Midwives' experiences of routine enquiry about intimate partner violence in pregnancy

Problem or Issue	Midwives may remain unclear about their role in addressing intimate partner violence (IPV) and find it difficult to listen or understand a woman's experience on disclosure.
What is already known	There has been a growing awareness for the need of health professionals to become more proactive around intimate partner violence. This includes the development of an enhanced knowledge and understanding of the consequences of abuse and its overall impact on health.
What this paper adds	For midwives to feel prepared and confident with the process of routine enquiry they must feel supported. Ongoing training on IPV that includes guidance on how to ask the question, deal with barriers, recognise signs of IPV and a clear referral pathway for positive disclosure is vital.

Abstract

Background: Reducing violence against women is a national public health priority in Australia. Routine antenatal intimate partner violence screening by a skilled midwife is essential for assessment, support and appropriate referral, but can be challenging to implement.

Aim: To explore midwives' experiences of routine enquiry, perceptions of facilitators and barriers, and suggested strategies to improve practice.

Method: A qualitative descriptive design was used. Participants were recruited via an e-mail bulletin by the Australian College of Midwives. In-depth telephone interviews were conducted with 21 midwives. Data was analysed using an inductive thematic analysis approach.

Findings: Three themes were identified: Asking the question incorporated the belief that whilst asking women about intimate partner violence was within the role of the midwife, participants felt unsupported and unprepared. The Big Fear Factor represented concerns around positive disclosures of intimate partner violence, including a sense of responsibility, worries about encouraging women to disclose without clear processes and resources to support them. The third theme Building a relationship incorporated the importance of continuity of care, trust and rapport-building. Continuity of care was identified as a positive enabler for routine enquiry. A perceived lack of support, time pressures and the presence of a partner at appointments were all considered as barriers to routine enquiry.

Conclusion: Routine enquiry about domestic violence is a valuable and important midwifery role. Midwives described frustration and fear when women disclosed domestic violence. The perceived level of support from health services is varied according to practice contexts and needs to be improved.

Key words: Intimate partner violence, pregnancy, routine enquiry

1. Introduction

Intimate partner violence (IPV) is any behaviour within an intimate relationship that causes physical, psychological or sexual harm.¹ Globally 1 in 3 women experience physical and/or sexual violence from a partner.² Women are particularly vulnerable to violence during pregnancy and separation³. Recent national census data in Australia revealed 17% of all women reported experiencing some form of IPV. Of those women experiencing IPV, 54% reported violence by a partner during pregnancy, 25% for the first time.⁴ Reducing violence against women is a national priority.⁵ In 2009 the National Council to Reduce Violence Against Women and Their Children (NCRVWC) devised a framework for social change over the next 12 years.⁶ The main challenges relate to fragmented services, a failure to invest in primary prevention, a lack of tailored and accessible responses, inadequate monitoring reporting and lack of evidence about what works.⁷

2. Literature Review

The debate as to whether routine enquiry, antenatal enquiry for IPV during pregnancy, is an effective intervention has led to some reluctance to introduce routine screening in health services within Australia.⁸ A systematic review of studies conducted in the United States of America (USA), New Zealand, Canada and Australia indicated that although routine screening for IPV in health settings increased the identification of women at risk, it did not demonstrate any specific benefit in reducing the incidence of IPV.⁹ More recently a cluster randomised trial by Taft et al¹⁰ investigated the impact of routine screening using a self-report check-list for IPV by maternal and child health nurses in Victoria, Australia. Nurses screened new mothers at 4 weeks after birth and if appropriate again at 3 months. There was no significant difference in reporting or referral of IPV between groups. Increased rates of screening and safety planning behaviour were sustained by nurses in the intervention group at 36 months suggesting that nurses had an increased awareness of IPV, valued screening process and continued to incorporate screening into their routine appointments. However, such findings contrast with an educational programme introduced for community midwives in Bristol in the UK promoting routine enquiry for IPV.¹¹ A five year follow up study evaluating the sustainability of the education and training program demonstrated a marked increase in both the identification and referral of IPV, as well as support of women disclosing IPV in the antenatal period.¹² Further support for routine screening for IPV in healthcare settings was identified in a recent Cochrane review which concluded routine screening increased identification of IPV but rates were still below prevalence estimates of IPV in all women seeking healthcare.⁹ Studies specifically focusing on antenatal screening had a higher rate of disclosure of IPV, however it is important to acknowledge that samples of the included studies were small.⁹

Midwives are well-placed to raise issues of IPV because the majority of women will access antenatal care at some time during their pregnancy.¹³ Research suggests pregnant women report comfort disclosing sensitive, personal information about IPV, as they perceive their

relationship with their midwife to be safe, supportive and professional.^{12,14} However, evidence suggests that midwives do not feel comfortable asking about or managing women who disclose IPV.¹⁵⁻¹⁸

The perceptions and experiences of UK midwives have been explored by a number of studies since the introduction of routine enquiry for IPV.^{11,12,16} Mezey et al¹⁶ interviewed 28 midwives from a London teaching hospital. Midwives reported that IPV was an important issue to discuss with women but identified several practical barriers to routine enquiry. These included the presence of the partner, time constraints and concerns around personal safety. These barriers were similar to those identified by Baird et al¹² in a follow up study evaluating the practice changes of midwives after the introduction of the Bristol Pregnancy Domestic Violence Programme in 2004. Fifty-eight midwives completed a questionnaire with 11 participating in a focus group interview. Despite the presence of barriers, midwives described feeling more confidence and having a sense of pride in regard to their role in routine enquiry. This increased confidence and commitment to routine enquiry assisted midwives to employ innovative strategies to overcome some of the identified barriers. Research conducted by Stenson, Sidenvall and Heimer¹⁸ also explored the experiences of midwives related to men's violence against women in pregnancy, using focus group discussions. Twenty-one midwives described a commitment to questioning women but also described obstacles they encountered including the perceived delicacy of the subject and routine presence of partners at all antenatal visits. The importance of ongoing training and counselling for midwives and access to support for women disclosing IPV were identified as enabling factors. The need for training was supported by a recent study by Finnbogadottir and Dykes¹⁹ with 16 Swedish midwives in focus groups who discussed the importance of knowledge and experience when recognising signs of IPV. The midwives did not routinely enquire about IPV in the antenatal period but asked if risk factors were identified. The midwives also highlighted barriers similar to those identified in previous studies.

A phenomenological-hermeneutical study by Mauri et al¹⁵ explored the knowledge and clinical experiences of IPV enquiry for 15 midwives working in a health district in northern Italy prior to the introduction of routine enquiry. Semi-structured interviews with the midwives identified three main themes. The first was based on difficulties identifying IPV and included common barriers. The second theme highlighted supportive factors such as training and education and clinical experience. The midwives described difficulties identifying IPV due to a lack of knowledge and preparedness for dealing with IPV. The midwives identified the benefit of building a relationship with women prior to asking about IPV. The third theme incorporated the role of the midwife in the multidisciplinary team when identifying IPV in pregnancy.

The context of midwifery care can differ markedly due to differences in health care systems and models of care between countries. Therefore it is difficult to generalise results from European studies to the experiences of midwives engaged in routine enquiry in the Australian context. McKosker-Howard et al.²⁰ investigated the impact of mandatory screening for IPV on registered midwives as part of the 1998 Domestic Violence Initiative in Queensland. Midwives were recruited to participate in one of four focus groups with 6 – 8 midwives in each group. Midwives reported valuing the identification and support for women experiencing IPV but felt overwhelmed by expectations and the additional workload screening created. Once again, midwives described having little preparation for the introduction of routine screening and no ongoing training. Midwives described the negative emotional impact of feeling unprepared and unsupported. However, these findings were in contrast with an evaluation of a 3 month Commonwealth funded pilot scheme for routine IPV screening in Sutherland Hospital Antenatal Clinic.²¹ Whilst some midwives also identified common barriers such as the presence of the partner, the majority of midwives reported feeling confident and strongly supported the introduction of routine enquiry. It should be noted that prior to the introduction of the pilot all midwives in the antenatal clinic received

specific training and site specific resources were developed including a clear pathway for referral.

Midwives play a key role in identifying women at risk of IPV, and antenatal screening about IPV enables women to be offered support and appropriate referral if required. However, little is known about midwives' recent perceptions and experiences of conducting an IPV assessment in Australia.²² In view of this lack of evidence, this study aimed to identify midwives' experiences in relation to screening, ongoing referral and support for women who positively disclose about IPV. This study was part of a larger program of work on midwives' knowledge, attitudes and practices in regards to IPV in Australia.²³

3. Method

A qualitative descriptive design was used to describe the experiences of the midwives in relation to routine enquiry of IPV in pregnancy.

3.1 Recruitment of participants

Participants were recruited via an e-mail bulletin by the Australian College of Midwives (ACM). Having completed an online survey about IPV knowledge, attitudes and practices, respondents could nominate to be interviewed by providing their contact details. Inclusion criteria were midwives engaged in antenatal service provision within Australia.

3.2. Data collection

Prior to the interview a brief overview of the research aims and interview questions were sent to each participant and a convenient time for an interview arranged. Due to distance and remote locations of participants, interviews were conducted by telephone. Each participant was interviewed once for around 30 – 60 minutes. The interviews were digitally recorded and transcribed verbatim. The interview guide included open ended questions that were asked in a flexible sequence depending on the direction of participant's responses.

124

125 3.3. *Data analysis*

126 The data was analysed by two researchers using a process of inductive thematic analysis.²⁴

127 Each interview transcript was read several times to obtain familiarity with the data. Initial

128 codes were generated within the transcripts and recorded as individual notes by the

129 researchers. Coding across the transcripts was continued until all the data extracts were

130 coded. Potential patterns in this coded data were examined by exploring any similarity or

131 overlaps in the codes and the relevance to the entire data set.²⁴ Provisional themes were

132 developed and refined as the data analysis continued over time. As themes and sub themes

133 were formed from the data a thematic map was developed to explore and refine the

134 connections between the developing candidate themes.²⁴

135

136 3.4. *Ethics*

137 Ethical approval was obtained from the Griffith University Human Research Ethics

138 Committee (NRS/23/13/HREC). A consent form was emailed, completed and returned by

139 participants prior to the interview. Consent to participate and permission to digitally record

140 the interview were re-confirmed prior to commencement of the interview. Participants were

141 offered the opportunity to receive a written copy of the interview once transcribed. Anonymity

142 of participants was assured and a pseudonym allocated. Confidentiality was discussed in

143 addition to the possibility that direct quotes from the interview could be used in reporting the

144 findings.

145

146 4. Findings

147 4.1 *Participant characteristics*

148 Of the 35 midwives indicating their willingness to be interviewed, twenty-one midwives from

149 across all Australian states and territories could be contacted and were interviewed. The

150 majority of participants were female, worked in the public health system, in a range of

151 different models of maternity care including shared care based in an obstetric antenatal

clinic, midwifery led clinics and midwifery caseload practice and practised in tertiary units, rural and remote hospitals and community. Participant characteristics are presented in Table 1.

4.2. Themes

Three major themes were identified. *Asking the question* was related to how participants saw the midwife's role in relation to routine enquiry. *Big fear factor* described the emotional impact that midwives perceived accompanied the process of asking of women about IPV. The third theme *Building a relationship* incorporated both the positive impact of continuity of care on enabling routine IPV screening to occur as well as identifying barriers that a fragmented maternity system created for midwives and women.

Table 1. Participant characteristics

Demographic Data	N	(%)
Sex		
Female	20	(95.2)
Male	1	(4.7)
State/Territory		
Queensland	5	(28.8)
New South Wales	4	(19.0)
Victoria	4	(19.0)
Tasmania	0	(0.0)
Western Australia	2	(9.5)
South Australia	2	(9.5)

Australian Capital Territory	2 (9.5)
Northern Territory	2 (9.5)
Health Care Sector	
Public	19 (90.5)
Private	2 (9.5)
Model of Care	
Public Hospital Based Antenatal Clinic	11 (52.4)
Public Midwifery Caseload Model	8 (38.0)
Private Midwifery Caseload Model	2 (9.5)

168

169 4.3. Asking the question

170 All participants regardless of workplace and model of care, identified that the role of the
 171 midwife should incorporate routine screening for IPV. The majority of participants also
 172 articulated a strong sense of a personal commitment to the role of the midwife in routine
 173 enquiry:

174 ... "often times seeing a midwife is a woman's first contact with some regular
 175 healthcare and social care as well. So I really think that it should be one of those
 176 things that midwives really should be championing and being a leader in". (Lyn)

177

178 Participants described different ways of screening women for IPV. These approaches were
 179 dependent on where they worked and processes in place within the health service they
 180 worked in. Some midwives reported asking all women directly at the booking interview,
 181 whereas others identified the use of a self-report screening tool either written or online that
 182 women completed at booking. Midwives working in fragmented models of care highlighted
 183 frustration with a system that did not allow time to build rapport with women before asking
 184 sensitive questions:

185 "I don't feel like there's time to build up a rapport with a woman, for her to feel
186 comfortable with me, because she's a complete stranger... it's like "here fill out
187 this piece of paper" kind of thing...I don't have the right to ask that question of
188 someone I've known 45 minutes." (Ange)

189

190 Participants working in a continuity of care model reported it was easier to "find the right
191 time" to ask questions about violence. This may be at booking or at a subsequent
192 appointment when they had the opportunity to develop rapport with the woman:

193 "I think if a woman is going to confide in anybody, it's going to be somebody
194 they're developing that trusting relationship with. It does not have to be part of
195 that first visit." (Bobbie)

196

197 Participants described feeling unsupported in their role when screening women for IPV.
198 Barriers discussed included having minimal time to spend with a woman in an antenatal
199 appointment:

200 "We are actually pressured now to do that booking interview in less than an hour
201 now, so there's another barrier. A push, push, push, get this all done." (Rose)

202

203 The lack of support for women was perceived as a potential barrier. Some participants
204 reported that at times their questions were not asked effectively or perhaps not at all due to
205 perceptions of insufficient support available for women who may make a positive disclosure:

206 "There was a time we got too many positive answers we found the funding
207 was cut for the social worker... so we just didn't ask the question anymore
208 because we had to deal with this problem..." (Enid)

209

210 "It's too difficult. It's really complex....there are some midwives who get involved,
211 but the majority of midwives do not want to get involved.... they just do their job
212 and they just want to go home...." (Louise)

213
214 Insufficient preparation for IPV screening was consistently described by all participants. This
215 lack of preparation impacted on the level of confidence participants felt when asking the
216 question:

217 “.... the practical side of asking is really neglected. Even coming to work as a
218 qualified midwife, this was lacking in our orientation. You’re just expected to know
219 what to do by osmosis.... It’s one of those things that is just quietly ignored in a
220 way” (Lyn)

221

222 4.4. *Big fear factor*

223 Feelings of being unprepared and unsupported in their role led some participants to describe
224 genuine feelings of fear and anxiety around the possibility of a positive disclosure of IPV:

225 “We are potentially opening this can of worms here; I’m asking a woman some
226 really difficult questions, what on earth will I do with the answers? If I can’t do
227 anything then I should not be asking, and if I’m not ready to deal with some pretty
228 nasty disclosures then I shouldn’t ask.” (Alison)

229

230 “.... that [disclosure] really threw me because I had no idea what to do with that
231 information. I walked out of the room in a bit of a daze....” (Lyn)

232

233 The majority of participants perceived that the lack of clear processes within their health
234 service added to their anxiety around asking and receiving a potentially positive IPV
235 disclosure from women:

236 “We all know the manoeuvres to assist a woman with a shoulder dystocia
237 situation so we should have the same sort of step by step things to do, almost
238 tick box things that you can do if someone discloses domestic violence. There
239 should be no question in your mind what the next step should be.” (Lynda)

240

241 The importance of being able to provide appropriate and safe support to women who
242 disclosed IPV was recognised as important by all participants. However many also described
243 feeling pressured to account for the time spent supporting women who required this
244 additional support:

245 “You may have just spent 3 or 4 hours with the woman on that day and I really
246 experience frustration trying to justify this time to management..... the “bean
247 counters” – they just don’t get it.” (Gail)

248

249 A lack of available resources to support women who disclosed IPV was identified as another
250 source of frustration for most participants. This was particularly true for those working in rural
251 or remote communities. Midwives working in these areas described having very little practical
252 support to offer women who disclosed IPV other than referral to the local police service:

253 “It comes from sitting in a little office somewhere with a woman telling me she’s
254 got nowhere to go and she can’t leave her partner because she has no money
255 and he won’t let her take the kids and she’s sitting there crying. I’ve started this
256 conversation and then I can’t offer her anything except a hug because she does
257 not want to go to the police and there are no other options for her.” (Susan)

258

259 Participants described anxiety around the mandatory reporting legislation in some states (for
260 example, New South Wales). Some participants reported that women would not answer
261 honestly if they knew the midwife was obliged to make a report to social services or other
262 community departments concerned about the safety of children. The midwives also
263 expressed concern that mandatory reporting would have a negative impact on their
264 relationship with women and lead to issues of trust between the midwife and the woman:

265 “So sometimes they [women] want the help but they don’t want to tell us because
266 they’re fearful that we might report them and DOCS [Department of Community
267 Services] will take their babies. There’s a big fear factor out there.” (Eloise)

268

269 All participants described receiving very little training in preparation for asking women about
270 IPV. The majority of midwives identified minimal education on IPV either during
271 undergraduate programs or after employment as a registered midwife:

272 "I was taught from another member of staff when I first started I just sat in on
273 a booking appointment and that would be the only training I had to ask those
274 questions." (Alice)

275

276 This lack of training was identified by the majority of participants as a contributing factor to
277 their feelings of unpreparedness for routine enquiry:

278 "I think we need to have training to pick up the less obvious things, to make sure
279 you are asking the questions right..... realistic training by people that know what
280 they are talking about" (Ange)

281 "... oh my god what am I going to do now, you know, because we haven't had the
282 training. So ... I'll just get social work to call her. I'll just "hand-ball" it straight to
283 social work." (Enid)

284

285 "We could all benefit in some really good solid training. If there was more
286 guidance for us then we would feel more confident about asking these
287 questions." (Lyn)

288

289 *4.5. Building a relationship*

290 Factors that enabled routine enquiry were also identified. In particular, building a trusting
291 relationship was viewed as paramount when asking women about IPV. Perspectives differed
292 according to whether participants worked in continuity of care models or in a fragmented
293 system of care. Participants working in shared GP care/ antenatal clinics spoke of their
294 frustration in having minimal contact with women during pregnancy and often only saw a
295 woman once during the antenatal period:

296 "...and we see the women once through pregnancy. It is so difficult to set up a
 297 relationship with a woman where you feel comfortable or where they feel
 298 comfortable to openly talk about it [IPV]" (Valerie)

299

300 Some participants made comparisons between their experiences of working in medical
 301 models and continuity of care models. For midwives now working in continuity of care
 302 models, their sense of connection with the woman was apparent:

303 "I've now got the advantage of time and the advantage of continuity of care.....
 304 Asking those questions can be done in a much more collegial way" (Alison)

305 "Because you can get to know them and can really champion their cause...it's
 306 such a difficult topic to broach when you first meet someone" (Lyn)

307

308 Participants identified that building a relationship with a woman was much more likely to elicit
 309 honest responses about IPV:

310 "...that's the importance of being able to develop a relationship with those
 311 women and not just seeing them on a one off basis and throwing those difficult
 312 questions at them and never seeing them again. That's one of the benefits of
 313 continuity for midwifery care.... As they go along through the pregnancy they do
 314 learn to trust you and to open up and disclose things." (Ange)

315

316 The opportunity to ask women about IPV on more than one occasion was also identified as a
 317 benefit of the continuity of care relationship. Participants described situations where they felt
 318 the woman was not ready to disclose IPV on the first appointment as they had not yet had a
 319 chance to build rapport with the woman:

320 "Trust is very important and when a young woman is newly pregnant it can take
 321 some time to build up trust. So we don't ask these questions just once. We'll ask
 322 them again later in the pregnancy when trust would have developed. If the time is
 323 right to disclose then they will disclose" (Tracey)

324

325 Building a relationship over time was described as a positive benefit to noticing changes in a
326 woman's behaviour. Participants described experiences of noting when a woman was not as
327 "happy" as she normally was or if she behaved differently when her partner was present.

328 These perceived changes were triggers for the midwife to enquire again about IPV:

329 "It's very complex. But I think for the midwife ... they have to be able to recognise
330 it. They have to be able to read the body language and they have to feel
331 comfortable in being able to say to a woman, look I know things are not good at
332 home and I am not going to push you. But if I can help you in any way then
333 please just give us a call. That just opens a door..." (Louise)

334

335

336 5. Discussion

337 For over a decade many health services across Australia have initiated and maintained
338 screening programs for IPV. The findings of this qualitative study provide a contemporary
339 view of midwives experiences of their day to day practice of routine IPV enquiry. Similar to
340 the findings of previous researchers the current study identified workplace barriers that
341 hindered routine enquiry. Barriers included midwives feeling unsupported and unprepared for
342 routine enquiry for IPV in the antenatal period, organisational constraints, and clinical
343 appointment arrangements. However, working in continuity of care models, receiving
344 training, and having access to services that support women experiencing violence were
345 highly valued. These elements are discussed in the following sections.

346

347 In line with previous findings from European studies, this study also identified several barriers
348 which inhibited midwives' confidence to routinely enquire about IPV. Participants in this study
349 supported policy and practice recommendations that routine enquiry is an essential and
350 valued aspect of the antenatal midwifery care. Yet, despite the importance they clearly
351 placed on routine enquiry, participants also felt unprepared and lacked confidence to both

ask women about IPV and to deal with a potentially positive disclosure. The sense of unpreparedness was described in emotive terms reflecting anxiety, even fear, when dealing with the perceived sense of responsibility to support women disclosing IPV. The findings from this study support the findings of Baird et al.²⁵ which emphasised that asking the question alone is not enough in itself; midwives need to feel knowledgeable and confident in their abilities to respond positively when women disclose abuse.

Participants associated the fear of a positive disclosure as potentially preventing them from enquiring about IPV in a meaningful way. They identified that fear of a positive disclosure along with multiple organisational barriers appeared to be reducing routine enquiry to a “tick box” exercise in some health services. The findings revealed that midwives want time to develop a relationship with women, have the flexibility to spend time with women at risk, and undertake a full antenatal assessment in a meaningful way. The diverse nature of the sample in the current study enabled some comparison between different health services and models of service delivery when analysing responses. Participants working in health services in states or territories where a robust process exists for routine enquiry and positive disclosures reported feeling more confident asking women about IPV and how to support women who positively disclosed IPV. The development of a reciprocal trusting relationship has been recognised as part of the foundation for enquiry by midwives.^{26,27} Similarly, women have identified the importance of the client-health professional relationship when disclosing IPV.^{8,28} Although previous research in Swedish countries have highlighted the benefits of continuity of care for routine enquiry^{18,19} this model differs from that in Australia where midwives care for women not only during pregnancy but during labour and postpartum as well. The provision of continuity of care throughout the perinatal period by a known midwife enhances the likelihood of effective routine enquiry across time; and provides opportunities to link women with support services and to bolster their social support network.

Conversely, participants who perceived little or no support around routine enquiry from the health service where they were employed described feeling unprepared and unsure if they were receiving “honest” answers from women. Responses from participants working in rural and remote communities described the lack of resources to support women disclosing IPV as a major barrier when screening for IPV. Participants working in remote Aboriginal and Torres Islander communities in Western Australia and the Northern Territory described a profound sense of powerlessness around the lack of available support for women disclosing IPV. In some communities, referral to the local police was the only option of support available for women. Available literature identifies a number of issues that are specific to the experience of violence for women living in rural and remote communities. Some of these barriers include, but are not limited to, geographical isolation of rural living, lack of transport and a shortage of Indigenous specific shelters.²⁹ These barriers are further compounded by concerns relating to privacy and confidentiality, as well as a possible delayed response by authorities due to a lack of service personnel and distance. There appears to be limited research on how rural and remote communities respond to and address the issue of violence against Indigenous women.³⁰ This is consistent with international research that suggests that this issue has been relatively neglected³¹ and is therefore an area which requires further exploration to ensure that all women living in rural and remote areas of Australia are able to access the support they need.

All participants regardless of location or health service model identified minimal education and training on IPV. A small number of participants reported receiving some brief initial training either prior to the introduction of screening programs or during their undergraduate program for midwifery registration. The majority of participants however reported receiving no initial or ongoing education on IPV. Recent research on Australian midwives’ knowledge about IPV and practices confirmed previous research from the United Kingdom about the consistent association between higher levels of knowledge and frequency of asking women about IPV.^{12,23} In line with previous findings this current study demonstrated that robust

educational programmes are vital if midwives are to carry out the role of IPV enquiry and support women who are experiencing IPV.^{15,19} Midwives need to possess appropriate knowledge and skills, as well as access to resources and tools in order to communicate about this sensitive issue with women. Indeed, if midwives do not know what cues to look out for, or how to sensitively ask a woman about IPV, they will not ask about issues related to IPV.

The barriers to IPV identified in this study are consistent with barriers previously identified by midwives in studies from Europe and include the presence of a partner at appointments, concerns around privacy, appointment time constraints, legislative requirements, and a lack of support mechanisms.^{12,15,19} The provision of education and peer-mentoring may enable midwives to generate suitable workplace solutions to these recurring barriers. The sharing of best practice amongst peers, either face to face or via the internet, could add considerably to midwives' sense of support and empowerment to address maternal psychosocial issues with confidence.

Routine enquiry continues to be an integral part of federal and state government responses to the global call to action on halting violence against women.^{3,32} Screening programs within maternity services were recommended in recognition that antenatal care provided an ideal window of opportunity to detect and support women experiencing IPV.^{32,33} Previous research has shown that primary care interventions for women can increase identification and referrals to support services.^{12,34} The WHO guidelines 'Responding to intimate partner violence and sexual violence against women' clearly articulates the key role of health can play in responding to IPV.² Yet it would appear that midwives feel unsupported by their organisation to carry out this role effectively. For this work to be successful there is a requirement for a sustained commitment from all hospital health services to support the introduction and continuation of a robust education and support program around IPV.

6. Limitations

The results of the study need to be considered in light of limitations. Participants for this study nominated to be interviewed after completing an on-line survey. It may be that these midwives had an existing interest in IPV and their views may not reflect those of other midwives who did not engage in this research process. It may not be possible to generalise these results to all health care systems in Australia or to those in other countries, but the consistent elements of experience expressed by participants across settings give some weight to understanding midwives' experience of routine IPV enquiry in the Australian context. It should also be noted that midwives working in public health services were over represented in this study. Two midwives were self-employed and there were no midwives employed in the private hospital system. Therefore, future studies could investigate the experiences of midwives working in emerging sectors (such as self-employed midwives) to better understand their experiences, adequacy of community support services, and their continuing professional development needs.

7. Conclusion

Midwives perceive that routine enquiry is an important midwifery role. Currently, some midwives are fearful of discussions with women around intimate partner violence due to a lack of professional development, preparation, and workplace support. The perceived level of support around routine enquiry from health services varied markedly according to different practice contexts. Midwives who worked in practice environments which incorporated training on IPV and had clear referral pathways reported feeling more confident in dealing with positive disclosures. Continuity of care was identified as a positive enabler for routine enquiry. Midwives valued both the trusting relationship and the opportunity to find the right time to discuss IPV with women.

For midwives to feel prepared and confident with the process of routine enquiry they must feel supported. Ongoing training on IPV that includes guidance on how to ask the question, deal with barriers, recognise signs of IPV and a clear referral pathway for positive disclosure

is vital. Health services should also ensure that barriers such as time constraints in antenatal clinics are made more flexible and models of care that support continuity and building of a relationship with their midwife are available for all women accessing maternity care. If antenatal routine enquiry is to be effective in all areas, there is a need for the further development of culturally appropriate support services to be available for all women living in rural and remote areas of Australia.

8. Implications for research and practice

The results from this study show that there is a need for a robust education and training program for all midwives. During the interviews the midwives clearly articulated that there continues to be some barriers to routine enquiry into IPV. These included, continued presence of partners, organisational barriers such as lack of privacy and time.

There is also a need for a continued commitment from health care organisations and professional bodies to the continuation of education and training around IPV and routine antenatal enquiry as part of mandatory training. Although the question is asked routinely, midwives should be skilled in their communication so that women do not experience it as a tick box exercise.

Conflict of interest

The authors have no conflicts of interests to disclose.

Acknowledgement

The authors would like to extend a big thank you to all the midwives who participated in the study and the research.

Funding

The study was conducted with an Early Career Research Grant from Griffith Health Institute,
Griffith University

References

1. World Health Organisation. Understanding and addressing violence against women: Intimate partner violence. 2012.
http://www.who.int/reproductivehealth/topics/violence/vaw_series/en/ (accessed 18/08/ 2015).
2. World Health Organisation. Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines. 2013.
<http://www.who.int/reproductivehealth/publications/violence/9789241548595/en/> (accessed 18/08/ 2015).
3. Morgan A, Chadwick H. Key issues in domestic violence. Research in Practice: Summary Paper No7. Canberra: Australian Institute of Criminology, 2009.
4. Australian Bureau of Statistics. Personal Safety Survey, Australia, 2012, cat. no. 4906.0. Canberra: Australian Bureau of Statistics; 2012.
5. Phillips J, Vandenbroek P. Domestic, family and sexual violence in Australia: an overview of issues. Parliamentary Library Research Paper series 2014-15 Canberra: Parliament of Australia; 2014.
6. The National Council to Reduce Violence against Women and their Children. Background Paper to Time for Action: The National Council's Plan for Australia to Reduce Violence against Women and their Children, 2009-2021 In: Department of Social Services, editor. Canberra: Australian Government; 2009.
7. Council of Australian Governments (COAG). The National Plan to Reduce Violence against Women and their Children 2010 – 2022. Canberra: Australian Government; 2009.

8. Spangaro J, Zwi A, Man W, Poulos R. Six Months After Routine Screening for Intimate Partner Violence: Attitude Change, Useful and Adverse Effects. *Women & Health* 2010; **50**(2): 125-43.
9. Taft A, O'Doherty L, Hegarty K, Ramsay J, Davidson L, Feder G. Screening women for intimate partner violence in healthcare settings. *Cochrane Database of Systematic Reviews* 2013; **4**(4): CD007007.
10. Taft AJ, Hooker L, Humphreys C, et al. Maternal and child health nurse screening and care for mothers experiencing domestic violence (MOVE): a cluster randomised trial. *BMC medicine* 2015; **13**(1): 150.
11. Salmon D, Murphy S, Baird K, Price S. An evaluation of the effectiveness of an educational programme promoting the introduction of routine antenatal enquiry for domestic violence. *Midwifery* 2006; **22**(1): 6-14.
12. Baird K, Salmon D, White P. A five year follow-up study of the Bristol pregnancy domestic violence programme to promote routine enquiry. *Midwifery* 2013; **29**(8): 1003-10.
13. Edin KE, Högberg U. Violence against pregnant women will remain hidden as long as no direct questions are asked. *Midwifery* 2002; **18**(4): 268-78.
14. Webster J, Creedy D. Domestic Violence- screening can be made acceptable to women. 2002.
15. Mauri EM, Nespoli A, Persico G, Zobbi VF. Domestic violence during pregnancy: Midwives' experiences. *Midwifery* 2015; **31**(5): 498-504.
16. Mezey G, Bacchus L, Haworth A, Bewley S. Midwives' perceptions and experiences of routine enquiry for domestic violence. *BJOG : an international journal of obstetrics and gynaecology* 2003; **110**(8): 744-52.
17. Price S, Baird K. Tackling domestic violence. An audit of professional practice. *The practising midwife* 2003; **6**(3): 15.
18. Stenson K, Sidenvall B, Heimer G. Midwives' experiences of routine antenatal questioning relating to men's violence against women. *Midwifery* 2005; **21**(4): 311-21.

- 544 19. Finnbogadottir H, Dykes AK. Midwives' awareness and experiences regarding
545 domestic violence among pregnant women in southern Sweden. *Midwifery* 2012;
546 **28**(2): 181-9.
- 547 20. McCosker-Howard HM, Kain VJ, Anderson DJ, Webster J. The impact on midwives of
548 undertaking screening for domestic violence-focus group findings. *Birth issues* 2005;
549 **14**(2): 49-56.
- 550 21. Jones C, Bonner M. Screening for domestic violence in an antenatal clinic. *Australian*
551 *journal of midwifery* 2002; **15**(1): 14-20.
- 552 22. Duncan J, Western D. Addressing'the Ultimate Insult': Responding to Women
553 Experiencing Intimate Partner Sexual Violence: Australian Domestic & Family
554 Violence Clearinghouse, University of New South Wales; 2011.
- 555 23. Baird KM, Saito AS, Eustace J, Creedy DK. An exploration of Australian midwives'
556 knowledge of intimate partner violence against women during pregnancy. *Women*
557 *and Birth* 2015.
- 558 24. Braun V, Clarke V. Successful qualitative research: a practical guide for beginners.
559 London: SAGE; 2013.
- 560 25. Baird K, Salmon D, White P. A five year follow up study of the Bristol Pregnancy and
561 Domestic Violence Programme (BPDVP) to promote routine antenatal enquiry for
562 domestic violence at North Bristol Trust: University of the West of England; 2011.
- 563 26. LoGiudice JA. Prenatal screening for intimate partner violence: a qualitative meta-
564 synthesis. *Applied Nursing Research : ANR* 2015; **28**(1): 2-9.
- 565 27. Rollans M, Schmied V, Kemp L, Meade T. Digging over that old ground: An
566 Australian perspective of women's experience of psychosocial assessment and
567 depression screening in pregnancy and following birth. *BMC Women's Health* 2013;
568 **13**(1): 18-.
- 569 28. Hindin PK. Intimate Partner Violence Screening Practices of Certified Nurse-
570 Midwives. *Journal of Midwifery and Women's Health* 2006; **51**(3): 216-21.

29. Blagg H, Bluett-Boyd N, Williams E. Innovative models in addressing violence against Indigenous women: State of knowledge paper. *Landscapes: state of knowledge*, 2015. http://anrows.org.au/sites/default/files/Ff%20150806%20-%208_4%203%20Indigenous%20Women.pdf (accessed.
30. Bagshaw D, Chung D, Couch M, Lilburn S, &, Waldham B. Reshaping responses to domestic violence: Final report. Adelaide: University of South Australia, 2009.
31. Jamieson S, Mikko Vesala K. Exploring men's perpetrator programs in small rural communities. *Rural Society* 2008; **18**(1): 26-38.
32. Australian Health Ministers' Advisory Council. Clinical Practice Guidelines: Antenatal Care – Module 1. In: Ageing AGDoHa, editor. Canberra: Australian Government; 2012.
33. National Institute for Health and Care Excellence. Domestic violence and abuse: how health services, social care and the organisations they work with can respond effectively. NICE guidelines [PH50]. 2014. <https://www.nice.org.uk/guidance/ph50> (accessed 29/09/ 2015).
34. Feder G, Davies RA, Baird K, et al. Identification and Referral to Improve Safety (IRIS) of women experiencing domestic violence with a primary care training and support programme: a cluster randomised controlled trial. *The Lancet* 2011; **378**(9805): 1788-95.