



Domestic Abuse - Pregnancy and the Early Years PROTOCOL

Developing Integrated Children's Services in Highland - Implementing Hall4

June 2006

Contents

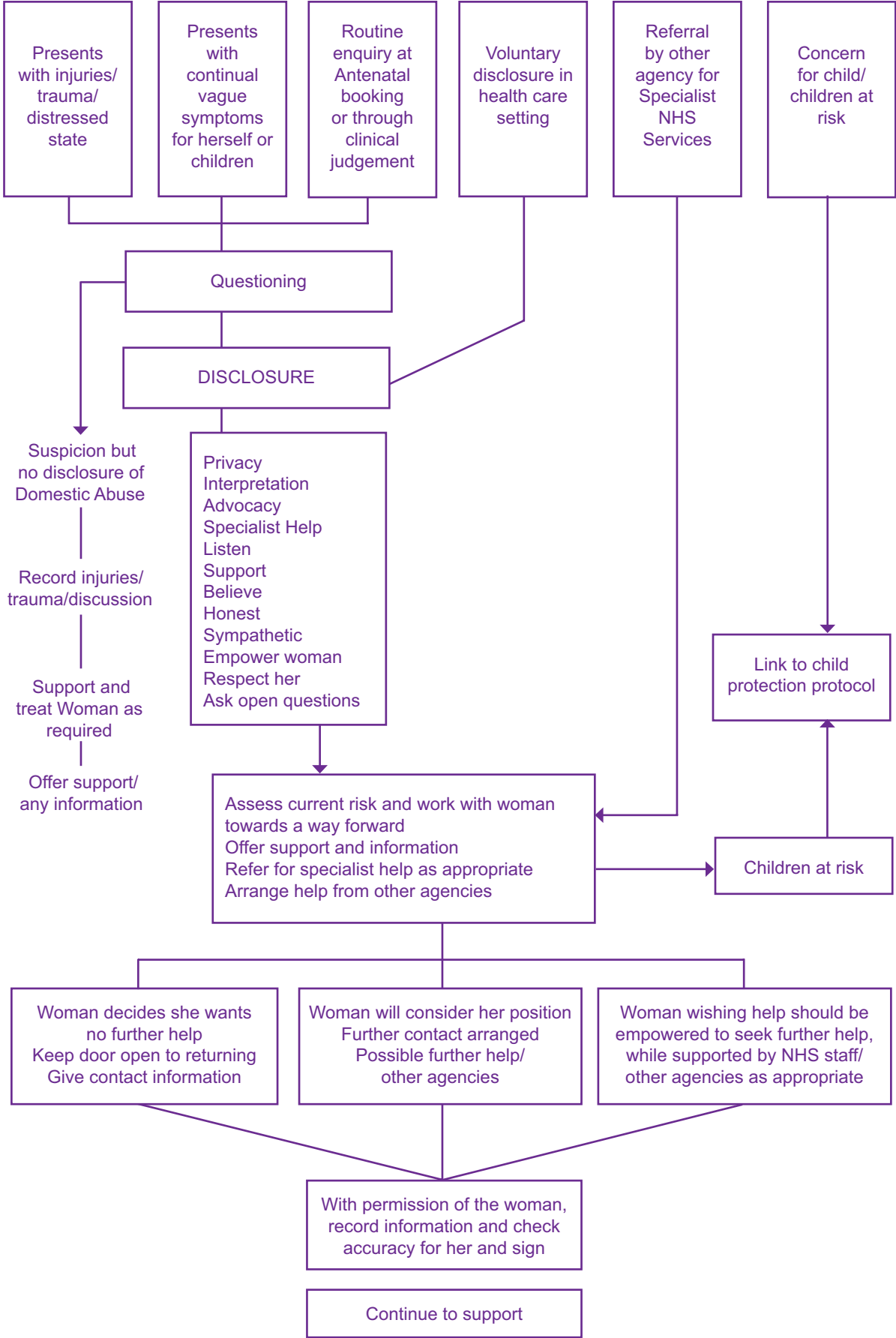
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Background

In response to the Scottish Executive Guidance 'Responding to Domestic Abuse: Guidelines for Health Care Workers' 2003 and the 'Confidential Enquiry into Child and Maternal Health - Why Mothers Die' 2004, NHS Highland reviewed and developed the 'Protocol on Domestic Abuse for Health care Workers'. This now includes a section on pregnancy and the early years and illustrates the implications of domestic abuse on women in pregnancy and their children. The full document forms the result of that work is available on NHS Highland's website, under Policies.

2. Care Pathway

Care Pathway for Responding to a Woman Experiencing Domestic Abuse



3. Introduction

Far from pregnancy being a time of peace and safety, over a third of women experiencing domestic abuse from their male partner have reported that the abuse began during pregnancy.

Pregnancy does not offer any protection for women in abusive relationships and because physical abuse at this time is generally focused on the abdomen, breasts and genitals it can be the cause of repeated miscarriage, antepartum haemorrhage and premature labour. The links between domestic abuse and adverse pregnancy outcomes suggest that maternity care providers should assume a proactive role in identifying the prevalence of and implications for women and children.

Community midwives provide women with the majority of their antenatal care and therefore have the opportunity to establish good relationships by offering support and opportunities to empower women to escape abuse.

Knowledge and confidence to effectively enquire about domestic abuse can only be achieved through adequate training and support for staff. Regular updating and clearly identified leadership, supervision and support is essential for successful implementation of routine enquiry.

All practitioners required to undertake routine enquiry must be made aware of counselling and occupational health services supervisory mechanisms and support arrangements available within their organisations. There will also be a number of staff who are themselves experiencing abuse. Particular sensitivity must be shown to the difficulties they may face through undertaking this work and where necessary appropriate workload arrangements made.

4. Routine Enquiry

Routine questioning about abuse which may be physical, sexual or emotional (including financial) must be included at booking or at another opportune time during the antenatal period. Women must always be given the opportunity to be seen on their own at least once during pregnancy to enable disclosure.

It is important that all staff have adequate training in asking open-ended questions, talking with women in a sensitive and appropriate way and in managing the ensuing discussion effectively.

Inappropriate questioning may further reinforce a woman's feelings of powerlessness and vulnerability.

The provision of a quiet, safe and private environment together with good principles of talking with women experiencing abuse is required (see table 1). Women should always be asked if they feel comfortable with that place.

Translation Services

Access to translation services must be sought and all written materials made available in a range of languages including information about specialist services. If Interpreting services are required they are available in two ways within NHS Highland.

If an interpreter is required immediately it is advisable to contact the National Interpreting Service. This is a telephone interpreting service and the cost of the call and the interpreter are paid for from a single NHS Highland Budget. This service can be contacted on: 0800 028 0073 or (020 7626 2929 from mobiles) using the ID Number: 269301

Face to face interpreters can be booked in advance by calling Global Language Services Ltd who have been commissioned by NHS Highland and Highland Council to provide interpreting on 01667 454658.

Table 1 - Talking with Women

- Listen carefully. The woman may talk around the subject before getting to the point. Often requests for help are veiled or oblique and must be identified and amplified. If necessary, clarify that you have understood she is talking about domestic abuse.
- Believe her and say so.
- Reassure her that she was right to disclose. Be careful not to make her feel inadequate for not having sought help sooner: remember she may have sought help and been rebuffed. Reaffirm that she is a valuable person and that her needs are as important as anyone else's.
- Affirm the strength the woman has shown in enduring continued abuse and the courage she has displayed in asking for help. Acknowledge her experience and accept her evaluation of the danger of her current situation. Stress that she does not have to continue in her situation and that you want to help.
- Be honest and sympathetic. Explain why questions are being asked so that the woman has a firm focus, and avoid making her feel judged or defensive. At this stage it is useful to ask direct questions that require direct answers. Under no circumstances should the woman be led to believe that she is in some way to blame for what has happened.
- Let her control the discussion. Talking about her abuse may be very difficult, so allow her to go at her own pace. She may only reveal a proportion of the abuse she has experienced.
- Respect confidentiality. Remind the woman that anything she chooses to tell you will be confidential, but also explain the limitations of your confidentiality, for example if there are any children or unborn children involved who may be at risk from the abuser.
- Be constructive. Following disclosure, whilst being supported and believed is most important, the woman may need accurate information on the law, benefits, local resources and local support groups. A worker would not be expected to know all of these and should offer to make contact with services that may help. A directory of relevant services available in Highland can be found on the NHS Highland intranet. Be realistic about what help can be offered and be aware that giving inaccurate information such as wrong telephone numbers, addresses or times of opening could further discourage or endanger the woman.
- Be prepared to deal with the disclosure over several meetings.
- Avoid saying 'why don't you?' – It's never that simple.
- Don't try to solve everything. Every woman has the right to make her own decisions. She should be allowed to ignore the advice of health care workers if she wishes, or cease contact, without being judged. Women whose lives have been controlled by abusive men need time and space to learn to take control of their own lives again.
- Make sure she knows she can approach NHS staff again in the future.

Responding to Domestic Abuse: Guidelines for Healthcare Workers Scottish Executive 2003

5. Suspicion of Abuse

Women may present at their local surgery or Accident and Emergency (A&E), with a variety of symptoms which may indicate a need for help. If abuse is suspected, the role and responsibility of the health care professional is to provide helpful information about the services and resources available locally, and to refer her to appropriate agencies such as Women's Aid, housing or benefits agency. A list of local contacts should form part of the hand held record of the woman and be given to all women at booking to avoid any notion of stigma or discrimination.

When a woman who has experienced domestic abuse also presents with mental health or substance misuse issues, it can often be difficult for health care providers to support someone with such complex needs. Multi-disciplinary and inter-agency working are essential when providing women with appropriate care to meet their needs and health care providers should ensure that together with local service providers both statutory and voluntary they provide a seamless and effective response to a woman seeking help.

Table 2 - Indicators related to maternity care

- Late booking.
- Unplanned or unwanted pregnancy.
- General unhappiness about the birth of the baby.
- Poor/non attendance at antenatal clinics.
- Frequent visits with vague complaints or symptoms 'of an unknown clinical cause' and without evidence of physiological abnormality.
- Recurring admissions usually for reduced foetal movements/abdominal pain/investigations of UTI (although these are common in pregnancy).
- Repeat presentation with depression, anxiety, self harm and psychosomatic symptoms.
- Minimisation of signs of violence on the body with vague explanations for injuries.
- Poor obstetric history with a higher incidence of miscarriage, termination, intrauterine growth retardation/low birth weight, fetal injury, stillbirth, pre-term labour/prematurity.
- Recurrent sexually transmitted infections.
- Non-compliance with treatment regimens/early self discharge from hospital.
- Constant presence of partner at examinations, who may answer all the questions for her and be unwilling to leave the room.
- The woman appears evasive or reluctant to speak or disagree in front of her partner.
- The woman may talk excessively when her partner is present and become very quiet when she is alone.
- On admission to hospital the woman has very little personal belongings including toiletries, underwear, nightwear and money for the telephone/newspapers. Also, very little money for the baby.
- Evidence, or a history of postnatal depression.
- Postnatally, removal of perineal sutures.

The Confidential Enquiry into Maternal And Child Health 2004,
Responding to Domestic Abuse: Guidelines for Health care workers, Scottish Executive 2003

6. Disclosure of Abuse

A woman who makes a disclosure of abuse requires adequate support and information given in a non-judgemental and supportive way. She needs to be given advice as to where she can get help and be provided with continuing support whatever her decisions may be. Health care providers should remember that their role should be one of enquiry and information giving and does not extend to in-depth support that other agencies can offer. However, their role is fundamental to the process of disclosure through appropriate questioning in a safe environment.

Women with known significant features of domestic abuse should not be regarded as 'low risk' and should be offered multi-disciplinary care to give access to a range of services that may be required. This may include admission.

It is important to remember that leaving an abuser is most often not a single act but a process. Many women face multiple obstacles in escaping abuse, often the same obstacles that make disclosure difficult. The one thing that she may have control over is in whom she confides, and may take many months to disclose, if at all. The woman may also withdraw, at a later date, what she has said during disclosure.

Remember that a woman is often the best judge of how to minimise risk to herself and/or her children, and she may believe that at a particular point in time staying is a safer option than leaving.

7. Keeping Children Safe

It is important that health care workers consider the risk to the unborn child and also to any other children in the household.

“Domestic abuse can have a direct and indirect impact upon children (including unborn children), and is likely to have a damaging effect on the health and development of children.”

Highland Child Protection Policy Guidelines,
Highland Child Protection Committee, Nov 2003

All women should expect the information that they share with healthcare workers will be treated as confidential. It is therefore important, when discussing abusive situations with women, that they are made aware at the beginning of the consultation, that any information they wish to divulge, but which may highlight that a child is at risk, will be shared in a controlled and confidential manner with other health professionals or agencies.

Disclosure of domestic abuse must give rise to concerns for any children that live within such a household; this includes concern for the unborn child. Concerns for any children must be based on a risk assessment which will need to include;

- seeing the child/children;
- assessing their development stage, understanding the family context in which they live; and
- awareness of those persons who care for the child/children.

Such a risk assessment may need to include other health professionals, and referral to social work colleagues or the police.

If it is suspected that a child/children are considered to be at risk of abuse or neglect then the Highland Child Protection Committee Policy Guidelines should be consulted. Each health care worker has access to a Designated Person for Child Protection within their working environment, who can offer clinical supervision and advice on the appropriate procedures to follow.

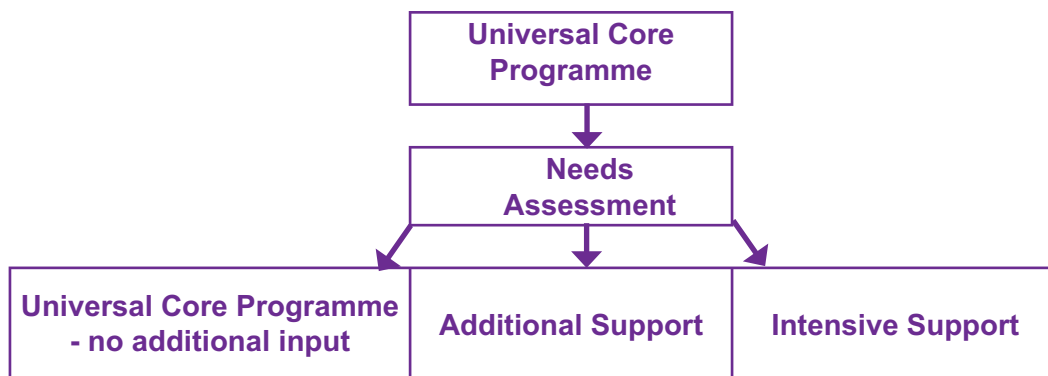
“All staff must act on any suspicion of abuse or neglect of a child.”

Highland Child Protection Committee – Policy Guidance 2004

When any children are thought to be at risk, including unborn children, health care workers will need to contact their local Designated Person for Child Protection who can offer advice, guidance and support to staff. All professionals should have knowledge and understanding of their local child protection procedures. The role of social services have a statutory responsibility for children at risk. They should not work in isolation and should always ask for advice and assistance if they have any concerns.

Work is currently being undertaken in Highland to develop a multi-agency common/integrated assessment framework to assist all agencies that work with children and families to identify those requiring additional support. This will mean providing a re-focused core universal service for all children whilst identifying those with particular health, development or social needs and ensuring agencies work together to ensure that resources are in place to meet their individual needs.

7.1 Example of Integrated Assessment Framework (Hall4)



Close liaison and effective handover with the family's health visitor and GP must be maintained throughout pregnancy and the postnatal period to ensure appropriate referrals, provision of information and sources of further help and support.

8. Follow-Up

The Confidential Enquiry into Maternal And Child Health 2004 documents all of the causes of maternal death in pregnancy and the first year following birth, reports that 14% of the 391 deaths were due to domestic abuse.

It is important to remember that if a pregnant woman is being abused, this may not stop once the baby is born, in fact it may escalate. The greatest risk of moderate to severe injury is after the baby is born.

“90% of children in violent homes will either be in the same or next room when violence occurs and 60% of children who live with domestic abuse are likely to have been abused by the same perpetrator.”

Responding to Domestic Abuse: Guidelines for Healthcare Workers,
Scottish Executive 2003

Domestic abuse can have a damaging effect on the health and development of children and it is vital health care workers remain proactive and vigilant to their needs. Children can experience not only emotional and physical disturbance but also a disruption to their lifestyle.

These indicators may include:

- Feelings of anger, guilt, isolation, fear
- Anxiety, self harm, low self esteem, depression, withdrawal
- Asthma, eczema, bed-wetting, tiredness, injury
- Homelessness, poverty, disruption to schooling, social exclusion
- Loss of family, friends, pets, possessions

Responding to Domestic Abuse: Guidelines for Healthcare Workers,
Scottish Executive 2003

No single agency is solely responsible for protecting vulnerable children; it is the responsibility of all. The correlation between domestic abuse and child abuse must always be considered.

9. Support Agencies

Name	Tel No
Domestic Abuse Helpline	0800 027 1234
Inverness Women's Aid	01463 220 719
Ross-shire Women's Aid	01349 863 568
Lochaber Women's Aid	01397 874 216
Caithness & Sutherland Women's Aid	0845 408 0151
Police	01463 715 555
Police - Emergency	999
Housing Dept (Emergency out of hours) (Daytime)	0845 700 2005 01463 702 888
Social Services (Emergency out of hours) (Daytime)	0845 769 7284 01463 703 456
Advocacy Highland	01463 233 460
Hemut Gryffe Women's Aid - Glasgow Asian, black minority ethnic women and children	0141 353 0859
Shakti Women's Aid - Edinburgh Asian, black minority ethnic women and children	0131 475 3299
Victim Support also Highland Against Racist Crime (Advocacy Service)	01463 710 806
<p>Useful Websites</p> <p>www.scottishwomensaid.co.uk</p> <p>www.womes-unit.gov.uk</p> <p>www.zerotolerance.org.uk</p> <p>www.scotland.gov.uk</p> <p>www.scottishparliament.gov.uk</p> <p>www.scotland.gov.uk</p>	
<p>See Highland Directory of Services for Women and Children and Young People Experiencing Domestic Abuse on the NHS Highland Intranet for further detail on resources in Highland.</p>	



10. Group Members

Name	Job Title
Sandra Harrington	Midwifery Development Officer, NHS Highland
Elaine Adams	Policy Manager, NHS Highland
Chris Gilmour	Designated Person Child Protection, Raigmore Hospital Training Co-ordinator/ Designated
Pam Gasking	Health Visitor, Inverness
Gillian Gunn	Domestic Abuse Campaign Manager, NHS Highland
Sheila Rennie	Community Midwife, Inverness
Angela Watt	Senior Midwife, Raigmore Hospital
Mary Burnside	Acting Community Midwife Team Leader, Fortrose
Marylou Kosseim	Consultant Obstetrician, NHS Highland
Mary Cosgrove	Social worker, Ross and Cromarty
Lisa Kennard	Women's Aid, Ross and Cromarty
Gloria Zentler-Munro	Women's Aid, Inverness
Susan Campbell	Nursing Sister, A&E
Hilary Munro	Midwifery Sister, Antenatal Clinic, Raigmore Hospital

