'*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.

Highlights

- Domestic violence is a major global public health issue
- Midwives are ideally placed to screen pregnant women for domestic violence
- Responding to a disclosure of domestic violence is highly emotional work
- Midwives and midwifery students lack confidence in responding to disclosure of violence
- Experiential learning activities of authentic practice and supported practise increases student confidence

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%- 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 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).

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). O'Brien et.al. (2007) 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.

Aim

The aim of this study was to increase midwifery students' confidence in screening for, and responding to, disclosure of domestic violence in maternity services.

Methods

Design

The project comprised of two phases; firstly an anonymous online survey of midwifery students' knowledge in relation to domestic violence was undertaken. This phase was used to inform the development of the intervention (interactive workshop) and is not reported on in this paper.

Phase two involved the conduct of the interactive workshop (intervention) and associated pre and post intervention confidence measures.

The Intervention

Prior to attending the workshop, midwifery students were asked to complete an anonymous online survey designed to determine existing knowledge of domestic violence in pregnancy. This survey was adapted with permission from Baird and colleagues' knowledge survey used with Australian midwives (Baird et al., 2015). The survey was used to scaffold learning through introducing the topic and concepts, and to identify knowledge deficits that then informed the development of the interactive workshop.

The intervention comprised of an interdisciplinary and interactive one day workshop aimed to provide students with theory and practise in regard to screening for, and responding to, domestic violence in pregnancy. An overview of the workshop is provided in Box 1.

Box 1.

1. Overview of domestic violence in Australia.
2. Discussion of the role of the social worker in assisting midwives working with women experiencing violence which was presented by a perinatal social worker.
3. Introduction to the "Counting Dead Women" project (Counting Dead Women Australia and Destroy the Joint, 2016) presented by an activist and journalist who established Destroy The Joint . *Destroy the Joint* is an online community that stands for gender equality and civil discourse in Australia.
4. Review of the evidence in relation to the impact of domestic violence in pregnancy and parenting.
5. Responding to the 'why doesn't she just leave' question through use of the TEDTalk 'Why Domestic Violence Victims Don't Leave' (Morgan-Steiner, 2012).
6. Routine screening for, and responding safely to disclosure of domestic violence in pregnancy through the use of a purposely developed authentic practice video
7. Overview of child protection issues.
8. Self-care strategies for students and midwives.

Given that the majority of midwifery students are women, it was important to consider that as many as one-quarter of the group may have experienced domestic violence in their personal lives. This was acknowledged at the commencement of the interactive workshop and students were asked to read the following pledge:

> "*We recognise the bravery (of women) and understand the complexity (of domestic violence) and pledge never to judge and only to support"*

The workshop focussed on the provision of learning activities in relation to eight main topic areas (see Box 2.).

Box 2. Eight main topic areas covered in the interactive workshop

1. **Asking people/partners to leave room -** Practising how to ask the partner/support person(s) to leave the room prior to the domestic violence screening questions as per requirements of screening the woman on her own.
2. **Explaining why screening for DV is undertaken -** Providing an explanation why midwives screen for domestic violence and using the routine screening preamble provided as per the local state policy.
3. **Asking women if they have been hit/hurt -** Asking the woman whether she has been 'hit, slapped or hurt by a partner or ex-partner in the past 12 months' and if they are 'frightened by their partner/ex-partner' as per policy.
4. **Providing DV information -** Providing information to all women about domestic violence.
5. **Responding appropriately and safely to DV disclosure -** Providing an appropriate response if the woman discloses current domestic violence.
6. **Discussing experience of DV -** Discussing the women's experience of domestic violence with her and responding appropriately.

7. **Assisting with access to support -** Assisting women to access support and referrals for domestic violence.
8. **Accessing support for self -** Accessing professional support following working with a woman who discloses domestic violence.

Pre and Post Intervention Survey

Data gathered by informal interviews with midwifery academics and researchers within the Faculty and critical review of the literature informed the development of the pre and post intervention surveys. The surveys were then reviewed by members of the midwifery academic and research team with regard to clarity of the questions and content validity. Feedback from this review further refined the surveys.

On the day of the workshop, the survey with the same quantitative questions and 5-point Likert scale was administered both prior to the commencement, and at the completion of, the face-to-face component of the workshop. Use of the Likert scale is common when measuring attitudes, beliefs or behaviours such as confidence levels (Everitt, 1995). Participants were asked to rate their confidence level for the eight topic areas covered in the workshop using a 5 point scale with 1 being not at all confident and 5 being very confident (See Box 2.).

In addition to the Likert scale the pre-workshop survey contained one qualitative question, '*What kinds of activities do you think would increase your confidence with the above aspects of midwifery practice?'* and the post workshop survey contained the qualitative questions, *'What was the most useful aspect of the workshop'* and '*What would you like more information on in regard to working with women who disclose domestic violence?'.* The qualitative questions were included to gain further insight to the student's perception of the workshop and to aid in improvements to the workshop in the future.

Recruitment and Sample

Convenience sampling was used to recruit students of midwifery into the study. All students enrolled in a public health focussed subject within two pre-registration midwifery programs in a single university in NSW were invited to participate. Approximately 60% of the students were in the Graduate Diploma in Midwifery, a 12-month pre-registration midwifery program for Registered Nurses and around 40% were in the final year of a three year pre-registration midwifery undergraduate degree.

Data collection and analysis

Data were collected through the administration and completion of three surveys.

1. Initial online knowledge survey – anonymous online survey administered in the weeks prior to attendance at the face-to-face workshop (not reported in this paper)
2. Pre-workshop confidence survey (immediately prior to the face-to-face workshop)
3. Post-workshop confidence survey (immediately following the face-to-face workshop)

Quantitative data were analysed using RStudio Version 0.99.489. A two sample t-test was used to determine whether the students' confidence level for each of the eight topic areas increased significantly after completing the face-to-face workshop. A content analysis was undertaken on the qualitative data using NVivo for Mac Version 10.2.2. An initial list of categories was developed and coded. Categories were added during the coding process, with the previously coded data reviewed and recoded every time a new category was added.

Ethical approval

Permission to conduct the research project was granted by the relevant university's Human Research Ethics Expedited Review Committee (HREC REF NO. 2015000087). In line with the conduct of research with students, the following actions were ensured. The project was explained to the

students and verbal consent was obtained. Only de-identified data were collected. Students who did not want to be involved were given the option of not completing the surveys. All analyses took place after the students had completed the subject and had formally received their results therefore involvement did not in any way affect students' grades.

Recognition of the potential for emotional distress also guided the development of the learning activities. Students were also encouraged to seek support and assistance through the provision of the university's counselling service contact numbers and the National Helpline for domestic violence contact details.

Results

There were 174 survey responses; 72/110 pre workshop and 102/110 post workshop surveys. Response rate for the pre workshop survey was 65% and the post workshop response rate was 92%. Pre-workshop means ranged from a minimum of 2.35 out of 5.00 for rating confidence in *'Providing an appropriate response if the woman discloses current domestic violence'* to a maximum of 3.53 out of 5.00 for confidence with *'Asking the partner/support person(s) to leave the room prior to the domestic violence screening questions.'* Post-workshop means ranged from 3.46 out of 5.00 for confidence in *'Providing an appropriate response if the woman discloses current domestic violence'* to 4.20 out of 5.00 confidence rating for *'Providing an explanation why midwives screen for domestic violence.'*

The workshop

A significant increase in students' reported confidence was demonstrated in all 8 topic areas covered in the workshop (Table 1). The minimum increase in students' confidence was 0.49 for the topic area *'Providing information to all women about domestic violence.'* The largest increase in students' confidence level was 1.11 for the topic area *'Providing an appropriate response if the woman discloses current domestic violence.'*

Table 1: *Results of two-sample one-sided t-test comparing pre and post-workshop confidence levels with topic areas covered in workshop*

	Pre-workshop mean	**Post-workshop mean**	**Increase**	***p-value***	**95% Confidence Interval**
1. Asking people to leave room for the purpose of screening	3.53	4.07	0.54	0.001	0.26 - 0.82
2. Explaining why midwives screen for DV	3.43	4.20	0.77	0.001	0.23 – 1.30
3. Asking if hit or hurt by partner/ex-partner in last 12 months	3.31	3.89	0.59	0.001	0.25 -0.92
4. Providing DV information to women following screening	3.35	3.83	0.49	0.001	0.24 – 0.73
5. Responding appropriately and safely to DV disclosure	2.35	3.46	1.11	0.001	0.24 – 1.99
6. Discussing woman's experience of DV	2.49	3.47	0.98	0.001	0.25 – 1.72
7. Assisting with access to support	2.63	3.65	1.02	0.001	0.24 – 1.81
8. Accessing support for self	2.71	3.68	0.97	0.001	0.26 – 1.68

The greatest increase in students' confidence levels came from the four topic areas that the students were least confident to begin with (see Table 2). These were appropriately responding to, and discussing domestic violence with, the woman; assisting women with access to support; discussing the woman's experience of domestic violence; and, accessing support for themselves following working with a woman who discloses domestic violence. The increase in students' confidence following the activities in the workshop suggests that the workshop provided effective learning activities for students to use when responding to domestic violence disclosure.

Unlike the other topic areas, the topics that demonstrated the largest increase in students' confidence were topics that cannot be scripted by the student, therefore may be harder for the students to confidently respond to. An appropriate response to a woman's disclosure of domestic violence will need to take into account what the woman discloses and her individual situation. Providing the opportunity for students to watch an experienced practitioner respond, and then to practise responding to different disclosures appears to have increased students confidence in this topic area. The results indicated that the workshop may have also provided the students with knowledge of avenues for support that the student was previously not aware of for both the woman and for themselves.

Table 2: *Results sorted from lowest to highest pre-workshop mean score for the top four topic area confidence increases*

	Pre-workshop mean	Post-workshop mean	Increase
5. Respond appropriately and safely to DV disclosure	2.35	3.46	1.11
6. Discuss experience of DV	2.49	3.47	0.98
7. Assist with access to support	2.63	3.65	1.02
8. Access support for self	2.71	3.68	0.97

Qualitative results

Both the pre and post workshop confidence surveys included open ended questions. The pre workshop survey asked the students to identify activities that they felt would increase their confidence in screening for, and responding to, disclosure of domestic violence. The post workshop survey asked the students what aspect of the workshop they found most useful and students were also asked to identify further information they would have liked to discuss in regard to screening for, and responding to, domestic violence.

What activities might increase confidence?

At the beginning of the face-to-face workshop, the activities that students that reported would increase their confidence were around the *process* of discussing domestic violence with the woman. The most frequently cited response was the opportunity to practise discussing domestic violence with the woman (27 out of 48 responses, 56% of total responses). For example, students wanted to be able to practise:

"The ability to run (rather than observe) antenatal appointments undertaking DV screening and gaining experience."

Specifically, students wanted to know how to respond appropriately, to be shown demonstrations on how to apply the techniques in practice, and then have the chance to practise it themselves. Students also reported that knowing the referral process, hearing real stories and having the ability to discuss the topic would increase their confidence. Immediately prior to the workshop, students reported that the following activities would be useful in increasing their confidence:

"A class/education on techniques in how we could approach these questions."

"Education of what to advise women who are currently in a domestic violence situation."

"Practise situations with allocated questions and answers in the form of an interview setting"

What activities in the workshop were most useful?

Following the interactive workshop, the most frequently cited response to the question *'What was the most useful aspect of this workshop?'* was the use of the authentic practice video (34 out of 78 responses, 44% of total responses). While many responses just mentioned the word video or TEDTalk (used to assist the students in responding to the 'why doesn't she just leave' question), some responses expanded on what it was about the video(s) that was useful.

"The video clip… demonstrating how to conduct the screening was particularly useful."

"The TEDTalk video was very useful in helping understand the reasons why women don't leave and what everyone can do to help"

Guest speakers were also cited by students as a useful aspect of the workshop (23 out of 78 responses, 29% of total responses). In particular, students mentioned the session by the activist and journalist from Destroy the Joint was particularly inspiring and informative.

"Hearing from (activist and journalist) from Destroy the Joint - realizing what a real issue violence against women is."

The other activities students found useful from the workshop were around the *process* of discussing domestic violence with the woman, consistent with what students reported would increase their confidence in the topic. Of these processes, the most frequently cited useful aspect was *how to ask questions* (21 out of 78 responses, 27% of total responses) and how to *respond appropriately* (16 out of 78 responses, 21% of total responses).

"Learning about how to approach the subject of DV in a sensitive, supportive and reassuring way."

"learning how to appropriately talk about DV with women and ask the 'hard questions'"

"The role play interview (video) with the actress showed a realistic experience that we might encounter. It was good to plan how to ask the questions"

Other useful activities identified by students as increasing confidence included having the opportunity to practise or role-play the interview; being shown examples or demonstrations of the process; being informed of the resources available that they can refer the woman to; and, hearing real stories from people who have experience with working with women experiencing domestic violence.

"Practising screening process of DV screening and learn (sic) new ways to ask woman about their experience of DV."

"The interactive videos and example of an interview where the woman experiences some sort of DV"

More information

In response to the question *'What would you like more information on in regard to working with women who disclose domestic violence?'* the most frequent response was about referral (19 out of 51 responses, 37% of total responses). In particular students wanted more information about both the process of referral as well as what support services are available to refer women to.

> *"Need more hospital relevant information eg where the DV info is kept; what people to call in and how, etc. So we know HOW to apply theory in practice"*

Other responses were for very specific information making it difficult to generalise to other students, or a vague request for more information without specifying what type of additional information would be required. This could indicate either that the students are unaware at the present time of what additional information would be beneficial to them, or that the workshop provided the right balance of information and educational experiences for the students to increase their confidence in working with women who have experienced domestic violence.

Discussion

Midwifery is well recognised as emotional work and it is difficult to prepare students, and indeed practitioners, to respond effectively to highly emotional and unpredictable disclosures such as domestic violence and other forms of abuse (Patterson and Begley, 2011). Research into the emotionally charged areas of midwifery practice indicates that this work is not only difficult for students to develop competence and confidence in but also recognises that qualified midwives continue to struggle in certain areas of practice throughout their careers (Hunter, 2004; Patterson and Begley, 2011). Midwives and midwifery students report low levels of confidence, high levels of discomfort and a lack of pre-registration and continuing education in this important area of practice (Baird et al., 2015; Bradbury-Jones and Broadhurst, 2015; Finnbogadóttir and Dykes, 2012; Mauri et al., 2015; McNeill et al., 2012; Patterson and Begley, 2011).

This study found that student midwives had low levels of confidence across a range of aspects related to screening for and responding to disclosure of domestic violence. Following an interactive workshop that focussed on improving knowledge and building confidence in screening and responding to disclosure of domestic violence, reported confidence levels were significantly higher. The workshop utilised authentic practice role-modelling through the use of a specifically developed video scenario and associated educational activities.

Pre face-to-face workshop survey results demonstrate that midwifery students lack confidence in a range of areas when both screening for domestic violence and, in particular, responding to disclosure of violence during pregnancy. Upon registration as a midwife in Australia, graduates must be able to meet the national competency standards. These include requiring midwives practice in accordance with a primary health care framework and understand the role midwifery has as a public health strategy (Nursing and Midwifery Board of Australia, 2006). While domestic violence is not specifically mentioned in the midwifery competency standards, it is now recognised as a major public health issue globally and it is of utmost importance that midwives feel confident and competent to work in this area. Numerous studies have demonstrated that midwives lack confidence in the area of domestic violence and other important areas of public health practice (McNeill et al., 2012). Confidence in practice-based professions is dependent on a number of factors including educational preparation, clinical exposure either real or simulated, and feedback on skill acquisition (Donovan, 2016). It is well understood that demonstration of competence and confidence in practice are not necessarily lineal processes. High levels of confidence do not always equate to competence and students may lack confidence but be able to demonstrate competence (Donovan, 2016).

Students' experience in practice differs from placement to placement and is somewhat dependent on the skill and practice of each practitioner they work alongside. Not all exposure in real life practice is beneficial to students learning and/or work readiness (Pollard, 2008). If a student

constantly witnesses mediocre or unacceptable practice then this is often what they learn. Students may not have the ability to filter their experiences and decide what appropriate practice looks like (Pollard, 2008). Simulated authentic practice situations or experiential learning scenarios are one way of addressing this lack of practice experience. In this study, providing students with a demonstration of expected practice, through use of the stimulus video clip and giving students supported time to practise responses increased students confidence in all aspects but in particular the responding to disclosure of domestic violence.

Giving students protected time for skills rehearsal provides great benefits and is an opportunity for them to synthesize how the knowledge they have learned at university informs their clinical practice (Kitson-Reynolds, 2009). So often, students are focused primarily on the overwhelming task of learning how to 'do things' to women that they do not take time to consider how they are developing their skills in learning to 'be with' women. Focus on competence in performing practical tasks in the clinical setting often takes precedence over development of communication and interpersonal skills (Davies et al., 2016; Patterson and Begley, 2011; Smith et al., 2012).

Taking a multidisciplinary approach to the design and delivery of the workshop broadened the students understanding of the issue as a wider problem. In particular, including a session with an activist/journalist appeared to widen the students' perspective on the issue and increase awareness of the global public health aspect of domestic violence.

Limitations

The research was undertaken at a single university in an Australian context. The sample size was relatively small and may make generalisations to a wider population of student midwives difficult. However, this research was informed by the findings of other research in this area and results are not dissimilar in relation to midwives and students' confidence levels, or lack thereof (Bradbury-Jones and Broadhurst, 2015; Mauri et al., 2015).

Implications for Practice/Education

Interactive workshops are recognised as an effective educational strategy that promote moderate improvements in professional practice (Forsetlund et al., 2009). Video stimulus clips of exemplary practice have traditionally been seen to support practice-based education and training in both skills development and in the development of complex social interaction and interpersonal skills (Heath et al., 2007). In the current climate of competition for clinical placements, strategies that bring the woman (patient) and practitioner into the classroom assist students to learn authentic practice in a safe and supported environment are essential (Brooks et al., 2010). Authentic practice is not limited to video clips but can include activities such as demonstration, experiential learning, simulations, and practice-based scenarios or case studies. Interactive and authentic educational strategies support learning both theoretical concepts, practice-based and interpersonal skills.

Conclusion

Current research recognises that screening for domestic violence and responding to women who experience domestic violence is an emotional area of midwifery practice. Midwives and students of midwifery often feel unprepared to work with women in this important area of midwifery practice. The findings of this study show that an interactive workshop designed around an authentic practice video proved useful in increasing students' confidence in screening for, and responding to, disclosure of domestic violence in pregnancy. Students identified being able to watch an authentic interview where an experienced midwife role-modelled asking the questions and responding to disclosure as one of the most useful aspects of the workshop. In addition, students felt that having time to practise in a supported environment improved their confidence in working with women who experience domestic violence. Further areas for educational development include supporting students with accessing information regarding referral services and pathways.

The findings of this research support the use of the authentic practice video and interactive workshop in increasing midwifery students' confidence in working with pregnant women who may be experiencing domestic violence.

References

Australian Bureau of Statistics, 2013. Personal Safety Survey, Australia, 2012. Australian Bureau of Statistics, Canberra.

Australian Health Ministers' Advisory Council, 2012. Clinical practice guidelines: antenatal care - module 1. Australian Government Department of Health and Ageing, Canberra.

Baird, K., Saito, A., Eustace, J., Creedy, D., 2015. An exploration of Australian Midwives' knowledge of intimate partner violence against women during pregnancy. Women and Birth Article In Press.

Bradbury-Jones, C., Broadhurst, K., 2015. Are we failing to prepare nursing and midwifery students to deal with domestic abuse? findings from a qualitative study. Journal of Advanced Nursing 00, 000-000.

Breckenridge, J., Hamer, J., 2014. Traversing the maze of 'evidence' and 'best practice' in domestic and family violence service provision in Australia, The Australian Domestic & Family Violence Clearinghouse, University of New South Wales, Sydney.

Brooks, N., Moriarty, A., Welyczko, N., 2010. Implementing simulated practice learning for nursing students. Nursing Standard 24, 41-45.

Campo, M., 2015. Domestic and family violence in pregnancy and early parenthood Overview and emerging interventions. Australian Institute of Family Studies, Melbourne.

Counting Dead Women Australia and Destroy the Joint, 2016. Counting Dead Women Australia 2016: We count every known death due to violence against women in Australia Destroy the Joint.

Davies, L., Page, N., Glover, H., Sudbury, H., 2016. Developing a perinatal mental health module: An integrated care approach. British Journal of Midwifery 24, 118-121.

Donovan, P., 2016. Confidence in Newly Qualified Midwives. British Journal of Midwifery 16, 510-514.

Everitt, B., 1995. The Cambridge Dictionary of Statistics in the Medical Science. Cambridge University Press, Melbourne.

Finnbogadóttir, H., Dykes, A.-K., 2012. Midwives' awareness and experiences regarding domestic violence among pregnant women in southern Sweden. Midwifery 28, 181-189.

Forsetlund, L., Bjørndal, A., Rashidian, A., Jamtvedt, G., O'Brien, M.A., Wolf, F.M., Davis, D., Odgaard-Jensen, J., Oxman, A.D., 2009. Continuing education meetings and workshops: effects on professional practice and health care outcomes. Cochrane Database of Systematic Reviews.

Heath, C., Luff, P., Svensson, M.S., 2007. Video and qualitative research: analysing medical practice and interaction. Medical Education 41, 109-116.

Hunter, B., 2004. The importance of emotional intelligence. British Journal of Midwifery 12, 605-606.

Janhafar, S., Howard, L., Medley, N., 2014. Interventions for preventing or reducing domestic violence against pregnant women (review). The Cochrane Library, Art. No. CD009414. DOI: 009410.001002/14651858.CD14009414.pub14651853.

Kitson-Reynolds, E., 2009. Developing decision making for students using interactive practice. British Journal of Midwifery 17, 238-243.

Koziol-McLain, J., Vandal, A.C., Nada-Raja, S., Wilson, D., Glass, N.E., Eden, K.B., McLean, C., Dobbs, T. & Case, J. 2015, A web-based intervention for abused women: the New Zealand isafe randomised controlled trial protocol. BMC Public Health 15, 56.

Leap, N., Sandall, J., Grant, J., Bastos, M., Armstrong, P., 2009. Using video in the development and field-testing of a learning package for maternity staff: Supporting women for normal childbirth. Internation Journal of Multiple Research Approaches 3, 302-320.

Lees, S., Phimister, D., Broughan, C., Dignon, A., Brown, M., 2013. Domestic violence: The base of the iceberg. British Journal of Midwifery 21, 493-498.

Mauri, E.M., Nespoli, A., Persico, G., Zobbi, V.F., 2015. Domestic violence during pregnancy: Midwives' experiences. Midwifery 31, 498-504.

McCosker-Howard, H., Kain, V., Anderson, D., Webster, J., 2005. The impact on midwives of undertaking screening for domestic violence - focus group findings. Birth Issues 14, 49-56.
McNeill, J., Doran, J., Lynn, F., Anderson, G., Alderdice, F., 2012. Public health education for midwives and midwifery students: A mixed methods study. BMC Pregnancy and Childbirth 12.
Morgan-Steiner, L., 2012. Why Domestic Violence Victims Don't Leave, in: Morgan-Steiner, L. (Ed.), Why Domestic Violence Victims Don't Leave. TEDxRainer.
National Institute for Health and Care Excellence (NICE), 2014. Domestic Violence and Abuse: Multi-Agency Working. National Institute for Health and Care Excellence (NICE).
New South Wales Government, 2006. Domestic Violence - Identifying and Responding PD2006_084, in: Health, N.S.W. (Ed.). New South Wales Government, North Sydney.
New South Wales Kids and Families, 2013. Domestic violence routine screening +: November 2013 Snapshot report 11: An early identification and intervention strategy to promote awareness of the health impact of domestic violence, ask questions about patients' safety in relationships, and to provide information on relevant health services for victims. New South Wales Ministry of Health, Sydney.
Nursing and Midwifery Board of Australia, 2006. National competency standards for the registered nurse. Nursing and Midwifery Board of Australia, Canberra.
O'Doherty, L., Hegarty, K., Ramsay, J., Davidson, L., Feder, G., Taft, A., 2015. Screening women for intimate partner violence in healthcare settings. Cochrane Database of Systematic Reviews 2015, Issue 7. Art. No.: CD007007. DOI: 10.1002/14651858.CD007007.pub3.
O'Brien, M., Freemantle, N., Oxman, A., Wolf, F., Davis, D., Herrin, J., 2007. Continuing education meetings and workshops: effects on professional practice and health care outcomes. . Cochrane Database of Systematic Reviews.
Patterson, D., Begley, A., 2011. An exploration of the importance of emotional intelligence in midwifery. Royal College of Midwives United Kingdom.
Phillips, J., Vandenbroek, P., 2014. Domestic, family and sexual violence in Australia: an overview of the issues, in: Services, D.o.P. (Ed.), Online.
Pollard, K.C., 2008. Non-formal learning and interprofessional collaboration in health and social care: the influence of the quality of staff interaction on student learning about collaborative behaviour in practice placements. Learning in Health & Social Care 7, 12-26.
Raymond, J., Homer, C.S.E., Smith, R., Gray, J., 2013. Learning through authentic assessment: An evaluation of a new development in the undergraduate midwifery curriculum. Nurse Education in Practice 13, 471-476.
Smith, R., Gray, J., Raymond, J., Catling-Paull, C., Homer, C., 2012. Simulated Learning Activities: Improving Midwifery Students' Understanding of Reflective Practice. Clinical Simulation in Nursing 8, e451–e457.
Spangaro, J.O., Koziol-McLain, J., Zwi, A., Rutherford, A., Frail, M., Ruane, J., 2016. Deciding to tell: Qualitative configurational analysis of decisions to disclose experience of intimate partner violence in antenatal care. Social Science and Medicine 154, 45-53.
Spangaro, J.O., Zwi, A.B., Poulos, R., 2009. The elusive search for definitive evidence on routine screening for intimate partner violence. Trauma, Violence & Abuse 10, 55-68.
United Nations Women, 2016. Facts and Figures: Ending Violence Against Women. United Nations, New York.
World Health Organization, 2011. Intimate partner violence during pregnancy: Information sheet. World Health Organization, Geneva.
World Health Organization, 2013. Global and regional estimates of violence against women: prevalence and health effects of intimate partner violence and non-partner sexual violence. World Health Organization, Geneva.