Australian College of Midwives

ACM: For midwives. With women. For the future.

ACT domestic, family and sexual violence strategy

ACM Submission

Issued April 2024

ACT domestic, family and sexual violence strategy

The Australian College of Midwives

The Australian College of Midwives (ACM) is the peak professional body for midwives in Australia; and welcomes the opportunity to provide a written submission to the ***ACT domestic, family and sexual violence strategy (the Strategy)***. ACM represents the professional interests of midwives, supports the midwifery profession to enable midwives to work to full scope of practice (SoP), and is focused on ensuring better health outcomes for women, babies, and their families.

Midwives are primary maternity care providers working directly with women and families, in public and private health care settings across all geographical regions. There are over 33,594 midwives in Australia and 1,195 endorsed midwives[1]. ACM is committed to leadership and growth of the midwifery profession, through strengthening midwifery leadership and enhancing professional opportunities for midwives.

Terms of Reference

This submission will address one of the priorities identified in the Strategy consultation draft 'early intervention' in relation to midwifery and maternity care.

Background

In Australia, domestic and family violence (DFV) is a public and social health issue. It is understood that women are at an increased risk of DFV commencing or escalating during pregnancy and the postpartum period. Approximately 30% of women will experience domestic violence for the first time while pregnant, and women who are already experiencing abuse are at increased risk of violence during pregnancy[2]. DFV leads to poor perinatal outcomes, including early pregnancy loss, premature birth and low birth weight babies[3]. Maternal mental health is affected and reproductive coercion and abuse may lead to unwanted pregnancies or the prevention of wanted pregnancies by coerced abortion[4]. Women most at risk of experiencing violence towards them are Indigenous women and young women aged between 18 and 24[5].

Given that more than 300,000 women seek antenatal care each year[6], midwives are ideally placed to identify women experiencing violence. The regular contact that most perinatal women have with midwives provides a unique and important opportunity for identifying and responding to DFV. Midwives can provide immediate support, and referrals to other agencies for emotional, financial, and practical assistance.

The priority opportunities for ACM include;

1) Increase upscaling of Midwifery Continuity of Care (MCoC) for all perinatal women in the ACT
2) Prioritise allocating women who disclose DFV to MCoC
3) Education on DFV for midwives should be standardised, trauma-informed, culturally responsive and safe, regular, in-person where possible, and should be supported by clear and appropriate referral pathways
4) DFV screening tool should be standardised and trauma-informed
5) Data on DFV screening and referrals should be collected

Early intervention

Continuing to build the capability and capacity of the ACT workforce to identify and respond to risk of domestic, family and sexual violence

Screening attended by health professionals during pregnancy can lead to higher rates of disclosure and identification of DFV[7]. The Australian Pregnancy Care Guidelines recommends that all women are asked about DFV during their pregnancy, as early as possible and at subsequent opportunities. Regular and repeat training is also recommended for health professionals. Midwives are often reluctant to engage with questions about DFV, because they feel they lack the knowledge, skills or resources to respond effectively to disclosures, and they don't feel that adequate time is allowed in appointments to respond appropriately[9]. An Australian study found that a full day in-person workshop increased preparedness to respond to disclosures from 40.8 to 53.2% [8]. However, some online education packages are very short. For instance, Domestic and Family Violence Screening by HETI qualifies for 0.5 Continuing Professional Development (CPD) points (so takes roughly 30 minutes to complete). The mandatory Canberra Health eLearning package 'CHS *Family Violence: A Shared Understanding'* is one hour long, and is not currently being implemented at all ACT health services. Other online courses are more in-depth, such as DV-alert, by Lifeline. Such courses are voluntary, and therefore there is a lack of consistency in training and knowledge.

There are currently deficiencies in the mandatory training and education of healthcare providers in the ACT public healthcare system, including maternity care providers. Training should be mandatory, regular, ideally in-person, and backed up by support and referral pathways. For instance in QLD, a face-to-face education program is in place at Gold Coast, Logan and Redland hospitals, with clear referral systems in place and specific midwives nominated to act as support and advise any midwife who receives a positive disclosure.

The DFV screening tool should be standardised and trauma-informed, to increase confidence for midwives and disclosure rates among women. Perinatal data on the use and effectiveness of the screening tool, and the uptake of referrals to external support services, should be reported on to ensure strategies are meeting their intended aims.

Recommendations:

- Education on DFV for midwives should be standardised, trauma-informed, regular, in-person where possible, and should be supported by clear and appropriate referral pathways
- DFV screening tool should be standardised, culturally responsive and safe, and trauma-informed
- Data on DFV screening and referrals should be collected

Midwifery Continuity of Care

Midwifery Continuity of Care (MCoC) is a maternity care model where women see the same midwife or small group of midwives throughout their perinatal experience. MCoC is known to be the gold standard of maternity care[9]. Women and babies experience reduced interventions and better outcomes, both physically and psychosocially[10,11]. Midwives are more satisfied working in MCoC models[12], with lower

levels of burnout and psychological distress[13]. In addition, MCoC costs the healthcare system 22% less than other models of care[14]. Midwives provide MCoC in publicly funded models and in private practice. According to Maternity in Focus_The Public Maternity System Plan 2022-2032 , only 30% of women in the ACT currently have access to continuity of care models.

Continuity of midwifery care is especially important for women experiencing DFV, as this trusting relationship can enable increased disclosure, and midwives are more able to tailor their care to the woman's unique needs[15]. The 'Canberra Health Services Procedure Identifying and Responding to Family Violence' document notes that abuse will not always be disclosed during the first episode of care, and that a conversation about DFV should be ongoing[16]. Midwives working in continuity models feel more comfortable asking questions about DFV, because they have the time to develop a trusting relationship and choose the right moment[17]. A continuity of care relationship is the ideal environment in which to facilitate an evolving conversation in a sensitive manner. Midwives in a continuity relationship also get to know the partner and other family members, and can be a valuable source of support for them during stressful times, which may reduce the incidence of abuse. MCoC midwives are also able to observe patterns of behaviour over time, and may identify DFV prior to disclosure. Continuity of care also reduces the need for repeated disclosures of traumatic or embarrassing information[18]. MCoC includes the postnatal period, which is important for women experiencing DFV, as this is a time when women are in a position of increased vulnerability and dependence, and regular ongoing contact with a known care giver can reduce the incidence of women 'falling through the cracks' when in a fragmented care model and subject to early discharge and a lack of ongoing support.

The ACM applauds the ACT Government commitment to increasing MCoC to over 50% by 2028, and notes the motion to increase this target to 75%. The ACM would encourage the ACT to consider this to be only a start, and to aim for 100% of perinatal women to have access to MCoC and its many benefits for women, babies and midwives.

The ACM notes ACT Government initiatives such as Health Justice Partnership

Recommendations:

- Increase upscaling of MCoC for all perinatal women in the ACT
- Prioritise allocating women who disclose DFV to MCoC

Conclusion

The ACM supports the ACT Government's domestic, family and sexual violence strategy and advocates for specific actions to be implemented within maternity services. DFV creates significant social and health related harm and midwives provide a unique and specific opportunity for early intervention and response. The ACM recommends prioritising the implementation of regular education for health care providers, a standardised and trauma informed screening tool, and universal access to continuity of midwifery care.

Alison Weatherstone
Chief Midwife

E: Alison.Weatherstone@midwives.org.au

W: https://www.midwives.org.au

Attribution: Hanako Sayers, Clinical Midwife Consultant and ACM ACT Branch member
Aya Emery, ACM Policy Officer

Consent to publish
ACM consents to this submission being published in its entirety, including names.

Consent to provide further information
ACM is available to provide further expert opinion and advice if required.

References

1. Nursing and Midwifery Board. AHPRA. (2023). *Statistics. Nurse and Midwife – Registration Data Table – 31 December 2023.* Nursing and Midwifery Board of Australia - Statistics (nursingmidwiferyboard.gov.au)
2. Baird, K. (2016). Midwifery: Midwives empowered through domestic violence training. *The Queensland Nurse, 35*(1), 34–35.
3. Australian Institute of Family Studies. (2015). *Domestic and family violence in pregnancy and early parenthood.* https://aifs.gov.au/resources/policy-and-practice-papers/domestic-and-family-violence-pregnancy-and-early-parenthood
4. Sheeran, N., Vallury, K., Sharman, L.S., Corbin, B., Douglas, H., Bernardino, B., Hach, M., Coombe, L., Keramidopoulos, S., Torres-Quiazon, R., and Tarzia, L. (2022). Reproductive coercion and abuse among pregnancy counselling clients in Australia: Trends and directions. *Reproductive Health,19*, doi:10.1186/s12978-022-01479-7.
5. Australian Institute of Health and Welfare. (2024). *Family, domestic and sexual violence: Pregnant people.* https://www.aihw.gov.au/family-domestic-and-sexual-violence/population-groups/pregnant-people
6. Australian Institute of Health and Welfare. (2023). *Australia's mothers and Babies*. Canberra, Australia: Australian Institute of Health and Welfare.
7. O'Doherty, L., Hegarty, K., Ramsay, J., Davidson, L. L., Feder, G., & Taft, A. (2015). Screening women for intimate partner violence in healthcare settings. *Cochrane Database of Systematic Reviews, 7.* https://doi.org/info:doi/10.1002/14651858.CD007007.pub3.
8. Baird, K. M., Saito, A. S., Eustace, J., & Creedy, D. K. (2018). Effectiveness of training to promote routine enquiry for domestic violence by midwives and nurses: A pre-post evaluation study. *Women and Birth, 31*(4), 285–291. https://doi.org/10.1016/j.wombi.2017.10.014
9. Cummins A., Griew K., Devonport C., Ebbett W., Catling C. & Baird K. (2022). Exploring the value and acceptability of an antenatal and postnatal midwifery continuity of care model to women and midwives, using the Quality Maternal Newborn Care Framework. *Women and Birth, 35*(2), 59-69. https://doi.org/10.1016/j.wombi.2021.03.006
10. Sandall, J., Soltani, H., Gates, S., Shennan, A., & Devane, D. (2016). Midwife-led continuity models versus other models of care for childbearing women. *The Cochrane Database of Systematic Reviews*, *4*(4). https://doi.org/10.1002/14651858.CD004667.pub5
11. Gamble, J., Browne, J., & Creedy, D. K. (2021). Hospital accreditation: driving best outcomes through continuity of midwifery care? A scoping review. *Women and Birth, 34*(2), 113–121. https://doi.org/10.1016/j.wombi.2020.01.016
12. Dawson, K., Newton, M., Forster, D., & McLachlan, H. (2018). Comparing caseload and non-caseload midwives' burnout levels and professional attitudes: A national, cross-sectional survey of Australian midwives working in the public maternity system. *Midwifery, 63*, 60–67. https://doi.org/10.1016/j.midw.2018.04.026
13. Fenwick, J., Sidebotham, M., Gamble, J., & Creedy, D. K. (2018). The emotional and professional wellbeing of Australian midwives: A comparison between those providing continuity of midwifery care and those not providing continuity. *Women and birth : Journal of the Australian College of Midwives, 31*(1), 38–43. https://doi.org/10.1016/j.wombi.2017.06.013
14. Callander, E. J., Slavin, V., Gamble, J., Creedy, D. K., & Brittain, H. (2021). Cost-effectiveness of public caseload midwifery compared to standard care in an Australian setting: a pragmatic analysis to inform service delivery. *International journal for quality in health care: Journal of the International Society for Quality in Health Care, 33*(2). https://doi.org/10.1093/intqhc/mzab084
15. Rayment-Jones, H., Silverio, S. A., Harris, J., Harden, A., & Sandall, J. (2020). Project 20: Midwives' insight into continuity of care models for women with social risk factors: what works, for whom, in what circumstances, and how. *Midwifery, 84*. https://doi.org/10.1016/j.midw.2020.102654
16. ACT Government. (2023). *Canberra Health Services Procedure: Identifying and Responding to Family Violence.* Canberra Health Services.
17. Eustace, J., Baird, K., Saito, A. S., & Creedy, D. K. (2016). Midwives' experiences of routine enquiry for intimate partner violence in pregnancy. Women and Birth, 29(6), 503–510. https://doi.org/10.1016/j.wombi.2016.04.010
18. Branjerdporn, G., Clonan, T., Boddy, J. et al. (2023). Australian women's perspectives of routine enquiry into domestic violence before and after birth. *BMC Pregnancy Childbirth.* 23, 4. https://doi.org/10.1186/s12884-023-05345-7