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Recognizing the Co-Occurrence of Child and Domestic Abuse in Pregnancy and the First Postnatal Year

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1. Introduction

Over recent years there has been an upsurge in research that has increased our knowledge and understanding of how pregnancy and the first postnatal year can lay significant foundations for positive child development. This new knowledge has created a consensus of opinion about the need to develop early interventions to help young children get the best start in life. Child abuse and maltreatment can have an impact early in an infant's life, even as early as pregnancy and the postpartum period and can affect infants' physical and emotional health, their learning and their capacity to form positive relationships throughout their lives. Child abuse is a major and complex public health and social welfare problem, caused by a myriad of factors that involve the individual, the family and the community. We know that child abuse or neglect and general trauma, including the witnessing of domestic abuse, are major threats to child health and wellbeing; they alter normal child development and, without intervention, may have lifelong consequences [1].

Infant maltreatment is one of the most serious events undermining healthy psychological wellbeing and development, and no other social risk factor has a stronger association with developmental psychopathology [2]. Parents are almost always the perpetrators and in the United Kingdom (UK) infants are eight times more likely to be killed than older children [3]. However, this may be only the 'tip of the iceberg' as some researchers suggest that well over 50% of fatalities due to maltreatment may be incorrectly coded as deaths due to accidents, natural causes, or other factors on the death record [4]. Evidence highlights that no single factor causes children to be maltreated, rather a 'toxic trio' of factors such as parental mental illness, domestic abuse and drug and alcohol misuse, can increase the risk of neglect or abuse. A recent NSPCC report shows that around 198,000 babies under one year of age in the UK have parents who are affected by domestic violence, substance misuse or mental

health problems [5]. An analysis of UK Serious Case Reviews (SCRs) shows that at least one of these three issues is present in many cases, and there is often a high degree of overlap of these factors in cases of child death and serious injury [6]. There is as yet no definitive explanation for this high incidence, though frailty and total dependence are important features. However, it also seems likely that the very real demands and stresses placed on a family by a newborn baby are almost certainly a factor.

2. Domestic abuse

Globally domestic abuse is also a major public and social problem, the prevalence and universality of which is well-documented [7-14]. It is a serious infringement of women's and children's Human Rights with a range of often serious health implications for women and their children [15-19]. Its prevalence in society is shocking and unacceptable with on average throughout the world one in four women experiencing domestic abuse at some point in their lives [18]. The term 'domestic abuse' is used to describe violence perpetrated by an adult against another with whom they have or have had a sexual relationship. This abuse can take many forms including the physical (hitting, kicking, restraining), the sexual (including assault, coercion, female genital mutilation), the psychological (verbal bullying, undermining, social isolation) and the financial (withholding money, unrealistic expectations with the household budget). The UK Department of Health's (2002) [19] definition is: "Any incident of threatening behaviour, violence or abuse (psychological, physical, sexual, financial or emotional) between adults who are or have been intimate partners or family members, regardless of gender or sexuality."

Domestic abuse not only can be physically, emotionally, psychologically and socially devastating to women, it can have similarly devastating effects on children [20-22]. Recent research affirms the notion that few infants and children living with domestic abuse remain unaffected by the experience [23-25, 22, 26], with one in 20 children witnessing frequent physical violence between parents [26]. In addition, the stress of domestic abuse can severely impair women's parenting abilities, making them less able to care for their children and more depressed than other women [27], factors that certainly would affect their infant's wellbeing [28]. The prevalence data suggests that there are very high numbers of children living with domestic abuse and that it is difficult to protect children from exposure to the effects of this violence. It is estimated that in the UK alone 750,000 children [29] are exposed every year. More recent research suggests that one in seven (14.2 per cent) of children and young people under the age of 18 will have lived with domestic abuse at some point in their childhood [30]. For instance, the reports from two different studies which interviewed adult participants reported 86% and 85% respectively that children were present either in the same or adjoining rooms during an incident of domestic abuse [31, 32]. It is not only the exposure to living with domestic abuse that creates vulnerability in children and young people. Children living with domestic abuse are also more likely to be directly physically or sexually abused. Numerous studies report on this problematic co-occurrence. The meta-analysis by Edleson [33] of 31 high quality research studies showed that between 30% and

66% of children who suffer physical abuse are also living in a context of domestic abuse. The variation is largely dependent upon research site and methodology, but either figure is disturbing. The severity of violence is also relevant. Ross, for example, found that in a US study of 3,363 parents there was an almost 100% correlation between the most severe abuse of women and the men's physical abuse of children [34].

The purpose of this chapter is to highlight how pregnancy and the first postnatal year should be described as a 'high-risk' period for violence, prompting the initial episode of domestic abuse, or an escalation of a pre-existing abusive relationship, and the effects of the co-occurrence of child abuse during this time [35, 36]. The chapter is divided into sections that cover issues such as: domestic abuse in pregnancy and early infancy and the understanding of the impact that both domestic and child abuse have on both mother and child; the impact of foetal abuse; domestic abuse as a child protection issue; the co-occurrence of domestic and child abuse in pregnancy; and the role of health professionals especially midwives in recognising and reporting the co-occurrence of domestic and child abuse. The chapter will also report on the findings of a larger study, which was conducted between December 2008 and August 2009, and identified midwives' knowledge, attitudes and experience of domestic and child abuse. Although the evidence base is rapidly expanding on midwives' identification and management of domestic abuse, to the best of our knowledge, no empirical work has been undertaken that focuses on how midwives, working in either hospital or community settings, are assessing the co-occurrence of domestic and child abuse in their client populations.

3. Domestic abuse in pregnancy and early infancy

A family problem such as domestic abuse is therefore clearly a child safeguarding issue. Domestic abuse during pregnancy has emerged as a national and global health issue that has the potential to harm a woman and her unborn child both physically and psychologically. We know that pregnancy and the first year are critical stages in child development, providing the essential foundations for all future learning, behaviour and health. Adverse prenatal and postnatal experiences can have a profound effect on the course of health and development over a lifetime. However, what is clear from the literature is that child abuse is likely to escalate in frequency and intensity over time and may increase at specific critical points, especially during pregnancy and the postpartum period [37] which creates a complex problem because of its dual risks to both a mother and her unborn child [38, 39]. The Confidential Enquiry into Maternal and Child Health estimates that 30% of domestic abuse commences during pregnancy [40, 41] which is why it is acknowledged as a high-risk period for domestic abuse. This period may prompt the initial episode or an escalation of a pre-existing abusive relationship [42, 43, 37].

The findings of a review by Jasinki highlight several factors associated with pregnancy-related abuse such as: poverty, low socioeconomic status; low levels of social support; first-time parenting; unexpected or unwanted pregnancy; ethnicity; drug and alcohol abuse [44]. Prev-

Prevalence rates for domestic abuse during pregnancy range from 1% to 20% depending on the definition of violence in the study, although most studies report prevalence rates between 3% and 14% [45, 46]. Concurring with the article by Gazmararian et al. [44], World Health Organization reported on 48 worldwide studies that show the incidence of physically abused pregnant women was greater than 5% in 11 of the 15 countries studied [47]. Additionally, between 13% (Ethiopia) and almost 50% (urban Brazil and Serbia and Montenegro) of women in these studies reported that they were abused for the first time during pregnancy [47]. Such findings suggest that domestic abuse during pregnancy is more common than preeclampsia or gestational diabetes [46]. Domestic abuse also produces a range of psychosocial effects upon the mother such as alcohol and drug dependence, unemployment, homelessness, suicide attempts, depression, anxiety, and post-traumatic stress disorder, and heightened maternal and foetal stress [48, 49]. In addition, pregnant women experiencing violence are at a higher risk of becoming victims of homicide than are pregnant women not experiencing violence [50, 51] and domestic abuse has been cited as a prime cause of maternal deaths during childbirth [50]. Evidence shows that within the six weeks following birth, eleven new mothers were known to have been murdered by their male partners during 2000-02, and 14% of all the women who died during or immediately after pregnancy (43 women) had reported domestic abuse to a health professional during the pregnancy [52]. Furthermore 12% of the 378 women whose death was reported to the Confidential Enquiry on Maternal Deaths had voluntarily reported domestic abuse to a healthcare professional during their pregnancy [50]. None had routinely been asked about domestic abuse so this is almost certainly an under-estimate.

Although a causal relationship between exposure to violence during pregnancy and adverse perinatal outcomes has not been clearly demonstrated, pregnant women who experience abuse are more likely than are non-abused women to have conditions that place their unborn child at serious risk [53]. Studies have shown that women attending accident and emergency departments with physical injuries owing to violence are more likely to be pregnant than women attending with accidental injuries [54]. Physical violence and trauma during pregnancy increases the risk of foetal abuse, and the risk of adverse pregnancy outcomes such as antepartum haemorrhage, urinary tract infections, premature birth, low birth weight, placental damage, a prime cause of miscarriage or stillbirth, chorioamnionitis, foetal injury and foetal death [38, 55, 56]. The risk for the unborn foetus is also considerable as violence may increase rates of miscarriage, premature birth, low birth weight, chorioamnionitis, foetal injury and neonatal death [57, 58, 38]. Infants under-one year are at the highest risk of injury, or death [59], and it is estimated that around 39,000 babies under-one in the UK have a parent who has experienced domestic abuse in the last year. However, this underestimates the extent of domestic abuse, as it captures only physical violence and not the full breadth of abuse that can operate within an intimate relationship such as sexual, emotional, psychological and financial abuse. Infants as young as one year old can experience trauma symptoms from witnessing domestic abuse. The situation where a woman and her children are both abused by the same male perpetrator is common [60]. The more severely a woman is harmed, the more severely her child is likely to be harmed [59].

3.1. Effects of maltreatment on an infant's early cognitive and psychosocial development

Exposure to abuse affects every dimension of an infant's cognitive and psychosocial development [61]. Development is taken in its broadest sense to include social, emotional, physical, cognitive, language, temperament and fine and gross motor skills development [62]. and abused children may be vulnerable across some or all of these areas. In particular, the attachment relationship between an infant and their primary caregiver has a profound impact on child functioning and future development [61]. Feeling secure, loved and having a safe base to explore from and return to, are ongoing needs met by the parent-caregiver relationship. Numerous studies, including some of the most comprehensive and well controlled, have demonstrated that a secure attachment style is most associated with parental behaviours that are consistently responsive to the child's needs and provide comfort during times of distress [63]. A disorganized attachment style has on the other hand been consistently linked to caregivers who are often abusive and/or neglectful [64]. As a result very young abused or neglected infants may be overwhelmed with intense negative emotions, manifesting in incessant crying, inability to be soothed, feeding problems, sleep disturbances, hyperarousal and hyper-vigilance, and intense distress during transitions. Toddlers may experience intense separation anxiety, wariness of strangers, social avoidance and withdrawal, and constricted and repetitive play [65, 66]. Hesse and Main have suggested that these behaviours characterize infants with a disorganized attachment style and may be the result of fear in approaching a possibly maltreating caregiver who must also be called upon to provide comfort [65]. Emotional neglect and early childhood deprivation are potentially the most severe risk factors for impaired emotional or intellectual development and are also found as cofactors in most cases of other types of child maltreatment. Neglected infants have been found to have more severe cognitive and academic deficits, social withdrawal and limited peer interactions than those who have been physically abused [68]. The infant suffers either from quantitatively inadequate emotional support, or else from only weak support, delivered by constantly changing individuals. Emotional neglect leads to educational underachievement and difficulties in peer relationships as well as to oppositional behaviour [66, 67].

Maltreatment may also inhibit the appropriate development of certain regions of the brain [65, 69]. Two recent and wide-ranging reviews of research conclude that 'there is considerable evidence for changes in brain function in association with child abuse and neglect' [65]. And, 'It is clear that early deleterious experiences can have significant negative effects on the developing brain that may be long-term' [70]. A neglected infant may not be exposed to stimuli that normally activate important regions of the brain and strengthen cognitive pathways. The connections among neurons in these inactivated regions can literally wither away, hampering the child's functioning later in life [71]. As a result, the brain may become 'wired' to experience the world as hostile and uncaring. This negative perspective may influence the infant's later interactions, prompting them to become anxious and overly aggressive or emotionally withdrawn. Neglect and other forms of abuse may also be associated with neuro-motor handicaps, such as central nervous system damage.

Foetal abuse can also have effects on the developing infant's brain, leading to childhood anxiety and hyperactivity [72]. For instance substance abuse during pregnancy is common and, unfortunately, may have many adverse effects, particularly on the infant, and subsequent parenting and child development. These include an increased risk of foetal alcohol syndrome (FAS), foetal growth restriction, abruptia placenta and premature delivery. Infants may become dependent on drugs that they are exposed to in utero and after birth suffer withdrawal symptoms [neonatal abstinence syndrome, (NAS)]. FAS mostly occurs from teratogenic effects early in the pregnancy when facial features and internal organs are at a crucial stage in their development. Brain damage from alcohol exposure can occur at any time during pregnancy. Prenatal exposure to alcohol is the leading cause of brain damage and development delay amongst children in industrial countries [73]. Although invisible, this alcohol-harm eventually shows up in learning disabilities and behavioural problems, and infants with NAS may require prolonged treatment and spend weeks or even months in hospital as a consequence [74]. Long-term neuro-developmental and behavioural abnormalities are more common in infants exposed to substance abuse in pregnancy, and these include lower intelligence quotient scores, delays in motor skills, speech, perceptual and cognitive disturbances, and behavioural problems.

Recent neurological research suggests that the link between maltreatment and many of these adverse health consequences is through stress and anxiety, which can influence the nervous and immune systems, and can be 'toxic' for the developing brain [75]. Early exposure to 'toxic stress' can cause physical effects on an infant's neurodevelopment which may lead to changes in their long-term response to stress and vulnerability to later psychiatric disorders [76,77]. Recent studies have found an association between childhood abuse and hormonal disruption, manifesting in a dysregulation of the HPA (hypothalamic pituitary adrenal) axis [78]. The HPA axis is not fully developed at birth and is thus subject to environmental experiences that shape its activity, such as the buffering protection of a supportive attachment from an adult. Most infants experience a decline in HPA activity during pre-school years as they learn to cope with identify most threats as mild, and receive appropriate and supportive feedback from parents. Infants faced with stressors such as neglect, severe maternal depression, parental substance abuse or domestic violence, however, may be at risk for poor regulation of the HPA axis [79], as these infants often do not have access to parental support to regulate and manage their stress. This places them at risk of experiencing severe and chronic states of stress that can have negative consequences on functioning [80], and can also impact upon the parenting abilities of those infants when they themselves become adults.

Exposure to stress during developmentally critical periods results in persisting hyper-reactivity of the physiological response to stress, increasing the risk of stress-related disease in genetically susceptible individuals [76, 81]. New technologies such as functional MRI (magnetic resonance imaging) and PET (positron emission tomography) have enabled scientists to identify the chemical and structural differences between the central nervous systems of abused and non-abused young people [82, 83]. Many health problems, including panic or post-traumatic stress disorder (PTSD), chronic fatigue syndrome, fibromyalgia, depression, some auto-immune disorders, suicidal tendencies, abnormal fear responses, pre-term la-

bour, chronic pain syndromes, and ovarian dysfunction can be understood, in some cases, as manifestations of infant maltreatment [84, 85, 77].

3.2. Effects of maltreatment on infant's emotional wellbeing and mental health

The earliest years of life are a critical period when infants are making socio-emotional attachments and forming the crucial first relationships which lay the foundations for future mental health [86, 87]. All types of maltreatment can affect an infant's emotional, psychological and mental wellbeing, and these consequences may appear immediately or years later. The immediate and longer-term impact of abuse can include anxiety, irritability, eating disorders [88]. Longitudinal and retrospective studies cited by Balbernie [86] link disorganised emotional attachment in infancy, as a consequence of abuse and neglect, to a number of severe mental health problems in adulthood, such as depression severe anxiety, addictions, drug and alcohol abuse, post-traumatic stress disorder, self-harming and suicidality; and being bullied. Infants who experience rejection or neglect are more likely to develop antisocial traits as they grow up and are more associated with borderline personality disorders and violent behaviour [89,90]. Most common negative effects of sexual abuse in childhood manifest in emotional and behavioural problems, post-traumatic stress symptoms, depression, suicidal ideation and self-harm behaviours, anxiety, substance abuse, aggression, self-esteem issues, academic problems, and sexualized behaviours [91]. Emotional abuse can have a severe impact on a developing child's mental health, behaviour and self-esteem, particularly when it occurs in infancy. Underlying emotional abuse may be as important, if not more so, than other, more visible forms of abuse, in terms of its impact on the child [65].

4. Impact of foetal abuse

Domestic abuse is clearly a child safety issue, and the unborn child is at significant risk from harm. Violence against pregnant women has been referred to as 'child abuse in the womb' [92]. There has been concern for some time, particularly in the US about the issue of 'foetal abuse', where a foetus may be damaged in-utero by acts of omission or commission [57, 56]. Men can physically harm a foetus by physically assaulting a mother and evidence suggests that controlling men may be particularly violent to women when they are pregnant [93]. Also abdominal trauma resulting in placental damage, uterine contractions, or premature rupture of membranes can directly lead to low infant birth weight [94]. Women who experience abuse are more likely than non-abused women to have conditions that place their foetuses at risk [95]. As stated previously, domestic abuse in particular causes heightened maternal stress [48, 49], which is of critical importance during pregnancy because the consequences extend to her foetus and, later, her newborn. Chronic maternal stress increases cortisol levels [96], and during pregnancy, elevated cortisol levels lead to decreased uterine perfusion and a decreased transfer of essential nutrients for foetal growth, a contributory factor to intrauterine growth retardation. Cortisol also increases uterine irritability, contributing to the increased number of preterm births [97]. However, a causal link between domestic abuse during pregnancy and adverse perinatal outcomes has not been clearly demonstrated. These

risks can be considerable as violence may increase rates of miscarriage, antepartum haemorrhage, premature birth, low birth weight, chorioamnionitis, placental damage, sexually transmitted infections, and effects on the developing infant's brain, foetal injury and even foetal death [57, 38, 39].

The Domestic Violence, Crime and Victims Act (2004) [98] which was introduced to increase the protection, support and rights of victims and witnesses, has produced the biggest overhaul of domestic violence legislation for 30 years. The Act aims to ensure better protection for victims and bring more perpetrators to justice through civil and criminal law. Legally, according to this Act if a miscarriage is caused by abuse, the assailant can be charged under S.58 of the Offences against the Person Act, "using an instrument with intent to cause a miscarriage", and if a baby is born prematurely as a result of an assault, and then dies, the assailant may be charged with manslaughter [98]. One of the most consistent empirical findings, however, is the delay of antenatal care among victims of violence [99] which often results in inadequate care during pregnancy. Research indicates that many abused women only begin antenatal care in the third trimester [100], and this may be a serious risk factor for the foetus with the risk of pregnancy complications such as low birth weight and premature birth [101].

5. Domestic violence as a child protection issue

Domestic abuse during pregnancy has the potential to harm both a woman and her unborn child both physically and psychologically. This violence during pregnancy should be seen as a complex problem because of its dual risks to both a mother and her unborn child [102, 103, 104]. However, assessing domestic abuse as a child protection issue has been relatively slow in gaining health professional acceptance, even though the international evidence suggests that there is a clear and irrefutable link between domestic abuse and the co-occurrence of child abuse [105, 106, 107]. If a woman is being abused by a current or former partner, and she has other children living with her, the likelihood is that they are being abused too. Indeed, the situation where a woman and her children are both abused by the same male perpetrator is common [60]. The more severely a woman is harmed, the more severely her child is likely to be harmed [59].

Although pregnant women may experience domestic abuse in the same ways as women who are not pregnant, it has only been recently that attention has been paid to the intricacies of the relationship between pregnancy and child protection [44]. Evidence suggests that domestic abuse during pregnancy, and the first six months of child rearing, is significantly related to all three types of child maltreatment: child physical abuse, neglect, and emotional abuse, up to the child's fifth year, with children under one year being at the highest risk of injury, or death [108, 59]. In addition, where it is believed that a child is being abused; those involved with the child and the family should be alerted to the possibility of domestic abuse. An association of between 45-70% has been found between a father's violence to the mother and his violence to the children [59].

6. Co-occurrence of child and domestic abuse

Children in violent homes face three risks: the risk of observing traumatic events, the risk of being abused themselves, and the risk of being neglected [109]. There is strong evidence to indicate that child abuse and exposure to domestic abuse often co-occur [110, 111], and that a high proportion of infants and children living with domestic abuse are themselves being abused, either physically or sexually, by the same perpetrator [110, 5]. According to published studies, there is a 30 percent to 60 percent overlap between violence against children and violence against women in the same families and many child deaths occur in situations where domestic abuse is also occurring [11]. Although the studies on which these ranges are based employ different methodologies (e.g., definitions of child and domestic abuse, case record reviews, case studies, and national surveys), use different sample sizes, and examine different populations, they consistently report a significant level of co-occurrence [104] and point to the importance of protecting the abused parent to ensure the safety of the child.

Prolonged and/or regular exposure to domestic abuse can, despite the best efforts of the parents to protect the child, seriously affects an infant's development, health and emotional wellbeing in a number of ways. Although, system responses are primarily targeted towards adult victims of abuse, recently, increasing attention has been focused on children who witness domestic abuse, as studies estimate that between 10 and 20 percent of children are at risk for exposure to domestic abuse [111, 112]. A growing body of research suggests that children who live in a household where mothers are being abused by a partner are significantly affected, and experience considerable emotional and psychological distress [20, 113]. Living with or witnessing domestic abuse is identified as a source of "significant harm" for children by the Adoption and Children Act (2004). In the US child abuse and maltreatment have been reported to be a risk marker of domestic violence with each year seeing an estimated 3.3 million children exposed to family violence and abuse [114]. There is also evidence to suggest that in 75-90% of cases, children are in the same or next room when their mother is being abused [115]. Indeed, Mullender et al [113,116] goes as far as saying that in 90 per cent of incidents, infants and children are witnesses to the violence. Infants may be greatly distressed by witnessing the physical and emotional suffering of a parent [19, 104, 116], which can in itself, be psychologically and emotionally harming. This can result in infants becoming more fearful, anxious, and depressed, having temper tantrums, sleep disturbances, and consistently crying, and having extreme difficulties in nurseries and play school [19].

7. The role of healthcare professionals

For some time health care and primary care professionals such as midwives, health visitors, obstetricians, general practitioners and paediatricians have been acknowledged as having a key role in child protection and family violence [117, 118]. They may be the first to detect that a child is at risk, and the consequences of them failing in this recognition can be dire.

However, until recently the UK National Health Service (NHS) has largely ignored the problem of identifying women who access health services for injuries caused by domestic abuse, while historically primary care health professionals have experienced difficulties when attempting to identify an abused child [119, 57]. There are now many clear messages from Government, professional organizations and research to indicate that health professionals, such as midwives, should be actively involved in tackling these significant public health and primary care issues [120, 121]. Historically, midwives have experienced certain difficulties when attempting to identify either or both domestic and child abuse [122]. These difficulties have led to low detection rates that are attributed to: midwives' attitudes towards victims of abuse [119, 123]; their general lack of knowledge, education and training; and a lack of understanding of their perceived professional role in addressing both forms of abuse [124, 125]. Furthermore, in a review of fatal child abuse cases by the Department of Health by Sinclair and Bullock [126] it was found that health professionals were more likely than any other group to have knowledge of the child, and over a quarter of children who died at the hands of their parents were unknown to social services. Also a NSPCC publication, "What Really Happened?" [127] highlights how many infant deaths and serious injuries could be prevented if all professionals within primary care were better informed and equipped to identify family abuse. Although research in this area is increasing, it is often difficult to determine the exact nature of the pregnancy-related violence and this is posing difficulties for both practitioners and researchers, who need a clear understanding of the relationship between domestic and child abuse and pregnancy in order to develop risk assessment and screening tools and effective prevention and intervention programmes. Worryingly, although abuse may begin or accelerate during pregnancy few women report the problem to their primary care providers [125].

8. Midwives response to domestic and child abuse in pregnancy

The provision of care to families where issues of possible, or actual child maltreatment have been raised is now seen as one of the most difficult and challenging areas of contemporary maternity practice [128, 129]. Community midwives have always had a role in primary care; however, there is now an explicit need for the profession to direct its attention to issues such as domestic abuse. Even though evidence suggests that 35% of women already suffering domestic abuse experience an increase during pregnancy, and the postpartum, they are rarely identified by midwives [123,125]. Midwives have experienced certain difficulties when attempting to identify, either, or both, domestic and child abuse [125], and this finding may represent a reluctance by midwives to discuss the topic of violence with their clients, arising in many cases, from fears and anxieties about causing offence; revealing something which may escalate out of control; of not knowing what to do if abuse is disclosed; of embarrassment; or at a personal level identification with abuse either as a victim or perpetrator [38]. However, this reluctance may also correspond in general to: midwives' attitudes towards victims of abuse [123]; their general lack of knowledge, education and training and available information about questioning and screening protocols [130, 125]; and a lack of understand-

ing of their perceived professional role in addressing both forms of abuse [124, 125]. Importantly, at a more basic level the opportunity to 'ask the question' may not always be available i.e. a partner or other family member may be present [130].

To assess and intervene appropriately to situations where domestic or child abuse are known or suspected, midwives, managers and supervisors must have a willingness to identify and report the abuse. They need to have had opportunities to undertake up-to-date education and training and skills necessary to ask questions, and to offer the appropriate multi-professional help and inter-agency support required [131] well as an understanding of domestic violence risk assessment and safety planning in child protection [132]. In addition, regular continual professional development updates should be available for all. The Department of Health 2006 publication *Domestic violence: a resource manual for health care professionals* [133] supports the need for education and training of health professionals, as the majority of women will use the health care system at some stage in their lives.

The most important factor in identifying domestic and child abuse is the awareness that it often commences or escalates during pregnancy. There are a number of physiological, psychological, emotional and behavioural indicators which can alert a midwife and other health professionals to the possibility of potential or actual abuse. Where abuse is suspected, the midwife has a duty of care to routinely ask the woman about problems with relationships, but only when it is safe to do so, i.e. not when a partner or other person is present. The midwife must not put the woman or her/himself at any further risk. The questioning must be undertaken very sensitively and very carefully. The midwife's role and responsibility is then to provide the appropriate response, believing the woman, showing her that someone cares, not judging her, respecting her reasons and decisions to stay or leave the relationship, offering her support, providing her with helpful information, referring her to appropriate agencies, or any other action that may be required [130]. All midwives should be aware of the services and resources [statutory, community and voluntary] available both locally and nationally to a woman and children suffering domestic abuse. Maternity services should be active in developing a multi-agency, interdisciplinary approach in local procedures and services, to ensure a seamless and effective response to a woman seeking help [128].

It must also be remembered that victims of domestic abuse may also be reluctant to disclose abuse for a variety of reasons which include: reprisals from their partner; an outsider becoming involved; embarrassment; and importantly fear of losing their children if social services become involved. Research, however, has shown that often these women hope that someone will realise that something is wrong and ask them about it [38,130]. Many women may not spontaneously disclose the issues of child or domestic abuse in their lives, but often respond honestly to a sensitively asked question [38]. For midwives routinely to ask women about domestic abuse and to offer support and information is therefore an extremely important issue in both community and primary care settings. However, although midwives approve in theory of routine questioning about domestic violence, and also broadly agree that it is their responsibility; in practice, only about two-thirds are happy to do it [134]. It appears that routine enquiry about domestic violence during antenatal booking is infrequent despite such enquiry being included in clinical practice recommendations and is made less frequent-

ly than any other aspect of social history taking [135]. Practical and personal difficulties, including lack of time, staff shortages, and difficulty in obtaining sufficient privacy are frequently cited.

9. Midwifery settings – Differences in community and hospital-based

Findings from research show that significantly fewer midwives in hospital settings are addressing the issue of domestic abuse with their clients, as they appear to be driven by more medically dominant organizational structures and targets, which result in them using a more standardized form of care that stresses measures of efficiency, effectiveness and risk management [125]. According to this study hospital midwives work in a setting that has an ideology which places less emphasis on the psychosocial needs of the individual woman and her child and more on providing care for women experiencing complications, and thus public health issues are seen as low priorities. These findings are consistent with work by Hunter [136] whose results suggest that the occupational ideology of the hospital midwife is 'with the institution' rather than with a more 'woman-centred' approach. On the other hand, more midwives from community-based settings appear to follow more women-centred and child-focused care.

Firstly, community midwives are able to create a healthy living environment for women experiencing domestic violence, by asking about 'abuse' with their clients [137]. Secondly, they integrate health promotion and health empowerment into the primary care setting by working in partnership with the woman in their own homes, frequently talking to them about issues such as domestic and child abuse, and are more aware of providing private facilities in which woman can discuss violent relationships. Thirdly, they develop links with other settings and with the wider community [138]. Community midwives are more empowered to use a joined-up approach that includes an understanding of evidence-based research in the area, a clear knowledge of local and national multi-professional support agencies, and inter-agency networks and refuges that allows them to give on-going and appropriate information that in itself can empower women to make their own informed choices about how to deal with abuse [125]. The Code of Professional Conduct exhorts midwives to work collaboratively, to enable them to strengthen areas of practice by liaising with other professionals and learning from them [139].

However, the biggest hindrance recorded for both hospital and community midwives is the reluctance of a partner to leave the consultation. Recent changes in midwifery practice designed to 'empower women' and demedicalize childbirth may in reality be reducing the possibility of effective intervention i.e. the traditional concept of women-only space is rapidly disappearing as more and more men are now accompanying their partners to their antenatal and postnatal visits. Women now hold their own notes, eliminating confidential documentation of suspicions of/or identified cases of domestic violence. This can lead women themselves to feel emotionally unable to, or physically prevented from, accessing support, either from their family and friends, or from statutory and voluntary agencies.

International research evidence illustrates that maternity services are no longer woman-only spaces because women are now accompanied by their partners when attending antenatal clinics, and partners are often present in primary care appointments [128, 130].

10. Multi-agency pre-birth child protection procedures

Research and experience indicate that very young babies are extremely vulnerable to abuse and that work carried out in the antenatal period to assess risk and plan intervention will help to minimise harm. Any concerns about the welfare of an unborn baby, or about the future care of the baby when born should be shared with the appropriate agency at the earliest opportunity, as plans for safeguarding may need to be put in place before the baby is born. Antenatal risk assessment is a valuable opportunity to develop a pro-active multi-agency approach to families where there is an identified risk of harm. The aim is to provide support for families, to identify and protect vulnerable children and to plan effective care programmes; recognising the long-term benefits of early intervention for the welfare of the child. The UK Local Safeguarding Children Board (LSCB) have produced a set of procedures that explain the action any person should take when they think a child needs protecting because they may have been abused, or are at risk of abuse or significant harm [132]. They also take into account any risk to the unborn child. They clarify the responsibility of the various agencies involved, for reporting and investigating allegations of abuse. However, the process of assessment is consistently criticized in inquiries particularly in relations to professionals' understanding of risk factors (Brandon et al. 1999). In assessing risk there is sometimes a tendency to overlook the mother's male partner.

11. Conclusion

Globally health services including maternity services play an important role in safeguarding children. Within the UK health care professionals ensure that children and families receive the care, support and treatment they need in order to promote children's health and development. Staff such as midwives, health visitors, obstetricians, general practitioners (GPs), and other staff who work as members of the primary care, or hospital maternity team have a safeguarding role to play in the identification of babies and children who have been abused, those who are at risk of abuse, and in subsequent intervention and protection services. In the UK we expect that every pregnant woman will have access to, and engage with, high quality maternity services. It is also increasingly acknowledged that for the majority of women, pregnancy and childbirth are normal life events and that care of these women and their babies may be undertaken exclusively through midwifery-led services. The universal nature of health provision means that maternity professionals such as midwives and obstetricians are often the first to be aware that families are experiencing difficulties. All health care organisations have a duty under the Children Act 2004 to make arrangements to safeguard and promote the welfare of children and young people. Every Child Matters marked

a shift of focus from child protection to improving and promoting the health and wellbeing of all children and incorporates several important themes.

However the evidence suggests that domestic abuse is a damaging social problem affecting the health of many women and children within pregnancy and the first postpartum year. It cannot be solved by one profession alone; however, the professional's role in identification and referral plays a critical part in primary care co-ordinated response. In order for such a response to be effective, all professionals need greater exposure to and familiarity with recommended good practice; and must be able to identify and support women and children who are experiencing abuse with a joined-up approach that has adequate resources and support of health service managers. Close inter-agency liaison is required with professionals who are accountable and not afraid to challenge historical working practices, and who are willing to work across traditional boundaries.

Importantly evidence shows it is possible to prevent abuse and neglect and that the pregnancy and infancy offer a unique window of opportunity to work effectively with families at risk. Although we know that sustained maltreatment can have major long-term effects on all aspects of children's health and mental wellbeing, and impair their functioning as adults [81], many health professionals still remain unaware of these long-term health and wellbeing impacts on infants and younger children [119]. We know that the earliest years of life are a critical period when infants are making socio-emotional attachments and forming the crucial first relationships which lay the foundations for future health and wellbeing [84]. All types of maltreatment can affect an infant's emotional, psychological and mental wellbeing, and these consequences may appear immediately or years later. Enhancing the prospects for healthy development in the lives of maltreated infants therefore requires attention to enhancing opportunities for positive, non-violent family and peer interactions. The evidence tells us that pregnancy and the first year of life is a window of opportunity for preventive interventions and a crucial time to reduce later emotional, psychological and developmental difficulties, and develop stronger infant-parent relationships. The importance of preventing child maltreatment and thereby its short and long-term developmental, health and mental health consequences cannot be underestimated. Whilst efficiency savings are clearly key drivers behind much of the recent 'Early Years' policy developments in the UK, it is also clear that there are great opportunities to rethink and redesign how we support parents of very young children. How midwifery, obstetrics, paediatrics, social care, education and criminal justice professionals develop mechanisms for sharing resources and working together creatively to meet the needs of families will be central to the success of this preventative agenda.

Given new evidence that trauma in pregnancy and infancy alters the physiology of the brain, it is time for all health and social care practitioners, teachers and counsellors to be educated about the full health impact of violence and abuse, and to be trained to explore these issues either as the true aetiology of the infant's ill-health, or as an underlying potentiating factor that has contributed to it. Nurses, midwives and health visitors as well as specially trained safeguarding nurse practitioners need to develop an early trusting relationship with parents and other family members to promote sensitive, empathic care of their infant.

Nursery school nurses also have a key role in the identification of infants who may have been abused or are at risk of abuse. More and better training is needed to assist health and social care professionals in making appropriate use of core assessments and the common assessment framework (CAF) to support abused and neglected infants, and to ensure appropriate decisions are made about when to intervene. The availability of appropriate treatments to meet the needs of these infants, however, still remains a challenge [140]. Developing effective interventions and services is vital in order to support parents in meeting their children's health and wellbeing needs. A radical rethink of early intervention services is underway, blueprints for integrated working are being developed, bringing with them the opportunity to deliver meaningful and long term changes to the lives of young children across the country. Primary prevention efforts could thus be marketed universally, to further reduce the stigma associated with 'parent training': every parent can benefit from parent skills training, not just the 'bad' ones.

Concerns over inadequate record keeping, poor information sharing, and communication have also been raised by the Commission for Health Improvement [141] between NHS organizations and other agencies with respect to violence and abuse [142]. Developing a system that allows the sharing of information and statistics on abuse would immensely benefit professionals and the families with which they work, as it could provide interpretation of the multiple contributing factors associated with domestic and child abuse. This information would provide baselines to establish education, prevention and treatment programmes [112], to formulate benchmarks for performance evaluation, as well as allow professionals to collaborate and provide assistance and protection to victimized children in a more efficient and effective way. As Lord Laming states in his report:

"Improvements to the way information is exchanged within and between agencies are imperative if children are to be adequately safeguarded. Effective action designed to safeguard the well being of children and families depends upon the sharing of information on a multi-professional, inter-agency basis [143]."

Finally the co-occurrence of risk factors for violence in pregnancy, where the health and safety of two potential victims are placed in jeopardy [53, 54, 55] stresses the importance for all health professionals and the primary care team to be able to recognize and report domestic and/or child abuse at this time. Identifying domestic abuse, however, may be a useful risk factor for recognizing child abuse, which is clearly within the appropriate domain of professionals working in maternity or primary care services. Although tensions between the 'best interests of the mother' and the 'best interests of the child' are not always easily responded to, Fleck-Henderson [144] suggests that best practices for families, where both children and women are at risk of violence, requires professionals to 'see double;' drawing from the knowledge and values of both perspectives to best meet the needs of these families. 'Seeing double' should therefore apply to all professionals in every child abuse case involving domestic violence.

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