A Five Year Follow-up Study of the Bristol Pregnancy Domestic Violence Programme to Promote Routine Enquiry

Abstract

Objective: a follow-up study to evaluate the degree to which practice changes identified in the 2004/ 2005 evaluation of the Bristol Pregnancy Domestic Violence Programme (BPDVP) for routine enquiry for domestic abuse have been maintained.

Methods: a multimethod approach was adopted, using a follow-up survey and focus groups.

Setting: an acute Trust within the South West of England.

Participants: 58 midwives completed the survey, 73% (n ¼ 36) of whom had taken part in the original study in 2004/2005. Eleven of those surveyed also participated in focus group interviews.

Measurements: participating midwives completed a 54-item questionnaire, where possible the questions were the same as those utilised in the original follow-up questionnaire. Similar to the previous study, the questionnaire was divided into a number of sections, including view of professional education, knowledge of domestic violence and abuse, attitudes and efficacy beliefs, barriers and support. The aim of the focus groups discussion was to obtain the overall views of midwives with the regard to the on-going implementation of routine enquiry. Frequency distributions for midwife responses in 2010 were compared with the corresponding frequency distributions in 2004/2005 and a statistical assessment of differences was performed using the w2 test of association.

Results: midwives have to feel confident in their abilities to ask about abuse and the findings from this study demonstrate that across the cohort there was a tendency to have an increase in confidence in asking about domestic violence. Midwives have to feel confident in their abilities to ask about abuse. The findings from this study demonstrate that across the cohort there was a statistically significant increase in

self-reported confidence in asking women about domestic abuse. In addition, there was a statistically significant increase in the degree of self-reported knowledge of how to deal with a disclosure of domestic violence when comparing the 2010 data with 2005 data.

Conclusions: results suggest that improvements in antenatal enquiry for domestic violence and abuse developed through the 2004/2005 BPDVP have improved over time, with the support of mandatory training. Nevertheless, barriers continue to exist, which include presence of a male partner and lack of face to face interpreting services, both these obstacles need to be addressed if all women and, in particular those who are most at risk of abuse are to be identified and supported.

Introduction

Over the last decade there has been a growing awareness for the need for health professionals to become more pro-active when responding to domestic violence and abuse. As a result, many health care organisations, both internationally and within the UK, have published guidelines promoting the introduction of routine enquiry (Royal College of Nursing, 2000; Department of Health. 2005a; Royal College of Midwives, 2006 World Health Organisation 2005; 2010). While the use of brief questioning by professionals is known to lead to higher rates of disclosure (Bacchus et al., 2002; Bacchus et al., 2007), there continues to be reluctance on behalf of some health professionals to embrace enquiry into domestic abuse; possibly because they lack the confidence and knowledge to do so (Department of Health 2005a, 2010; Lewis 2007, 2011).

Although there have been a number of international reviews establishing the effectiveness of training in identifying victims of domestic abuse (Wathen and MacMillan, 2003; Ramsay et al., 2002; Kataoka, et al., 2004; U.S. Preventive Service Task Force, 2004; Feder et al., 2009). None to date have undertaken follow up research to establish the longer term outcomes for midwifery services, or women who use maternity care. The Bristol Pregnancy and Domestic Violence Programme (BPDVP) was developed in 2004/5, and aimed to equip community midwives with

both the knowledge and confidence to effectively enquire about, and respond to, domestic violence in the antenatal period. The original intervention included a feasibility study, to evaluate the effect of this educational programme on midwives' knowledge, skills, attitudes and implementation of routine antenatal enquiry for domestic violence in pregnancy. Outcomes from the formal evaluation, suggested that the programme was positively received, particularly in relation to an increased awareness and confidence in dealing with domestic violence. It was also associated with improvements in knowledge, attitudes and efficacy at six months post introduction. As a result of these findings the BPDVP was adopted as an exemplar of best practice within the UK, resulting in the training being cascaded nationally through a 'train the trainers programme' (Department of Health, 2005a).

This paper reports on a five year follow-up study, which aimed to measure the degree to which progress identified at practitioner level in 2004/2005 (in relation to knowledge, attitudes and efficacy) have been maintained in 2010. Analysis is underpinned by questionnaire data from midwives in 2010; with 2004/5 follow-up data used as the comparator. In addition, focus group data is presented from community and hospital based midwives to explore in-depth the implications for practice. The focus of this paper is to discuss interventions aimed at women, rather than the discussion of perpetrator programmes.

Literature review

Domestic abuse during pregnancy is now recognised as a global health issue that has the potential to harm a woman and her unborn child (O' Reilly et al., 2010). A recent review examined the prevalence of physical violence and abuse during pregnancy in economically advanced and disadvantaged countries. Prevalence rates were found to range from 0.9% to 30.0% and 1.3% to 12.6% respectively. However, researchers were subject to a number of restrictions in the economically disadvantaged countries, which may account for the identified differences in prevalence rates (Taillieu and Brownridge 2010). In addition to the human costs, research also revealed that violence has huge economic costs, including the direct costs to health, legal, police and other services (Walby, 2004, 2009).

Despite the prevalent nature of abuse, there has been, and continues to be some reluctance amongst professionals to enquire about, or respond to, domestic violence within personal and family relationships. This reluctance has been attributed to health professionals' lack of awareness, lack of training and a lack of attentiveness to deal with positive disclosure of domestic violence. In addition the fear of offending women, time constraints within clinical practice or practitioners own biases regarding who is 'at risk', often results in selective rather than routine screening (Bacchus et al., 2007; Salmon et al., 2006; Bohn et al., 2004). Indeed, clinicians may remain unclear about their role in addressing domestic violence, and find it difficult to listen to or understand a woman's experience on disclosure (Bacchus, et al., 2002; O'Reilly, 2007; Department of Health, 2010). Despite this, health care professionals are in a unique position to identify and offer support to women who are experiencing domestic abuse during pregnancy and influence wider public attitudes (O'Reilly et al., 2010).

Irrespective of the on-going debate as to whether pregnancy acts as a trigger for domestic abuse, or exacerbates existing abuse, the violence itself causes physical injuries and psychological trauma to the pregnant woman and serious threats to the unborn child (Helton et al., 1987; Gazmararian et al., 1995; Taillieu and Brownridge, 2010). Health consequences include: recurrent miscarriage, low birth weight, fetal injury, stillbirth, and maternal death (Helton et al., 1987; Bullock and McFarlane 1989; Mc Farlane et al., 1992, 1996; Hunt and Martin 2001; Valladares et al., 2002; Neggers et al., 2004; El Kady et al., 2005; Faramarzi et al., 2005; Fanslow et al., 2008). The most serious cases in the UK were identified in the 'Centre for Maternal and Child Enquires Report' (CMACE) (Lewis, 2011) which highlighted that between 2006 – 2008 of the fifty deaths reviewed, thirty four of the cases where women had died, domestic violence had been a significant feature of their experience. For 11 of the 34 women, violence was the actual cause of death and women, especially from non-English speaking backgrounds were particularly at risk. In most of these cases the perpetrator was the woman's partner.

Lessons learned from enquiries such as this have led to recommendations which included routine enquiry for all pregnant women and the development of clear policies for non-English speaking women. In the UK, the maternity services have been at the forefront of introducing routine enquiry for domestic violence (Bacchus, et al., 2007) with an increased focus on pregnancy associated deaths (Martin et al., 2007; Lewis, 2007, 2011) which occur during pregnancy and in the postpartum period, and are referred to as maternal deaths.

Internationally while there is some evidence of good educational practice; this is not universal, as the provision of domestic abuse training for health professionals, including midwives, continues to be inconsistent and often poorly integrated (World Health Organisation 2005; Charles and Perreira, 2007; Farid et al., 2008; 2009; Department of Health, 2010). The main cause for concern is that clinicians will be expected to carry out routine enquiry, without undertaking an evaluated training programme and without access to domestic violence services to refer women on to.

There continues to be an on-going debate about the effectiveness of routine enquiry: for example, in the UK, it has been recently suggested that with the exception of maternity care, there is insufficient evidence to support routine enquiry for all women in health care settings. Instead, the promotion of safe enquiry, with a low threshold for asking women about abuse, linked to safe referral to an appropriate service has been advocated (Department of Health, 2010). The benefits of universal rather than selective enquiry are that it avoids the stigmatisation of women and prevents the labelling of particular groups. It also provides all women with the opportunity to disclose either at the time of asking or at a later date, once the relationship with the midwife has been established. Routine enquiry can only be implemented when it is accompanied with a strategy which includes; evidence based guidelines, evaluated training for all staff, and safe systems of working. Safe and confidential documentation, lone working policies, interagency working and referral

pathways are crucial to appropriate delivery of care (Salmon et al., 2005; Department of Health, 2010).

The purpose of this follow-up study was 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 analyse the degree to which changes identified at practitioner level in 2004/5 (in relation to knowledge, attitudes and efficacy) had been maintained, to understand the impact on midwifery practice and identify the longer term issues of for service development.

Subject and methods

Sample

Participants and recruitment

Midwives were contacted through managers. Seventy two were invited to take part, six were subsequently excluded due to long term ill health and absence from work, of the remaining sixty six midwives, fifty eight midwives (n=58) completed the questionnaire. The final sample included both the original community midwives who had taken part in 2004/5 and those who had been subsequently recruited or had transferred into the Trust. Of these, a purposive sample of eleven took part in two focus group interviews.

Research Design and measures

The methodological approach adopted for this follow-up study included both process and outcome data from midwives. This meant adopting quantitative and qualitative approaches in the form of semi-structured questionnaires and focus group interviews. Understanding the emic perspectives was an important aspect of this work, collecting the views and experiences of midwives in relation to routine enquiry for domestic abuse allowed for detailed contextualisation of the quantitative findings from a practitioner perspective. This created synergy between the two

elements of both education and practice and made it possible to create a more sensitive relationship between the overall evaluation of an educational programme and on-going practice (Pawson and Tilley, 1997).

The 58 participating midwives completed a 54-item questionnaire. Midwives were asked to reflect on the content and learning outcomes of the original training and subsequent mandatory follow up study days. Perceptions around practice were explored in more depth within the focus group interviews.

Measures

The questionnaire was divided into a number of sections, including: views of professional education, knowledge of domestic violence and abuse, attitudes and efficacy beliefs, barriers, and support. Views of professional education, were measured using a four point scale (none at all, minimal amount, moderate amount and great deal) to assess previous coverage of domestic violence. The category 'unsure' was also included, if respondents were unable to remember. Knowledge was measured via multiple choice questions, assessing estimated rates and types of risks, effects of domestic violence and the role of support agencies.

In the questions relating to attitudes to domestic violence and routine enquiry, midwives were presented with statements and were asked to use a five point Likert scale, ranging from "strongly disagree" (1) to "strongly agree" (5). The statements related to a number of stereotypes associated with ethnic minority groups and women's responsibility for violence, other questions related to the roles of health professionals in routine enquiry. Individual questions were analysed, to assess strength of agreement. Midwives also rated their skills of asking about, and dealing with, domestic abuse by responding to efficacy statements. The same "strongly disagree" to "strongly agree" five point Likert Scale was used, coupled with statements related to perceived confidence in their knowledge base, support structures, and personal beliefs about the role of midwives in identification of abuse.

Data Collection

Data collection was undertaken by two academic researchers in two phases. Phase one was the quantitative aspect, focusing on 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 questionnaire and using similar measurement scales. As previously indicated, areas 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. Phase two included focus group interviews with eleven midwives. Ten of the midwives were based in the community, one in the antenatal ward in the hospital. The aim of focus group discussion was to obtain the overall views of midwives with regard to the introduction and on-going implementation of routine enquiry. It was also possible to analyse the experiences of midwives, identifying opportunities and barriers to practice and implications for future development.

Ethics

All those asked to participate in the research were given 14 days to consider their involvements participation. This was explained verbally and reinforced in written information sheets. Ethical considerations and research governance was addressed throughout the process, including, informed consent, voluntary participation, confidentiality and anonymity (Department of Health, 2005b). Particular attention was paid to issues of safe guarding, particularly during the focus group interviews. This was in accordance with the Nursing and Midwifery Council Code of Professional Conduct (2008) which highlights the requirement to disclose information about 'risk of harm to children' or 'vulnerable adults'. Ethical review and approval was awarded through the LREC and the UWE, Bristol Research Ethics Committee. Pseudonyms have been used to protect the identity of the participants.

Data Analysis

Midwife questionnaire data was independently double-entered into SPSS version 19.0 and frequency cross-tabulations performed to assess data entry accuracy followed by scrutiny for face-validity. Frequency distributions for midwife responses in 2010 were compared with the corresponding frequency distributions in 2004/2005 and a statistical assessment of differences was performed using the chi-square test of association. The chi-square test of association is an asymptotic test and the quality of statistical conclusions drawn from its application is reliant on expected cell frequencies. An exact test, the Fisher-Freeman-Halton test, which is an extension of Fisher's exact test for a two by two contingency table was also used. In all cases the same statistical conclusions were obtained from asymptotic and exact test when using a contemporary nominal significance level of alpha = 0.05. The magnitude of specific contrasts between the 2005 data and 2010 data was quantified using the odds ratio and its 95% confidence interval. Qualitative data collected from the interviews and questionnaires was analysed to identify the key emergent themes (Strauss and Corbin 1998). This allowed identification of factors that have contributed to or hindered the successful introduction of routine enquiry. NVivo 8 was employed a qualitative data management package to support consistent treatment of the data.

Findings

A profile of those midwives who took part

Three (6%) of the participating midwives had been qualified for less than five years, 15 (29%) qualified between five and 15 years, three (6%) between 15 and 20 years and 31 (60%) more than 20 years. It is estimated that 36 (73%) of the 2010 respondents took part in the original study; of those who responded 14 (27%) held a certificate, another 15 (29%) held a diploma and a further 15 (29%) held an honours degree. 23 (44%) covered some form of domestic violence education in their pre-registration training; 37 (71%) of the midwife population had attended update sessions as part of their mandatory programme either annually or biannually. Updates included: awareness raising; policy development; referral pathways, and documentation, with particular emphasis on women's safety. 49 (96%) of the

midwives taking part self- reported some level of professional experience in dealing with domestic abuse, with four (7%) reporting a great deal of experience, 19 (37%) reporting a moderate amount, and 26 (51%) reporting a minimal amount.

Comparing 2005 with 2010: Reflecting on Domestic Violence Training in 2004/05 and the impact on practice

The following discussion is based on the results outlined in table 1 below. Participants were asked to reflect on the domestic training in 2004/2005 and the effect it had on improving knowledge of domestic abuse in general, indicating a great deal; a moderate amount; a minimal amount; not at all, or unsure. Results demonstrated that there is no marked changes in response profile between 2004/5 and 2010, suggesting improvements in knowledge have been maintained.

INSERT TABLE 1 HERE

Midwives were also asked to report on the effect the training had on their knowledge of screening for domestic violence. Data suggested there was a tendency to an increase in knowledge of screening for domestic violence when comparing 2010 with 2005. In 2010, 61.0% reported "a great deal" compared with, 42% in 2005 [and this difference is borderline statistically significant, $p = 0.059$]. 2010 respondents were also 2.1 times more likely to report "a great deal" than those in 2005 [odds ratio = 2.1, 95% confidence interval = 0.99 to 4.66].

It is important to analyse the impact of the training on knowledge of 'how to ask'. Results suggested that there was an increase in knowledge in how to enquire about domestic violence and abuse when comparing 2010 with 2005. In 2010, 61.0% reported "a great deal" compared with 37% in 2005 [$p = 0.013$]. Midwives in 2010 were therefore, 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]. In terms of those midwives reporting 'not at all', there were 0% in 2010 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. As the data in Table 1 illustrates, across the cohort there was a tendency to report an increase in confidence in asking about domestic violence, following training in 2005. None of the midwives in 2010 reported "not at all or unsure" compared with 26.8% in 2005 [$p < 0.001$]. 2005 respondents were 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]. However, asking the question is not enough; midwives need to feel knowledgeable and confident in their abilities to respond positively when women disclose abuse. Results identified that 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 were therefore 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] and 0% in 2010 reported "not at all or unsure" compared with 15.5% in 2005 [$p = 0.007$].

There was also a tendency of increased confidence in 'how to deal with a positive disclosure' when comparing 2010 with 2005. 39.5% in 2010 reported "a great deal" compared with 21.1% in 2005 [$p = 0.034$], with 2010 respondents 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 a wide range of agencies. For this to happen successfully practitioners need to have knowledge, understanding and confidence in working with relevant agencies. There was a tendency to an increased knowledge of how to work with other agencies when comparing 2010 with 2005, 44.2% in 2010 reported "a great deal" compared with 19.7% in 2005 [$p = 0.005$], with those 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] and 0% in 2010 reporting "not at all or unsure" compared with 19.7% in 2005 [$p = 0.002$]. Similarly, in 2010 nobody, (0%)

reported “not at all or unsure” compared with 29.6% in 2005 [p < 0.001] when asked to assess their level of confidence in working with other agencies.

The data in Table 1 suggests that across the cohort, the training was perceived to have had a positive on-going impact on practice, comparing 2010 and 2005 data. In 2010, 65.9% reported “a great deal” compared with 42.9% in 2005 [p = 0.016], with 2010 respondents 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].

Influences on ability to ask the question

The numbers of times midwives had the opportunity to ask women about domestic abuse were important to support the identification of women at risk and offer appropriate care. The following cross-tabulation is based on the percentage of times midwives were able to ask about domestic violence. The reported levels have increased when comparing 2010 with 2005 data. In particular, in 2005 25.4% reported that they are only able to ask up to 20% of the time, whereas all those surveyed in 2010 reported being able to enquire in more than 20% of cases (p < 0.001). In 2010 only 3.8% reported being able to routinely enquire in up to 40% of cases compared with 45.1% in 2005 (p < 0.001), while in 2005 respondents were 20 times more likely to report a percentage of less than 40% compared with 2010 [odds ratio = 20; 95% confidence interval, 4.5 to 90]. In 2010 41.5% of respondents claim to be able to routinely enquire at least 80% of the time compared with only 12.7% in 2005 [p < 0.001]. 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 to asking

Midwives were asked to consider the barriers to routine enquiry, the results are summarised below in Table 2. In contrast to 2004/5, more than of half of midwives believed that personal experience of domestic violence (79%), concern about on-

going relationships with women (55%) and perceived lack of organisational support (60%) **were no longer** barriers to effective enquiry. However, nearly all (95%) considered presence of a partner and language barriers (84%) as the main obstacles.

INSERT TABLE 2

Findings from the focus groups with midwives

Eleven midwives participated in the focus group interviews. The interviews were held on two separate occasions, attendees had a mean average of ten years' experience. The main themes to emerge from the data focused around: confidence in asking women about domestic abuse and coping with disclosure.

Confidence in asking pregnant women about domestic abuse

Midwives reported feeling 'quite confident' with reference to asking women about domestic violence and abuse. It was also considered as an integral part of their role, and this had resulted in a sense of pride:

> *Yes I think midwives take a bit of pride in it, in that we are now asking these questions and we're going to be able to help and provide the sort of support they need (***midwife 2).**

Since the introduction of routine enquiry in 2004/2005 they believed that they had developed a lot more confidence in the role:

> *Yes, I would say that midwives feel much more confident in asking now* **(midwife 5).**

Midwives within the UK are now expected to ask women several times during the antenatal period about their wellbeing and mental health. Some of the clinicians considered that this change in practice provided them with additional opportunities to explore further about domestic abuse when women described themselves as feeling unhappy or depressed:

> *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).**

As the midwife - woman relationship developed, the midwives reported that women sometimes felt able to share their experiences:

> *And again perhaps if you're asking the question again they may not have told you at 12 weeks but they may actually tell you at 36 weeks because of the relationship that you have built up with them* **(midwife 1).**

However, when an enquiry resulted in a positive disclosure from a woman it was experienced as emotionally demanding:

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

The midwives articulated some anxieties about responding effectively to a positive disclosure particularly in relation to their own workload demands; time constraints and their own emotional capacity to deal with a positive disclosure. Some minor frustrations were also articulated when 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)**.

The midwives also acknowledged the emotional burden to this work and discussed

some of the strategies they had developed to help them cope. Including, talking it through with colleagues and relying on supportive relationships at home. Nevertheless, practitioners also articulated that they sometimes continued to be 'troubled' about a woman's well-being following a disclosure even with support. In spite of this, midwives considered offering support to the women was vital; this included listening to their stories, offering emotional support and offering to refer the women onto the relevant women's support agencies.

Barriers

On-going barriers to routine enquiry were identified as similar to those in the original study. These included, continued presence of partners, lack of provision for women whose first language was not English and organisational barriers such as lack of privacy and time. This said, midwives reported being committed to routine enquiry, highlighting innovative strategies to facilitate discussions with women: placing domestic violence posters around the clinics, often in the toilets and advising women to place a blue sticker on the urine pot if they wished to speak to the midwife about domestic abuse in privacy:

> *We all know that domestic violence 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 do the urine samples, in the women's toilets* **(midwife 7).**

Concern and frustrations were expressed about the inability to enquire when partners were present, particularly when they attended all antenatal appointments. It was considered unsafe practice to ask women about domestic violence when they were accompanied by a partner. However, several midwives reported developing

strategies to cope with the continuous presence of a partner. These included purposely placing 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 midwife would ask the woman about domestic violence. Although the midwives did acknowledge such 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).**

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

Non English speaking women

All those interviewed identified challenges when women did not understand or speak English; this was a particular difficulty when midwives had not been given information about the woman prior to the appointment:

> *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 too, for example those women who are perhaps fairly good at English themselves, or some that are British born* **(midwife 5).**

While language line was available during consultations, this was viewed as an unsuitable way to ask about abuse. The presence of an interpreter was felt to be the most acceptable approach to asking however, concerns were raised in relation

interpreters who lived within the local community or knew the family personally. In addition, women were often accompanied by a partner or a family member who acted as the interpreter between the midwife and the woman:

> *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).**

> *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).**

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 provision of leaflets in a range of languages, an understanding of local specialist services and the use and availability of trusted interpreters.

Discussion

This is the first UK based follow up study to evaluate the outcomes of a maternity educational intervention in domestic violence enquiry five years on from its introduction. Outcomes from the study included midwives abilities to ask women about domestic abuse, feeling supported and appropriate referral. Five years on, the statistical evidence suggests that the skills, knowledge and confidence associated with antenatal enquiry for domestic abuse developed through the 2004/5 BPDVP programme have been maintained, with the support of mandatory training. However, it was midwives attitudes in relation to their role in domestic violence that had changed significantly, with all (100%) of those surveyed reporting that enquiry was now considered a fundamental part of their role. In addition, interviewees reported a strong sense of pride in supporting women, and providing opportunities for women to appraise their abusive relationships. As well as exploring alternatives

with advice from specialist domestic violence agencies. This was evidenced by the increased numbers of opportunities midwives had created to ask women.

While results suggest midwives had, gained confidence in asking women about abuse and in responding to positive disclosure, a numbers of barriers were also identified. Similar to those in 2005, these included the continued presence of a partner; lack of appropriate interpreter services for non-English speaking clients, and a lack of privacy in some clinical areas. Midwives also expressed some anxieties around time constraints and their capacity to respond to a positive disclosure alongside other workload demands. Alongside previous studies, this study demonstrated that the most significant barrier to routine enquiry about domestic abuse is the presence of a partner (Taket 2004; Salmon et al., 2005). 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 acted as an interpreter. Data from midwives suggested the potential benefits for women of having at least one appointment with the midwife alone. Indeed, 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, policymakers and professional bodies.

There is no doubt that asking about a history of domestic abuse is a challenging and difficult subject for many health professionals including midwives. However, due to the intimacy of the relationship which can sometimes develop between a woman and midwife, midwives may be the first professional that a woman may feel able to disclose her situation too (Price et al., 2007). Similarly, 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 (Taket et al., 2004; Salmon et al., 2006; Bacchus et al., 2007; O'Reilly et al., 2010). Antenatal and postnatal care provides a rare opportunity for midwives to build up a rapport with

the women in their care where women may feel safe enough to discuss a history of abuse (O'Reilly et al., 2010). Indeed, it has been suggested that multiple enquiry during pregnancy further increases the opportunity for disclosure (Covington, et al., 1997). Taket et al., (2004) proposes 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.

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Table 1

Question	Cohort	A great deal	Moderate Amount	Minimal Amount	Not at all	Unsure	N
Effect on general knowledge of	2010	62.8	34.9	2.3	0.0	0.0	43
domestic violence following training	2005	52.1	45.1	0.0	2.8	0.0	71
Effects on knowledge of screening	2010	60.5	34.9	4.7	0.0	0.0	43
following training	2005	42.3	48.3	0.0	8.5	0.0	71
Effect on knowledge of asking	2010	60.5	34.9	4.7	0.0	0.0	43
Following training	2005	36.6	45.1	0	18.3	0.0	71
Levels of confidence in asking about	2010	58.1	34.9	7.0	0.0	0.0	43
domestic violence following training	2005	36.6	36.6	0.0	25.4	1.4	71
Levels of knowledge in responding	2010	46.5	44.2	9.3	0.0	0.0	43
to domestic violence following training	2005	21.1	63.4	0.0	14.1	1.4	71

Levels of confidence in responding to domestic violence following training	2010	39.5	48.8	11.6	0.0	0.0	43
	2005	21.1	60.6	0.0	15.5	2.8	71
Overall impact of the training on practice	2010	65.9	31.8	2.3	0.0	0.0	44
	2005	42.9	41.4	2.9	12.9	0.0	70

Table 2

Question	Percentage					
	A great deal	A moderate amount	A minimal amount	Not at all	Unsure	N
Lack of organisational support	3.6	10.9	25.5	60.0	0.0	
Personal experience of domestic violence	0.0	3.6	17.9	78.6	0.0	
Concern about personal safely	0.0	16.1	39.3	44.6	0.0	

Lack of resources	1.8	16.1	41.1	39.3	1.8
Concerns about ongoing relationships	3.6	10.7	30.4	55.4	0.0
Presence of partner	82.5	12.3	3.5	1.8	0.0
Language barriers	45.6	38.6	10.5	5.3	0.0