was finding one to one time with some of the women in their caseload. This is especially pertinent for non-English speaking women as a male partner or family member frequently accompanied them to

their antenatal appointments and was used as an interpreter. Data from midwives suggested the potential benefits for women of at least one appointment with the midwife alone. Women only consultations have been recommended by the last two confidential maternal enquires. (Lewis 2007, 2011). However, implementing such a change in practice will require a commitment and obligation from service directors, policy makers and professional bodies.

An explanation for the reported increase in confidence and acceptance of the role of routine enquiry by the midwives could be attributed to an increased exposure to disclosure and greater understanding and awareness of the complex issues involved (Mezey et al 2003; Taket et al 2004; Bacchus et al 2007). Taket et al (2004) maintain that the availability of domestic violence trained staff will not only increase the chances of a woman being asked about domestic abuse, but will also provide support to practitioners by sharing their knowledge and experiences with other members of staff.

Stakeholders

All the stakeholders interviewed recognised the important role that the health service and in particular the midwifery service has in supporting women and their children experiencing domestic abuse. Stakeholders acknowledged there were significant benefits for women and reinforced the importance of midwives supporting women who are experiencing domestic violence on an ongoing basis.

The stakeholders, like the midwives, perceived there had been significant changes in health professional's attitudes to their role in addressing domestic abuse. This has resulted in a more responsive and proactive approach towards domestic violence with more emphasis on early intervention, rather than the consequences of attack. There was an acceptance that the NHS now has to be thought of as a safe place for women to disclose about abuse and be offered help, support with information and referral for advice to the third sector voluntary agencies, which specialise in domestic abuse.

Some of the stakeholders believed that maternity had led this field of work, but that it was important that it is now extended to other professional groups involved in the care of women and children. It was considered that it was every health professional's responsibility and business to enquire about a history of violence and provide support and advice to a

woman and her children. This view is supported by the NHS Taskforce enquiry, which recognises that too many NHS staff fail to support families experiencing abuse, not because they do not care but often because they do not know what to do or do not have the confidence to respond effectively. They stipulated that good training and education would address both these barriers (DH 2010). It was suggested by several of the stakeholders that perhaps the service would benefit from a specialist practitioner who could lead on and co-ordinate all the training needs of staff, whilst supporting clinicians in the long term complex cases, whilst driving this work forward.

Due the Government and NHS competing priorities, there is a need to keep the domestic violence agenda very visible. To do this and maintain its current status as a health priority it may be necessary to link it to other public health priorities such as the sexual violence agenda, teenage pregnancy, alcohol and drug abuse and mental health as a mechanism of keeping domestic violence high on the agenda. It is important that local service needs are based on the needs of the local population, and commissioners who have the expertise to provide services that meet the needs of the local population are employed (DH 2010).

Multi-agency working is vital in meeting the needs of women and children experiencing domestic abuse. This was recognised by the majority of the stakeholders. There was a strong conviction that responding to domestic abuse was not just a NHS response and that every agency has an important role to perform to development a responsive and safe response and support mechanism for women and children. The third sector has a vital role to play in supporting women and families who experience violence and abuse, indeed the women we spoke too during the research articulated how vital and supportive they were.

Recommendations

- Commitment to the continuation of education and training around domestic violence and routine antenatal enquiry as part of mandatory training. Links should be made with other aspects of safeguarding, including child protection and substance misuse.
- A continued commitment to universal, not selective screening. Although the question is asked routinely, midwives should be skilled in their communication so that women do not experience it as a tick box exercise.

- All women should be seen alone at least once during the pregnancy; this has implications for informing women in advance this will happen, written information changes, and cultural changes. This could be possibly the third appointment. This should reduce the numbers of women who are not asked during pregnancy.
- Although enquiry is often done at booking visit, this is early in the relationship with the midwife in terms of the development of trust; a second opportunity to ask about abuse should be created at six months.
- Policy makers need to work collaboratively across safeguarding and inequalities agendas to support the continuation of domestic violence as high on policy and commissioning agendas.
- Further, development of national policy and practice guidance from government departments and professional bodies enquiring a woman only appointment during the antenatal period.
- The enhancement of more proactive services for women who speak English as an additional language. Language line can be inappropriate in relation to asking about violence. Concerns remain that this group of women are the most likely group not to be asked about violence.
- The introduction of an assessed practice based competency connected specifically to antenatal enquiry for domestic violence in pre-registration midwifery programmes.

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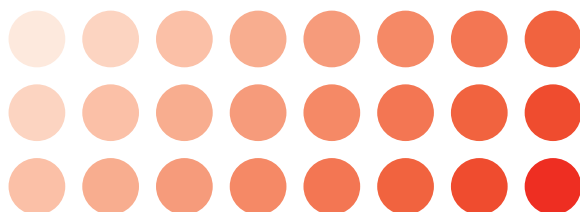
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2008]

Appendix 1 Women's Recruitment Poster



Domestic Violence Research

A research study on domestic violence and abuse in pregnancy

Your views matter

- Have you had a baby in the last two years?
- Are you willing to speak to a researcher about the response of the maternity services to domestic violence?



Kathleen Baird and Debra Salmon from the University of the West of England, Bristol are keen to interview women. You will be asked to undertake an interview in a setting of your choice and at a time that is convenient to you.

In return for each interview we will give you a £10 voucher as a thank you.

If you would like to take part please give your contact details to your support worker who will pass them on, or contact Kathleen, e-mail Kathleen2.Baird@uwe.ac.uk or telephone 0117 32 88776.



University of the
West of England

bettertogether

Appendix 2 Women's Postcard Survey

We would be grateful if you could complete this questionnaire and return it in the **confidential** envelope provided.



University of the West of England

1. How many weeks pregnant are you?

.....

2. Age in years.

.....

3. Ethnicity. Tick one box

White British

White other

Black or Black British, African or Caribbean

Asian or Asian British, Bangladesh, Indian, Pakistani

Other ethnic background

Other mixed background

Prefer not to say

4. Which type of accommodation are you currently living in?

Private owned

Private rented

Council

Temporary accommodation

Staying with friends

Other

If other – Please specify.

.....

5. During your pregnancy has a midwife asked about domestic violence?

Yes

No

If yes – When were you asked (weeks pregnant)?

.....

6. What do you think are the main reasons why midwives ask about domestic violence?

.....

.....

.....

7. Are you experiencing domestic violence in your current relationship? Yes No

If yes – Have you discussed this with the midwife or any other health professional? Yes No

Who have you discussed this with?

.....

8. How much do you agree with the following statements?

	Strongly Agree	Agree	Neither	Disagree	Strongly Disagree
--	----------------	-------	---------	----------	-------------------

a. I feel comfortable with a midwife asking about domestic violence

b. I think it is appropriate for a midwife to ask about domestic violence

c. I understand the reasons why the midwife asks about domestic violence

d. **I do not think** it is the role of the midwife to ask about domestic violence

e. I think domestic violence is too sensitive or too embarrassing to discuss with the midwife

f. I think that women who are experiencing domestic violence would benefit from telling a midwife

g. I think midwives should be able to offer advice and support to a woman experiencing domestic violence

9. Is there anything else you would like to say about being asked about domestic violence and the role of the midwife?

.....

Thank you for completing this questionnaire.

Appendix 3 Midwifery Survey

North Bristol 
NHS Trust

 University of the
West of England

A follow up study of the impact of 'The Bristol Pregnancy Domestic Violence Programme' Introduction of Routine Antenatal Enquiry

Questionnaire ID Number:

Thank you for completing this questionnaire. We would be grateful if you could complete the questionnaire and return it in the Freepost envelope provided.

Before filling this form in, please remember it is not a test! There are no right or wrong answers. We are very interested in what you can tell us. Please try to answer all the questions. ***All your answers are confidential, so please do not write your name on this form.***

Professional Education and Training

1. How many years have you been qualified as a midwife?

	less than 5 years	more than 5 years	more than 10 years	more than 15 years	more than 20 years
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

2. Do you currently have a...

	Masters Degree	Bsc (Hons) Degree	Diploma	Certificate	Other
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

> If you answered "other", please tell us your qualification here:

.....

3. To what extent within your midwifery pre-registration training and education were the following areas taught?

	A great deal	Moderate amount	Minimal amount	Not at all	Unsure
a. Domestic Violence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

> If your answer is 'not at all' please go to question 5.

1

3. To what extent within your midwifery pre-registration training and education were the following areas taught?

	A great deal	Moderate amount	Minimal amount	Not at all	Unsure
b. Domestic Violence and the impact it has on a woman's health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Domestic violence and the impact it has on a woman's childbirth experience	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

4. What impact has this pre-registration education and training had on your practice?

> Please explain your answer – give an example.

.....

.....

.....

.....

5. Did you participate in the original Bristol Pregnancy Domestic Violence Programme training conducted by Kathleen Baird & Sally Price in 2003/4 ?

	Yes	No
_____	<input type="checkbox"/>	<input type="checkbox"/>

2

6. Have you undertaken any further update sessions since the training as part of your mandatory update programme?

	Every Year	Every 2 Years	Less	Never
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

7. What experience have you had of dealing with domestic violence in your midwifery practice?

	A great deal	Moderate amount	Minimal amount	Not at all	Unsure
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

> Please explain your answer – give an example.

.....

.....

.....

.....

8. Do you work?

	Full Time	Part Time	Occasional Bank work
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

3

Professional Education

Please reflect on the domestic violence training you participated in during Spring 2003/4. To what effect has it...?

	A great deal	Moderate amount	Minimal amount	Not at all	Unsure
9. Improved your knowledge of domestic violence in general.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Improved your knowledge of screening for domestic violence.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Improved your knowledge of how to ask women about domestic violence.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Improved your confidence in asking women about domestic violence.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Improved your knowledge of how to deal with women's responses.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Improved your confidence in dealing with women's responses.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Improved your knowledge of how to work with other agencies.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Improved your confidence in working with other agencies.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

4

17. What impact do you think the education and training delivered in Spring 2003/4 has had on your practice?

	A great deal	Moderate amount	Minimal amount	Not at all	Unsure
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

> Please explain your answer – give an example.

.....

.....

.....

.....

5

18. To what extent has the support provided by the following helped you in your role in enquiring about domestic violence?

	A great deal	Moderate amount	Minimal amount	Not at all	Unsure
Domestic Violence Trainers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Peers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Manager	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Supervisory midwives	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medical colleagues	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Someone else >	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

> Please state who.

.....

6

19. In the last 12 months how many of your clients have disclosed experiences of old or new abuse?

	None	1-10	Unsure	More than 10	More than 20
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

20. Do you have any comments on how midwifery support should be delivered to women experiencing domestic violence?

.....

.....

.....

.....

21. Have you accessed the North Bristol Trust Midwives Domestic Violence web site?

Yes No

> If yes – how useful was this?

	Very useful	Useful	Fairly useful	Unsure
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

7

22. Routine antenatal enquiry for domestic violence was introduced at North Bristol NHS Trust in April 2004. Since its introduction can you estimate the percentage of times that you have been able to ask the women you have seen about domestic violence.

	0-20%	21-40%	41-60%	61-80%	81-100%
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

> Please outline any difficulties that can prevent a routine antenatal enquiry for domestic violence:

.....

.....

.....

.....

8

Knowledge about domestic violence

23. What percentage of women experience domestic violence at some point in their lives?

> Please tick one answer only.

0-10%	11-20%	21-30%	31-40%	41-50%
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

24. On average how many times is a woman assaulted by her partner or her ex partner before she will report the incidence? > Please tick one answer only.

5	10	15	20	25	30	35	40	45	50
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

25. During pregnancy does domestic violence...?

> Please tick one answer only.

Decrease

Stay the same

Increase

26. A woman who is encountering domestic violence is most at risk at which time?

> Please tick one answer only.

At the beginning of a relationship

During the relationship

If she attempts to leave

When she actually leaves

27. During pregnancy the perpetrator will usually direct violence towards which part of the body?
> Please tick as many as you feel are relevant.

- Head
- Arms
- Legs
- Abdomen
- Face
- Genitalia
- Back
- Breasts

11

28. Which of the following can be caused by domestic violence?
> Please tick many as you feel are relevant.

- Miscarriage
- Ectopic pregnancy
- Preterm labour
- Urinary tract infection
- Pre eclampsia
- Obstetric cholestasis
- Intrauterine death
- Growth restriction
- Macrosomia
- Polyhydramnios

12

29. Identify the three most important social risk factors associated with domestic violence.

1.

2.

3.

30. I am aware of the support agencies that provide support to women experiencing domestic violence.

I regularly refer to Women's Aid

I regularly refer to Local Women's Advocacy Support Agencies

I regularly refer to Social Services

I regularly refer to MARAC (Multi Agency Risk Assessment Conference)

Other support agency

> Please state who.

.....

13

Attitudes towards domestic violence in pregnancy

	Strongly agree	Agree	Neither	Disagree	Strongly disagree
31. Some ethnic minority groups view domestic violence as acceptable.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
32. Women can be responsible for the violence perpetrated against them.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
33. Domestic violence is a crime and should not be tolerated.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
34. Pregnant women should be asked by midwives if they are experiencing domestic abuse.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
35. Pregnant women should be asked by health visitors if they are experiencing domestic abuse.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
36. Pregnant women should be asked by general practitioners if they are experiencing domestic abuse.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
37. Pregnant women should be asked by obstetricians if they are experiencing domestic abuse.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

14

About You

	Strongly agree	Agree	Neither	Disagree	Strongly disagree
38. I think screening for domestic violence is important.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
39. I feel confident in my practice to routinely enquire about domestic violence.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
40. I feel confident in my practice to offer advice for the issue of domestic violence in pregnancy.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
41. I feel confident in my practice to refer women to relevant agencies for the issue of domestic violence in pregnancy.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
42. I feel confident in my practice to offer ongoing support for the issue of domestic violence in pregnancy.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
43. I feel knowledgeable about domestic violence.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
44. I feel supported in my practice by my peers to screen for domestic violence in pregnancy.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
45. I feel supported in my practice by my manager to screen for domestic violence in pregnancy.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
46. I feel supported in my practice by my medical colleagues to screen for domestic violence in pregnancy.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

15

	Strongly agree	Agree	Neither	Disagree	Strongly disagree
47. I feel supported in my practice by my supervisor of midwives to screen for domestic violence in pregnancy.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
48. I feel supported in my practice by professional guidelines to screen for domestic violence in pregnancy.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
49. I feel supported in my practice by the domestic violence trainers to screen for domestic violence in pregnancy.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
50. I feel supported in my practice by other agencies to screen for domestic violence in pregnancy.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
51. I think screening for domestic violence is effective.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
52. I feel it is the midwives role to enquire about domestic violence.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

16

Barriers to Screening

53. Reflecting on your own experience to date. To what extent do the following factors prevent you from effectively enquiring about domestic violence

	A great deal	Moderate amount	Minimal amount	Not at all	Unsure
Lack of organisational support.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Personal experience.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Concern about personal safety.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lack of resources to support women who disclose experience of abuse.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Concern about the effects of asking on the midwives ongoing relationship with the women.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Presence of partner.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Language (e.g. Non -English speaking woman).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

17

54. Is there anything else that prevents you from routinely enquiring?
 > Please state – give examples.

.....

.....

.....

.....

Thank you for completing our questionnaire!

If this has raised any issues for you or you require support for your own experiences of domestic violence please contact the help line numbers below.

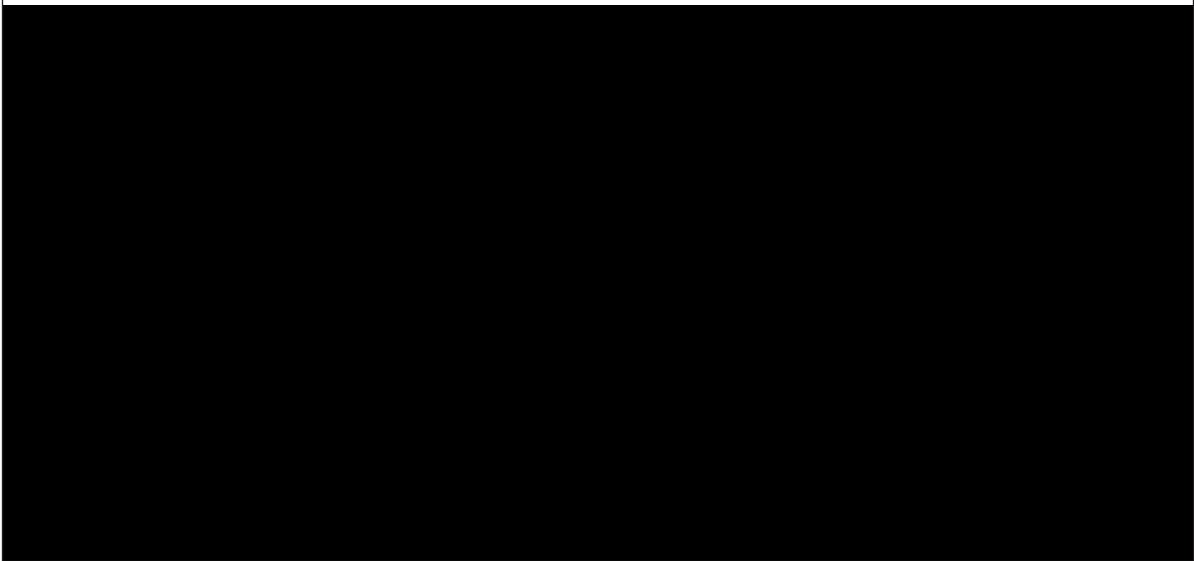
**Women's Aid FREE 24hr National Domestic Violence Helpline
 0808 2000 247**

**Contact on call North Bristol NHS Trust Supervisor of Midwives via Central Delivery Suite
 0117 3235305**

18



North Bristol **NHS**
NHS Trust



Appendix 4 Women's Information sheet



University of the
West of England

A Five Year evaluation study of the 'Bristol Pregnancy Domestic Violence Programme' Supporting the Introduction of routine antenatal enquiry for domestic violence within North Bristol NHS Trust

Information Sheet for Women – Interview

We would like to invite to take part in a research study. Before you decide you need to understand why the research is being done and what it will involve for you. Please take time to read the following information carefully, and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

Part 1 will advise you about the purpose of the study and what will happen if you agree to take part. **Part 2** provides you with more detailed information about the conduct of the study. Please ask me if there is anything that is not clear or if you would like more information. **Take time your time to decide whether or not you wish to take part.**

Part 1

What is the purpose of this study?

The Bristol pregnancy and Domestic Violence Programme Evaluation clearly demonstrated that for routine enquiry to be effective and responsive staff required education, training and support (Salmon et al, 2004). This study would endeavour to ascertain whether routine enquiry about domestic violence continued to be effective after completion of the study and whether 5 years later the midwives feel that they have remained equipped and empowered to ask every woman on their caseload about domestic violence. Another important finding of the study will be to ascertain whether women find it acceptable to be asked about domestic violence during pregnancy by a midwife.

Why have I been chosen?

Part of the research will aim to find out if pregnant women find it acceptable to be asked by a midwife about domestic violence. Therefore we would like to you to participate in a semi structured interview with a researcher. The overall aim of the interview will be to ask you about your experiences of using the maternity services and whether you consider it acceptable for midwives to ask pregnant women about domestic violence.

Do I have to take part?

No, it is entirely up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form, the consent form is to show that you have agreed to take part. Even after you sign the consent form you are still free to withdraw from the study at any time, without giving a reason.

What do I have to do, if I agree to take part?

I would like to meet with you to discuss the study in more detail. If you agree to take part, you will be asked to complete a consent form. If you consent to

take part I would like to meet with you to talk about your experiences of using the maternity service. I anticipate the interview may last 30 – 45 minutes or for as long as you wish to talk to me. This will be a one to one private discussion. All meetings will take place in a safe environment (away from the home where you are currently living) with your permission I would like to tape record our conversation; this will help with the transcribing of our meetings at a later date. It is up to you whether our discussions are tape-recorded. All meetings will take occur in a place of safety and at a date and a time that is convenient to you. Whether you decide to take part or not your care will not be compromised. **If you wish you will be able to check all typed transcripts from our interviews for accuracy.**

What are the possible disadvantages of taking part?

A few people might be upset by taking part, particularly if they have had personal experience of domestic violence. The researchers have experience of working with the survivors of domestic violence and will be sensitive to this. Support is also available from your midwife who is equipped and supported to provide help and advice to any pregnant women experiencing domestic violence. 24 hour help and advice is also available from the National Women's Aid free phone Helpline: Tel **0808 2000 247**.

What are the possible benefits of taking part?

We hope that the research will help midwives and midwifery education and maternity services to provide appropriate professional care. However this cannot be guaranteed. The information we get from this study will help midwives provide support to pregnant women who are living with domestic violence.

Will my taking part in this study be kept strictly confidential?

All information that is collected about you during the course of this research will be kept confidential. If we use any information from the study there will no details published that will identify you. No information collect from the postcard survey will have your name on it, so you will not be from it. All data will be destroyed at the end of the study. ***However, there are some things that I can't keep confidential; an exception to this would be a disclosure in the case of child protection for example if any information shared leads me to believe a child is at serious risk of harm then I am bound by the Nursing and Midwifery Council Code of Professional Conduct to inform the relevant authorities to prevent you or someone else being harmed.***

Will I be paid for taking part?

No, however, we would like to offer you a £10.00 voucher as a small 'thank you' for your participation in the study.

How will you keep my information secure?

To keep your information completely secure all of the tapes and relevant study information will be kept in a locked cabinet. Information, which is collected, about you during the research will be kept strictly confidential, only the research team will have access to them. All publications will have any identifying removed. **You will remain anonymous at all times.**

What will happen to the results of the research study?

The results of the research will be written up in a report for Avon Primary Care Research Collaborative (APCRC) who may use the findings to determine local policy. It will also be published in professional journals and presented at conferences to inform midwives, the maternity services and midwifery educationalists of the education and support that is necessary for routine antenatal screening to be introduced successfully.

Part 2

What will happen if I don't want to carry on with the study?

You are free to withdraw from the study at any time. However, any information already obtained may still be used.

What if there is a problem or you wish to make a complaint?

If you have a concern about any aspect of the study, you should speak to me and I will do my best to answer your questions, you can contact me on telephone 0117 32 88776. If you remain unhappy and wish to complain formally, you can do this by contacting Leigh Taylor at University of the West of England, telephone number 0117 32 81170

Who is organising and funding the research?

The research is being organised by researchers from the University of the West of England and North Bristol NHS Trust. Both members are experienced researchers, and one is also a midwife with experience of working in the field of domestic violence. The research has been funded by the Avon Primary Care Research Collaborative.

Who has reviewed the study?

Nearly all research carried out is looked at by independent group of people, called a Research Ethics Committee this is to protect your safety, rights, well being and dignity. This study has been reviewed and given favourable opinion by the Ethics committee at the University of The West of England.

What happens next?

If you are interested in taking part in the study, please discuss with the Freedom Programme Support Worker who will contact me. I will come to the centre and see you in person to discuss the study in more depth. If you decide you still want to take part, I will arrange a suitable date and time to come back to conduct the first interview at the centre. If you change your mind and decide you do not want to take part, you can let me know at any time before our first interview.

Thank you for taking the time to read this information sheet.

Contact details for further information

Kathleen Baird, Principal Researcher, Senior Midwifery Lecturer, School of Life Science, Glenside Campus, University of the West of England. BS16 1DD.

Tel: 0117 32 88776. E-mail: Kathleen2.Baird@uwe.ac.uk

Professor Debra Salmon, Professor of Nursing, School of Life Science, Glenside Campus, University of the West of England. BS16 1DD.

Tel: 0117 32 88468. E-mail: Debra.Salmon@uwe.ac.uk

Thank you for taking the time to read this information sheet. Please keep this copy. You will also be given a signed copy of the consent form to keep, if you decide to participate.

Appendix 5 Consent Form



University of the West of England

Consent Form for Women (Interviews)

A Five Year evaluation study of the 'Bristol Pregnancy Domestic Violence Programme' Supporting the Introduction of routine antenatal enquiry for domestic violence within North Bristol NHS Trust.

Name of Researchers: Debra Salmon, Professor of Nursing, University of the West of England, and Kathleen Baird, Principal Researcher and Senior Midwifery Lecturer, University of the West of England.

I confirm that I have read and understood the information sheet for the above study. I have also had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected.

I agree to my anonymous data being used for teaching purposes, conference and publications.

I agree to the use of audio tape recording.

I agree to take part in the above study.

.....
Name of participant

.....
Date

.....
Signature

.....
Name of person taking consent

.....
Date

.....
Signature

Appendix 6 Midwifery Focus Group Interview Schedule



University of the
West of England

Midwives Focus Group Schedule

A Five Year evaluation study of the 'Bristol Pregnancy Domestic Violence Programme' Supporting the Introduction of routine antenatal enquiry for domestic violence within North Bristol NHS Trust

- 1 Have any additional concerns emerged since the introduction of routine enquiry for domestic violence in the antenatal period
If yes, what are those concerns?
- 2 Do you think there are barriers to the introduction of routine enquiry, have these barriers changed since the initial period of introduction?
- 3 Are there any practical difficulties for you as the midwife or the woman in asking the woman about domestic violence? Have these difficulties changed across the period of their introduction?
 - Potential violence
 - Lone working
 - Support services
 - Support for the midwife
 - Partner always being present at each visit
 - Non English speaking women

Role of the midwife

- 4 Do you feel routine enquiry into domestic violence is an area of practice that midwives should take lead on?
- 5 Has asking a woman about domestic violence caused any offence to your clients?
- 6 Do you currently feel prepared and able to take on the task of routine enquiry?

Organisation, support and education

- 7 Do you think that the organisation of midwifery care, impacts on midwives ability to enquire: Are there any issues that are specific to team working, working alone etc, if yes, what where they?
- 8 Have you attended any further training or study days run by the midwifery service
How has this helped you in the role?
If none attendance at extra study days - why not?

- 9 Do you feel midwives require extra support to undertake routine enquiry into domestic violence, if yes, what are the mechanisms you consider necessary?
How far do you feel these are being met?
- 10 Are you aware of the supporting agencies that exist for referral and support for women?
- 11 Do you feel able to support women who are experiencing domestic violence in their relationship but do not want to leave their partner?
- 12 Can you describe any tensions that may be raised within your role when asking about domestic violence, particularly in relation to child protection?
- 13 Is there anything you would like to say, which has not been discussed?

Appendix 7 Women's Interview Schedule



University of the
West of England

An Evaluation Study of The 'Bristol Pregnancy Domestic Violence Programme' Introduction of Routine Antenatal Enquiry.

Indicative Content for semi-structured interview for Women

Introductions

Explanation of the study

Written consent (if not already obtained) and consent for use of tape recorder

Right to withdraw

Expectations (to include a discussion about motivations to participate in the study)

Confidentiality

Right to stop interview at any time

Contact Information

Biographical information

Age

Children & ages

How many times pregnant

Were their pregnancies planned?

Ages of children

Occupation

Whether they had maternity care at NBT? If not, where?

When did they first experience violence during their relationship?

Role of health professionals including midwifery

- 1 Do you think midwives should be asking about domestic violence?
- 2 When you were pregnant did the midwife ask you about domestic violence?
Did you find that acceptable?
- 3 Did you feel able to answer honestly, if not why not?
- 4 Were you asked about domestic violence in a sensitive manner?
 - If positive disclosure
 - Prompt, can you tell me how you experienced the support offered by the maternity services?
 - What was the outcome of that support?
 - If you had been experiencing domestic violence what may have prevented you from telling the midwife?

- Did you seek help for your injuries from any health professional eg GP midwife, A & E or were you admitted for any care during your pregnancy?
- Did you seek admission to the maternity ward

5 Have you discussed the abuse with any other health professionals?

If so who was that person eg family, friends, GP, practice nurse, health visitor, midwife A & E staff, and women's service groups such as Refuge, Woman's Aid or local support agencies. Do you get a sense that the services you were offered were communicating with each other on how best to help you?

6 Is there any ways that you feel the maternity services could be changed to improve your experience?

Is there anything else you would like to add to the interview?

Finally ensure ongoing support is available for participants following interview.

Appendix 8 Stakeholders Interview Schedule



University of the
West of England

An Evaluation Study of The 'Bristol Pregnancy Domestic Violence Programme' Introduction of Routine Antenatal Enquiry.

Interview Schedule - Stakeholders

Introduction

As you are aware, community midwives at North Bristol NHS Trust for the last five years have been routinely enquiring about domestic violence in pregnancy.

The purpose of the follow up study is to evaluate the impact on midwifery practice and to consider the issues of sustainability for the service when midwives routinely screen pregnant women for domestic violence.

- 1 What do you think are the likely implications of domestic violence screening for service management in the short term?
And in the longer term?
- 2 How do you perceive how these developments have impacted on service management in the short term?
And also in the longer term?
- 3 What kind of support and education do you think midwives might need to continue to develop good practice in this field?
- 4 Where do you think domestic violence sits in the overall service planning, given the trusts ongoing priorities?
- 5 Is there a way in which domestic violence could be connected with other priorities?
 - eg safeguarding children
 - other areas?

Are there any areas you feel that have not been discussed in this interview?



April 2011

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