

Does routine antenatal enquiry lead to an increased rate of disclosure of domestic abuse? Findings from the Bristol Pregnancy and Domestic Violence Programme

*Sally Price*¹ MSc, BSc, MICG, RM, NNEB. *Kathleen Baird*² MAEd, PGDipHE, BSc, HDE, RM. *Debra Salmon*³ PhD, MSc, BA, RGN, RSCN, HV, RNT, CertEd.

¹ Consultant midwife, University of the West of England, Glenside Campus, Blackberry Hill, Bristol BS16 1DD England. Email: sally2.price@uwe.ac.uk

² Senior lecturer in midwifery, University of the West of England, Glenside Campus, Blackberry Hill, Bristol BS16 1DD England. Email: kathleen2.baird@uwe.ac.uk

³ Reader in community health, University of the West of England, Glenside Campus, Blackberry Hill, Bristol BS16 1DD England. Email: debra.salmon@uwe.ac.uk

The authors would like to acknowledge the invaluable contributions of the midwives who participated in the research, the managers and supervisors of midwives who supported them and Leigh Taylor for her administrative support.

Abstract

Background. Domestic violence (DV) during pregnancy is especially serious, but can be a challenging and difficult subject for midwives to raise with women. The Bristol Pregnancy and Domestic Violence Programme was introduced in an NHS Trust in the south-west of England to equip community midwives with the knowledge and confidence to enquire effectively about DV in the antenatal period.

Aim. To evaluate the effect of routine antenatal enquiry about domestic abuse on disclosure outcomes.

Method. Semi-structured self-completion questionnaires, face-to-face interviews and focus groups were used to collect data from a group of community midwives. An audit was also conducted to assess changes in levels of DV reporting after the introduction of routine enquiry.

Results. Eight instances of DV were identified in the 17-month period prior to the programme, and 25 cases of current DV were identified in the nine months following its introduction – an almost six-fold increase. The midwives viewed routine enquiry as important and believed that they have a key role to play. They also identified a lack of pre- and post-registration training and of previous experience in dealing with issues relating to DV.

Conclusions. This study supports previous evidence that routine enquiry may increase the number of disclosures of DV during pregnancy. It also implies that any programme of enquiry must include support, appropriate referral and follow-up mechanisms for women, and that midwives require pre- and post-registration education, training and support if they are to be confident and effective in routine antenatal enquiry.

Key words: Pregnancy, domestic violence, domestic abuse, antenatal, routine enquiry, disclosure, midwives

Introduction

The risks of domestic violence (DV) during pregnancy are especially serious, since the health and safety of not one but two individuals are placed at risk. Studies have shown that DV during pregnancy is associated with increased risks of miscarriage, premature birth, low birthweight, fetal injury and even fetal death (Stark et al, 1979; Bohn, 1990; Webster et al, 1996). Pregnant women in abusive situations are more likely to use prescribed and illegal drugs, alcohol and smoking to help them cope with living

in an abusive relationship (Bhatt, 1998). It is apparent that there is a need for the maternity services to provide an effective, coordinated approach to the management of DV.

There is no doubt that DV is a challenging and difficult subject for many midwives. Due to the nature of the midwife's role and the intimacy of the relationship between a woman and her midwife, midwives could be the first people to whom women needing help and support may disclose their situation. However, there is evidence that suggests that midwives do not feel able to deal with

the victims of DV, and that a gap in knowledge and practice exists that requires further education and support (Scobie and McGuire, 1999; Price and Baird, 2003). In many cases pregnancy may be the trigger for the onset of DV, with the first incidence of DV occurring during pregnancy for almost 30% of women who suffer from domestic abuse in their lifetime (Helton et al, 1987; Women and Equality Unit, 2004).

The Bristol Pregnancy and Domestic Violence Programme (BPDVP) was introduced in North Bristol NHS Trust in the south-west of England to equip community midwives 'to have both the knowledge and confidence to effectively enquire about DV in the antenatal period' (Salmon et al, 2004: 2). It consists of a programme of education and support, and funding was secured from the Department of Health (DH) to explore its impact. The Trust provides care for up to 5000 women each year and has been working actively in the field of DV and pregnancy for several years. In 2002, an audit conducted within the Trust identified that midwives felt unwilling to implement routine antenatal enquiry for DV due to a lack of training and support. A further audit demonstrated that without routine enquiry, less than 1% of women who experienced DV in pregnancy were being identified within the Trust. Research studies show that with active intervention, the incidence of disclosure of DV in pregnancy can be between 4% and 17% (Johnson et al, 2003; Mezey and Bewley, 1997; Webster et al, 1996; McFarlane et al, 1992). The BPDVP was implemented on the basis of these audits and the evidence that active intervention enables the disclosure of DV.

This paper focuses on the findings of the research into the impact of the BPDVP that are related to the identification of the number of women disclosing their experience of DV as a result of routine enquiry.

Literature review

Literature on DV and pregnancy was identified through a range of databases including BIDS, CINAHL, MEDLINE, Web of Science, ASSIA and Science Direct. The term 'domestic violence' was used alone and in combination with 'pregnancy', 'education', 'women's views', 'children' and 'policy context'. Where useful articles were identified, a manual search of reference lists was also conducted. An emphasis was placed on educational and policy literature published since the mid 1990s. Literature regarding the policy context was also located through a search of key government agency and associated online databases. These included websites for the DH, Department for Education and Skills, Home Office and NMC. Further policy-related literature was located by utilising major relevant electronic database searches of appropriate midwifery, medical, health promotion, social policy, cultural and educational policy journals. The literature review focused on broader social aspects of midwifery practice, in particular examining the policy context relating to initiatives that target routine enquiry into DV during pregnancy.

The literature review established that women's health is affected by their personal and social circumstances, and that DV in particular has serious implications for individual, family and community health (James-Hanman, 1998). The restructure of public health policy with a focus on tackling health inequalities and social exclusion can also be attributed to the emergence of DV into the healthcare forum. DV is now widely accepted to be a public health issue in the UK, as it affects the physical and psychological health and functioning of victims (British Medical Association, 1998). Until recently, the NHS has for the most part dealt with the physical consequences of DV, but pro-active screening and identification have been poor. In an attempt to address this, many healthcare organisations have published guidelines or made recommendations that promote the routine enquiry of DV within healthcare settings, including maternity services (RCM, 1997, 2006; RCN, 2000; Department of Health, 2000, 2005). The DH supports an interagency approach and has issued direction and guidance for healthcare professionals on their roles and responsibilities (Department of Health, 2005). The RCM also recommends that every midwife should assume a role in the detection and management of DV (RCM, 2006). The Confidential Enquiry into Maternal and Child Health (CEMACH) (2004) made several key recommendations for maternity services in relation to DV issues within practice. These include the local development of guidelines for the identification of DV, and provision of support for women who experience it.

DV is a significant factor in maternal and perinatal morbidity and mortality. According to CEMACH (2004), 12 of the women whose deaths over a two-year period were reported to the enquiry were murdered by their partner. Another 43 women had voluntarily reported violence to a healthcare professional during their pregnancy. These 55 women represented 14% of those whose deaths were reported to the enquiry, but this may be an underestimation since this information was not actively sought through routine questioning at any point during their pregnancy.

Several studies have revealed that the more severely and frequently a woman is beaten, the more likely she is to experience increased DV when pregnant, with the most serious consequence being the death of the mother and/or the fetus. The risk of domestic abuse during pregnancy increases the risk of miscarriage, preterm labour and maternal and fetal injuries (Bullock and McFarlane, 1989; Helton et al, 1987). Destructive reproductive health outcomes are also associated with DV, and these include the non-use of contraception leading to unplanned and/or unwanted pregnancies. It is difficult to estimate the exact prevalence of DV during pregnancy, as women may be reluctant to disclose their experiences. However, for almost 30% of women who suffer from domestic abuse in their lifetime, the first incidence occurs during pregnancy (Helton et al, 1987; Women and Equality Unit, 2004). A study by Johnson et al (2003) revealed a prevalence rate

of 17%, and this is consistent with several other studies (Webster et al, 1996; McFarlane et al, 1992). Another study carried out by Mezey and Bewley (1997) reported that between 4% and 17% of women disclosed they were experiencing DV in their current pregnancy. This is also consistent with the work of McWilliams and McKiernan (1993), who suggested that 33% (n=19) of 56 women residing in a refuge in Northern Ireland had experienced DV during their pregnancy, and 23% (n=13) had suffered the loss of their babies as a result of the violence.

It has been identified that women will rarely disclose information voluntarily about their abusive experiences to healthcare professionals, but the use of brief screening questions is known to lead to a higher rate of disclosure (Bacchus, 2002). The antenatal period could be a pivotal time for identifying women who may be affected by domestic abuse, since during pregnancy, midwives have frequent contact with women as they access maternity care (Taket et al, 2003). Research has also shown that the majority of women are in favour of routine questioning if asked in a sensitive manner and by a well-trained healthcare professional (Bacchus et al, 2002). Ramsey et al (2002) challenge this view, claiming that implementation of a screening programme in healthcare settings cannot be justified because of the lack of evidence available on the impact or benefits of specific interventions on women. Their systematic review consisted entirely of non-UK based research and did not consider midwifery practice specifically. Nevertheless, Ramsey et al (2002) make a valuable contribution to the ongoing debate on whether to introduce routine enquiry for DV. Their work leaves important unanswered questions around routine enquiry into DV in relation to outcomes for women and the role of healthcare professionals in undertaking this new extended role. Before the universal introduction of routine enquiry into DV – as recommended by professional bodies – it was vital to conduct UK-based research.

Aim and objectives

The aim of the study was to evaluate the effect of routine antenatal enquiry by midwives for domestic abuse. The objectives were to:

- Identify the impact of routine enquiry on the number of disclosures regarding the experience of domestic abuse in pregnancy
- Explore the midwives' experience of making routine enquiries about DV
- Understand the challenges that midwives face when routinely enquiring about domestic abuse.

Method

Design

This research evaluated both the process and impact of routine antenatal enquiry for DV. The main research tools employed for data collection were semi-structured self-completion questionnaires, as well as face-to-face and focus group interviews. An audit was also included to assess changes in levels of DV reporting following the

introduction of routine enquiry. Each tool was developed to elicit data that were appropriate to the aims of the study, and all of the tools were piloted to establish validity and fitness for purpose.

Sample

A total of 83 community midwives from North Bristol NHS Trust took part in the education programme. All of them – a census – were invited to participate in the research evaluation, but four refused. This gave a response rate of 79/83 (95%). The participants completed questionnaires on three separate occasions.

A sample of 34 midwives from the original 79 participants also took part in the face-to-face and focus group interviews. This was a purposeful sample, although care was taken to ensure that midwives were included to represent all areas of the city, and both traditional and team midwifery models of care.

Data collection

Three questionnaires were completed by each participant. The pre-implementation questionnaire included baseline information to establish pre-existing levels of identified DV within community caseloads, describe attitudes to DV, analyse levels of existing knowledge and skills in relation to working with women experiencing violence, and understand the implications of routine enquiry for midwifery practice. Similar data were collected from the sample via questionnaire immediately after completion of the programme and six months later to enable post-intervention comparisons. Qualitative data were also collected through open-ended questions incorporated into all three questionnaires. This gave respondents the opportunity to elaborate on their views regarding their experience of routine antenatal enquiry and dealing with DV within their professional practice.

Data were collected from 34 participating midwives during face-to-face and focus group interviews at three and six months post-introduction. Focus groups and interviews were conducted by the non-midwife researcher who had no previous links with the Trust. Interview and focus group schedules were developed, based on analysis of pre- and post-training programme questionnaire responses. During the interviews at three months, midwives described and analysed their experiences of both undertaking BPDVP and delivering care to women in relation to routine antenatal enquiry and DV. They were also asked to expand on their experiences of asking women about DV during pregnancy and the implications for professional practice. The same questions were administered to participants at six months, when midwives were also asked to assess the degree to which any issues identified earlier had been resolved. The individual interviews were tape-recorded and fully transcribed, while focus group interviews were recorded through detailed field notes that were made by another researcher.

Data were also collected to assess changes in identification rates of DV during the antenatal period. An initial

audit was undertaken of the pre-implementation documentation ('cause for concern' forms) to discern the numbers of women disclosing DV to midwives over the previous 17 months. 'Cause for concern' forms were completed by any midwife who had anxieties related to the welfare of clients in her care. This acted as a mechanism for communication between practitioners and managers, and facilitated the documentation of a plan of care. Forms were analysed in relation to the primary reason for concern as recorded by the midwife. The numbers primarily recorded for DV were noted.

The numbers of disclosures were re-audited over the nine-month period following the introduction of routine enquiry. This was undertaken by reviewing 'cause for concern' forms along with a specific monitoring form that midwives were asked to complete for the purpose of the study. Information gathered included how the midwife became aware of DV, the professional support sought to deal with the disclosure, agencies that were liaised with and the amount of time spent with the woman at the time of disclosure and subsequently. Comparisons were made between the two sets of data for the larger BPDVP study, but for the purpose of this paper, only the numbers of disclosures have been used.

Data analysis

Completion of the three questionnaires yielded data for post-intervention comparison. All measures were subjected to descriptive statistics. Repeat analysis of variance was used to identify differences between pre-test, post-test and follow-up data. Stepwise multiple regression analysis was used to identify predictors of disclosure reported by midwives at follow up. Data from the face-to-face and focus group interviews were categorised and analysed for emergent themes using the thematic approach set out by Strauss and Corbin (1998).

Ethical issues

Ethical issues were particularly important in this study, not least because significant numbers of the participants may have had personal experiences of DV themselves. UK national guidance on healthcare research governance (Department of Health, 2001) was followed throughout the study, including informed consent, voluntary participation, confidentiality and anonymity. Ethical approval was obtained from the South West Research Ethics Committee. Approval was also obtained from the University of the West of England Research Ethics Committee, since this was a requirement of the university as the employer of the researchers.

In accordance with the ethical principles of doing no harm, all participants had access to full written information about the study. They also had confidential access to an occupational health counsellor, supervisor of midwives and the DV trainers. All of the participants were also made aware of the fact that they were free to decline to take part in the study or to withdraw at any time and without prejudice.

Findings

Of the 83 midwives who took part in the educational programme, 79 participated in the research programme (response rate=95%). Pre-test, post-test and follow-up questionnaires were completed by 70 (89%) of these midwives. One respondent was lost to the study at post-test and a further eight at follow up. The 79 midwives who completed the pre-test showed a broad range of qualifications and experience. The mean number of years for registration was 14.8 (SD=9.63), with a minimum of one and maximum of 34 years' experience within the group. The majority were qualified to diploma level (43%), followed by certificate (39%), degree (12%) and masters level (5%). An examination of the highest qualifications of the nine midwives lost to the study found that four had certificates, three diplomas and one a degree.

In the 17-month period prior to the introduction of routine enquiry, a total of 6764 women were cared for at the maternity unit. During this same period, 27 'cause for concern' cases were formally recorded. In eight of these instances, DV was identified as the primary reason for concern. This gives an identification rate of less than 1%. Following the introduction of routine enquiry, midwives continued to record 'cause for concern' in the same way, but more information was recorded in cases of DV using additional disclosure forms. This included the amount of midwifery time required to support women, multi-agency liaison time and types of referrals. The impact of the programme on the level of disclosures of experiences of domestic abuse facilitated by the midwives was noticeable. Following the introduction of routine enquiry, 25 cases of current DV were identified in a nine-month period. During the same nine-month period, maternity care was provided for 3779 women. This represents an increase of almost six times the number of formally recorded incidents of current DV.

The follow-up questionnaires at six months also asked midwives to identify the number of clients who had disclosed old or new episodes of violence since the introduction of routine enquiry. The area of interest was the midwives' ability to facilitate disclosure rather than the formal documenting of 'cause for concern'. This is because not all cases of disclosed DV would automatically result in a 'cause for concern' form. For the 65 midwives responding to this question, the total number of disclosures was 100. The range was zero to ten (with 25 midwives identifying no cases, 12 identifying one case, 13 of them two cases, ten recording three cases, one identifying four cases, three of them six cases and one midwife identifying ten cases).

The midwives who facilitated clients' disclosure of their experience of violence clearly recognised the limitations of their role and the need for inter-agency working:

'I think it has to be part of our role yes.. The reason why there are high maternal morbidity and mortality rates isn't so much now from medical problems, it is the social problems. I think we have to be addressing these sorts of issues and mental health problems. Because we are only

going to be involved for those few months during the pregnancy, you need to think as part of a team, as part of a multidisciplinary team... Yes, we should be involved' (midwife 98).

Of the midwives who completed 'cause for concern' forms, 24 also identified the amount of time that dealing with each disclosure took. The time spent with the client was found to be lengthy, with most ($n=9$) reporting more than an hour spent with the client, and in two of these cases this was more than three hours. Seven midwives reported spending between 30 and 59 minutes with the client. However, eight reported that dealing with disclosure took less than 30 minutes. The time spent on follow up for the case also varied, with five midwives reporting less than 30 minutes, three reporting between 30 and 59 minutes, and five reporting over an hour. A total of 11 responses were blank, suggesting that follow up might not have been initiated or completed at the time of filling in the disclosure form.

These figures need to be understood in the light of the number of times participants had been able to ask women about DV since the introduction of routine enquiry. Only three respondents had asked between 81% and 100% of the women that they had seen. The majority (59%, $n=38$) estimated that they had asked between 41% and 60% of women. This was followed by 16 midwives who had asked between 61% and 80% of women seen, and seven midwives who had asked between 21% and 40%, while one had only asked between 0% and 20%. Many midwives ($n=42$) highlighted a number of difficulties in asking women about DV in an open-ended question. The vast majority of these referred to the presence of a family member ($n=30$). Other perceived difficulties included lack of time and resources – including interpreter services – difficulty in finding the appropriate time to ask and not feeling comfortable with asking the question:

'It was difficult initially. It was difficult. The initial interview was very difficult... to know how to word it. And I changed my wording, how I approached it after a while. The only difficulty is a lot of my clients come along with partners or husbands and so I don't... you obviously can't bring it up then... and I'm finding it difficult... how you approach it again after the initial meeting' (midwife 92).

'Difficulty to address the question, under pressure with allotted time' (midwife 75).

These findings were not necessarily reflected in midwives' ratings of a range of barriers to enquiring about DV. Using a five-point Likert scale where five represented 'a great deal' and one 'not at all', midwives were most likely to express either uncertainty or to state 'not at all' in relation to experiencing potential barriers. The highest rating was related to a concern about the effects on their ongoing relationship with the women (2.84, $SD=1.33$). This was followed by the midwives' personal experience of DV (2.59, $SD=1.12$), concerns about their safety (2.51, $SD=1.23$), a lack of resources to support women who disclose (2.40, $SD=1.34$) and a lack

of organisational support (2.25, $SD=1.19$). There was little association between responses, with only weak correlations identified between a lack of resources and a lack of support ($r=0.26$, $p=0.04$) and concerns over safety and relations with women ($r=0.26$, $p=0.03$). No additional barriers were identified by the midwives.

To assess the potential influence of the training programme on routine enquiry, correlations between post-test measures, previous experience and training, the percentage of women asked and numbers of disclosures were examined. Number of disclosures was significantly correlated with previous experience of dealing with DV ($r=0.34$, $p=0.01$), post-test efficacy* ($r=0.32$, $p=0.01$) and percentage of women asked ($r=0.27$, $p=0.05$). Stepwise multiple regression analyses were conducted, with the number of routine disclosures as the dependent variable and the three correlated variables as independent variables. Previous experience and post-training efficacy, but not percentage of women asked, appeared as significant predictors (see Table 1). The R-squared with both of these variables entered was 0.181. Past experience contributed to 10.9% of the variance and efficacy contributed an additional 7.2%. In a separate regression analysis, follow-up efficacy remained a significant predictor, accounting for an additional 7.5% of the variance after experience. Pre-test efficacy did not appear as a significant predictor of disclosures.

Discussion

Midwives identified a lack of pre- and post-registration training and previous experience in dealing with issues of DV. Existing knowledge of DV was variable, with areas of uncertainty and the expression of some commonly-held stereotypes. However, attitudes toward routine enquiry showed that participants viewed it as important and believed that midwives have a key role to play.

The training was positively received by participants, who saw it as impacting on practice, improving confidence and raising awareness. The programme was also associated with increases in knowledge, belief in efficacy, positive attitudes toward routine enquiry and the reduction of stereotypes. Although subject to some decreases, these improvements were maintained above pre-test levels at six months. The findings suggest that both past experience and the training programme influenced levels of disclosure by increasing the midwives' effectiveness at routinely enquiring about DV. However, these results need to be viewed in light of the absence of a control group and the relatively small numbers of participants. Nevertheless, the number of incidents of disclosure facilitated by the midwives reached 100 out of 2508 women in the six-month period following the programme.

Although all of the participants perceived the training to have had a strong impact on practice, the post-test data

*In the context of this study, 'efficacy' refers to improvements in the midwives' knowledge and confidence, as determined from their responses to the questionnaires.

Table 1. Results of multiple regression analysis of disclosure incidents

Model-adjusted R	Measures	Beta	SE	Standardised beta	R-square change	95% CI
1.181*	Constant	-3.955*	1.89			
	Past experience	0.650*	0.27	0.292	0.109**	0.12 to 1.18
	Post efficacy	1.047*	0.46	0.270	0.072*	0.13 to 1.97
0.209**	Constant	-4.183*	1.89			
	Past experience	0.697*	0.27	0.313	0.134**	0.16 to 1.23
	Follow up efficacy	1.176*	0.51	0.075	0.075*	0.16 to 2.19

** p<0.01, * p< 0.05.

indicated that the proportion of times practitioners had been able to ask women was lower than anticipated, with the majority stating that they had been able to ask women only 50% of the time. The midwives described a number of barriers that prevented them from asking women, the most common of which was the presence of a family member. Others included language barriers and the lack of interpreter services.

It is not possible to say in absolute terms that the educational programme led to an increased level of disclosure, because data were not collected in relation to the numbers of disclosures facilitated by midwives prior to introduction. However, data collected about the level of prior experience that participants had of dealing with DV within practice showed this to be minimal, with 80% of midwives claiming no experience or being uncertain about their involvement. Level of previous experience was predictive of disclosure incidents at six months, and post-training improvements in questionnaire responses also appeared as a predictor, suggesting that increasing the confidence and skills of practitioners opened up the possibility of women discussing their experience of violence and its potential impact on the pregnancy. A lack of a matched comparison area also meant that it was not possible to attribute the increase in disclosures directly to the programme, particularly when viewed in the context of recommendations set out in the Laming Report (Department of Health, 2003). The development of more stringent methods of child protection recording and referral meant that reporting as a whole had increased three-fold in the nine-month period under review.

While few studies have been undertaken to examine disclosure rates, the level of increase that was identified in this study was consistent with others published recently (Mezey et al, 2003). This study also supports the views of many feminist commentators that open and direct questioning brings family violence into the public domain (Hanmer and Itzin, 2001). Clearly, implementing mechanisms for seeing women alone is an area that requires further service development.

In terms of support for practitioners when making routine enquiries about DV, mechanisms were clearly in place to advise, support and guide in complex situations. From a practitioner's perspective, DV trainers were viewed as particularly helpful and the creation of a specialist in this area is a possible area for development. However, closer links need to be made with the voluntary sector, and in particular with the services that midwives regularly refer on to. A lack of regular inter-agency contact meant that staff were unclear about the types and quality of arrangements available to support women. While only a minority of practitioners had regular contact with non-English speaking women, those who did had very strong views about the shortcomings of the maternity services in relation to the introduction of routine enquiry and the lack of interpreter services. This is an area that could be a significant barrier for these women in terms of accessing equitable services, yet to date it has been scarcely debated in literature analysing the merits of routine enquiry (Ramsey et al, 2002).

One dominant theme to emerge was that significant demands were put on midwifery time and workload through the introduction of routine enquiry. Combined with financial concerns, this left some ambivalent about whether routine enquiry should continue on completion of the research project. If it was to continue, all were clear that distinctions must be made between initial enquiry and the longer-term specialist management of family violence. The expansion of the midwifery role into the field of DV, unlike child protection, was felt by some potentially to compromise the position of midwives, who have traditionally been welcomed into family homes. Yet this concern was balanced with recognition of the wide range of skills, information and support that midwives could bring to those living with violence. Another barrier to implementation that was identified was lone working and practitioner safety, since enquiry about DV was perceived by a significant minority to heighten the potential threat to practitioners working alone in community settings.

Conclusions

The impact of the programme on the level of disclosures of DV was noticeable, with an increase of almost six times the number of formally recorded incidents. The programme was viewed very positively by the midwives, giving them the practical skills necessary to feel confident in enquiring routinely about DV. Attendance on the training programme, combined with the universal nature of the enquiry and its routine integration into the initial booking visit helped practitioners to develop their practice. The most significant practical difficulty was the attendance of male partners at consultations. Other perceived barriers to enquiry included lone working and the potential threat of violence, shortages of staff and for a small but important minority, a lack of interpreter services. Concern that midwives might be welcomed less into family homes was tempered by the recognition of the wide range of skills, information and support that they could bring.

Given the lack of a non-intervention comparison group, the relatively small numbers undertaking the training and low response rates to some questions, this evaluation may be best viewed as a feasibility study. Future studies could usefully include a comparison group of midwives not undertaking training and examination of different geographical regions. They could also include a comparative analysis of the outcomes for women based on differing models of questioning employed.

This study supports previous evidence that routine enquiry may increase the number of disclosures of DV during pregnancy. However, it also implies that any programme of enquiry must include support, appropriate referral and follow-up mechanisms for women. In addition, midwives require pre- and post-registration education and training, combined with professional support mechanisms if they are to be confident and effective in routine antenatal enquiry.

References

- Bacchus L. (2002) *Report on the joint meeting of the All-Parliamentary Party Group on Maternity and Domestic Violence*. RCOG: London.
- Bacchus L, Mezey G, Bewley S. (2002) Women's perceptions and experiences of routine enquiry for domestic violence in a maternity service. *International Journal of Obstetrics and Gynaecology* 109(1): 9-16.
- Bhatt RV. (1998) Domestic violence and substance abuse. *International Journal of Obstetrics and Gynaecology* 63(1): 25-31.
- Bohn DK. (1990) Domestic violence in pregnancy. Implications for practice. *Journal of Nurse Midwifery* 35(2): 86-98.
- British Medical Association. (1998) *Domestic violence: a healthcare issue?* British Medical Association: London.
- Bullock L, McFarlane J. (1989) The battering low-birthweight connection. *American Journal of Nursing* 89(9): 1153-5.
- Confidential Enquiry into Maternal and Child Health. (2004) *Why mothers die 2000 to 2002*. RCOG: London.
- Department of Health. (2000) *Domestic violence: a resource manual for health professionals*. Department of Health: London.
- Department of Health. (2001) *Research governance framework for health and social care*. Department of Health: London.
- Department of Health. (2003) *The Victoria Climbié inquiry: report of an inquiry by Lord Laming*. Stationery Office: London.
- Department of Health. (2005) *Responding to domestic abuse: a handbook for health professionals*. Department of Health: London.
- Hanmer J, Itzin C. (Eds.). (2001) *Home truths about domestic violence: feminist influences on policy and practices*. Routledge: London.
- Helton A, McFarlane A, Anderson E. (1987) Battered and pregnant: a prevalence study. *American Journal of Public Health* 77(10): 1337-9.
- James-Hanman D. (1998) Domestic violence: breaking the silence. *Community Practitioner* 71(12): 404-7.
- Johnson JK, Haider F, Ellis K, Hay DM, Lindow SW. (2003) The prevalence of domestic violence in pregnant women. *BJOG* 110(3): 272-5.
- McFarlane J, Parker B, Soeken K, Bullock L. (1992) Assessing for abuse during pregnancy. *JAMA* 267(23): 3176-8.
- McWilliams M, McKieran J. (1993) *Bringing it out into the open*. HMSO: Belfast.
- Mezey G, Bacchus L, Haworth A, Bewley S. (2003) Midwives' perceptions and experiences of routine enquiry for domestic violence. *BJOG* 110(8): 744-52.
- Mezey G, Bewley S. (1997) Domestic violence and pregnancy. *BMJ* 314(7090): 1295.
- Price S, Baird K. (2003) Domestic violence: an audit of professional practice. *Practising Midwife* 6(3): 15-8.
- Ramsey J, Richardson J, Carter Y, Davidson L, Feder G. (2002) Should healthcare professionals screen for domestic violence? Systematic review. *BMJ* 325(7359): 314.
- RCM. (1997) *Domestic abuse in pregnancy (position paper number 19)*. RCM: London.
- RCM. (2006) *Domestic abuse: pregnancy, birth and the puerperium*. RCM: London.
- RCN. (2000) *Position paper on domestic violence*. RCN: London.
- Salmon D, Baird K, Price S, Murphy S. (2004) *In brief: an evaluation of the Bristol Pregnancy and Domestic Violence Programme to promote the introduction of routine antenatal enquiry for domestic violence at North Bristol NHS Trust*. University of the West of England: Bristol. See: www.nbt.nhs.uk/midwives/domesticviolence/uwe_dv_exec.pdf (accessed 17 August 2007).
- Scobie J, McGuire M. (1999) The silent enemy: domestic violence in pregnancy. *British Journal of Midwifery* 7(4): 557-62.
- Stark E, Flitcraft A, Frazier W. (1979) Medicine and patriarchal violence: the social construction of a 'private' event. *International Journal of Health Service* 9(3): 461-93.
- Strauss A, Corbin J. (1998) *Basics of qualitative research: techniques and procedures for developing grounded theory*. Sage: London.
- Taket A, Nurse J, Smith K, Watson J, Shakespeare J, Lavis V, Cosgrove K, Mulley K, Feder G. (2003) Routinely asking women about domestic violence in health settings. *BMJ* 327(7416): 673-6.
- Webster J, Chandler J, Battistutta D. (1996) Pregnancy outcomes and healthcare use: effects of abuse. *American Journal of Obstetrics and Gynecology* 174(2): 760-7.
- Women and Equality Unit. (2004) *Domestic violence: key facts*. Women and Equality Unit: London. See: www.womenandequalityunit.gov.uk/domestic_violence/key_facts.htm (accessed 13 August 2007).