POLICY AND PRACTICE BRIEFING # 1

SAFEGUARDING THE RIGHTS OF PREGNANT WOMEN AFFECTED BY DOMESTIC VIOLENCE

NONE in 3

Preventing Domestic Violence

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This Policy and Practice Briefing is drawn from qualitative research carried out as part of the None in Three Project, an EU-funded initiative for the prevention of domestic violence in the Caribbean (www.noneinthree.org). Overall 109 participants (49 women and 60 men) from Grenada and Barbados participated in the research which was carried out between April and July 2016. (Full report available here - http://eprints.hud.ac.uk/30898/). The focus of Policy and Practice Briefing No 1 is on safeguarding the rights of pregnant women – other briefings are available as follows:

- Policy and Practice Briefing No 2 - Safeguarding the Rights of Disabled Women affected by Domestic Violence
- Policy and Practice Briefing No 3 -Safeguarding the Rights of Women living with HIV affected by Domestic Violence
- Policy and Practice Briefing No 4 -Safeguarding the Rights of Women in Same-sex Relationships affected by Domestic Violence
- Policy and Practice Briefing No 5- Engaging Men and Youth in Tackling Domestic Violence.

Overarching Themes from the Research

There is a high degree of intentionality that lies behind much abuse. Domestic violence is rarely a one-off incident of aggression which happens as a consequence of loss of control and for the women in this study was more likely to reflect a continuum of violence and abuse.

From the evidence provided by women, perpetrators often plan how best to inflict harm; they make choices that suggest the acts of coercion, control and violence they inflict are intended and targeted. Where violence was regarded as being a consequence of the loss of control, this was primarily because of the influence of drugs or alcohol.

Violent behaviour (physical, sexual and emotional) as a feature of interpersonal relations can become embedded within family and community life and in this, women as well as men are implicated in that this becomes the primary means by which children learn to emulate adversarial rather than non-violent conflict resolution skills.

There are clear links between early abuse in childhood (especially child sexual abuse) and domestic violence in adulthood – for many of the women in our research, these experiences simply could not be disentangled.

The influence of gender inequality, gendered identities and gendered role expectations is geared towards promoting patriarchal values and seems unremitting in protecting male privilege and sense of entitlement and in creating the social and cultural conditions in which domestic violence flourishes.

Men and youth are impacted by violence too (though to a lesser extent) but they have no avenues to access support. Male victims of abuse by women are treated in a derisory manner by peers and professionals since they are expected to be in control. Furthermore there are few social spaces available for men to challenge cultural expectations and pressure to behave in dominant ways.

KEY RESEARCH FINDINGS

- Women may be at an increased risk of domestic violence during pregnancy
- Violence often begins during pregnancy or, if it already exists, is likely to increase in severity during pregnancy
- Young women, aged 18-24 years, are more likely to experience domestic violence during pregnancy. Teenage mothers may be at particular risk
- Pregnancy may actually be a consequence of sexual violence - unintended pregnancy is often an outcome of an existing abusive relationship
- Domestic violence has a damaging, sometimes even life-threatening impact on the physical and mental wellbeing of a woman and her baby
- Domestic violence during pregnancy endangers both the pregnant woman and her unborn child. It increases the risk of:
  - low birth weight (Gentry & Baily, 2014)
  - premature labour and miscarriage (Sharps et al., 2007)
  - foetal trauma and/or injury (Howard et al., 2013)
  - post-natal depression (Brownridge et al., 2011)
  - sexually transmitted infections (Mercedes, 2015)
- Women who experience domestic violence are more likely to misuse drugs and alcohol in an attempt to cope with the effects of the abuse. Risks to the unborn child occur both because of the violence and *also* because of drug and alcohol abuse
- Neurobiological research suggests that babies exposed to domestic and family violence in utero are born with high levels of stress-related hormones and may experience behavioural and emotional problems in childhood (Mercedes, 2015)
- Victims of domestic violence often experience extreme fear and may be too frightened to talk about the abuse or to leave the abusive situation
- There are many intersecting reasons why women stay in abusive relationships – understanding this can help professionals provide appropriate non-judgemental support
- Though pregnancy provides an excellent opportunity for early intervention, victims of domestic violence may have particular difficulties using antenatal care services for several reasons:
  - the perpetrator of the abuse may try to prevent her from attending appointments
  - the woman may be afraid that disclosure of the abuse will worsen her situation
  - the woman may feel ashamed or guilty about being abused and worried about the reaction of others
  - the woman may be concerned that the information will not be kept confidential.

POLICY IMPLICATIONS

- Health professionals should be trained and equipped with the tools to effectively identify signs of abuse and to know what action to take to help prevent harm to the woman and the unborn baby

- Pregnant women should be routinely screened for domestic violence during ante-natal and other health checks. **However** clear protocols and procedures must be in place before universal screening is introduced within health care settings. This is necessary to ensure that health professionals are properly trained to respond to disclosures and have a good understanding of domestic and family violence – without adequate training they may respond in ways that cause harm

- Screening should occur at the first prenatal visit, at least once per trimester and at the postpartum check-up. Where this intervention has been introduced, there is strong evidence that it is a cost-effective way of identifying abuse and signposting women to available help and support

- Domestic violence during pregnancy is a major threat not only to the life and wellbeing of the woman, but also to her child. There is a need for health and child care services to examine how they might work together to provide protection before the child is born and also during infancy since these are periods of increased risk for children born into violent homes

- Pregnant women may find it more difficult than other women to leave a violent relationship for both physical and emotional reasons. Leaving the father of the baby one is carrying is exceptionally hard especially if the woman and her family have invested emotionally in the idea of family life and if the woman does not have independent economic means. Social services need to be cognizant of these challenges in designing interventions

- HIV screening, counselling and treatment services for pregnant women should routinely provide opportunities for women living with HIV to report domestic violence and should also ensure effective referral systems so that they can access appropriate services

- There is need for training aimed at increasing sensitivity, empathy and understanding of domestic violence victims among professionals. This is especially the case in respect of the reasons why women stay. Chronic abuse generates multiple barriers to escaping violence; professionals need to appreciate that effective support should include a range of short, medium and long term interventions that can help women with immediate problems and also over time

- There is need for more collaborative, interagency work involving the police, social workers, social services and health professionals to explore proactive strategies for prevention and to improve responses to protecting pregnant women from violence. This may require legislation which requires government agencies to work together, shared protocols, shared resources and inter-professional training

- There is need for more training concerning confidentiality and direct and serious penalties for when it is breached

- Dealing with domestic violence requires clear policy, protocols and procedures that are widely understood by the professionals who implement them and who in turn can be held accountable for systemic failings in protecting women from violence and accessing justice

PRACTICE IMPLICATIONS

Principles

- Respect the right of every woman to live without violence
- Act immediately on disclosure and respond to risks – remember, a woman is likely to have been beaten many times by the time she discloses abuse – it is **always** urgent and serious
- Ensure child safety is paramount and consider the rights of the child to live safely
- Ensure adult safety is a priority
- Initiate contact and assessment of risk factors at the earliest point e.g. pregnancy
- Work in line with protocols and agency policy and be aware of local services and referral procedures
- Respect confidentiality but be aware of when to share information with other agencies (only with consent).

Asking questions

- Consider the environment - is it conducive to ask? Is it safe to ask?
- Never ask in the presence of another family member, friend, or child
- Create the opportunity to ask the question
- Frame the topic first then ask a direct question. Examples: Framing: “As violence in the home is so common we now ask about it routinely” Direct Question: “Are you in a relationship with someone who hurts or threatens you?” Did someone cause these injuries to you?”
- Researchers suggest three simple questions which used together can help health workers to identify long-term DV: "Have you ever been in a relationship where your partner has pushed or slapped you?" "Have you ever been in a relationship where your partner threatened you with violence?" and "Have you ever been in a relationship where your partner has thrown, broken or punched Things?" (Paranjape & Liebschutz, 2003)
- Validate what’s happening to the woman – e.g. “You are not alone” “You are not to blame for what is happening to you” “You do not deserve to be treated in this way.”

Assessing the situation (there are various tools available, e.g. the CAADA-DASH Risk Identification Checklist - http://www.dashriskchecklist.co.uk/)

- Enquire sensitively; create an opportunity, providing a quiet environment where confidentiality can be assured for the woman to talk about her experience
- “Is your partner here with you?”
- “Where are the children?”
- “Do you have any immediate concerns?”
- “Do you have a place of safety?”
- Focus on safety - assess the immediate safety of the mother and child by asking if it‘s safe for her to return home with her child
- Ask the woman what help she needs from you right now
- Ask the woman if she knows where she can get help – explore who in her circle of family/friends knows about the situation and where she can go.

Action

- Never assume someone else is addressing the problem of domestic violence – **you** must act

- If a woman does not disclose but you suspect domestic violence, accept what is being said but offer other opportunities to talk and consider giving information (e.g. 'for a friend')
- Be familiar with and give relevant information about local domestic violence agencies – if safe to do so. Offer to make a referral
- Check where and how to send safe correspondence e.g. texting
- Discuss and construct a basic safety plan if necessary (It is not the professional's role to comment on or encourage the woman to leave her partner)
- Follow up any child protection concerns
- Document - consider safety and confidentiality when recording information in patient notes.

Taken from:
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/211018/9576-TSO-Health_Visiting_Domestic_Violence_A3_Posters_WEB.pdf

SUMMARY - WOMEN EXPERIENCING DOMESTIC VIOLENCE DURING PREGNANCY NEED:

1. Health care professionals who are knowledgeable about the complexities and impact of domestic violence on both mother and child and the challenges of leaving violent relationships

2. Health care professionals they can trust and who treat them with dignity and respect

3. To be asked sensitively, as part of routine care, whether they are experiencing abuse

4. To be asked more than once – most women will not disclose abuse the first time they are asked

5. To be asked about abuse only when they are alone, which means that they need to be seen alone at least once during the pregnancy, even if normally accompanied by partner or family member

6. To be believed when they disclose abuse

7. Assurance that information disclosed will be confidential (subject to any child protection issues raised), and will not be recorded in any notes that she takes home

8. To be given useful information including:
    i. a credit card-sized information card that includes helpline numbers (this format means the card can be hidden from an abuser) if your agency doesn't have these, create them yourself e.g. using blank business cards or pieces of stiff paper
    ii. safety information, and encouragement to make a safety plan (but not to write it down, again to avoid the risk of an abuser finding it)
    iii. information about the risks to the unborn child

9. Planned follow-up care, such as additional appointments, referral to a domestic violence support agency and if appropriate, information sharing (with consent) with the woman's doctor or other professionals

10. To be offered flexible appointments especially if the woman seems to need time to disclose

11. To have their fear about involvement of agencies and confidentiality addressed

12. To be allowed to make their own decisions about what to do next without being pressured into a particular course of action (e.g. to leave the abuser)

13. To have their decisions respected non-judgmentally, even if it is a decision that the healthcare professional finds frustrating (e.g. to return to the abuser)

14. To know they are not alone in the experience of being abused

(Adapted from NICE, 2011, http://guidance.nice.org.uk/CG1100)

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Mercedes, M., & Lafaurie, V. (2015). Intimate partner violence against women during pregnancy: a critical reading from a gender perspective. *Revista Colombiana de Enfermería*, 10(10), 64-77.

Paranjape, A., & Liebschutz, J. (2003). STaT: a three-question screen for intimate partner violence. *Journal of Women's Health*, 12(3), 233-239.

USEFUL RESOURCES

http://www.womensaid.org.uk/default.asp

http://refuge.org.uk/

http://guidance.nice.org.uk/CG1100 - A model for service provision for pregnant women with complex social factors, NICE guidance 2011.

http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4126619.pdf -Responding to domestic abuse: a handbook for health professionals Department of Health (2005).

http://www.dashriskchecklist.co.uk/

http://www.nhs.uk/Conditions/pregnancy-and-baby/pages/domestic-abuse-pregnant.aspx

http://www.seeabuse.com/- Free online training on identifying and responding to domestic abuse.