Effectiveness of training to promote routine enquiry for domestic violence by midwives and nurses: A pre-post evaluation study

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Effectiveness of training to promote routine antenatal enquiry for domestic violence: A pre-post evaluation study

Running head: Evaluation of DV training

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Effectiveness of training to promote routine enquiry for domestic violence by midwives and nurses: A pre-post evaluation study.

Abstract

Background: Asking women about experiences of domestic violence in the perinatal period is accepted best practice. However, midwives and nurses may be reluctant to engage with, or effectively respond to disclosures of domestic violence due a lack of knowledge and skills.

Aim: To evaluate the impact of training on knowledge and preparedness of midwives and nurses to conduct routine enquiry about domestic violence with women during the perinatal period.

Method: A pre-post intervention design was used. Midwives and nurses (n = 154) attended a full day workshop. Of these, 149 completed pre-post workshop measures of knowledge and preparedness. Additional questions at post-training explored participants' perceptions of organisational barriers to routine enquiry, as well as anticipated impact of training on their practice. Training occurred between July 2015 and October 2016.

Findings: Using the Wilcoxon signed-rank test, all post intervention scores were significantly higher than pre intervention scores. Knowledge scores increased from a pre-training mean of 21.5 to 25.6 ($Z=-9.56$, $p <.001$) and level of preparedness increased from 40.8 to 53.2 ($Z=-10.12$, $p <.001$). Most participants (93%) reported improved preparedness to undertake routine enquiry after training. Only a quarter (24.9%) felt their workplace allowed adequate time to respond to disclosures of DV.

Conclusions: Brief training can improve knowledge, preparedness, and confidence of midwives and nurses to conduct routine enquiry and support women during the perinatal

period. Training can assist midwives and nurses to recognise signs of DV, ask women about what would be helpful to them, and address perceived organisational barriers to routine enquiry. Practice guidelines and clear referral pathways following DV disclosure need to be implemented to support gains made through training.

Keywords: Domestic violence, midwives, nurses, training, evaluation, routine enquiry

Significance

What is known

- Domestic violence is a leading cause of morbidity and mortality in women, contributing to poor mental and physical health, substance abuse and poverty.
- Asking women about their experiences of domestic violence in the perinatal period is accepted best practice.
- Midwives and nurses report feeling unprepared and unsupported for routine enquiry about domestic violence.

What this paper adds

- Brief training improved knowledge and preparedness of midwives and nurses to conduct routine enquiry and support women disclosing domestic violence.
- Training programs need to address common myths associated with DV to prompt positive attitudes, focus on knowledge and preparation for routine enquiry, provide information on local resources, and promote adherence with best practice.
- A ‘whole of work unit’ approach where all staff attend training is recommended.

Effectiveness of training to promote routine enquiry for domestic violence: A pre-post evaluation study.

Introduction

Violence against women and children incurs an enormous cost to countries around the world. Domestic violence (DV) (also referred to as intimate partner violence or family and domestic violence) [1] in Australia is estimated to cost $13.8 billion, with costs to heath estimated at $863 million alone.[1] DV is a leading cause of morbidity and mortality in women, contributing to poor mental and physical health, substance abuse, poverty and exclusion. [2] Experiencing DV during pregnancy is of special concern, as the violence not only poses a threat to women but also to their babies. The consequences of DV during pregnancy include a higher incidence of miscarriage, neonatal death, premature labour, and low birth weight infants. [3,4]

The continuing high prevalence and significant impact of DV on women's health requires an urgent response by health services. [3] Routine enquiry about violence during pregnancy and throughout the perinatal period is recognised as best practice. [3,5,6] However, regardless of policy and research drivers, the overall response from many maternity services and clinicians has been sporadic.

Although women rarely voluntarily disclose their experiences of DV to health professionals, [7] women do find questions about DV acceptable in maternity settings. [8]. A qualitative meta-synthesis of healthcare providers' experiences of antenatal DV screening in the United States, New Zealand, Sweden and United Kingdom identified that health professionals sometimes struggle to identify unspoken cues from women, were uncertain about when and how to ask about violence, and complained of a lack of tools and processes to guide screening and referral. [9] Other workplace barriers to routine enquiry include presence of the partner and time constraints during the consultation. [9]

The reluctance of health professionals to ask women about DV has also been attributed to a lack of preparedness and negative attitudes.[10] A recent qualitative study found that midwives in Australia felt not only unprepared for screening, but fearful about what to do if a woman disclosed DV.[11] Personal feelings of discomfort and/or fear of causing offence have also been reported.[12] Similarly, negative preconceived ideas of staff about women experiencing abuse have been identified as barriers to routine enquiry.[9,13]

Impact of domestic violence education and training

A range of training programs have been developed to advance midwives' and nurses' understanding of DV, identification of women at risk, and use of referral pathways for women. A recent scoping review by Crombie, Hooker & Reisenhofer,[14] highlighted not only a paucity of DV education and training programs for midwives and nurses, but wide variation in available program content, educational approaches and length of training. Seven of the 35 studies identified for initial review were excluded because they did not report on impact or outcomes of DV training. Of the 20 included studies, eight originated from the USA, four from the UK, with the reminder conducted in countries such as Australia, Canada, New Zealand and Turkey. This relative paucity of studies confirms a lack of evaluative research on DV education and training for midwives and nurses.

The relatively few published evaluations of DV education and training programs for midwives and nurses have produced positive results. The Bristol Pregnancy Domestic Violence Programme (BPDVP), for example, was well evaluated using a longitudinal pre-post intervention design. This skills-based training course for community midwives demonstrated improvements in knowledge, attitudes and efficacy which were sustained at six months.[15] Five years after the introduction of the BPDVP participating midwives described continued feelings of confidence and a sense of pride about their role in routine enquiry.[16] Their sustained commitment to routine enquiry also prompted the use of innovative workplace strategies to overcome some of the previously identified barriers.

A four-day training program in Sri Lanka offered to community-based midwives drew on experts, used case-based experiential learning, and role-play.[17] Evaluation of the program revealed improved knowledge and confidence to provide support to victims of DV and overcome barriers to enquiry. Similarly, a Canadian study explored factors affecting decisions by doctors and nurses about whether to address and respond to DV.[18] Staff who had participated in training felt better prepared when responding to a positive disclosure compared to those without training.

Characteristics of effective training

WHO [3] recommends that DV training programs need to address staff attitudes, and include safety planning, effective communication and referral to specialist community services. Furthermore, health professionals need to view routine DV enquiry as an important part of their role.[9] Training is also more likely to be more effective for those who want to improve their practice rather than for those who attend training as a mandatory requirement.[15]

To increase levels of staff preparedness, program content should reflect available evidence and best practice. [3,19] Information also needs to be relevant to the practice context of participants, with information about referral pathways and local community agencies available to support women disclosing DV. [20] There also needs to be opportunities to practice the skills required for routine enquiry as well as critical decision-making.[15] Training programs also need to address the responsibilities of midwives and nurses in relation to child safety and mandatory reporting requirements to the appropriate authorities. [21] Relevant strategies need to be discussed, as mandatory reporting can be an area of concern and anxiety for many midwives and nurses.

In summary, although routine enquiry for domestic violence during the perinatal period is best practice, there is variability in the use of screening in practice. There is a paucity of research

describing and evaluating DV training. Published papers often provide little detail on program content and processes. Some programs have not been rigorously evaluated and standardised measures and/or mixed method approaches to evaluation are not always used. This paper presents one part of a larger program of evaluation that sought to determine the impact of training on knowledge and preparation of midwives and nurses to routinely enquiry about DV during the perinatal period.

Method

A pre-post intervention design was used.

Sample

All midwives offering antenatal care at three hospitals in south east Queensland and nurses in contact with new mothers (such as neonatal intensive care nurses, community child health nurses) were invited to attend a full day workshop by their unit manager. Workplace arrangements such as paid study leave, backfill, and closing the antenatal clinic, were offered to support workshop attendance for interested staff during work time. Approximately 160 midwives were invited and 154 attended, giving a response rate of 96%.

Measures

Survey items were drawn predominantly from the literature and the Bristol Domestic Violence Study.[15] All scale items are in the public domain and used here with permission of the authors. The survey form was adapted for the Australian context and modified to enhance reliability and validity. The survey consisted of five sections.

Respondents generated a two-part personal identification code. For example, participants could provide their mother's maiden name and birthdate. This code enabled anonymity to be preserved as well as assisting the researchers to monitor individual and group changes over time. Participants provided information about their professional role, years of experience, and

previous DV training in Section 1 of the survey.

Section 2 explored workplace factors that may impact on routine enquiry. This new 15-item scale included factors such as familiarity with hospital policies and guidelines, perceptions of support to undertake screening, fear of personal safety, and presence of a partner. Responses were given using a 5 point Likert scale of 1=strongly disagree to 5 = strongly agree. Six variables were reverse coded for scoring purposes (items 8, 9, 10, 11, 13 and 14). A total score was calculated. The reliability for this scale was satisfactory with a Cronbach's alpha coefficient of .74.

Section 3 sought respondents' perceptions of preparedness to undertake routine enquiry and support women experiencing DV. Responses were given using a five point Likert scale of 1=unsure, 2=not at all prepared, 3=minimally prepared, 4=moderately prepared, and 5=well prepared. An additional item also asked respondents to provide a "global" self-assessment of preparedness on a 10 point Likert scale. The pre- and post-training Preparedness Scales were found to be reliable with a Cronbach's alpha coefficient of .93 and .89 respectively.

Section 4 presented a series of questions related to knowledge of DV issues with responses on a true, false, don't know basis. Correct answers were awarded 2 points, 1 point for don't know and 0 for an incorrect answer. Item content included the influence of alcohol and drugs on violent behaviour, respecting women's choice to remain in a violent relationship, and the extent to which strangulation injuries occur in cases of DV. Content validity of these items was established in a previous national survey of midwives.[10]

Support to undertake routine enquiry was assessed in Section 5. Participants were asked about the likelihood of seeking support from various resource people within their organisation (such as peers, manager, doctors). Responses were recorded using a scale of '1' (least likely to seek support from) to '5' (most likely to seek support from).

Workshop quality evaluation

The post-workshop survey included an evaluation about the impact of training on a 5 point Likert scale (1=not at all to 5= a great deal). Participants rated the quality of presentations, format, duration and areas for improvement. These items formed a scale with a Cronbach's alpha of .86.

Intervention: Overview of the workshop program

The training program provided participants with protected time to develop their knowledge and preparedness to ask women about DV. The creation of a supportive and informed learning environment was essential. The existing knowledge and skills of participants was acknowledged and program facilitators used a range of learning and teaching approaches.

The workshop commenced with an overview and acknowledgement of the sensitivity of the topic. Given the high prevalence of DV for one in four Australian women, some participants may potentially have personal experiences of DV. Information was provided on how participants could access confidential support should they experience distress. One volunteer from each training site had agreed to be the workplace “champion” for routine enquiry about DV. The concept of the “champion” was to provide staff with a resource person they could approach for support and guidance around DV after training. The “champions” for each workplace were also session facilitators during the program so participants would see them as a knowledgeable resource about DV.

Teaching approaches included lectures, group activities, video, role-play, and analysis of case studies. Group-work sessions encouraged discussion around topics such as what constitutes violence against women and why women may choose to stay with a violent partner. Participants completed a quiz on stereotypical attitudes and myths about DV. Discussing the answers as a group allowed exploration of common misconceptions about DV

in a safe way. A segment on the effects of DV on children and legislation around mandatory reporting for child safety included a video of a child telling their story about witnessing DV. The role of midwives and nurses in identifying and supporting women experiencing DV included discussions on responding, boundaries, safety, and record keeping.

To acknowledge the voices of women experiencing DV, a survivor shared her story and experiences of maternity care during pregnancy. This session was followed by a presentation from a DV community support agency on referral processes and services. A recorded role-play was used to identify respectful communication skills, before encouraging participants to practice in groups of 2 to 3. Participants were given summaries of real case scenarios to encourage discussion and critical thinking. The session included discussion of strategies to overcome potential barriers for routine enquiry. The final session of the day provided an opportunity for participants to debrief.

Procedure

Recruitment

An information sheet and consent form to participate in the evaluation research was emailed to all participants prior to the training day. Time was allocated for participants to complete the survey prior to commencement of the first session. Completion of the post-training survey concluded the day. Training was conducted between July 2015 and October 2016.

Ethical Approval

Ethical approval was obtained and granted by Griffith University Human Research Ethics Committee and participating Health Service Human Research Ethics Committee (HREC/15/QGC/8) prior to the start of the study.

Approach to analysis

Data were entered into SPSS V22. All data were scanned for missing values and patterns of

distribution. Continuous variables were checked for normality using the Shapiro Wilks test. Descriptive analyses were conducted for participant characteristics. For scales in each section, items were reversed scored where necessary. Total and subscale scores were calculated and frequencies run to produce means, standard deviations and range of scores. Internal reliability of scales was assessed using Cronbach's alpha coefficient. Inferential statistics (Spearman's rho and Wilcoxon Signed rank test) were conducted to determine changes from baseline to post-intervention.

Results

Full day training workshops were conducted with 8 groups of health professionals (n = 154). Of these, 149 pre-post survey responses were matched using the personal ID code. Missing data were left as missing in the analysis.

Sample characteristics

Most participants were midwives (n = 131) working in antenatal clinics or a Midwifery Group Practice which offers continuity of care to women during pregnancy, labour and birth, and postpartum up to 6 weeks. The remainder of participants were registered nurses, managers, educators, and child health nurses. More than half (59.1%) worked part time. The mean years of practice was 19.86 years (SD =12.91, range = 1-46). Participant characteristics are presented in Table 1.

Table 1. Characteristics of participants.

Characteristics	n (%)
Occupation	
Registered Midwife	131 (85.1)
Registered Nurse	16 (10.4)
Other (Manager, Educator, Child Health)	7 (4.5)

Employment		
Fulltime	59 (39.6)	
Part-time	88 (59.1)	
Casual	2 (1.3)	
Years of experience		Mean:
19.86, SD =12.9 Range = 1 – 46 yrs		
Previous Training on DV		
Read hospital policy	67 (45.0)	
Watched a DVD	55 (36.9)	
Attended a lecture or talk	64 (43.0)	
Hospital training (½ day)	21 (14.1)	
Attended skills based workshop (1 or more days)	25 (16.8)	
Completed an online training module	43 (28.9)	
Other	9 (6.0)	
None	27 (18.1)	
Time since previous training		
Within last month	4 (2.7)	
Within last 6 months	16 (10.7)	
Within last year	37 (24.8)	
Between 2-5 yrs	41 (27.5)	
More than 5 yrs ago	16 (10.7)	
Don't remember	7 (4.7)	
None	28 (18.8)	
Overall hours of DV training		Mean 5.8 SD
=11.09 Range = 0-99 hours		

When asked about previous education/training on DV training, 45% had read the hospital's policy on routine enquiry, 43% had attended a lecture on DV, 36.9% had watched a DVD. Participants reported an average of 5.8 hours of previous DV training. Twenty-seven participants (18.1%) had no previous training.

Workplace factors impacting on routine enquiry about DV

Responses on the 15-item scale about workplace factors supporting routine enquiry produced a total mean score of 52.85 (SD = 6.83) (see Table 2). Nearly all participants (94%) felt encouraged to respond to women disclosing DV; and supported by their managers (75.9%) and peers (79.9%) to conduct DV screening. Most (89.9%) felt their own personal experience of violence did not interfere with their ability to conduct routine enquiry. A quarter (24.9%) of respondents felt their workplace allowed adequate time to respond to disclosures of DV and 38.9% were too busy to participate in multidisciplinary team meetings about women experiencing DV. More than half (56.4%) felt that language barriers with clients interfered with routine enquiry.

Table 2. Perceptions of workplace factors.

	Strongly disagree n (%)	Disagree n (%)	Unsure n (%)	Agree n (%)	Strongly agree n (%)
My workplace encourages me to respond to women disclosing DV.	1 (0.7)	1 (0.7)	7 (4.7)	64 (43.0)	76 (51.0)
I am familiar with hospital policies and guidelines in regard to routine enquiry and management of DV.	3 (2.0)	8 (5.4)	47 (31.5)	65 (43.6)	26 (17.4)
I feel supported by medical colleagues to routinely enquire about DV.	3 (2.0)	15 (10.1)	41 (27.5)	63 (42.3)	27 (18.1)
I feel supported by my manager to routinely enquire about DV.	1 (0.7)	10 (6.7)	25 (16.8)	67 (45.0)	46 (30.9)
I feel supported by my peers to routinely enquire about DV.	1 (0.7)	6 (4.0)	23 (15.4)	76 (51.0)	43 (28.9)
I am supported to make appropriate referrals for women experiencing DV.	1 (0.7)	5 (3.4)	20 (13.4)	78 (52.3)	45 (30.2)
I am familiar with the protocol for dealing with DV in my clinical area.	3 (2.0)	11 (7.4)	52 (34.9)	63 (42.3)	20 (13.4)
Sometimes my own personal experience of violence interferes with my routine enquiry.	75 (50.3)	59 (39.6)	8 (5.4)	5 (3.4)	2 (1.3)

Sometimes my concern about personal safety interferes with my routine enquiry.	37 (24.8)	60 (40.3)	26 (17.4)	24 (16.1)	2 (1.3)
Fear of offending a woman interferes with my routine enquiry.	26 (17.4)	63 (42.3)	24 (16.1)	31 (20.8)	5 (3.4)
Presence of a partner at the interview interferes with my routine enquiry.	7 (4.7)	16 (10.7)	9 (6.0)	66 (44.3)	51 (34.2)
My practice setting allows me adequate time to respond to disclosures of DV.	17 (11.4)	65 (43.6)	30 (20.1)	29 (19.5)	8 (5.4)
I am too busy to participate in multidisciplinary team meetings to manage DV cases.	7 (4.7)	43 (28.9)	41 (27.5)	47 (31.5)	11 (7.4)
Language barriers (e.g. non –English speaking clients) interfere with my routine enquiry.	6 (4.0)	39 (26.2)	20 (13.4)	73 (49.0)	11 (7.4)
There is adequate private space in my workplace for me to enquire about DV with women.	8 (5.4)	25 (16.8)	16 (10.7)	82 (55.0)	18 (12.1)

Knowledge

Participants were asked about how their knowledge of DV issues. Baseline mean knowledge score was 21.5 out of a possible 28 (SD = 2.79, range 15-28). A third of participants (n=54, 36.2%) knew that alcohol consumption was the greatest single factor associated with intimate partner violence, or that women experiencing DV are the best person to make choices about how to manage their situation (n=51, 34.2%). The majority knew that ‘even if a child is not in

immediate danger, it is best practice to report an instance of a child witnessing DV to the social worker' (n=130, 87.2%), and that 'specialist training is needed to support women experiencing DV' (n=135, 90.6%). At post intervention, participants' mean level of knowledge increased to 25.6 out of a possible 28 (SD = 2.24, range 18-28). There was a significant, improved difference between pre-post intervention scores (Z=-9.56, p <.001). The majority (n=143, 98.6%) understood 'there may be good reasons why a woman stays in an abusive relationship', 'being supportive of a woman's choice to remain in a violent relationship does not condone the violence' (n=140, 96.6%); and that 'partners or friends should not be present during a woman's history and physical examination to ensure safety' (n=142, 97.9%).

Preparedness

At baseline, participants' mean score on the Preparedness Scale was 40.87 out of a possible 60 (SD = 6.9, range = 24-60) indicating a low to moderate level of preparedness (as shown in Table 3). The highest level of preparedness related to compliance with mandatory reporting requirements for child abuse (70% felt moderately prepared). At post-intervention participants' mean preparedness score was 53.25 out of a possible 60 (SD = 4.05, range = 44-60). There was a significant improved difference between pre-post intervention scores (Z=-10.12, *p* <0.001). Most participants (over 80%) felt at least moderately prepared on all aspects of routine enquiry.

Table 3. Pre-post intervention preparedness to undertake routine enquiry.

I feel prepared to:	Phase	Unsure n (%)	Not at all prepared n (%)	Minimally prepared n (%)	Moderately prepared n (%)	Well prepared n (%)
Ask questions about DV.	Pre	-	10 (6.7)	56 (37.6)	57 (38.3)	26 (17.4)
	Post	-	-	-	58 (40)	87 (60)
Appropriately respond to disclosures of abuse.	Pre	-	10 (6.7)	61 (40.9)	67 (45)	11 (7.4)
	Post	-	-	-	62 (42.8)	83 (57.2)
Identify indicators of DV based on a woman's history.	Pre	1 (0.7)	7 (4.7)	57 (38.3)	71 (47.7)	13 (8.7)
	Post	-	-	-	54 (37.2)	91 (62.8)
Document my assessment of DV in a way that ensures the woman's safety.	Pre	2 (1.3)	12 (8.1)	62 (41.6)	55 (36.9)	18 (12)
	Post	-	-	2 (1.4)	51 (35.2)	92 (63.4)
Help a woman assess her degree of danger.	Pre	-	17 (11.4)	78 (52.3)	46 (31)	8 (5.4)
	Post		-	6 (4)	84 (58)	55 (38)
Conduct a safety assessment for a woman and her child(ren).	Pre	1 (0.7)	32 (21.5)	72 (48.3)	38 (25.5)	6 (4)
	Post	-	-	10 (7)	95 (65.5)	40 (27.6)
Help a woman experiencing DV to create a safety plan.	Pre	-	51 (34.2)	73 (49)	21 (14)	4 (2.7)
	Post	-	1 (0.7)	17 (11.7)	91 (62.8)	36 (24.8)
Make appropriate and safe referrals for a woman to other agencies.	Pre	2 (1.3)	20 (13.4)	55 (36.9)	58 (38.9)	14 (9.4)
	Post	-	-	2 (1.4)	53 (36.6)	90 (62.1)

Comply with the mandatory reporting requirements for DV.	Pre	2 (1.3)	16 (10.7)	53 (35.6)	59 (39.6)	19 (12.8)
	Post	-	-	3 (2.1)	58 (40)	83 (57.2)
Comply with mandatory reporting requirements for suspected cases of child abuse.	Pre	-	4 (2.7)	16 (10.7)	75 (50.3)	54 (36.2)
	Post	-	-	2 (1.4)	38 (26.2)	105 (72.4)
Gather information to identify DV as the underlying cause of a woman's injuries (e.g., bruises, fractures, etc).	Pre	-	23 (15.4)	76 (51)	44 (29.5)	6 (4)
	Post	-	-	2 (1.4)	79 (54.5)	64 (44)
Discuss DV with a woman from a different cultural/ethic background.	Pre	-	41 (27.5)	74 (49.7)	32 (21.5)	2 (1.3)
	Post	-	1 (.07)	32 (22)	94 (64.8)	18 (12.4)

Quality and impact of training

Participants rated the quality and impact of training. The mean impact score was 27.86 (SD =2.59, range 12-30). Most (87.6%) reported the training program improved their awareness of DV in the community. Over 60% reported their knowledge had improved a great deal in relation to (1) screening and asking women about DV; (2) how to respond to a woman's disclosure of DV; (3) awareness of referral pathways; and (4) how to work with other agencies to support women experiencing DV.

Discussion

In line with previous evaluations of DV training, [10,12,16] the current study found that a structured,

one-day program improved knowledge and preparedness of midwives and nurses to routinely enquiry about DV during the perinatal period. Education programs about DV are essential to prepare staff to ask women about DV on more than one occasion; appropriately respond to a woman's disclosure of DV; and offer referral to support within the hospital and community. Findings from a systematic review of screening programs identified that health care providers were much more likely to feel prepared to carry out routine enquiry when they had attended a detailed training program. [6]

A recent scoping review identified a lack of consistency in content and processes of DV education programs for midwives and nurses.[14] Indeed, not all researchers describe the content and processes of their training programs. In line with best available evidence, [3] our education program included staff from community agencies, consumers, experiential components, addressed misconceptions about DV, and explored some of the negative attitudes midwives and nurses may have towards women surviving DV. Understanding the cycle of violence, why some women stay or return to an abusive relationship, and acknowledging the leading role of a woman in her own care are central concepts for routine DV enquiry. [22, 23]

Midwives and nurses constitute the largest workforce in maternity services, can create a trusting a supportive environment for women and their families, and are therefore in a unique position to facilitate DV disclosure. Consistent with past research, [10,11,13,15, 24,] clinicians in the current study identified barriers to their role in relation to routine enquiry, with only a quarter of respondents reporting that their workplace allowed adequate time to respond to positive disclosures of DV, and more than half believing that language barriers hindered their ability to conduct routine enquiry with all women. These findings highlight the importance of having organisational support and flexibility to facilitate longer appointment times and the provision of appropriate resources when providing care for women from culturally and linguistically diverse groups. Previous qualitative research has confirmed that midwives believe it is necessary to

have sufficient time to pick up on any signs of violence and allow for a trusting relationship to develop and support disclosure. [16,25,26,] The provision of continuity of care through midwifery caseload models are useful in this regard, as women are afforded numerous encounters with a known midwife that can enhance the development of a trusting relationship.[27]

DV training programs, which improve awareness and preparedness, can contribute to improved practice and consequently better health outcomes for women and their families. Coker, Garcia, Williams, Crawford, Clear, McFarlane et al. [28] compared pregnancy outcomes of women who had been universally screened for domestic violence during pregnancy with women who received normal care prior to the introduction of the screening program. Women who had been screened for DV had better pregnancy outcomes regarding low birth weight, preterm birth, and any maternal complication.

Workshop attendees were asked to assess the usefulness of workshop content and processes, as well as competency of the trainers. The trainers were viewed as competent and knowledgeable, with most attendees believing the workshop increased their preparedness to conduct routine enquiry for DV. Having a survivor share her story about her experiences of DV during pregnancy was considered by workshop attendees as powerful and thought provoking. Community agencies discussing their resources and how they could support a victim also increased the participants' awareness about referral processes to community agencies.

For the implementation of routine enquiry to be a success, continuing professional development programs form only one part of a larger process of change in practice and in the organisation. Crombie et al. [14] suggested a whole of system approach was required, including the development of policies, application and execution of guidelines, mandatory staff training at all levels and inclusion of external agencies in the training program. These elements were

considered in the current training program but not evaluated at this time. There is a need for organisational commitment to ongoing education and support of staff, as well as the introduction of clear policies and referral pathways. [3, 14 -16]

Limitations

There are several limitations associated with this intervention study. Although we report on outcomes for a relatively large sample who attended this training intervention, participants volunteered to participate and may differ from those midwives and nurses who did not wish to attend. Although participants were sent printed materials and a survey form prior to the workshop, the majority completed baseline and post-workshop surveys on the same day. Completing the forms in this short space of time may have elevated knowledge scores and other short-term outcomes and/or given a false impression of preparedness as participants may have felt enthused to change practice at the end of the workshop. Longitudinal evaluation of training effects is warranted. Furthermore, outcome measures were self-report and future studies could include other evidence of practice changes, such as practice audits and peer supervision. Participants were drawn from three hospitals and our analysis did not investigate workplace conditions across sites. It could be that some workplaces are more supportive of routine enquiry than others and contributed to some participants' sense of preparedness. A follow-up study on the effects of workplace factors on routine enquiry is needed. The outcome measures were found to be reliable but could benefit from testing with large diverse samples of midwives and nurses. Longitudinal follow-up of participants is needed to investigate the extent to which the training made an impact on practice and if knowledge and preparedness levels are retained.

Conclusion

A range of obstacles can prevent health care professionals from identifying and supporting women experiencing DV, including a lack of education and training, time constraints and a lack of organisational support. It is vital that midwives and nurses are knowledgeable and

skilled in their role to routinely enquire about a woman's perceptions of personal safety and respond safely and sensitively to positive DV disclosures. It is also important that any DV training program should be of sufficient length to address the complexities of DV, including addressing attitudes and stereotypes as well as ousting common myths, which surround DV.

As well as a validated DV education and training program for staff, ongoing support of staff to change their practice and routinely enquire about women's experiences of violence is required. A 'whole of work unit' approach where all staff attend training is recommended. A key benefit of routine enquiry for DV, regardless of whether the woman elects to seek help or not, it helps to break the silence that often surrounds DV, and provides women with opportunities to talk about their experiences and receive information about community resources.

References

1. Australian Government Department of Social Services (AGDSS). The National Plan to Reduce Violence against Women and their Children 2010 – 2022. Available from:https://www.dss.gov.au/our-responsibilities/women/programsservices/reducing-violence/the-national-plan-to-reduce-violence-against-women-and-theirchildren-2010-2022 .

2. Australian Bureau of Statistics. 2012, *Personal Safety Survey, Australia, 2012*, cat. no. 4906.0, ABS, Canberra. Available from: http://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/4906.02012

3. World Health Organisation. Responding to intimate partner violence and sexual violence against women: World Health Organisation, clinical and policy guidelines, 2013. Available from: http://www.who.int/reproductivehealth/publications/violence/9789241548595/en/

4 Shah PS, Shah J. Maternal exposure to domestic violence and pregnancy and birth outcomes: a systematic review and meta-analyses. *Journal of Women's Health,* 2010;**19**(11):2017-31.

5 Special Taskforce on Domestic and Family Violence in Queensland. Not Now, Not Ever: Putting an end to domestic and family violence in Queensland. 2015: Available from: https://www.qld.gov.au/community/getting-support-health-social-issue/dfv-read-report-recommendation/index.html

6 O'Doherty L, Taft A, Hegarty K, Ramsay J, Davidson LL, Feder G. Screening women for intimate partner violence in healthcare settings: abridged Cochrane systematic review and meta-analysis. *British Medical Journal*, 2014;348: 2913.

7 Bacchus L, Mezey G, Bewley S. Women's perceptions and experiences of routine enquiry for domestic violence in a maternity service. *BJOG:* An International Journal of Obstetrics & Gynaecology*. 2002;* **109**;(1):9-16.

8 Webster J, Creedy DK. Domestic violence. Screening can be made acceptable to women. *BMJ*, 2002;325(7354):44.

9 LoGiudice JA. Prenatal screening for intimate partner violence: a qualitative meta-synthesis. *Applied Nursing Research*, 2015;**28**(1):2-9.

10 Baird K, Saito A, Eustace J, Creedy DK. An exploration of midwives' knowledge of domestic violence against women during pregnancy. *Women and Birth. 2015;* **28**;(3):215-20. http://dx.doi.org/10.1016/j.wombi.2015.01.009

11 Eustace J, Baird K, Saito A, Creedy, D. Midwives' experiences of routine enquiry for intimate partner violence in pregnancy. *Women & Birth* 2016;**29**(6) 503-510.

12 Sprague, S, Madden K, Simunovic N, Godin K, Pham NK, Bhandari M, Gosling JC. Barriers to screening for intimate partner violence. *Women and Health 2012;***52**(6): 587-605.

13 Mauri EM, Nespoli A, Persico G, Zobbi VF. Domestic violence during pregnancy: Midwives′ experiences. *Midwifery* 2015;**31**(5):498-504.

14 Crombie N, Hooker L, Reisenhofer S. Nurse and midwifery education and intimate partner violence: a scoping review. *Journal of Clinical Nursing* 2016;(15-16):2100-2125. doi: 10.1111/jocn.13376.

15 Salmon, D., Murphy, S., Baird, K. & Price, S. (2006). An evaluation of the effectiveness of an educational programme promoting the introduction of routine antenatal enquiry for domestic violence. *Midwifery* 2016;**22**(1):6-14.

16 Baird K, Salmon D. White P. (2013). A five-year follow-up study of the Bristol Pregnancy Domestic Violence Programme to promote routine enquiry. *Midwifery* 2013,**2**;(8):1002-1010.

17 Jayatilleke AC, Yoshikawa K, Yassuoka J, Poudal KC, Fernando N, Jayatilleke AU, Jimba M. (2015). Training Sri Lanka public health midwives on intimate partner violence: a pre and post-intervention study *BioMed Central Public Health* 2015;15: 331.

18 Gutmanis I, Beynon C, Tutty L, Wathen CN, MacMillan H. Factors influencing identification of and responses to intimate partner violence: a survey of physicians and nurses. *BMC Public Health* 2007;7:12.

19 World Health Organisation. *Violence prevention the evidence reducing violence through*

victim identification, care and support programmes. World Health Organisation, 2010. Geneva, Switzerland.

20 Feder GS, Hutson M, Ramsay J, Taket AR, Women exposed to intimate partner violence: expectations and experiences when they encounter health care professionals: a meta-analysis of qualitative studies. *Arch Interm Med* 2006;**166**(1):22-37.

21 Bacchus LJ, Bullock L, Sharps P, Burnett C, Schminkey D, Buller AM, Campbell J. 'Opening the door': A Qualitative interpretive study of women's experiences of being asked about intimate partner violence and receiving an intervention during perinatal home visits in rural and urban settings in the USA. *Journal of Research in Nursing* 2016; 21**;**(5-6):345-364. doi:10.1177/1744987116649634.

22 Bennett H, Cohen Silver R, Ellard, RH. Coping with an Abusive Relationship: I. How and Why Do Women Stay? *Journal of Marriage and Family* 1991;**5** (2); 311-325.

23 Enander V. Why Does She Leave? The Leaving Process(es) of Battered Women, *Health Care for Women International* 2008;**29**:200-226.

24 Falb KL, Diaz-Olvarrieta C, Campos PA, Valades J, Gardenas R, Carino G, Gupta J. Evaluating a health care provider delivered intervention to reduce intimate partner violence and mitigate associated health risks: study protocol for a randomized controlled trial in Mexico City. *BMC Public Health* 2014;14: 772.

25 Finnbogadottir H, Dykes, AK. (2012). Midwives' awareness and experiences regarding domestic violence among pregnant women in southern Sweden. *Midwifery* 2012;**28**(2): 181-189.

26 Mauri EM, Nespoli A, Persico G, Zobbi VF. Domestic violence during pregnancy: Midwives′ experiences. *Midwifery* 2015;**31**(5):498-504.

27 Fenwick J, Sidebotham M, Gamble J, Creedy DK. The emotional and professional wellbeing of Australian midwives: A comparison between those providing continuity of midwifery care and those not providing continuity. *Women & Birth*, 2017; Available e-print from: http://dx.doi.org/10.1016/j.wombi.2017.06.013

28 Coker AL, Garcia LS, Williams C M, Crawford T N, Clear E R, McFarlane J, Ferguson J E.

(2012). Universal psychosocial screening and adverse pregnancy outcomes in an academic obstetric clinic. *Obstet Gynecol 2012;**119***(6): 1180-1189.