

Care during the perinatal period for women who have suffered sexual abuse

Process followed to develop guidance

30 April 2011

Background

This guidance was drawn up by the Maternity Team Improvement Forum at NHS QIS. It was developed following one of the annual meetings of the forum in March 2010 where a member of a maternity team shared the experience of caring for women who had been sexually abused. The forum agreed that some high level guidance would be helpful for all members of the maternity team.

The forum was anxious not to replicate resources already available and to ensure that any activity they undertook was as efficient as possible, given pressure on staff time. In a parallel acknowledgement that all practitioners are under pressure and have little time it was agreed that any product should be useful, accessible and distil the available resources to top pointers for practice. It was acknowledged that more extensive guidance and information would be available elsewhere and that the purpose of this work was to provide a first step in supporting and giving confidence to practitioners.

The literature searched

To establish what guidance was already in circulation Knowledge Services at NHS QIS was commissioned to conduct a literature search.

A small working group from the Improvement Forum was established in August 2010 (Appendix1) and agreed the parameters of this search.

The group identified the relevant search terms; labour, pregnancy, woman's experience, post natal, in combination with violence, sexual abuse, incest, rape, midwifery care, midwife, post traumatic stress syndrome, child sex abuse, survivors of sexual abuse.

The literature searched was written in English and had been published in the ten years preceding January 2010. Primary literature and national documents were identified; the group agreed that local guidelines would not be included in the search. On-line literature only was accessed. Over 60 articles were identified and these included policy documents, reviews, journal articles, case studies and stories of the patient experience, book chapters and dissertations and theses.

Findings were further interrogated and summarised by a researcher.

Although the search identified some case studies these were not accessed or reviewed since it was agreed the maternity improvement forum members could contribute this type of material from their own experience. Since the aim of this piece of work was to produce the more obvious pointers to less experienced practitioners, only the abstracts for documents not online were considered; in some cases the expert group pursued some publications which were not online, but it was agreed that the purpose of the activity was to extract key points and principles rather than accumulate detail.

The literature findings and annotations were systematised by the researcher and are available [here](#).

The findings were recorded in a template which included the following;

- Source
- Aim of literature
- Type of document (eg literature review, survey results, expert working group, survivor stories)
- Target audience (eg midwives, managers / employers)
- Summary – a brief abstract / key points
- Availability (ie whether the full text is available online and was reviewed.)
- Inferred dos and don'ts of practice

It was not possible to complete every section of the template. For example, many writers are not explicit about their target audience although this can often be implied from the journal in which the article is published. Despite the gaps, however, and the different methods used to research and approach the issue, there was a high degree of consistency in terms of the implications for practice. It was relatively straightforward to translate these into 'dos' and 'don'ts' and from this work it was possible to produce a 'long-list' of pointers for practice for subsequent consideration by the expert group. These are outlined below;

Key messages from the literature review

- Sexual abuse affects many women – estimates of the incidence of childhood sexual abuse range from 12-40%.
- There is no typical profile of a sexual abuse survivor and they can present an almost infinite range of signs and symptoms.
- All members of the maternity team who physically touch women need to be aware of potential symptoms that might signal sexual abuse as well as potential distress triggers.
- Given the nature of their contact with women, midwives are highly likely to receive information about sexual abuse.
- Talking about sexual abuse does not make things worse but rather is part of the healing process so midwives should make opportunities for people in distress to disclose it.
- Midwives are in a good position to help survivors through displaying the basic human skills and characteristics of empathy, trust, understanding and respect – where more than this is needed, midwives need to know how and where to refer the woman for specialist help.

- Obtaining explicit consent is important before and during “hands on” procedures
- Good record keeping is essential. Patient consent requirements, however, also need to be addressed.
- Sharing information should be on a strictly ‘need to know basis’ and subject to patient consent, (except in extenuating circumstances eg where child protection issues are involved)
- Managers and employers need to put in place strategies, policies and procedures to identify and manage vulnerable women. This needs to include appropriate training and support for staff.

The process of identifying the top dos and don’ts

The summary document and the key points was sent to the working group several weeks in advance of a meeting held to narrow the list of pointers for practice to a shorter and more useful list. NHS QIS reconvened and facilitated the expert group, using the Nominal Group Technique to assist the group to sift out what they considered to be the top comments to include.

At the outset of the meeting, the group briefly reassessed the project and once again agreed that there was a gap for members of the maternity team and in particular, the midwife, in this important area of care. They reconfirmed the need to proceed and develop short summary guidance that supports those in the maternity team. The group identified a series of clear principles that would govern any ‘product’ they developed. These were as follows;

- Any work coming from this short project would be incorporated into and complement the general framework for members of the maternity team who encounter women who disclose sensitive information and would seek consistency with use of language in other areas of disclosure.
- Consideration of this issue should be incorporated into the current frameworks for practice such as the Scottish woman held maternity record (SWHMR) and Getting it right for every child (GIRFEC).
- That any guidance would be given in the context of professional skill and empathic listening and be clear and accessible.
- That the guidance would be simple and presented in a way that is easy to print and distribute inexpensively.
- Any product would be checked by the Lead for gender based violence project, in the Healthcare and Policy Directorate, Scottish Government for consistency of language across disciplines and within Scotland.
- That any guidance would be supplemented with extra reading and sources of further information for members of the maternity team.

It had already been agreed that the best help that can be given to members of the maternity team is in the extension of the skills and confidence to articulate the woman's requirement for help if she discloses that she had been a victim of sexual abuse or sexual violence. Any product was required to support this.

There were many factors in this work that suggested the nominal group technique would be appropriate for this exercise: it ensures equal participation and these participants were of equal skill and experience in midwifery leadership; it supports consensus and minimizes differences; its single focus was appropriate for the topic; and the technique allows the participants to arrive at a consensus within a structured process, potentially saving time.

Using the technique, in this case a two step process, and considering not just the key findings above but all the elements in the summary document the group swiftly identified a consensus 'top ten'. In addition they agreed a means of incorporating other considerations through use of the surrounding text. Some considerations had both positive and negative implications, for example the member of the maternity team is encouraged not to 'underestimate yourself or your actions.'

The list was sent to the group for comment and retrospectively it was agreed that since this is a public document no follow up web-based resources would be published in the page of guidance. This is for the following reasons;

- this future-proofs the guidance
- it was considered unhelpful to publicise websites which supply support to women who may experience abuse, since some of these websites employ 'irrelevant' website addresses to give a woman privacy from someone following her browsing history.

It was agreed that one of the expert group would write a more expansive article that furnished more detail. This alerts practitioners to particular issues which may arise at points on the pathway of pregnancy, labour and the post partum period.

The final guidance

The guidance, entitled 'Care during the perinatal period for women who have suffered sexual abuse' is available as a pdf from the Healthcare Improvement Website www.healthcareimprovementscotland.org for printing and distribution.

Appendix 1

Members of the working group of midwives representing the Midwifery Improvement Forum who worked on the project were as follows:

Sheona Brown, Programme Lead, SWHMR, Healthcare Improvement Scotland

Geraldine Butcher, Consultant Midwife, NHS Ayrshire & Arran

Annette Lobo, Consultant Midwife, NHS Fife

Janice Ramsey, Professional Development Midwife, NHS Tayside

Rhona Jack, Researcher appointed by NHS QIS

Supported by Healthcare Improvement Scotland Team

Fiona Dagge-Bell, Clinical Development & Improvement Team Leader, Healthcare Improvement Scotland

Rosemary Hector, Programme Coordinator, Healthcare Improvement Scotland

Dawn Robb, Project Administrator, Healthcare Improvement Scotland