THE IMPACT ON MIDWIVES OF UNDERTAKING SCREENING FOR DOMESTIC VIOLENCE– FOCUS GROUP FINDINGS.

Heather M .**McCosker- Howard** [1]
RN RM PhD
Lecturer
Queensland University of Technology
h.mccosker@qut.edu.au

Victoria J. **Kain** [1]
RN NICC MN
Senior Research Assistant
Queensland University of Technology
v.kain@qut.edu.au

Debra J . **Anderson** [1]
RN PhD
Lecturer
Queensland University of Technology
dj.anderson@qut.edu.au

Joan **Webster** [2]
RN BA
Nursing Director
Royal Brisbane Women's Hospital
joan_webster@health.qld.gov.au

Abstract:
***Objective*: To investigate the impact mandatory screening for domestic violence has had upon registered midwives.**
***Design*: Three phase study – Phase one involved focus group interviews.**
***Setting*: Hospitals in South-East Queensland undertaking mandatory domestic violence screening.**
***Participants*: Registered midwives undertaking screening for domestic violence.**
***Results*: Several barriers were identified that directly impacted upon the midwives' potential to screen effectively. Barriers identified were classified as intrinsic (intrapersonal and perception) and extrinsic (interpersonal, environmental and organisational infrastructure).**
***Principle, conclusions and implications for practice*: Although midwives have strong beliefs about the value of domestic violence screening, there is a negative perception about it's efficacy and an assumption of failure due to the barriers identified by the registered midwives.**
Keywords: *Domestic Violence; Screening; Barriers; Midwifery practice; Focus groups.*

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Introduction:

During the past twenty years domestic violence (DV) or, more recently defined as intimate partner abuse (IPA) has been recognised as a serious health issue and increasing evidence has demonstrated the existence of abuse of women as a serious health problem[1-3]. It contributes to maternal and neonatal mortality and morbidity as significantly as other more commonly recognised risk factors, such as pre-eclampsia, diabetes and haemorrhage.[4]

There are specific periods of time in many women's lives when health professionals, particularly midwives, have an opportunity to identify and respond to domestic violence as part of the provision of traditionally acknowledged and accepted health care arrangements, such as maternity care during childbearing. Women are not required to justify seeking care for a specific problem. The Health care system, in many countries, offers continuity of care during this time providing multiple windows of opportunity for women and health professionals to discuss issues affecting the outcomes of the childbearing experience.

There are some review and professional papers advising midwives about their role in assisting women abused during pregnancy [5-8], but little has been written about the responses of midwives to including domestic violence as an issue of increasing significance to the outcome of care.

As part of the nation wide response to domestic violence, Queensland Health implemented the Domestic Violence Initiative (DVI) [9, 10], which lead to mandatory screening, by midwives in Southeast Queensland maternity units, for domestic violence. In the 1980's there was little evidence of identification of domestic violence [11]. Since then screening has received considerable research attention, possibly as a result of studies in the mid 1990's that recommended routine screening [12-14].

Literature Review

Research amongst health workers has focussed on their perceptions of the barriers or factors that prevent them identifying domestic violence[15-20]. These barriers can be divided into two areas: perceptions of factors within the environment or work context which limit or affect the response (extrinsic barriers), and those that are about personal understandings of the midwife's personal and professional ability to respond to DV (intrinsic barriers).

Extrinsic barriers identified include, lack of privacy and time to screen[18], lack of education or training [21-23], and organisational structures that fail to support those who do identify[4]. Intrinsic barriers relate to the clinician's perceptions, attitudes, values and previous experiences of identifying IPA [4]. These may manifest in a range of ways including fear of offending by discussing areas culturally defined as private [24], a lack of comfort in dealing with the issues, a sense of powerlessness regarding what were considered to be suitable interventions and a sense of loss of control over the outcome of care [25, 26].

Fogarty [27] reviewed ten (10) instruments for screening for domestic violence and reported that "…unlike a biochemical screening test the effectiveness of these tools relies critically on the clinician-patient relationship" (p. 372). The evidence was highly

suggestive that the interpersonal nature of the questioning has more to do with disclosure than the questions themselves. They have also raised questions about the personal and professional costs of asking about domestic violence. The nature of the interaction between the registered midwife and the woman clearly has an influence on whether or not the matter is discussed in the most effective manner. Women have reported that they are aware when midwives are not really interested or told to ask and fear about the consequences of revealing [28-30]. There is currently a lack of evidence that there is any benefit to women of specific interventions once the screening has been implemented, nor is there evidence that the screening itself causes no harm [31, 32]. In fact, it has been suggested that there is some evidence that there is an emotional, if not physical cost, for both women and the health professional during the process of caring for women experiencing DV[33-38].

The National Committee on Violence Against Women defined violence against women as behaviour adopted to control women, which results in physical, sexual and/or psychological damage, forced social isolation, economic deprivation or behaviours which leaves women living in fear[39]. In the context of this study domestic violence was defined as abusive behaviours by an intimate partner. An intimate relationship was defined as a relationship between the perpetrators and partners, in which the perpetrators "…were current or former spouses, cohabiting partners, boyfriends/girlfriends, and dates" [40: 13].

Screening, whether by questionnaire or other means,[41] is the first step in recognising DV and its debilitating health consequences, however, the impact on midwives undertaking screening has not been explored, nor is there evidence in the literature of an exploration of the educational and professional support needs of this group. This study aimed to identify the midwives' perceptions of the barriers that minimise the effectiveness of screening for domestic violence, and to inform the development of educational, professional and clinical management strategies to address the barriers.

This study was divided into three phases. Phase one involved conducting focus group interviews to identify barriers to screening and inform the development of a questionnaire to be administered in phase two. The final phase involved further focus groups to identify strategies leading to the development of clinical management or intervention recommendations. This following paper reports the findings of Phase one.

Methods:

Utilising interpretive methods, four focus group interviews were conducted with groups of registered midwives at hospitals in South-East Queensland were involved in Queensland Health's DVI. Focus group interviews can be used as a means of obtaining reliable and constructive information from participants about phenomena [42], and there are several advantages associated with this research method. Focus groups allow for the capitalisation of communication between the research participants to generate data [43] and allow participants in the group to have control, and provide a process for focus group participants to build upon the responses of others in group to create a synergistic environment that is conductive to eliciting quality information [44].

In the current study, focus group interviews were undertaken to encourage and explore perceptions of barriers and strategies to support the screening process. Participants were midwives who were screening in their clinical areas. Each group had between 6 and 8 participants. The size and number of groups was influenced by

organisational dynamics and staff availability, although the topic and the characteristics of the participants also influence the desirable size of any focus group [44]. A smaller group encourages discussion in areas which might be recognised as sensitive or which might evoke strong emotional reactions from the participants [4, 45]. Purposive sampling was used to gain representatives from areas conducting the screening: antenatal clinics and general maternity areas.

Data collection*:*

Once ethical approval was obtained from the participating sites, the midwives were informed in writing with details of the study, prior to attending the focus group interviews.

At the commencement of the focus group, the study, confidentiality and consent were explained, and a written consent form was completed. Participants were asked to sign an attendance sheet, identified only by their first names, which were to be changed to pseudonyms during the transcription process. A stenographer was present at the focus groups, and the focus groups were recorded verbatim.

Data analysis:

Systematic analysis of the first focus group transcripts was carried out as soon as the information had been collected. Key themes and theories emerged from collapsed data and were introduced to the next group using a reflective, iterative process. Re-categorizing, highlighting, cross-referencing and re-visiting the audio and written transcripts captured perceptions of barriers within these categories. This was an essential step in identifying themes, concepts and theories that emerged from the data, not just the spoken word, but in feelings as well. Once the data had been collapsed and re-categorized to the point of saturation, the following themes emerged.

Results:

There were several salient themes to emerge from the focus groups – concerns and issues that were congruent across the four sites. These major themes and sub themes are summarised in table one.

Prior to the exploration of issues, participants were asked whether they felt domestic violence screening was necessary, or even relevant. The response to this question was overwhelming certainty that it was both important and relevant. Demographics were often cited as a reason for why it was important to screen.

> LAUREN: *"I think we need to screen for it. Our demographics here are particularly relevant. We have a lot of DV here."*
>
> BERTHA: *"I think it (screening) does (benefit). We are all very, very concerned for our clients and if there is a situation where we have a concern for our client we will try and get the social workers out."*

This finding is congruent with several studies that state domestic violence and abuse during pregnancy is reported to affect as many as one in four women [46-50].

Thematic categories derived from focus groups **Table one**

Major themes	**Sub themes**
Screening is valid	▪ Screening is valid – but the DVI in it's current context may not be the optimal way to ask women about it; ▪ A desire to make a difference to the social issue of DV; ▪ Does not belong here. Perhaps under 'feedback?
Screening is time-consuming	▪ Midwives felt overloaded in their working day; there is not enough time to screen, especially when a woman discloses that she is experiencing abuse;
There was no training to accompany the introduction of the DVI;	▪ Complaints that there was not training at the beginning, or consultation with the midwives; ▪ Positive feedback from those who did receive training;
Screening causes embarrassment, discomfort;	▪ No training in communication skills or 'how to ask'; ▪ No time to establish a rapport with the woman;
Lack of privacy to screen;	▪ Women will not disclose if there is no privacy; ▪ No privacy from partners or family members, hence disclosure will not occur; ▪ Poor infrastructure of working environment;
Screening causes vulnerability to abuse and violence to the midwife;	▪ DV often 'spilled over' into the working environment; ▪ Midwives felt 'unsafe'; ▪ Midwives had received threats;
Lack of feedback when a woman was referred for assistance;	▪ Midwives did not receive feedback; ▪ Receiving feedback may have validated the efficacy of screening;
Unsupportive management;	▪ First-line management and hospital management did not support the midwives in their screening role;

Often contrary to the belief that DV screening was both important and relevant, focus group discussion identified many barriers to screening, both intrinsic and extrinsic in nature. When Queensland Health announced the DVI, the initiative was met with frustration from those expected to implement it. Midwives already felt overwhelmed by their workload, and the expectation that they would have to raise questions of such a personal and delicate nature, for which they felt they did not have the appropriate skills or training was met with derision and frustration.

> CARLY: *"I didn't want to do it. We went to a meeting for 10 minutes. We were told 'This is how you are going to do it.' In ten minutes flat!'*
> CAMERON: *"Another form. More paper work. That was initially what everybody thought."*

Participants believed that in order to screen confidently and effectively, and counteract the mounting pressure from this apparent expansion of the nursing role, the training needed to be ongoing. We know from other focus group interviews that nurses and midwives gain confidence and competence with training and experience[9].

However, training needs to be ongoing, and it would also be useful to include feedback about the outcome of the women's care

Many participants found screening for domestic violence to be a disconcerting experience, arousing feelings of discomfort and embarrassment. Although a lack of training in the requisite skills may have exacerbated these negative feelings, there was also discussion about time constraints inhibiting the development of a rapport with the women being screened.

> DOT: *'Professional counsellors - the social work workers come in knee-deep in human emotions, day in and day out. They seem to come out the other end not so bruised. I would like to know what is the secret.'*
> SYBILL: *'I would like some more education. I would like some counselling skills.'*

Most felt uncomfortable about initiating screening until they had developed this rapport, yet developing such a relationship was often at odds with a lack of time.

Participants discussed their vulnerability, particularly when having to screen the woman when their partner was present for the visit as has become accepted, and in fact encouraged in maternity care. Often, this was carried out in a clandestine manner, leaving the midwives feeling 'guilty' and 'vulnerable' for excluding the partner, which was paradoxical to a model of care that encouraged 'inclusiveness.

A pervading theme throughout the focus groups was the clinician's desire to 'make a difference' – to know that screening was making a difference and having an impact on the social issue of DV. When they felt they were not having an impact, there was a sense of hopelessness and helplessness in what seemed like an insurmountable problem.

> BERTHA: *"It is important for her (the woman) to know that we are on her side. She has to live with this creep (the perpetrator). We don't want to do anything to make her life more miserable. We know she can talk to someone and get that assistance. That is what we are here for."*
> ALICIA: *"We don't know whether it is making inroads. You don't get feedback or data."*

A lack of privacy was identified as a major extrinsic barrier to screening for DV. Privacy issues were identified as a direct result of the poor infrastructure of the working environment, which did not promote adequate privacy, the presence of partners and/or other family members which did not support an environment in which the questions could be asked and the impression that the midwives were imposing upon the privacy of the women by screening.

Time restraints were identified as an extrinsic barrier. The midwives judgement on priorities clouded effective screening, did not allow the building of rapport between the midwives and their clients and added to their workplace stressors – stressors that the midwives perceived as directly attributable to the DVI.

> CARLY: *'How can you sit in front of women? I felt vulnerable. I didn't want to ask them these questions. These women will tell you what they want to tell you anyway. I felt that I was imposing on their privacy.'*

DOT: *' I take them out of the 4-bed bay to ask them that. I don't think it is appropriate. You are not going to get an honest answer if you have got a curtain, a secret barrier.'*

Concern for workplace safety was a recurring theme in the focus groups. Domestic violence in the home often spilled over into the workplace resulting in considerable stress and concerns for the midwives.

SYBILL: *'We have had a few threats of being shot, that they are going to come with a gun.'*

The referral system was often cited as a source of great disappointment by the midwives. Even when women experiencing DV were identified, the midwives felt that the system often let them down by being too overwhelmed to deal with the referrals; a feeling them wondering why they had bothered to refer clients in the first place. When referrals were made, many wondered what had happened to their clients, and were left with many unanswered concerns due to an absence of feedback.

First-line managers and hospital management were often touted as being 'unsupportive' of staff involved in screening. It was reported by the midwives that they were constantly required to screen all their clients, but the infrastructure and absence of support mechanisms did not support them in their efforts. There was also discussion that first-line management were being pressured from higher levels of management to meet screening demands.

Like the focus group participants, midwives in another study [51] found that the emotional impact on midwives was important. Midwives clearly identified the need for supportive systems and organisation structures, in order to enable them to them to deal with the impact of screening. This support was in addition to specific education and training. This study is one of few that has identified the potential personal cost to midwives, and by extrapolation other health professionals, of identifying and responding to these issues.

The findings of the focus group interviews have identified several key barriers to undertaking DV screening that need to be address if DV screening is to be effective and sustainable.

Discussion:

Draucker [52] suggested that the research focus in the area of DV has remained the same over the past thirty years: case-finding and clinical screening. We know that abuse is a significant health problem for millions of women throughout the world, and the childbearing period is no exception. In fact, research suggests this might be a crucial period both for significant negative health effects for women and their babies, and also has the potential for intervention. This intervention requires that health professionals who work with women during the childbearing period understand this phenomenon and view appropriate responses as integral to the outcomes of their clinical practice. Studies of interventions, especially education and training designed to increase awareness, identification and interventions have failed thus far, to address the significant barriers perceived by health professionals. Many of the barriers relate to their understanding of the phenomenon, and the relationship between that understanding and their own clinical practice.

The relevance of identifying domestic violence is irrefutable, but the findings from the focus group interviews strongly suggest that the way in which the DVI was introduced and the subsequent lack of training that accompanied its introduction was unconducive to it's long term success. The act of screening for domestic violence appears to accentuate key issues that are directly and indirectly related to the clinician's perception of screening. These issues require attention, and are fundamental to effective screening. The issues raised from the focus groups are barriers to screening for domestic violence, and as such, require timely attention and consideration.

There are several approaches that are required for ongoing staff development in the area of DV screening. These include widespread and accessible training that address knowledge about the issue of DV, counselling skills, stress management and education in conflict resolution skills. In addition, infrastructure requires urgent address: the midwives lament the lack of privacy and strongly feel it is not conducive to encouraging a woman to disclose information. There are legitimate concerns about the tight-timeframes under which they practice, and safety in the workplace is a serious issue that also requires attention.

Limitations of the study:

Generalising the findings from focus group interviews may be considered contentious because the data collected is generally context specific, which may limit it's extrapolation to other settings. However, the data that has been collated from the exploratory first phase of this study has significant implications for clinical practice. The focus group interviews have been conducted in four of the hospitals undertaking mandatory screening. Although the hospitals were disparate in terms of location and client demographics, the identification of barriers between the groups were distinctly similar.

The next two phases of this study are designed to explore the impact on midwives using a self-administered, voluntary questionnaire, with items informed by the focus groups findings, and focus groups to ask the midwives themselves what strategies they have used to effectively manage their own issues and concerns surrounding screening.

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