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'*Asking the hard questions*': Improving midwifery students' confidence with domestic violence screening in pregnancy

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ABSTRACT

Domestic violence is a global public health issue. Midwives are ideally placed to screen for, and respond to, disclosure of domestic violence. Qualified midwives and midwifery students report a lack of preparedness and low levels of confidence in working with women who disclose domestic violence. This paper reports the findings from an education intervention designed to increase midwifery students' confidence in working with pregnant women who disclose domestic violence. An authentic practice video and associated interactive workshop was developed to bring the 'woman' into the classroom and to provide role-modelling of exemplary midwifery practice in screening for and responding to disclosure of domestic violence. The findings demonstrated that students' confidence increased in a number of target areas, such as responding appropriately to disclosure and assisting women with access to support. Students' confidence increased in areas where responses needed to be individualised as opposed to being able to be scripted. Students appreciated visual demonstration (video of authentic practice) and having the opportunity to practise responding to disclosures through experiential learning. Given the general lack of confidence reported by both midwives and students of midwifery in this area of practice, this strategy may be useful in supporting midwives, students and other health professionals in increasing confidence in working with women who are experiencing domestic violence.

1. Introduction

Domestic Violence (DV), also referred to as Intimate Partner Violence (IPV) and Family Violence, is a major global public health issue (World Health Organization, 2013). Across the world, it is estimated that one in three women have experienced physical or sexual violence and the majority report this was by an intimate or ex-intimate partner. In 2012, intimate partners were responsible for approximately half of all homicides that involved women (United Nations Women, 2016). Unfortunately, it is also known that the rate of violence against women can increase in both incidence and severity during pregnancy and in the early postnatal period (Phillips and Vandenbroek, 2014).

Current data in Australia report up to 22% of women experienced violence during a pregnancy (Phillips and Vandenbroek, 2014). The World Health Organization multi-country survey report rates from 1% to 28% with an average rate of 12% of women reporting intimate partner violence in pregnancy (World Health Organization, 2011). Women are at increased risk of experiencing domestic violence during pregnancy and if present, the violence is likely to increase during this time (Campo, 2015). The social, economic and health costs as a result of domestic violence are considerable. Domestic violence in pregnancy is associated with poorer health outcomes for both mother and baby and these include an increase in maternal substance use, an increase in maternal depression and anxiety and poorer pregnancy outcomes such as higher rates of low birth weight babies, premature labour and miscarriage (Campo, 2015).

Midwives and other health professionals working in maternity services are ideally placed to work with women who identify experiencing domestic violence and provide support and appropriate referral (Australian Health Ministers' Advisory Council, 2012). In the Australian context of practice, national guidelines advocate that maternity care providers ask all women about violence at the initial contact with the service (Australian Health Ministers' Advisory Council, 2012). There is considerable advocacy

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and recommendations for routine screening for domestic violence in pregnancy and the practice is now widespread in a number of countries, although debate continues due to the lack of definitive evidence to support the practice (Australian Health Ministers' Advisory Council, 2012; National Institute for Health and Care Excellence (NICE), 2014; O'Doherty et al., 2015; Spangaro et al., 2009). Whilst screening for domestic violence is common and generally well supported in relation to increasing disclosure, there is insufficient evidence in regard to successful interventions once domestic violence has been identified (Janhafar et al., 2014). However, the term 'best-evidence' is contested in regard to examining domestic violence impact and interventions. Breckenridge and Hamer (2014) state it may be better to ask why and how interventions in domestic violence work rather than which intervention causes what outcome. Many interventions in domestic violence rely on changes in perpetrator behaviours, although more recently there has been a focus on providing support and access to safety planning for women who identify as experiencing domestic violence (Campo, 2015; Koziol-McLain et al., 2015).

2. Background

Across Australia, although routine screening has been in place to varying degrees since the early 1990s, uptake into practice has been poor (Baird et al., 2015). Even when routine screening has been established, such as during public antenatal care in the state of New South Wales (NSW), recent reports indicate that only 80% of women who were eligible for screening were actually screened (New South Wales Kids and Families, 2013). In this state, a standardised and direct approach to screening is mandated in public maternity services (New South Wales Government, 2006). Following an introduction to the screening that includes the reasons for screening and information on confidentiality, the midwife is required to ask two standard questions. The first question is '*In the last 12 months, have you been hit, slapped or hurt in any way by your partner or an ex-partner?*' The second standard question is '*Are you frightened of your partner or an ex-partner*'. If the woman answers no to both of these questions she is offered information on domestic violence and the screening is complete. Should the woman disclose domestic violence then the midwife must respond appropriately and ask further standard questions in regard to whether the woman is safe to go home, whether she would like some assistance with managing her safety and if children were in her care at the time and did they witness the violence (New South Wales Government, 2006). In NSW, the disclosure rate for the women screened antenatally was 3.2% with 18% of these women accepting offers of assistance. With the Australian Bureau of Statistics Personal Safety Survey (2013) reporting that 22% of women report experiencing violence in pregnancy the low disclosure rates are concerning, although it is well recognised that many women will never disclose the violence (Spangaro et al., 2016). Barriers to disclosure include feelings of shame, self-blame, financial implications and fear (Spangaro et al., 2016). In addition to choosing not to disclose, many women will initially decline offers of assistance. Declining assistance may be linked to the barriers to disclosing and some women may not feel ready or able to access external assistance. When asked about seeking help in relation to domestic violence, approximately 16% of women sought assistance from specialist agencies, yet more than 75% of women report seeking assistance from family, friends or a neighbour (Phillips and Vandenbroek, 2014). Whilst the uptake of routine screening for domestic violence in pregnancy in Australia widespread, a large number of women are still not being screened and therefore not able to disclose or be offered assistance. Reasons for not screening include presence of a partner (40%), presence of others (18%), not recorded (2%) and 'other' (40%) (New South Wales Kids and Families, 2013).

Evidence from a number of studies would suggest that 'other' reasons for not screening may be in part due to practitioners' discomfort; lack of training and lack of confidence in adequately screening; and, lack of confidence in appropriately responding to disclosure when this occurs (Baird et al., 2015; Bradbury-Jones and Broadhurst, 2015; Finnbogadóttir and Dykes, 2012; Lees et al., 2013; Mauri et al., 2015; McCosker-Howard et al., 2005). Lack of training appears to be the common theme from pre-registration curricular (Bradbury-Jones and Broadhurst, 2015; Lees et al., 2013) to limited preparation prior to implementing screening programs (Finnbogadóttir and Dykes, 2012; McCosker-Howard et al., 2005) and, reduced opportunity for ongoing practice development (Mauri et al., 2015).

Training to assist health care professionals with screening for domestic violence is usually provided for those employed by health services/organisations. Midwifery students are often unable to access this training as they are not employed by the health services. Staff at one university in NSW, Australia identified an urgent need to provide some formal training to midwifery students as due to the nature of the structure of the pre-registration midwifery programs, students are exposed to screening early in their clinical placements. Not only are students undertaking screening early in their practice experiences, they may be working with practitioners who are not confident in screening and responding to disclosure of domestic violence. Numerous studies have identified that midwives lack training and confidence in screening and responding to domestic violence (Baird et al., 2015; Bradbury-Jones and Broadhurst, 2015; Finnbogadóttir and Dykes, 2012; Mauri et al., 2015; McNeill et al., 2012). This lack of confidence in the practitioners may result in midwifery students not receiving the necessary mentoring and role-modelling support in undertaking the screening in practice. In previous studies, midwifery and nursing students identified a lack of preparedness in screening for, and responding to, domestic violence as having an ongoing impact as once registered they would not feel able to support future students in developing these skills (Bradbury-Jones and Broadhurst, 2015).

Teaching interpersonal skills such as communicating with women is difficult when women are not readily available for interaction, observation and assessment as in the university setting. To overcome this, we brought both the woman and the practitioner to the students in the form of a video clip of an 'authentic' practice situation (Heath et al., 2007). Authenticity in relation to learning simply refers to the resource or activity being 'true to life' or 'real-world' in relation to practice situations (Raymond et al., 2013). The clip was developed by the midwifery team for the purpose of role-modelling practice in relation to screening for domestic violence in pregnancy and was based on experience in practice, current policy and guidelines, and best available evidence. The use of video in health education has been found to provide appropriate role-modelling opportunities and improve interpersonal skill development (Heath et al., 2007); be a stimulus for interactive discussion; and, promote learning retention particularly in relation to complex issues (Leap et al., 2009).

Interactive learning is an exciting and energising method of teaching that can be used to effectively bridge the transition from student midwife to newly qualified midwife (Kitson-Reynolds, 2009). Forsetlund et al. (2009) suggest that interactive workshops are potentially one of the most effective methods to achieve moderately large changes in professional practice. With this in mind, an interactive workshop based around the authentic practice video was developed and evaluated in relation to increasing students' knowledge and confidence levels in screening for, and responding to disclosure of domestic violence in pregnancy.