C E S | The Centre for Effective Services | Women's Aid

Evaluation of the Women's Aid Maternity Project

Final Report

November 2024

Table of Contents

List of Tables

List of Figures

Note on definitions and terms used in this report

The Women's Aid Maternity Project is focused on domestic violence and abuse (DVA) during pregnancy and the post-natal period. We use Women's Aid's definition: "Domestic abuse can include emotional, physical, economic and sexual abuse from a current or former intimate partner. Coercive control is at the core of all domestic violence and abuse. Someone may also experience domestic abuse from a family member"[1]. We recognise that DVA can be perpetrated by anyone but, in the vast majority of incidents, it is perpetrated by men against women, making DVA a profoundly gendered issue. The Domestic Violence Act 2018[2] makes it clear that DVA is not exclusively physical violence– it is complex and manifests in different ways[3].

[1] Women's Aid. (2024, June 27). *Women's Aid: Types of Abuse.*
[2] Irish Statute Book (2018). Domestic Violence Act 2018. (Ireland).
[3] Geraghty & Morgan (2022) *Access Evidence: Intimate Partner Violence*.

Controlling or coercive behaviour, a pattern which exploits, controls, creates a dependency or dominates another person. Coercive control (CC) is a consistent pattern of controlling, coercive and threatening behaviour including all or some forms of domestic violence and abuse (emotional, physical, economic and sexual including threats) by a current or former partner"[1]. CC has been recognised in law relatively recently in the UK and Ireland[2], and coercive control is as a key component in DVA[4].
Physical violence or abuse, which involves the intentional use of force against someone or something, including scratching, hitting, suffocating, weapons, or restraint.
Sexual violence, where a person is emotionally pressured or physically forced to partake in a sexual activity without their consent.
Psychological or emotional abuse, which is any intentional act (verbal or non-verbal) which causes distress or harm to a person.
Financial or economic abuse, where abusers may interfere with access to money and finances.
Harassment, including unwanted contact and abuse in public places, or online and stalking, with additional elements such as following, loitering or monitoring. This kind of abuse is characterised by obsessive, unwanted and repeated contact.

The terms DVA and perinatal DVA will predominantly be used throughout this report. **Perinatal** refers to the period of time during pregnancy and up to one year after giving birth.

DVA perpetrated by a current or former partner can be described as intimate partner violence (IPV)[5].

The terms **victim, survivor,** and **perpetrator** are also used in this report. We appreciate the potential sensitivity around the use of the term 'victim' to refer to a woman subjected to abuse. The terms 'victim' and 'perpetrator' refer to language used in academic literature to recognise DVA as a criminal act by law. The term 'survivor' is used to describe women

[4] Department of Justice (2022) Third National Strategy on Domestic, Sexual & Gender-Based Violence 2022-2026, Government of Ireland.
[5] World Health Organisation (2024). *Violence against women factsheet.*

recovering from DVA or actively resisting DVA who may or may not be still in the relationship.

The report outlines evidence and policy objectives in relation to how maternity services can support women subjected to DVA. **Maternity services** include healthcare services provided during antenatal care (from discovery of pregnancy until labour); intrapartum care (during labour); postnatal care (care up to six weeks following the birth of the baby); and neonatal care (hospital care for new-born babies). Termination of pregnancy (TOP) and sexual health services are also referenced where appropriate.

In this report we use the term **collaborate** to indicate a model of working where partners are engaged to seek input and cooperation but control of decision-making rests with the lead organisation. **Co-design** takes this a step further where partners have much greater involvement and control of the direction of the work throughout planning, design, delivery and monitoring.

List of abbreviations in this report

(A)DOM	(Assistant) Director of Midwifery
CES	Centre for Effective Services
DoJ	Department of Justice
DSGBV	Domestic, Sexual and Gender-based Violence
DVA	Domestic violence and abuse
EU	European Union
GP	General Practitioner
HSE	Health Service Executive
IDVA	Independent Domestic Violence Advisor
IPV	Intimate Partner Violence
MN-CMS	Maternal & Newborn Clinical Management System
MSW	Medical Social Work
NMH	National Maternity Hospital
NMS	National Maternity Strategy

NWIHP	**N**ational **W**omen and **I**nfants **H**ealth **P**rogramme
OW	Outreach Worker (for the Maternity Project Outreach Support Service)
PHCW	Primary Health Care Workers (on Pavee Point's Traveller Primary Health Care Project)
PTSD	Post-Traumatic Stress Disorder
WA	Women's Aid
WHO	World Health Organisation

Acknowledgements

The CES evaluation team would like to extend their sincere thanks to everyone who contributed in any way to the evaluation.

We are very grateful to the hospital staff and project stakeholders who collated and shared data, participated in interviews, focus groups and meetings and who shared their knowledge, expertise, experience, and views with us.

Thanks to the members of the Women's Aid project team for their assistance throughout the evaluation, their openness and bravery in commissioning and fully participating in an independent evaluation of their project. This was greatly appreciated.

We would also like to acknowledge the Maternity Project External Advisory group for their ongoing advice and constructive feedback throughout the evaluation.

Specific thanks to Jeanine Webster, a member of the Maternity Project External Advisory Group, who reviewed the training evaluation survey.

Women's Aid wish to express their immense gratitude to the many individual donors and funders in particular, the 'Creatives against Covid' team at RichardsDee and KKR who made this pilot project possible.

Finally, to the women who contributed directly and indirectly to this evaluation through sharing their experiences and engaging with the project we thank you.

Executive Summary

Pregnant women who are subjected to domestic violence and abuse (DVA) face a range of barriers to help-seeking and disclosure, during a vulnerable and high-risk period. The Maternity Project aimed to enhance the response of the maternity services in Ireland to victims/ survivors of DVA by collaborating with maternity services to implement co-designed awareness raising materials, a specialist outreach worker role, and a bespoke co-designed training course for maternity staff.

DVA in pregnancy is common[6]. There is no current robust data on prevalence of DVA during pregnancy in Ireland, nonetheless the evidence is clear that the physical and emotional impacts of DVA during such a vulnerable period can be profound. International and Irish research evidence and policy recognise that the period when a woman is engaged with maternity services provides a unique opportunity to identify DVA and provide appropriate support[7],[8]. Maternity services need to support women to disclose DVA and ensure women are offered timely referral to specialist support.

The goals of the maternity project were to create safe conditions for women to disclose, address some of the known barriers to effective identification of women subjected to DVA in the perinatal period and to strengthen timely access to appropriate supports.

[6] World Health Organisation. (2011) Intimate partner violence during pregnancy: Information sheet.
[7] Centre for Effective Services (2023), *Perinatal Domestic Violence and Abuse, Review of Evidence and Policy for the Women's Aid Maternity Project*. Unpublished
[8] Webster J, Lawlor S, Kavanagh D, Breen A, Sheil O, McCarthy AM, O'Brien Green S, Kirby F, Leahy M, (2024) *National Clinical Practice Guideline: Screening and Management of Domestic Violence and Abuse in Pregnancy and the early postnatal period*.

Women's experience of Irish Maternity Services

Women's Aid commissioned CES to conduct a survey of women who have experienced DVA while accessing maternity services in Ireland in the last 5 years (May 2022- June 2023, 74 respondents).

- This survey indicated that screening for DVA in pregnancy was not universal.
- Women accessing private care were much less likely to have seen information about DVA and much less likely to have been asked about DVA during their pregnancy.
- The majority of survey respondents reported that they did not disclose DVA to the maternity service they attended. Fear and shame appeared to be key contributing factors (including fear about the involvement of child protection services), along with a belief that the service would not know how to help.
- For the survey respondents who did disclose abuse, the strongest encouraging factor for disclosure was their belief that their information would be kept confidential.
- Over half of the respondents who disclosed abuse felt that the healthcare professional they spoke with did not know how to help them.
- The majority of survey respondents indicated that they had not accessed any other specialist support services for DVA during pregnancy and the majority also indicated that they were not aware of any local support services at that time.
- Survey respondents were strongly in favour of women being asked about DVA frequently at their appointments with maternity services.
- Women called for improved understanding of coercive control and the behaviours that constitute domestic abuse. They recommended that staff in maternity services be trained to ask questions about DVA that relate to controlling relationships, and to recognise signs of psychological abuse.

Focus group with Pavee Point Traveller and Roma Centre

A focus group was conducted with Primary Health Care Workers (PHCWs) for the Traveller community, a Community Development Worker for the Pavee Point Roma Programme, the Pavee Point Violence Against Women Programme Coordinator, and the Pavee Point coordinator for Pavee Mothers- Maternal Health Initiative. Similar to the survey of women's experiences participants unanimously supported women being asked about DVA more frequently when attending maternity services. They emphasised the importance of trust for women to talk about DVA and discussed the discrimination and poor treatment that women from Traveller and Roma communities often experience when attending maternity services. Other structural barriers to accessing support for abuse that were discussed in the group included inadequate translation services in healthcare settings, and a lack of alternative accommodation and income for women to live independently of an abuser, particularly those women who are not 'habitually resident'**. The focus group participants advocated for a specific care pathway for Traveller and Roma women in the maternity service, with staff who are trained to support Traveller and Roma women.

** 'Habitually resident: many of the social welfare payments in Ireland can only be claimed by those who are "habitually resident", which means people who can prove they have lived in Ireland and plan to continue living in Ireland for the foreseeable future.

Summary of the objectives of the maternity project

The Women's Aid Maternity Project built on existing relationships with maternity services and worked in collaboration with them to improve awareness of DVA and supports available, implement an Outreach Support Service and co-design training to improve maternity staff knowledge, confidence and skills in supporting women to disclose and to access specialist DVA support.

The project was borne out of years of Women's Aid work with maternity hospital staff and with survivors. The idea for the project came from extensive practice-based knowledge on the vulnerability and particular risks to pregnant women who are subjected to abuse combined with insight into midwives and other hospital staff experiences around routine enquiry and their appreciation for further training and

support around the complex societal issue of domestic violence and abuse (DVA). A significant body of both international and Irish research reinforced the need to offer a more dedicated and sustainable resource to support the midwives, doctors, nurses and social workers who care for the pregnant women and pregnant people who may be in this situation. Finally, the recommendation from Ireland's first Maternity Strategy 2016-2026 on training and referral pathways underlines the need for this project:

> *"Midwives, obstetricians and GPs are alert to the heightened risk of domestic violence during pregnancy and postpartum. Women will be asked about domestic violence at antenatal and postnatal visits, when appropriate. This will be supported by appropriate training for frontline staff to ensure that all such enquiries and disclosures are handled correctly, and that referral pathways and support options for women who disclose domestic violence are clear."* [9],[10] *- National Maternity Strategy*

Women's Aid worked with maternity services to develop the three components of the project:

- Co-design of awareness raising materials for hospital staff and women using maternity services. Co-design involved Women's Aid and representatives from multiple services in each of the four partner hospitals. The co-design process did not directly involve women themselves but was informed by Women's Aid's learning from supporting women in the perinatal period.
- Collaborate on the design and implementation of a referral pathway from maternity services to Women's Aid Outreach Support Service.
- Co-design and roll out of evidence informed training for maternity services staff.

[9] Department of Health. (2016). *Creating a better future together: National Maternity Strategy 2016-2026.*
[10] Department of Health (2021). *National Maternity Strategy: Revised Implementation Plan 2021-2026.*

Training

To collaborate with the key stakeholders to design and develop a bespoke training course and pilot and evaluate this among a sample of staff from the 4 key maternity hospitals and some elected regional maternity units.

Awareness

To design and develop awareness raising materials. This material should raise awareness for both staff and patients on pathways into specialist services and on the links of DVA and maternal health. To create hospital environments that are visibly disclosure friendly

Referral

To develop links between maternity hospitals and appropriate specialist DVA services in their community. To enhance referral pathways for support, information and advocacy for women (including staff) when required. The three Dublin hospitals have a named specialist DVA Maternity Outreach Support Worker.

Resources have always been the primary barrier to progress in this area. Women's Aid resourced this ambitious pilot project over its duration from May 2021 to December 2024, entirely through generous donations from the public and non-statutory funds. The investment in the project was a total of €536k.

Here we report on the independent evaluation of the project, commissioned by Women's Aid and undertaken by the Centre for Effective Services (CES).

Evaluation methods

The aim of the evaluation was to analyse data gathered during the pilot (2021-2024), to explore how the Maternity Project was implemented across four pilot sites (The Rotunda, The Coombe, The National Maternity Hospital Holles Street and Cork University Maternity Hospital) and report on any early impact or outcomes achieved.

Evaluation of the pilot phase of any new intervention or initiative in healthcare plays a key role in understanding the feasibility of its implementation and how this can be improved. This was a 'formative' evaluation. Formative evaluation is usually conducted in parallel with the early implementation stage of an intervention or initiative, with the view to exploring and identifying factors that may influence the progress and effectiveness of the intervention. The learning from a formative evaluation typically informs future decision-making about the later stages of intervention design and roll-out.

This formative evaluation of the Maternity Project has been guided by Proctor et al.'s Outcomes for Implementation Research[11], a useful framework for conceptualising and evaluating successful implementation of a project within health services. The implementation outcomes from this framework that were selected as most relevant for the evaluation of the Maternity Project were:

- **acceptability**, perceived need and satisfaction with the intervention,
- **appropriateness**, the fit between the intervention and the context,
- **adoption,** the level of uptake or intended uptake
- **feasibility,** could the intervention practically be implemented?
- **sustainability**, could the intervention be maintained?

The evaluation adopted a mixed-methods approach using a combination of quantitative data (training feedback surveys, routinely collected data from hospitals and from Women's Aid, surveys of staff experience of the project implementation and impact) and qualitative interviews and focus groups with key staff involved in the design and rollout of the project including medical social workers, service leads (including primarily directors and assistant directors of midwifery) and Women's Aid project coordinator, training and development manager and outreach workers.

[11] Proctor, E., Silmere, H., Raghavan, R., Hovmand, P., Aarons, G., Bunger, A., Griffey, R., & Hensley, M. (2011). *Outcomes for implementation research: conceptual distinctions, measurement challenges, and research agenda*. Administration and policy in mental health and mental health services research, 38, 65-76.

Findings

Overall, this pilot project was successful in meeting its aims. Implementation of the project was largely successful, with key learning gained on necessary adaptations and considerations to inform any future rollout.

The collaborative approach to the project, was essential to successful implementation. The collaborative approach was vital for designing an offer that was acceptable and implementable. In particular when *co-design* was adopted to design and implement the project components *with* services this created the conditions for successful implementation. The majority of those who participated in the evaluation had a positive experience of the collaborative approach, for the small minority who expressed a negative view of the collaboration, the evaluation found that this was associated with slower uptake of the project components.

The presence of a dedicated coordinator for the project was necessary to enable co-design. The project coordinator was also essential to driving the project forward in partnership with maternity services.

Early findings on the impact of the project indicate that it has had a positive effect on awareness of DVA for both staff and women using services. The Outreach Support Service has improved the speed and type of support provided to women referred to the service. Training was largely successful in improving staff awareness of DVA, recognition of the signs of DVA, preparedness to ask women about DVA and confidence in responding appropriately to a disclosure of DVA.

This pilot project demonstrated great potential for improving maternity services response to DVA. The strong co-design approach has generated excellent resources that meet the needs of maternity services in supporting and enhancing their approach to DVA. Barriers remain to its wider rollout that need to be addressed to enable the project to have impact at scale.

Any wider rollout should adopt the successful co-design approach, extend this to include women with lived experience, and be accompanied by an evaluation of implementation and impact, adopting an experimental design to provide more robust evidence on the impact of the project.

Data and monitoring

Our survey exploring the experiences of women who have used maternity services while they were experiencing DVA in the past 5 years[12] indicated that screening was not universal, nor was it effective in identifying all women subjected to DVA. As part of the evaluation, we sought data on screening for DVA and rates of referrals to MSW following disclosure. The work involved in liaising with the hospitals about

[12] Centre for Effective Services (2023), *Survey of Women's experience of maternity services while subjected to DVA.* Interim report for the evaluation of the Women's Aid Maternity Project. Unpublished

this data has helped identify gaps in what is recorded by maternity hospitals in relation to DVA and informed recommendations about data collection on DVA at maternity hospitals.

Awareness raising materials

The Third National Strategy on Domestic Sexual and Gender-Based Violence (DSGBV)[13], the National Standards for Maternity Services[14], and the National Clinical Practice Guideline: Screening and Management of Domestic Violence and Abuse in Pregnancy and the Early Postnatal Period[8] all recommend the availability of information about local, specialist DVA services within maternity service settings. The awareness-raising intervention of the Maternity Project is aligned with these policies. Women find awareness raising materials to be helpful and welcome their presence throughout maternity settings[7],[12]. They can prompt women to self-refer, contribute to a disclosure friendly environment and improve women's recognition of abuse, particularly coercive control.

In this evaluation we found that there was a high level of support from maternity services staff, who agreed that awareness raising materials were needed and welcome in their services. Co-design of materials with Women's Aid and maternity services led to greater adoption and reach of materials with greater impact.

- Awareness raising materials were acceptable and effective in contributing to disclosure friendly environments, improving awareness of DVA and opening conversations.
- Sustaining year-round visibility of materials is important and requires leadership to champion DVA awareness to ensure that materials remain visible and bring focus to DVA.
- The materials were perceived to contribute to improved recognition of DVA. Medical social workers felt that materials and the 16 days campaign led to increased referrals to Medical Social Work services.
- We identified substantial gaps in the distribution of awareness raising materials between public and private care settings, with very low uptake in private settings. This is reflective of a wider pattern of much poorer recording of screening data, screening practices, identification of women subjected to DVA and referral to support in private care settings, as compared to public care settings, found throughout this evaluation.

The Outreach Support Service

The Outreach Support Service is an initiative in three Dublin maternity hospitals, supported by a dedicated Women's Aid Outreach Worker (OW) who manages referrals from the medical social work teams, operating

[13] Department of Justice. (2022). *Third* National Strategy on Domestic, Sexual and Gender-Based Violence *Implementation Plan*.
[14] Health Information and Quality Authority. (2016). National Standards for Safer Better Maternity Services.

since May 2021. The service supports women experiencing domestic violence and abuse, with a focus on timely interventions and referrals. The Outreach Support Service's focus on offering same-day responses is crucial, aligning with several key policies. The Istanbul Convention (Article 20) mandates timely access to support services[15]. The Third National Strategy on Domestic, Sexual and Gender-Based Violence 2022-2026[13] emphasises clear and responsive local pathways. The Health Service Executive (HSE) Policy on Domestic, Sexual and Gender-Based Violence (2010[14] highlights the need for prompt assistance. The National Maternity Strategy 2016-2026[9,10] supports timely responses during pregnancy, and the National Clinical Practice Guideline Screening and Management of Domestic Violence in Pregnancy and the Early Postnatal Period (2024)[8] stresses the importance of immediate intervention.

Referrals to the service have increased rapidly over time with 353 referrals received over the study period. The Outreach Support Service has successfully maintained a same-day response and engagement levels with the service have been consistently high. The service primarily supports pregnant women, though it also aids women post-pregnancy or following-pregnancy loss.

Learning from implementation:

- There were high levels of acceptability among project partners for the Outreach Support Service. The aspects of the intervention that were particularly valued by project partners included the co-design of the referral pathway, the expertise of the Outreach Worker (OW), the capacity of the OW to support with legal needs including court accompaniment, the services ability to connect women to wider Women's Aid supports, the community-based nature of the work, the continuity of the OW for women and for the maternity social work department and the independence of the project from the hospital and from social work.
- Co-design has proved to be a valuable approach to securing project partner buy-in but was not used as extensively with the implementation of the Outreach Support Service compared to other aspects of the project. This resulted in the Women's Aid project coordinator having to spend a lot of time at the beginning engaging with social work departments to secure buy in for the service. This was largely successful and helped increase project partner perceptions of appropriateness (i.e. fit) and resulted in increased adoption of the service, as evidenced by increased referrals.
- There was strong support for the continuation of the pilot and for wider rollout to other hospital settings. Variation in the context of implementation sites (i.e. hospitals) however has the potential to influence delivery and ultimately outcomes and as such the evaluation has made recommendations for considering wider rollout, particularly in services where there is no maternity social work department.

[15] Council of Europe (2011) *Convention on preventing and combating violence against women and domestic violence.*

Impact of the Outreach Support Service:

- Feedback from the evaluation of the Outreach Support Service was overwhelmingly positive, with participants advocating for the continuation of the pilot and its extension into other hospital settings.
- Social workers from across all three hospitals and the OWs discussed a number of different ways that the Outreach Support Service was contributing to a broadening of support and greater efficiency in terms of how women engaged with maternity services can be supported with DVA, and how the social work teams also benefit from the Outreach Support Service.
- Overall, findings from the evaluation suggest that the Outreach Support Service contributed to a more 'joined up' approach to supporting the needs of women accessing maternity services and experiencing DVA.

Having a ring-fenced community outreach service for women engaged with maternity services:

- allowed women to access immediate support from the Outreach Support Service during the perinatal and postnatal periods which research has shown is a particularly vulnerable period.
- enabled strong working relationships to be developed and maintained between the Outreach Support Service and the medical social work department which worked to ensure women were well supported throughout their pregnancy.
- Women who accessed the service were overwhelmingly positive about their experience of accessing support from the OW, with the majority agreeing that they received information and support about their rights and options; received emotional support and felt stronger and more confident in managing their situation following engagement with the OW.
- There was also some indication from evaluation participants that the OW's capacity to accompany women to court was resulting in an observable improvement in the number of women who were attending court to secure protection orders.

Training

The Women's Aid Maternity Project Domestic Violence and Abuse Training Programme is designed to enhance the response of maternity hospitals to victims of domestic abuse. This pilot programme developed collaboratively with multidisciplinary staff in the four pilot hospitals, offers a blended learning approach, including self-paced eLearning, interactive online sessions, and face-to-face workshops. The training was structured in three levels, with trainees having to complete the previous level in order to be eligible to progress to the next. The course was accredited for 4 RCPI CPD credits & 5 NMBI CEU's on completion of the 3 levels. The training levels were:

- Bronze level, *Recognising and understanding the impacts of domestic abuse on women, a* 45-minute self-paced eLearning, focused on recognising domestic abuse and signposting support options available.
- Silver level, *Enquiring about and responding to women subjected to domestic abuse*, a 1.5 hour, facilitated online multidisciplinary group training, addressing how to enquire about and respond to abuse.
- Gold level, *Skills workshop facilitating and managing disclosures of domestic abuse*, 1.5 hour facilitated in-person multidisciplinary group workshop using case studies and role plays to allow participants to practice skills in managing disclosures.

This training aimed to empower clinical staff to sensitively work with women subjected to DVA during the perinatal period, ensuring appropriate referrals and support for survivors. Training was made available to all clinical staff within the four pilot partner maternity hospitals (The Coombe, The Rotunda, CUMH, NMH) and two additional regional maternity units at University Hospital Kerry and St Lukes General Hospital Kilkenny.

Implementation of training

Training was rolled out between November 2023 and July 2024. Across the four pilot partner sites and two regional sites, 345 people availed of bronze training, 166 silver and 67 gold. Uptake was strongest for medical social workers with 4 in 5 availing of training. Uptake was lowest for doctors, with 1 in 20 accessing the training.

- Training was highly acceptable and appropriate, with the training content described as ’excellent and in depth’ and highly relevant to trainee’s professional role, with 99.31% of respondents finding it directly applicable to their work.
- Satisfaction with all three levels of the training was high. For trainees, 92% were very satisfied with the course content describing it as "excellent" and highly relevant.
- Post-training feedback indicated that 97% of respondents felt the training either met or exceeded their expectations and very nearly unanimous agreement that trainees would recommend the course to colleagues at all three levels (99.5%).
- Trainees valued the multidisciplinary approach to training. Hospital C was particularly successful in securing multidisciplinary engagement with the project, which resulted in greater uptake across all professional groups.
- The demanding schedules of hospital staff posed significant challenges, with many struggling to make time to participate in training sessions. Despite high satisfaction with the content, logistical issues such as time constraints and resource limitations were significant barriers to greater uptake.

- The co-design work, development of training content and resources and roll out of training was delivered by Women's Aid at no cost to the maternity hospitals who were offered the training. This investment by Women's Aid is wholly unsustainable nor scalable without funding from statutory agencies.

Impact of training: early findings

- The training programme was effective in improving trainees' preparedness to recognise, identify signs and ask women about DVA and refer women to specialist support both within and without the hospital setting. This positive impact appeared to be stronger for the group of silver trainees as compared to bronze, and for gold as compared to silver[16].
- Early evidence indicates that this improved preparedness has had a positive impact on trainees' confidence in discussing DVA, with colleagues and with women.
- There was also some evidence, from focus group participants' observation of colleagues and responses to follow-up survey, that training improved trainees' ability to identify and respond to DVA cases in practice.
- Several practical challenges hindered trainees from applying the learning in practice including partner presence during consultations, language barriers, and insufficient private spaces for confidential discussions.

Summary of Recommendations

A number of recommendations emerged from this work and are summarised here. The full list of recommendations is here.

Overarching recommendations for the project

Based on our findings on the projects' overall implementation and impact and additional learning from the evaluation process we recommend that:

- The project should continue with adaptations to respond to the learnings from this evaluation.
- Funding to continue the project and build on the resources developed should be made available to Women's Aid and participating hospitals by HSE or relevant state bodies.
- Any continuation of the project should include monitoring of implementation and impact by both Women's Aid and partner hospitals.

[16] The impact appears to be very positive but as trainees are a self-selecting group, there is no control or comparison group and we were unable to track the progress of individual trainees through the three tiers of training, as such we are cautious in our interpretation of this finding.

- Any further rollout should include a robust evaluation adopting an experimental design.
- We strongly recommend that the Outreach Support Service is funded to continue operating, with sufficient resourcing to maintain a same-day response in the context of increasing referrals.
- We strongly recommend that awareness raising materials should continue to be distributed and displayed throughout all maternity settings, with supports in place to ensure materials are visible in all maternity settings year round and adequate funding provided to support the annual 16 days campaign.
- We recommend that the training programme be continued and extended to other maternity hospitals with adaptations to the structure and delivery to improve the fit with maternity settings needs and constraints on time.
- Wider rollout to other maternity hospitals should continue to utilise a co-design approach in partnership with maternity hospitals.
- Any extension of the project to other health settings (GPs, emergency departments, public health nursing) should build on the resources developed and the learning generated.
- Any extension of the project should first consider the feasibility of implementation in new contexts or services.
- We recommend that funders of any further roll out or extension to other services, acknowledge the value of co-design and provide specific funding to enable this resource intensive approach, including a dedicated coordinator role to lead and manage the process.

Summary of Recommendations relating to data and monitoring

We recommend that:

- Hospitals continue to use computer aided data collection systems that provide prompts to support DVA screening and recording of screening.
- All maternity hospitals review their processes for capturing data on screening and referral to MSW and take appropriate action to ensure that:
    - screening at booking is always taking place and recorded correctly.
    - prompts for asking about DVA are not limited to booking appointment. Consider adding prompts for asking about DVA throughout pregnancy and in other services (e.g. early pregnancy, termination of pregnancy) and postnatal screening.
    - gaps in screening and referral for patients in private/semi-private compared to public care are closed.
    - every woman who makes a disclosure of DVA is offered support.

- All maternity hospitals, led by medical social work, consider implementing a system of reviewing screening data so that all women are asked about DVA and all women who disclose DVA are offered specialist DVA support.
- All maternity hospitals commit to ongoing monitoring of DVA disclosure and referrals.
- All maternity hospitals/MN-CMS[17] review and adjust the IT systems so that ongoing monitoring of DVA disclosure and referral does not require manual review of individual cases.
- MN-CMS to include a way to capture and easily report on the point in pregnancy a referral was made to MSW so that monitoring of progress towards earlier identification of women in need of support can be undertaken more easily.

Summary of recommendations for Awareness raising materials

We recommend that:

- Women's Aid continue to provide high-quality co-designed awareness-raising materials to maternity services.
- Funding to continue to deliver this annual campaign should be made available to Women's Aid and extended to allow hospitals to work with Women's Aid to create more opportunities to bring focus to DVA in pregnancy, not limited to 16 days campaign.
- That maternity services work to close gaps in uptake of materials:
    - between private, semi-private and public care in maternity hospitals
    - between the full range of services that women have contact with during the perinatal period, taking a multidisciplinary team approach
    - for women whose first language is not English. Costs of translation of existing materials to be funded by HSE to provide equity for service users.
- Partner hospitals and Women's Aid identify, train and support champions within services to lead on maintaining year-round visibility of materials and creating more opportunities to focus on DVA, not limited to the 16 days campaign.
- Hospitals commit to regular review of all services that women may be in contact with to ensure that services have the materials, that staff are aware of them, particularly in teams with high turnover of staff, and that materials are consistently on display and visible to women and staff members.

[17] The Maternal & Newborn Clinical Management System (MN-CMS)

Summary of recommendations for the Outreach Support Service

We recommend that:

- The Outreach Support Service should be continued, and appropriate funding provided to Women's Aid to maintain this service by HSE/relevant state body. This should include sufficient resources to enable the service to maintain same-day response for women referred, manageable caseloads and the excellent quality of the service for women.
- Women's Aid to work with the MSW departments to analyse trends in rates of detection and referral to inform understanding of resource requirements.
- Continued access for the OWs to Women's Aid line management as well as monthly clinical supervision.
- Women's Aid to consider the suggestion from a medical social worker to bring the three Dublin hospitals together on a regular basis to share learning and ideas about how they could make best use of the Outreach Support Service.

If wider rollout to other hospital settings is considered, we further recommend:

- An analysis of the feasibility of rolling out the Outreach Support Service to support regional hospitals with maternity units, who may or may not have access to dedicated DV MSW.
- Women's Aid to factor into implementation plans the time required to build relationships and garner support for the Outreach Support Service in any future rollout of the service.
- Ongoing review and evaluation of the implementation of the service in other contexts to inform an understanding of its impact.

Summary of recommendations for training

We recommend that:

- HSE provide funding to support further roll out and evaluation of the training in partnership with Women's Aid, building on the existing resources and insights gained through Women's Aid's and pilot partner hospitals' investment in the co-design and delivery of this high-quality training. This is in line with National Clinical Practice Guidelines that there should be mandatory training for all Midwives, Nurses, Doctors and Health and Social Care Professionals and students working in maternity settings.
- Senior leaders in partner maternity hospitals commit to working with Women's Aid to address the barriers to training uptake and application of learning identified in this evaluation.
- Hospitals identify, resource and support champions to lead the adoption of training across all services, roles/disciplines and types of care to address the gaps in training uptake.

- Any rollout of training retain the multidisciplinary approach to training different professional groups together, potentially jointly delivered with MSW where feasible.
- Realistic timelines and allocation of resources are adopted for any further rollout of training. Those who availed of training to date may represent keen early adopters and more time and effort may be required to support a wider rollout to those with more pressing priorities.
- HSE/ National Women and Infants Health Programme (NWIHP) to consider commissioning the rollout of this training to other health professionals who are in contact with women during pregnancy. Any further rollout beyond maternity hospitals should include funding for co-design/adaptations to training to fit within each new service context/needs/constraints.

Introduction

Pregnant women who are subjected to domestic violence and abuse (DVA) face a range of barriers to help-seeking and disclosure, during a vulnerable and high-risk period. The Maternity Project aimed to enhance the response of the maternity services in Ireland to victims/ survivors of DVA by collaborating with maternity services to implement co-designed awareness raising materials, a specialist outreach worker role, and a bespoke co-designed training course for maternity staff.

The Centre for Effective Services (CES) was commissioned by Women's Aid in February 2022 to evaluate the Women's Aid Maternity Project pilot. The purpose of the evaluation was to analyse data gathered during the pilot period (2021-2024), to explore how the Maternity Project was implemented across sites and any early impact or outcomes achieved. This report aims to support Women's Aid and other project partners to reflect on the learning, impact, outcomes and potential for wider roll-out of the Maternity Project.

We outline evidence-based recommendations arising from this evaluation for addressing gaps identified in maintaining, improving and scaling-up of the Maternity Project in national maternity services for the benefit of women subjected to DVA in the perinatal period.

Structure of report

The remainder of this report is structured as follows; First we offer a brief synthesis of the research evidence and relevant policy to give context to the evaluation, followed by a description of the evaluation methodology. The findings are then set out beginning with a summary of the overarching learning. This is followed by detailed description of findings in relation to data and monitoring of screening and referral, the awareness raising materials, the outreach support service and finally training. We include recommendations after each section and repeat these recommendations again in the summary of recommendations, organised by responsibility for implementation.

Background and context

Domestic violence and abuse (DVA) is a pervasive and far-reaching international issue, with intergenerational, economic, social, workforce, and healthcare ramifications. In the Republic of Ireland (hereafter referred to as Ireland), the estimated cost of DVA is at least €2.7 billion each year.[18] These costs include direct costs such as health care and legal costs and indirect costs such as lost income, property damage or theft and debt accrued by the perpetrator. The average cost for individual women over her journey to safety was €113,475[19]. These estimates do not include the costs, typically borne by government or charitable organisations, of delivering services to deal with the impact of perpetrators abuse. Nor do they include the economic costs of harm done to children in the family which is known to be costly and have long term negative economic consequences[20],[21].

DVA is widely accepted as a preventable public health issue[5], yet globally, little investment is devoted to prevention and early intervention supports.[22]

The perinatal period represents a particularly vulnerable period in a woman's life. For women with abusive partners this vulnerability is magnified. The presence of a child/children leaves a woman in a situation of having to maintain contact with an abusive partner/former partner as the father of her children[23] and risk of continued abuse of her and her children even after a relationship ends.[24] Pregnancy and the perinatal period is also a time of significant opportunity for maternity services to identify and respond to women who may benefit from referral to expert DVA support.

The impact of perinatal DVA

Perpetrators of DVA in the perinatal period put victims at increased risk of a wide range of negative outcomes; for women's mental health and wellbeing; physical and reproductive health; birth outcomes; socio-economic opportunities; and long-term negative outcomes for her children. These outcomes are summarised in Figure 2, adapted from a WHO graphic of health outcomes of IPV during pregnancy.[25]

Impact on reproductive and physical health

[18] Forde & Duvvury (2021) Assessing the Social and Economic Costs of DV: A Summary Report. Safe Ireland and NUI Galway.
[19] Doyle, J., Ashe, S., Lawler, L., (2021) Addressing domestic, sexual and gender-based violence Part One: Overview. Houses of the Oireachtais Library and Research Service Note
[20] Bywaters, P., Bunting, L., Davidson, G., Hanratty, J., Mason, W., McCartan, C., & Steils, N. (2016). The relationship between poverty, child abuse and neglect: An evidence review. *York: Joseph Rowntree Foundation*.
[21] Bunting, L., Davidson, G., McCartan, C., Hanratty, J., Bywaters, P., Mason, W., & Steils, N. (2018). The association between child maltreatment and adult poverty–A systematic review of longitudinal research. *Child abuse & neglect*, *77*, 121-133.
[22] Chisholm et al. (2017) Intimate partner violence and pregnancy: epidemiology and impact.
[23] Baird (2021) Intimate Partner Violence in Pregnancy and the Post-partum Period: A Research and Practice Overview.
[24] Katz et al. (2020). When Coercive Control Continues to Harm Children: Post Separation Fathering, Stalking and Domestic Violence.
[25] World Health Organisation. (2011) Intimate partner violence during pregnancy: Information sheet.

Women subjected to DVA during pregnancy are at risk of delayed and reduced access to care and monitoring during the antenatal period, with high rates of late presentation to maternity services and missed appointments.[26] IPV substantially increases the risk of haemorrhage or bleeding during pregnancy, and the risk of hypertension and pre-eclampsia, which are both associated with serious risk of maternal and foetal morbidity and mortality.[27] Miscarriage may be an indicator of physical abuse during pregnancy[28], as is repeat presentation at accident and emergency (A & E) departments[29] or emergency obstetric units. Victims may also suffer from subtler physical ailments such as frequent headaches, chest, abdominal, lower back or pelvic pain and chronic pain.[30]

Women subjected to DVA are at higher risk of unintended pregnancy and reproductive coercion[31, 32] sexually transmitted infections (STIs) and urinary tract infections (UTIs)[33].

In its most extreme form, DVA may culminate in suicide, femicide, or other forms of domestic homicide.

[26] Alhusen et al. (2015) Intimate Partner Violence During Pregnancy: Maternal and Neonatal Outcomes.
[27] Pastor-Moreno et al. (2020). Intimate partner violence and perinatal health: a systematic review.
[28] NICE Clinical Guidelines. (2010) Pregnancy and Complex Social Factors: A Model for Service Provision for Pregnant Women with Complex Social Factors.
[29] Elvey et al. (2022) A hospital-based independent domestic violence advisor service: demand and response during the Covid-19 pandemic..
[30] Vicard-Olagne et al. (2022) Signs and symptoms of intimate partner violence in women attending primary care in Europe, North America and Australia: a systematic review and meta-analysis.
[31] Pallitto (2013) Intimate partner violence, abortion, and unintended pregnancy: Results from the WHO Multi-Country Study on Women's Health and Domestic Violence.
[32] Hall et al. (2014) Associations between Intimate Partner Violence and Termination of Pregnancy: A Systematic Review and Meta-Analysis.
[33] Vicard-Olagne et al. (2022) Signs and symptoms of intimate partner violence in women attending primary care in Europe, North America and Australia: a systematic review and meta-analysis.

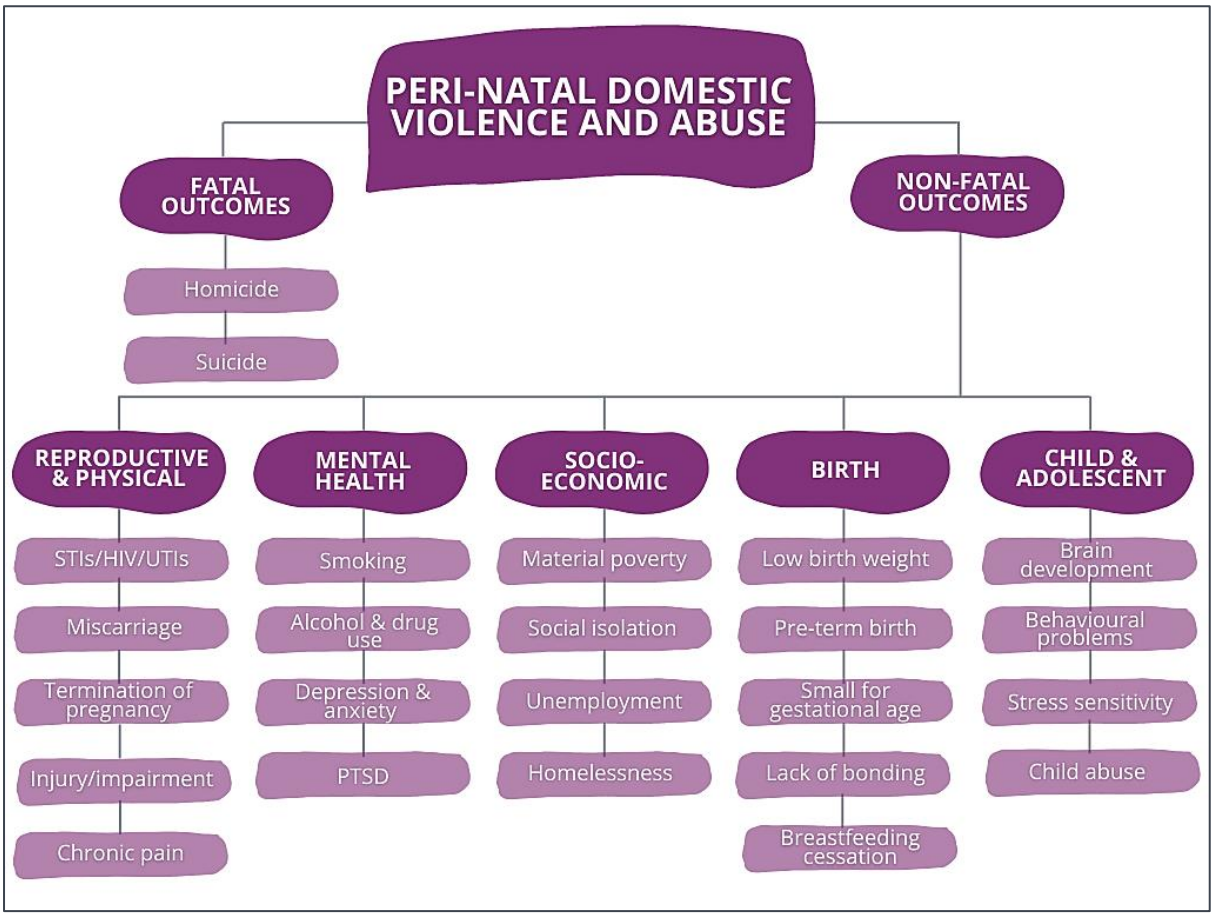


Figure 1: The impact of perinatal DVA on wellbeing (adapted from WHO 2011)

Impact on perinatal outcomes

Pre-term birth and low birth weight are leading causes of neonatal death[34] and women subjected to any kind of perinatal DVA are two to six times more likely to have a pre-term birth, with the strongest risk for those subjected to physical IPV.[27] Physical assault during pregnancy that results in hospitalisation triples the risk of baby having a low birth weight, with an associated range of short- and long-term negative child outcomes[35]. Neonatal death is six times more likely in these cases.[26]

Coercive control may also induce premature labour through activating stress pathways in the body and raising cortisol levels which cross the placenta.[36] Perpetrator behaviour causing continuous stress during pregnancy can cause epigenetic changes which are known to alter foetal brain development, leading to

[34] Health Service Executive (2021). Neonatal death.
[35] Mueller & Tronick (2019) Early Life Exposure to Violence: Developmental Consequences on Brain and Behavior.
[36] Baird et al. (2021). Red flags and gut feelings – Midwives' perceptions of domestic and family violence screening and detection in a maternity department.

reduced attention span for infants, and making them more sensitive to stressors in later life.[3535] Women subjected to DVA are more likely to stop breastfeeding earlier[37].

Prevalence of DVA

DVA remains a serious and prevalent issue in Ireland. Reports of DVA in Ireland are increasing. Calls to Gardaí regarding domestic abuse incidents totalled 48,400 in 2021, representing a 10% increase from 2020 and almost a 60% increase since 2017.[38] Women's Aid national statistics echo this increasing trend, with 28,096 disclosures of abuse against women received in 2021, representing a 13% increase on the year before.[39] Social restrictions and self-isolation, in addition to financial distress and/ or unemployment, may have heightened exposure to perpetrators and diminished opportunities for women to seek help.

Prevalence of perinatal DVA

DVA in pregnancy is common[5]. There is a lack of current or consistent data on the prevalence of perinatal DVA, both internationally and in Ireland specifically[878]. Prevalence rates of perinatal DVA (DVA during pregnancy and the postnatal period) differ across research studies, partly due to inconsistencies in how it has been defined and measured in different settings. Recent reviews suggest a wide variation in estimates by country with most studies falling within a range of 3.9%-8.7%.[40 41] and European countries having an average prevalence of 5.1% in pregnancy[42]. Older data from 2014, indicates that women in Ireland may be slightly more likely to be subjected to DVA in pregnancy than the EU average[43].

Type of abuse

Recent and reliable data on the different forms of abuse experienced during pregnancy is limited, but psychological abuse is typically the most prevalent, more so than physical and sexual abuse.[44] The insidious nature of psychological abuse, including coercive control and emotional abuse, makes it particularly challenging for women themselves and for health care providers to recognise.

---

[37] Normann et al. (2020) Intimate partner violence and breastfeeding: a systematic review.
[38] An Garda Síochána (2021) 2020 Annual Report.
[39] Women's Aid. (2022) Annual Impact Report 2021.
[40] Ghanzanfarpour et al. (2018). The Relationship between Abuse during Pregnancy and Pregnancy Outcomes: An Overview of Meta – Analysis.
[41] Devries et al. (2010) Intimate partner violence during pregnancy: analysis of prevalence data from 19 countries.
[42] Román-Gálvez et al. (2021). Prevalence of intimate partner violence in pregnancy: an umbrella review.
[43] EU FRA Survey VAW Ireland, 2014 cited by O'Brien- Green, (November 2021), Pregnancy & Domestic Violence: findings from recent Irish research, Webinar for Women's Aid.
[44] Mojahed et al. (2021) Prevalence of Intimate Partner Violence Among Intimate Partners During the Perinatal Period: A Narrative Literature Review.

Screening for perinatal DVA in maternity services

Pregnancy can be a time when women are thinking more about the future, presenting an opportunity for intervention and support[45, 46]. Regular, ongoing healthcare appointments in pregnancy not only offer multiple opportunities for disclosure and space to build trusting relationships, but also provide a situation where women can access services without arousing suspicion from an abusive partner.[47]

Screening simply refers to asking women, usually within healthcare settings, to identify whether they are experiencing DVA now, or have done in the past[48]**.** Screening can be universal (i.e., asking all women at all healthcare encounters, or at the same point in their healthcare pathway) or selective/ 'context specific', where clinicians use their own knowledge and risk assessment skills to decide who should be screened, e.g. those in higher risk groups, those presenting with signs of DVA.

Most women accessing maternity care find it acceptable to be asked about DVA at least once with wide support for enquiry at multiple points in pregnancy[49],[50]. CES' own survey on the experiences of women who have used maternity services[51] in the previous 5 years while they were experiencing DVA (May 2022- June 2023) demonstrated that a large majority of women who participated agreed that DVA should be asked about at least three times during pregnancy[12].

Despite high acceptability of universal screening and selective enquiry for DVA during maternity care in Ireland, actual screening rates often lag[52], [53]. In Ireland universal screening in maternity services should be done at booking appointments, meaning every woman should be asked at least once about DVA during pregnancy. Our survey exploring the experiences of women who have used maternity services while they were experiencing DVA indicated that screening was not universal, nor was it effective in identifying all women subjected to DVA.

Barriers & enablers to screening and disclosure in maternity services

Women are active help seekers who need to choose carefully where, when and to whom they can safely disclose. Screening within healthcare services is therefore an opportunity to "*plant a seed"*, even if a

[45] Bacchus et al (2010). Evaluation of a domestic violence intervention in the maternity and sexual health services of a UK hospital.
[46] O'Reilly et al. (2010) Screening and Intervention for Domestic Violence During Pregnancy Care: A systematic Review.
[47] Rivas et al. (2019) A realist review of which advocacy interventions work for which abused women under what circumstances.
[48] O'Doherty et al. (2015) Screening women for intimate partner violence in healthcare settings.
[49] Salmon et al. (2013) Women's views and experiences of antenatal enquiry for domestic abuse during pregnancy.
[50] Boyle & Jones, P. (2006) The acceptability of routine inquiry about domestic violence towards women: a survey in three healthcare settings..
[51] Maternity services include services for pregnancy, birth, pregnancy loss, or termination of pregnancy.
[52] Higgins et al. (2017). Perinatal mental health: an exploration of practices, policies, processes and education needs of midwives and nurses within maternity and primary care services in Ireland.
[53] O'Shea et al. (2016) Domestic Violence During Pregnancy-GP Survey Report.

woman chooses not to disclose at that point in time.[54] Supportive, sensitive screening from a midwife, even without disclosure, can influence a victim's thinking by naming and recognising abuse.[55]

Table 1 summarises the barriers and enablers for the effective implementation of DVA screening in maternity services at a system, organisational, healthcare professional and service-user level based on our review of the international literature[77] and survey of women's experiences in Irish maternity services[12].

Table 1: Barriers and enablers for perinatal DVA screening and disclosure in maternity services

Level	Barriers	Enablers
System	• System overload • Lack of community resources • Lack of education/training	• Funding • Specialist Domestic Violence Services & referral pathways
Organisational	• Poor documentation practices • Lack of screening instruments • Lack of appropriate private space • Lack of opportunity/ partner presence • Lack of guidance • Unclear referral pathways	• Consistent approach to recording DVA • Culturally sensitive tools • Co-location & partnership with DVA specialist support • Up to date policies • Workplace champions and peer support
Healthcare professional	• Inconsistency/ tone • Lack of confidence • Personal experience of DVA • Lack of time • Conflict of confidentiality • Not wanting to 'offend' • Stereotyping	• Training & CPD • Ongoing support & debrief • Awareness materials • Access to independent/non-statutory DVA specialist (e.g. IDVAs in UK, WA outreach worker) • Computer assisted screen/checklist/reminders • Multi-disciplinary teams • Non-judgemental tone & sensitive language
Service-user	• Fear of consequences, including fear of partner reprisal and fear that her children could be removed from her care. • Shame or embarrassment	• Awareness materials & self-referral • Invitation to seek help • Disclosure friendly environment • Emotional support • Specialist DV support

[54] Tarzia et al. (2020). Women's experiences and expectations after disclosure of intimate partner abuse to a healthcare provider: A qualitative meta-synthesis.
[55] Spangaro et al. (2020). "Made Me Feel Connected": A Qualitative Comparative Analysis of Intimate Partner Violence Routine Screening Pathways to Impact.

	• Concern for privacy/confidentiality • Lack of awareness/recognition of abuse • Vulnerability & complexity • Language barriers • Immigration status • Lack of confidence in health care providers interest in/ability to handle disclosure appropriately	• Interpreters • Computer assisted screening • Legal protection • Female practitioners • Direct questions asked multiple times during pregnancy • Trust and choice • Continuity of carer • Culturally sensitive & individualised approach • Assurance of support without discrimination or repercussions • Strengths based approach

Women's experience of Irish Maternity Services

Women's Aid commissioned CES to conduct a survey of women who have experienced DVA while accessing maternity services in Ireland in the last 5 years (May 2022- June 2023, 74 respondents).

- This survey indicated that screening for DVA in pregnancy was not universal.
- Women accessing private care were much less likely to have seen information about DVA and much less likely to have been asked about DVA during their pregnancy.
- The majority of survey respondents reported that they did not disclose DVA to the maternity service they attended. Fear and shame appeared to be key contributing factors (including fear about the involvement of child protection services), along with a belief that the service would not know how to help.
- For the survey respondents who did disclose abuse, the strongest encouraging factor for disclosure was their belief that their information would be kept confidential.
- Over half of the respondents who disclosed abuse felt that the healthcare professional they spoke with did not know how to help them.
- The majority of survey respondents indicated that they had not accessed any other specialist support services for DVA during pregnancy and the majority also indicated that they were not aware of any local support services at that time.
- Survey respondents were strongly in favour of women being asked about DVA frequently at their appointments with maternity services.
- Women called for improved understanding of coercive control and the behaviours that constitute domestic abuse. They recommended that staff in maternity services be trained to ask questions about DVA that relate to controlling relationships, and to recognise signs of psychological abuse.

Focus group with Pavee Point Traveller and Roma Centre

A focus group was conducted with Primary Health Care Workers (PHCWs) for the Traveller community, a Community Development Worker for the Pavee Point Roma Programme, the Pavee Point Violence Against Women Programme Coordinator, and the Pavee Point coordinator for Pavee Mothers- Maternal Health Initiative. Similar to the survey of women's experiences participants unanimously supported women being asked about DVA more frequently when attending maternity services. They emphasised the importance of trust for women to talk about DVA and discussed the discrimination and poor treatment that women from Traveller and Roma communities often experience when attending maternity services. Other structural barriers to accessing support for abuse that were discussed in the group included inadequate translation services in healthcare settings, and a lack of alternative accommodation and income for women to live independently of an abuser, particularly those women who are not 'habitually resident'*. The focus group participants advocated for a specific care pathway for Traveller and Roma women in the maternity service, with staff who are trained to support Traveller and Roma women.

* 'Habitually resident: many of the social welfare payments in Ireland can only be claimed by those who are "habitually resident", which means people who can prove they have lived in Ireland and plan to continue living in Ireland for the foreseeable future.

Screening for DVA in pregnancy is effective in identification of abuse[4848]. The process of supporting women subjected to perinatal DVA is far from simply 'ask-disclose-leave'; sufficient community resources need to be available to manage and support cases effectively after referral.[56] Referral leads to a positive outcome only where there is system capacity. The shortage of refuge spaces in Ireland (140 in 2022 as opposed to the 498 required by the Istanbul Convention), legacy of austerity, an uncertain funding situation, and ongoing cost-of-living crisis is likely to have serious consequences for victims of perinatal DVA.[57]

Research evidence and policy recognise that the period when a woman is engaged with maternity services provides a unique opportunity to identify DVA and provide appropriate support. Evidence suggests that

[56] Bradbury-Jones et al. (2016). Recognising and responding to domestic violence and abuse: the role of public health nurses..
[57] Foley (2022) Gender-Based Violence in Ireland.

screening in healthcare settings is particularly effective in identifying abuse during pregnancy, more so than in any other healthcare setting[48]. Health care staff need to be aware of how DVA can present in the maternity/health care setting for their patients. Women need to be supported to disclose through enabling environments and effective non-judgemental screening and offered appropriate referral to specialist support. This is the goal of the maternity project; to address some of the known barriers to effective recognition, safe-disclosure and referral for women subjected to DVA in the perinatal period.

DVA advocacy and support within maternity services

A core part of the Women's Aid Maternity Project is the Maternity Project Outreach Support Service which seeks to support women subjected to DVA who are engaged with the three Dublin maternity hospitals. This section outlines evidence about similar specialist advocacy and support services for DVA that are provided within maternity or wider healthcare settings.

Advocacy work varies in nature, but typically in the context of DVA support in healthcare settings it relates to engaging with women who have been subjected to DVA, to empower them and connect them with community services.[58] The importance of the relationship between the woman and the advocate has been consistently demonstrated in studies of advocacy for IPV.[47] Advocacy services have been found to be highly valued by service users, due to the holistic nature of the support received.[59] The advocate role usually involves the provision of a range of supports including information about legal, housing and welfare rights; facilitating access to community resources and support services; advice about safety planning and risk assessment; and empathic support.

In 2010, an evaluation was conducted of a package of interventions at a maternity service in London that included the introduction of DVA guidelines, a one-day DVA training programme for staff, and an on-site DVA advocacy service provided by a community organisation.[60] The advocacy component of the intervention used a 'woman-centred' approach, whereby support was provided based on a woman's analysis of her own situation and the risks she perceived from the options available to her. Qualitative research with a sample of the women who received the intervention identified that for women who were in the early stages of deciding what to do about their abusive relationship, the support provided opportunities to re-assess their situation, gain confidence in their ability to initiate change, and consider their options, in terms of legal and welfare supports.

A systematic review of advocacy interventions for women subjected to DVA, including women attending antenatal and other healthcare services, found that most studies were not robust enough to draw

[58] Rivas et al. (2016) Advocacy Interventions to Reduce or Eliminate Violence and Promote the Physical and Psychosocial Well-Being of Women who Experience Intimate Partner Abuse: A Systematic Review.
[59] Cleaver et al. (2019) A review of UK based multi-agency approaches to early intervention in domestic abuse: Lessons to be learnt from existing evaluation studies.
[60] Bacchus et al. (2010) Evaluation of a domestic violence intervention in the maternity and sexual health services of a UK hospital.

conclusions about the impact of the interventions on reductions in abuse, or on women's longer-term health and wellbeing outcomes.[58] However, brief advocacy (typically with a maximum of 2-3 hours of total advocacy time) was indicated to provide some short-term mental health benefits and reduction in abuse for pregnant women, while more intense advocacy (typically increased hours over a period of two to four months) was indicated to potentially improve short-term quality of life.

For service providers, there are also benefits to advocates providing specialist DVA support and expertise in healthcare settings. A DVA support worker can consult with and advise healthcare professionals in terms of ongoing training needs and bridge a support gap for vulnerable women attending services, which healthcare professionals may not have the capacity to provide.[59] [29]

A specific model of intervention for DVA developed in England and Wales is the role of Independent Domestic Violence Advisor (IDVA). IDVAs are typically co-located (i.e., based on-site) in hospital departments and provide the core features of advocacy and support work outlined above[61]. Independence from healthcare services is a key aspect of the IDVA role (they are often managed by third sector organisations), although they also work in a 'joined up' way with other roles within the service[62].

An evaluation of five co-located hospital IDVA projects found them to be cost-effective in terms of healthcare use (savings of £2,050 per patient) and that they were more likely to lead to a decline in abuse[63] and increased feelings of safety.[64] In interviews, healthcare professionals felt that the IDVA role provided immediate support to women that might otherwise be lost via standard referral pathways.[80] An evaluation of an IDVA service at a maternity hospital in Manchester found that the IDVAs' specialist knowledge and skills enhanced women's confidence when it came to understanding their options and making decisions[65].

Research has documented concerns about high caseloads and stretched capacity for IDVAs, particularly when cases are ongoing longer than the recommended timeframe.[64] Advocates are required to maintain a current knowledge of services and supports available, as well as the complex legal systems and processes women using their service may require support to navigate, including issues relating to accommodation and immigration.[65] Advocates need ongoing training, role clarity, and peer and organisational support, in order to carry out their role effectively.[47]

- The Istanbul Convention requires countries to ensure that DVA victims can access services for a range of needs to support their recovery[15] and the third National Strategy on DSGBV aims to develop

[61] Dheensa et al. (2020). "From taboo to routine": a qualitative evaluation of a hospital-based advocacy intervention for domestic violence and abuse.
[62] Robinson & Payton (2016) Independent advocacy and Multi-Agency responses to Domestic Violence. In *Domestic Violence: Interdisciplinary Perspectives on Protection, Prevention & Intervention*
[63] Halliwell et al. (2019). Cry for health: a quantitative evaluation of a hospital-based advocacy intervention for domestic violence and abuse.
[64] Hobson (2014) IDVA literature review for the Mayor's Office for Policing and Crime.
[65] Granville & Bridge (2010) PATHway Project: An Independent Domestic Violence Advisory service at St Mary's Maternity Hospital, Manchester. Independent Evaluation: Final Report.

integrated local pathways for victims to access information and support[9]. Research indicates that specialist support in maternity services can help to bridge the gap between services and make help-seeking easier for victims. The DVA Outreach Worker role within the Maternity Project can meet these policy needs, by providing timely wrap-around support for pregnant and postnatal women subjected to DVA and connecting women with local specialist DVA services and wider supports to meet their individual needs (such as immediate financial needs, and support in navigating the legal and criminal justice system).

- The Outreach Worker provides women with empowerment-based support and help is tailored to the needs of individual women. The Outreach Worker will require ongoing training and support to meet their own needs to be able to carry out the role effectively.
- The Maternity Project will need to consider how language and communication barriers for some women may be a barrier to accessing the support provided by the DVA Outreach Worker.
- A planned outcome from the National Maternity Strategy is to develop a dedicated pathway for women subjected to DVA in the perinatal period, with a community-based social work team. The Maternity Project can work with these developments to determine how the specialist expertise and support from the Outreach Worker role can contribute to the new pathway.
- As noted above, advocates need ongoing training, role clarity, and peer and organisational support to carry out their role effectively. Women's Aid have suggested that situating a specialist DVA support worker within a service operated by an organisation independent of the health service is a possible route to addressing some of these concerns.

Overview of the Policy Context

In September 2022, the CES team drafted a review of literature and policy in relation to perinatal DVA to inform the ongoing development and evaluation of the Maternity Project.

Overall, our review of policy found that the three components of the Maternity Project, awareness raising, training and outreach support, are closely aligned with national and international policy objectives in relation to the identification and appropriate management of DVA in maternity care settings. The relevant policy documents and initiatives, including any updates are summarised in table 2.

Table 2; Summary of relevant internation and national policies and guidelines

International policies and guidelines	

The Istanbul Convention[15]	The Convention sets out minimum standards on prevention, protection, and prosecution; and it mandates the development of integrated policies. This was ratified by Ireland in 2019. The two articles that are of particular relevance to the Maternity project include: **Article 15 – Training of professionals (under the Prevention pillar):** states that parties 'shall provide or strengthen training for professionals engaging with victims or perpetrators…' (Article 15(1)) **Article 20 – General support services (under the Protection pillar):** states particles shall 'ensure victims can access services to facilitate recovery' (Article 20(1)) including access to 'health and social services that are adequately resourced with professionals trained to assist and refer victims to appropriate services' (Article 20(2)).
The WHO recommendations on Antenatal care for a Positive Pregnancy Experience 2016[66]	Provides specific recommendations relating to the detection of DVA in pregnancy and emphasises that antenatal care is an appropriate setting within which universal screening or routine enquiry can be implemented, provided staff are trained to respond appropriately to disclosures.
National policies and guidelines	
The Third National Strategy on Domestic, Sexual and Gender-Based Violence 2022-2024[4]	The new strategy is structured around the four pillars, or goals, of the Istanbul Convention- Prevention, Protection, Prosecution and Co-ordinated Policies. The two pillars most relevant to the Maternity Project are the prevention and protection pillars, with the objectives of increasing public awareness, enabling frontline professionals to recognise and respond to DVA, and developing clear and integrated local pathways to access information, services and supports. A central element of the Strategy was the establishment of a statutory agency to work in collaboration with the NGO and DSGBV services sector to ensure that the best possible services are in place to meet the needs of victims and survivors. Cuan, the new DSGBV Agency was established in January 2024 and will coordinate the implementation of the Strategy going forward.

[66] World Health Organisation (2016). WHO Recommendations on Antenatal Care for a Positive Pregnancy Experience

Revised implementation plan (2024)[67]	The National Strategy published in June 2022 was supported with the publication of an implementation plan by the Department of Justice in 2023. A 2024 update introduced with a bigger focus in the implementation plan on deliverables. Relevant deliverables being taken forward this year include: **HSE healthcare worker training** to assist identification of domestic violence and refer victims/survivors to appropriate services. Modules 1 & 2 launched in Q2 with plans for training Modules 3 'Respond' and 4 'Refer' to launch in Q4 2024.
HSE Policy on Domestic, Sexual and Gender Based Violence (2010)[68]	The HSE policy emphasises service improvement, including training staff in the HSE and related organisations to equip them to implement the '*3Rs*' of *Recognise, Respond* and *Refer.* The policy identified the importance of a trained and skilled workforce to ensure that a comprehensive and appropriate health service response to DSGBV is delivered at all points of entry to the HSE. In 2016, the HSE developed a national training programme in partnership with Sonas to support frontline HSE staff to develop the skills to recognise and respond to victims of DSGBV in vulnerable or at-risk communities. The 2019 Training Resource Manual was developed to complement the training programme.[4]
The National Maternity Strategy 2016-2026[9]	Emphasises that pregnancy and birth can provide an opportunity for victims/survivors of DVA to access support for their safety and wellbeing.[5] The strategy recognises that maternity hospital staff "*are uniquely placed to help women and their babies access support*" and outlines that the National Women & Infants Health Programme (NWIHP) will ensure that: *"midwives, obstetricians and GPs are alert to the heightened risk of domestic violence during pregnancy and postpartum. Women will be asked about domestic violence at antenatal and postnatal visits, when appropriate. This will be supported by appropriate training for frontline staff to ensure that all such enquiries and disclosures are handled correctly, and that referral pathways and support options for women who disclose domestic violence are clear*" (p.112). Actions reported on in the implementation plan which are relevant to the Maternity project include:

[67] Department of Justice (2024). 2024 Implementation Plan for Zero Tolerance: Third National Strategy on Domestic, Sexual and Gender Based Violence
[68] Health Service Executive (2010). HSE policy on domestic, sexual and gender-based violence.

	• Roll out a Make Every Contact Count (MECC) training programme[6] for all staff in maternity hospitals/units. Engage with Primary Care to consider how the MECC training can be provided to GPs and Public health nurses to ensure consistency of approach (Yet to Start) • Prepare and submit a business case for a minimum of one dedicated social worker for each maternity unit (in Progress) • Ensure implementation of HSE policy on DSGBV framework for health sector response to domestic violence in all maternity hospitals/units. All women are screened for domestic violence as part of their antenatal social history in line with HSE policy (Complete) • A dedicated pathway will be developed, with access to a community-based social work team to support women and infants who are at risk of DVA (In Progress)
National Standards for Safer, Better Maternity Services (2016)[14]	The national standards for maternity services provided by the Health Information and Quality Authority (HIQA) recommends that all women are screened for DVA as part of their antenatal social history. The standards also recommend that information about local DVA services is made available to all pregnant women and that healthcare professionals are trained to recognise the signs of domestic violence, and to make appropriate referrals (Standard 6.3).
Clinical Practice Guidelines for Antenatal Routine Enquiry Regarding Violence in the Home[69]	These guidelines recommend that: • pregnant women have at least one consultation with a professional involved in their care without their partner or another adult family member in attendance. • medical professionals are discrete in their questioning and documentation. • maternity hospitals display information about DVA and how to access support from specialist agencies The guidelines also acknowledge the need for training for healthcare professionals to support the building of knowledge and skills that will improve screening and responses to DVA.

[69] HSE & Institute of Obstetricians and Gynaecologists (2014) Clinical Practice Guidelines for Antenatal Routine Enquiry Regarding Violence in the Home.

National Clinical Practice Guideline Screening and Management of Domestic Violence in Pregnancy and the Early Postnatal Period (May 2024)[88]	Among other recommendations, the guidelines recommend: • mandatory antenatal screening for DV for all women attending public, semi-private, private and all community care settings. • DV screening should only be undertaken by trained staff. • appropriate DV training is provided to all staff in maternity settings. • that the introduction of the electronic healthcare record system to all maternity hospitals/units would ensure consistency in screening for domestic violence in pregnancy. • discharge packs should provide information on DV, including local community and maternity supports • there are Medical Social Workers in all maternity hospitals/units.

The Women's Aid Maternity Project

The Women's Aid Maternity Project is a training, awareness raising and referral programme for domestic violence and abuse (DVA) in the perinatal period, that aims to enhance the response of the maternity services to victims/ survivors of DVA. The Maternity Project has been piloted at four maternity hospitals in Ireland (the three maternity services in Dublin- the Rotunda, the Coombe, the National Maternity Hospital (NMH)- and Cork University Maternity Hospital (CUMH)), where it was being developed and delivered in partnership with the participating services. The project was led by the Women's Aid Maternity Project Coordinator, a dedicated role, funded by Women's Aid. The coordinator was responsible for managing all aspects of the design and delivery of the project including building and maintaining relationships with pilot sites, managing the collaboration/co-design process, coordinating the roll out of the project, delivering training and supporting the evaluation of the project. The work of the Maternity Project was guided by an External Advisory Group and the Coordinator was supported by the Women's Aid Internal Advisory Group consisting of Head of Regional Services, Head of Training and Development, and Women's Aid CEO. The Coordinator also worked closely with the Women's Aid Outreach Worker, whose contact with survivor-victims influenced the training content development. The Outreach Worker also shared information on training and awareness campaigns to her contacts within the pilot hospitals. The Coordinator's key contact in each partner hospital was the Medical Social Worker with a DVA specific focus, with their support the Coordinator developed a group of multidisciplinary contacts within each hospital to be actively involved in the training co-design process.

The pilot began in April 2021 and the project will end in December 2024. The evaluation data is gathered up to July 2024.

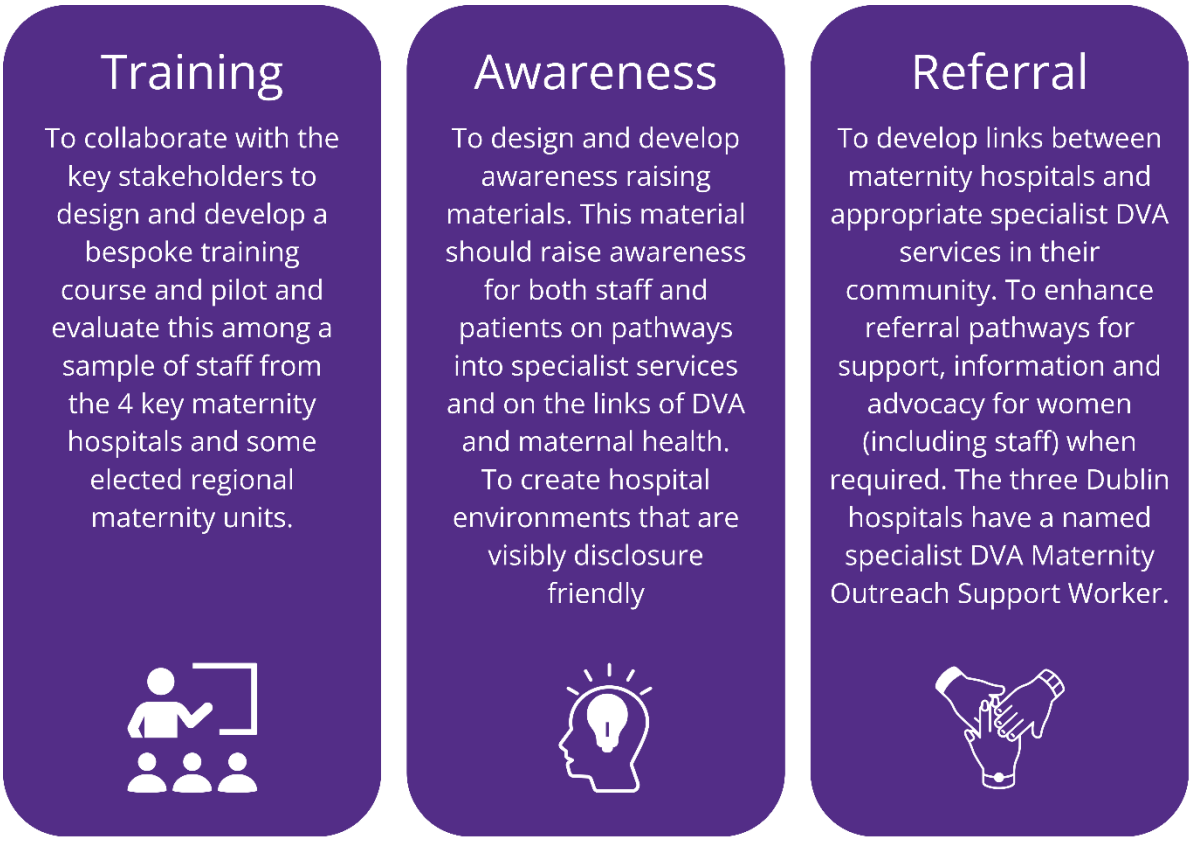


Figure 2 Summary of the objectives of the maternity project

The project contains three key interventions for maternity services:

1) **Awareness raising materials** for the maternity service setting that aim to provide information on the prevalence and impact of DVA in pregnancy as a public health issue and to raise awareness for staff and patients on pathways to specialist support. The awareness raising materials were developed in collaboration with maternity services. Printed materials (posters and leaflets) and videos are available for maternity services to display year-round. The awareness raising materials are promoted in all maternity services in Ireland in November each year, as part of the wider '16 Days of Action' international campaign to raise awareness of DVA.
2) A **Maternity Project Outreach Worker**, to provide short-term information, support and advocacy for women engaged with the pilot maternity services as needed, and to enhance referral pathways to specialist DVA services in the community. The Maternity Project pilot had funding for one full-time Outreach Worker, who worked across the three Dublin maternity hospitals. The Outreach Worker began receiving referrals from maternity services in the pilot since May 2021.
3) A **bespoke training course** for maternity staff and medical social work teams in pilot sites, to develop foundational knowledge on DVA in pregnancy and its impacts, how to recognise signs of DVA, and how to support and manage a disclosure of DVA. The training course was co-designed with maternity

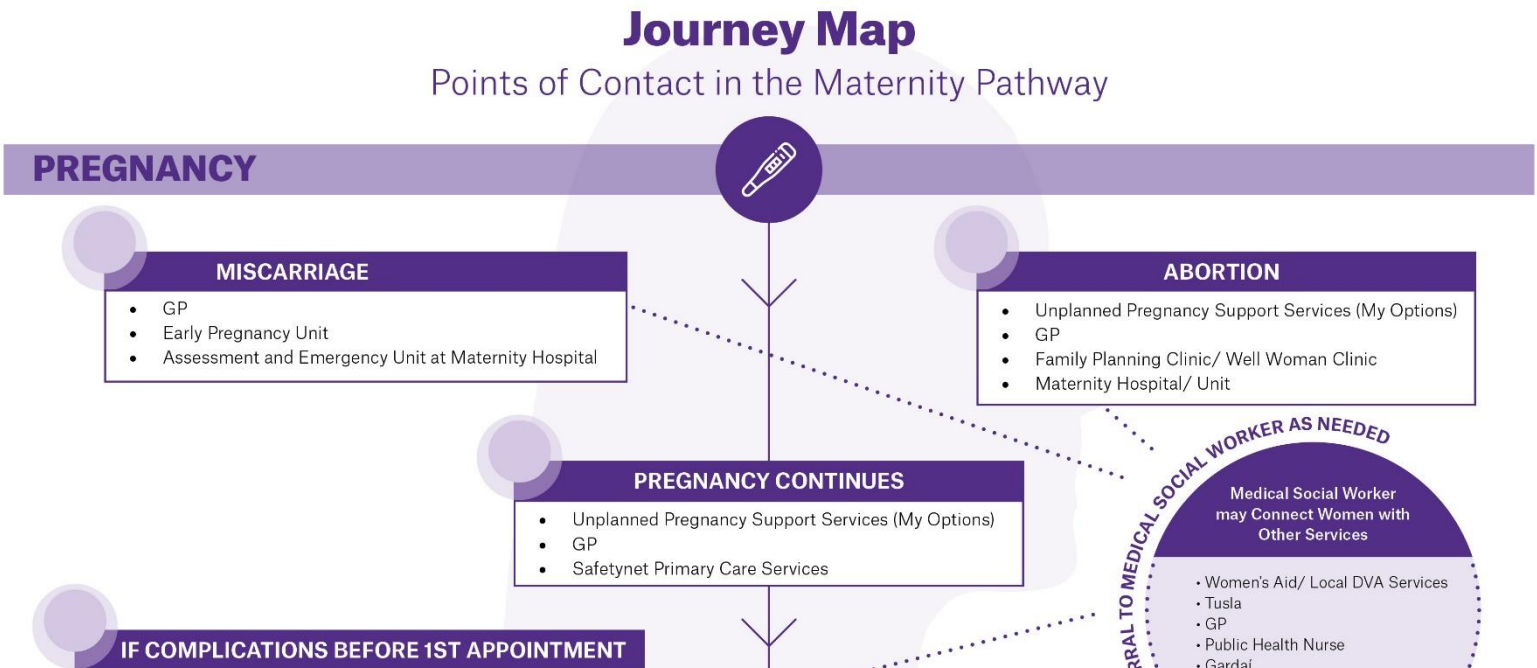
services staff from multiple disciplines. There were three levels in the training course, containing a mixture of self-paced digital learning, and interactive online and face to face sessions. The course was delivered at pilot maternity services from November 2023 to early July 2024. The training rollout was expanded beyond the original pilot sites (Coombe, NMH, CUMH and Rotunda) to include the maternity unit at Kerry University Hospital and the maternity unit at St. Luke's general hospital Kilkenny.

Resources have always been the primary barrier to progress in this area. Women's Aid resourced this ambitious pilot project over its duration from May 2021 to December 2024, entirely through generous donations from the public and non-statutory funds. The investment in the project was a total of €536k.

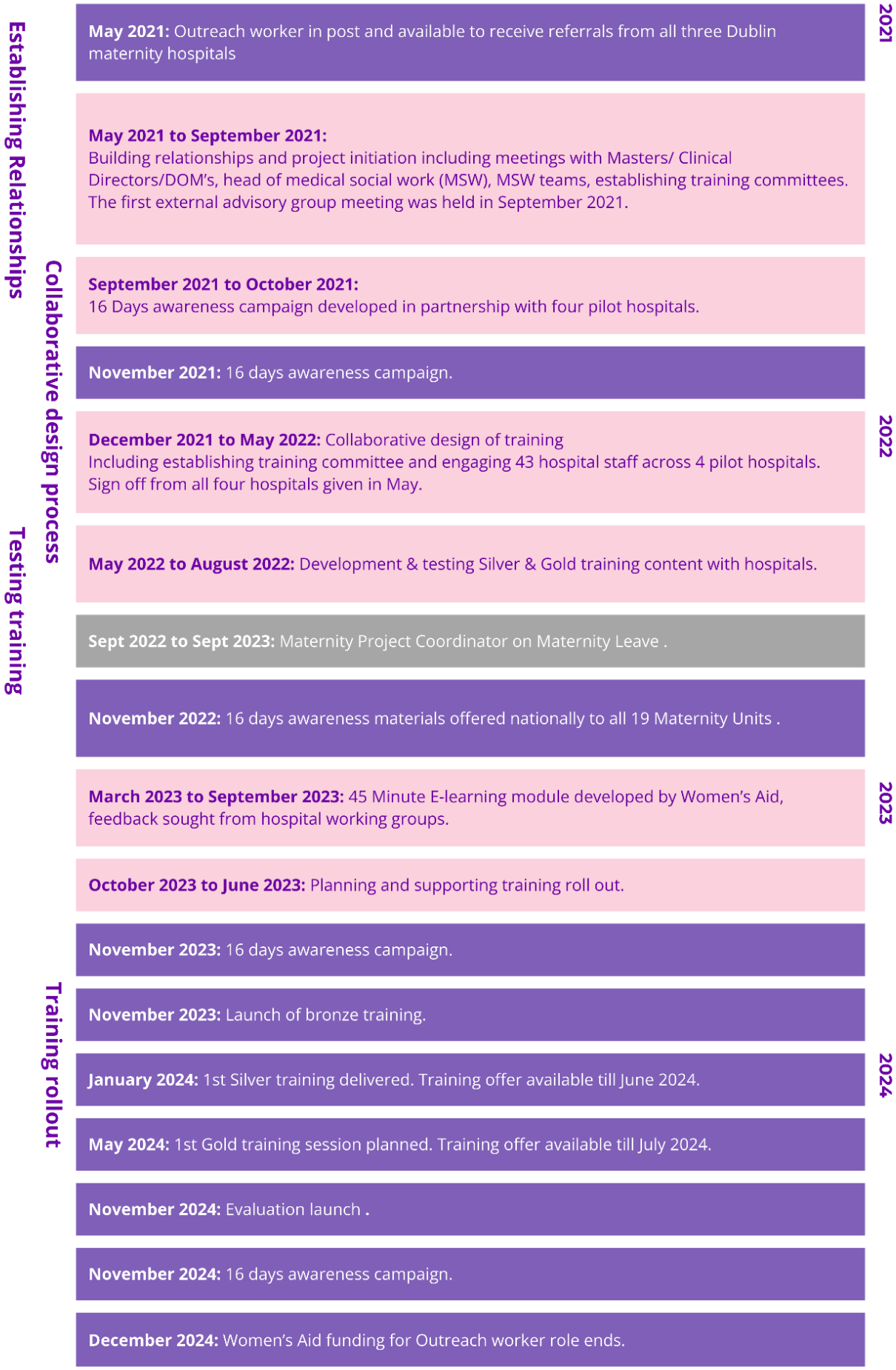
The Journey Map

Journey mapping is an approach to reviewing all of the points of contact and interactions that a service user will potentially experience with a particular service. The original tender for the evaluation of the Women's Aid Maternity Project requested that the evaluator would assist the Women's Aid Maternity Project team to "visually represent the journey of a pregnant woman through the health sector, identifying the professionals she may meet on her journey." In August 2023, the CES produced a journey map to visually represent the points of contact in the maternity pathway, in order to identify the various different healthcare professionals and wider maternity services staff that women may meet when they engage with maternity services. The journey map could be used to pinpoint opportunities to enhance the support provided to pregnant and postnatal women who are subjected to DVA. Input on the drafted journey map was gathered from members of the Maternity Project External Advisory Group, and medical social workers from the maternity services that participated in the pilot.

The logic model (appendix A) details the theory of how the project aims to improve outcomes, wider contextual factors that may have impacted on the project, and the detail of the core project components.



Women's Aid Maternity Project Timeline



Evaluation Approach and Methodology

The aim of the evaluation was to analyse data gathered during the pilot (2021-2024), to explore how the Maternity Project was implemented across sites and report on any early impact or outcomes achieved.

Evaluation of the pilot phase of any new intervention or initiative in healthcare plays a key role in understanding the feasibility of its implementation and how this can be improved. The evaluation of the pilot Maternity Project was a 'formative' evaluation. Formative evaluation is usually conducted in parallel with the early implementation stage of an intervention or initiative, with the view to exploring and identifying factors that may influence the progress and effectiveness of the intervention. The learning from a formative evaluation typically informs future decision-making about the later stages of intervention design and rollout.

This formative evaluation of the Maternity Project has been guided by Proctor et al.'s (2011) Outcomes for Implementation Research[11], a useful framework for conceptualising and evaluating successful implementation of a project within health services. The implementation outcomes from this framework that are most relevant for the evaluation of the Maternity Project are:

- Acceptability refers to the recognised need for an intervention, satisfaction amongst service providers, service users and other key stakeholders with the various aspects of an intervention. Acceptability is related to stakeholder buy in for the intervention – the extent to which they believe it is a 'good' thing.
- **Appropriateness** encompasses whether the intervention was perceived to be "good fit" with the service; whether it was useful in terms of meeting the needs of service providers and service users. It relates to a perception that the project is a good fit for the context (i.e. not just that it's a 'good thing' but that it's a 'good thing' for us in our context).
- **Adoption** is the extent of uptake and utilisation of the intervention within a service. Indicators you might look for to demonstrate adoption include high rates of utilisation (i.e. referrals to the project or infrastructure being in place to support it e.g. partnership working and strong/clear referral pathways).
- **Feasibility** denotes whether the intervention was practical in terms of how it was delivered. Where appropriateness relates to perceived fit, feasibility relates to actual fit i.e. it was practical and feasible for us to do.
- **Sustainability** reflects the extent to which an intervention is maintained or becomes embedded within a service.

The Maternity Project is what is known as a 'complex intervention'[70] because it contains several different interacting components that are delivered in different maternity service settings, each with a different context that is likely to influence how the project is delivered (e.g., different staff in each setting, potentially different local policies and initiatives, etc.). The evaluation therefore explores, where possible, whether there are **contextual factors at each pilot site that act as barriers or facilitators** to the above project implementation outcomes. The complexity means that it is difficult to disentangle the impact of any one component of the intervention from its interaction with the other components *and* the context in which it is delivered.

The pilot Maternity Project does not have an experimental design and therefore we are unable to conclude that any changes detected in the hospital data are directly or exclusively attributable to the project. Attributing change to a single initiative, taking place within a wider interconnected system, is challenging. Any outcomes observed may be due to other changes or initiatives occurring around the same time or occurring cumulatively over several years.

The evaluation uses a mixed-methods approach, involving the collection and analysis of **both qualitative and quantitative data**. The sources of data this report draws upon are:

- Online survey for trainees in the Maternity Project training programme, to assess the impact of training on trainees' preparedness to recognise and respond to DVA. Trainees were also asked about their reaction to the training and recommendations for improvements. Data was gathered pre-training, immediately after training (bronze, silver and gold) and two to three months following training (see appendices C-G).
- Qualitative research interviews with the DVA Outreach workers (n=2), medical social workers (n=7) from the three Dublin hospitals that had access to the Outreach Support Service, the Maternity Project Coordinator and the Head of Training and Development (see appendices H-I and K for interview schedules).
- Qualitative focus groups (two groups, 8 participants) with maternity hospital staff who were involved in the development and roll out of the project at two pilot sites (the focus group topic guide is included in appendix J).
- An anonymous online survey of maternity hospital staff who were involved in the development and roll out of the project across four pilot sites (appendix L).
- Online survey of women referred to DVA Outreach worker (appendix M).

[70] Craig et al. (2008). Developing and evaluating complex interventions: the new Medical Research Council guidance.

- Routinely collected data by DVA Outreach Worker on referral rates, response times and demographic information on service users (see appendix B for summary).
- Routinely collected hospital data was requested from the four pilot sites on screening, disclosure and referral rates for DVA.
- Contextual information on each hospital site was also requested from the four pilot sites including number of births, number of staff in each role, proportion of women accessing public, semi-private or private maternity care.

Table 3 below presents the key research questions for the evaluation and the methods used to address each. The five questionnaires developed for the training evaluation were reviewed by Jeanine Webster, a member of the Maternity Project External Advisory Group, who has conducted academic research on midwives' experiences of screening for DVA.

Table 3: Research questions & methods

Research Questions	**Method**
What was the impact of the DVA Outreach Support Service- for maternity services, medical social work services, and service users?	• Analysis of data routinely collected by Outreach Support Service • Survey with women referred to Outreach Support Service • Interviews with Outreach Workers • Interviews with medical social workers • Focus groups with staff involved in implementation
How did the co-design of the awareness raising materials impact on their implementation and impact?	• Focus groups and online survey with staff involved in implementation • Interviews with medical social workers • Hospital data on disclosure and referrals
Was the training programme viewed as acceptable, appropriate, and feasible in terms of its content and implementation?	• Questionnaires with staff who undertake training • Focus groups and online survey with staff involved in implementation • Interview with Maternity Project Coordinator & Training and Development manager

Did the training lead to improvements in staff knowledge, attitudes, skills, and preparedness around DVA in pregnancy?	• Questionnaires with staff who undertake training • Focus groups with staff involved in implementation
What contextual factors at the pilot sites affected the implementation of the Maternity Project?	• Focus groups with staff involved in implementation • Interviews with Outreach Workers, medical social workers, and Maternity Project Coordinator
Did the pilot Maternity Project have an impact on screening, disclosure, and referral rates for DVA at the four participating maternity sites?	• Routinely collected hospital data • Focus groups and staff survey

Participating Hospitals

The evaluation of the pilot involved four maternity hospitals in Ireland: The Rotunda Hospital, the National Maternity Hospital (NMH), The Coombe Maternity Hospital and the Cork University Maternity Hospital (CUMH). The largest hospital is the Rotunda, with roughly a quarter more births annually than the other three sites. The Rotunda also serves more women annually, with between 43-53% more women cared for each year compared to the other three sites. Below we provide an overview of the four partner pilot sites (Table 4: Overview of the four pilot sites). To note, DVA referrals to MSW are counted in different ways in each site. NMH provided a count of DVA specific referrals. The Coombe reported the percentage of women cared for who disclosed any history of DVA, current or past, this figure may not include women who were referred to MSW for another 'primary' reason (e.g. addiction or teenage pregnancy) where DVA was also a present concern. The Rotunda report on referrals that had Tusla involvement related to DVA, the MSW team would have received other referrals for DVA but this is not extracted from MN-CMS[71] and, like the Coombe, referrals for another primary reason would not be counted in these figures. CUMH provided data on disclosure rate at booking, this would not include women who disclosed earlier or later in pregnancy nor those whose pregnancies did not continue, due to loss or termination of pregnancy.

The Rotunda Hospital, the National Maternity Hospital (NMH), and the Cork University Maternity Hospital (CUMH) all use the Maternal & Newborn Clinical Management System (MN-CMS) to electronically record information about the women and infants who receive care in their services. These three hospitals therefore

[71] The Maternal & Newborn Clinical Management System (MN-CMS)

collect data in the same way. The Coombe Hospital currently uses a different IT system but plans to adopt the MN-CMS in 2025.

Table 4: Overview of the four pilot sites

	NMH	The Coombe	The Rotunda	CUMH
Number of births in 2022	6948	6914	8292	6539
Number of women cared for in 2022	6815	6786	9757	6382
% in public care	unknown	76%	72%	unknown
% in semi-private care	unknown	8%	3%	unknown
% in private care	unknown	15%	25%	10%
DV specific referrals to medical social work team	2021-2024: 53, 68, 75, 16 to July 2024	Giving history of domestic violence (%) 2016-2022; 0.9, 0.9, 1.1, 1.0, 1.0, 0.9, 0.9	DVA referrals requiring Tulsa involvement 2018-2022: 48, 38, 30, 37, 34	Disclosure rate at booking 2021-2024 2.1%, 1.8%, 0.9%, 0.5%

Following engagement with the four hospitals CES requested data from the four pilot sites, broken down by month from Jan 2021 to June 2024:

- The % of women who are asked about DVA at their booking appointment
- The % of women who disclose DVA
- The % of women who receive a referral to a medical social worker following a disclosure

We were assured that this data would be available. In practice, the process of hospitals compiling the data was more time consuming than they anticipated. At the time to writing this data from pilot sites is incomplete. Learning from the process of data collection and analysis is summarised in the section on hospital data.

Findings

In this section we summarise learning on the implementation and impact of the project overall followed by specific findings on the implementation and impact of each aspect of the work beginning with awareness raising materials, the Outreach Support Service and the outreach worker role and training.

Overall learning

The project adopted a blend of collaboration and co-design with hospital and key staff in its implementation. We use the term **collaborate** to indicate a model of working where partners are engaged to seek input and cooperation but control of decision-making rests with the lead organisation. A collaborative approach was adopted for the Outreach Support Service. The Outreach Worker role was conceived and funding in place at the outset of the project. Maternity services were consulted on the design of referral pathways to the service but not on the existence of the service/outreach worker role itself. **Co-design** takes this a step further where partners have much greater involvement and control of the direction of the work throughout planning, design, delivery and monitoring. A co-design approach was adopted for all other aspects of the project including developing awareness raising materials and the training design and rollout.

There was strong evidence that when a co-design approach was embraced fully this had a direct positive impact on implementation. The co-design of the awareness raising materials was a ‘quick win’ for the implementation of the project. The co-design approach engendered trust and confidence in the project and generated buy in from key staff members in the hospitals, for both the distribution of the materials developed and for the project overall. There was a strong sense that the collaborative approach and feedback sought from maternity services helped to enhance the appropriateness and fit of the project for each hospital.

Co-design was time consuming and resource intensive, requiring Women’s Aid to invest time and sustained effort to build relationships and engage with services and key staff across the four pilot sites. The Maternity Project Coordinator role was essential in this process. Both Women’s Aid and maternity services needed to be willing to spend the time working together and learning from each other for co-design to be successful.

This positive experience of co-design of awareness raising materials and training stood in contrast to the initial mixed reception to the other aspect of the project, the Outreach Worker role. This indicated that true co-design is a powerful route to acceptability and appropriateness. Women’s Aid had to invest more time and effort to overcome early resistance to the OW role. These efforts were largely very successful.

For a small minority of staff in one service, this resistance extended to their attitude to the project as a whole. Despite Women’s Aid’s extensive effort to engage with all services a small number of staff felt that the hospitals’ current good practice on DVA and opinions/advice on the implementation of the training in particular were disregarded. This resistance meant that training was not championed to the same degree

and the Outreach Support Service was initially underutilised. This finding reflects the challenge of co-design with multiple partners with varying needs, opinions and capacity to fully engage in the process as an equal partner.

Hospital Data

In requesting data on screening, disclosure and referrals for DVA from each of the pilot sites we found that there were a number of issues with the data. We outline the findings on each in the following sections.

Screening data

Every woman should be asked about DVA at booking therefore the expected rate of screening at booking appointment is 100%. Table 5 summarises the data we received on screening rates at booking in each of the four partner pilot sites.

Table 5: Screening rates at booking in the four pilot sites

	NMH	Coombe	Rotunda	CUMH
2021 (May-Dec)	79.0%	100%	95.90%	24.04%
2022	80.7%	100%	97.20%	27.78%
2023	81.4%	100%	97.80%	38.40%
2024 (to July)	79.0%	100%	97.60%	30.66%

Data on screening rates in the NMH indicated that screening rates were at 80% on average with little fluctuation throughout the study period. Additional data shared by MSW indicated that of those women who were referred to medical social work at some point in pregnancy, 69% were asked about DVA at booking, 7% were not asked and for 24% screening information was not recorded.

Data from the Coombe indicated that screening was consistently recorded at 100%.

Rotunda screening data indicated that screening rates were consistently high (95.90% to 97.80%). Rotunda data reported on the percentage of women who had “no response” to the DVA screening questions. A 'no response' indicates one of three things; that DVA screening questions were not asked, that screening questions were asked but responses not recorded, or that screening questions were asked but the woman refused to answer. There is currently no option to record which of these is the case.

Data analysts at the Rotunda advised that the hospital had moved to manual records for 6 weeks in May 2021 as a result of a cyber-attack on the HSE. The screening rates were lower in the months following the cyber-attack (average of 94.8% in June, July and Aug 2021 compared to 95.8% in Sept, Oct, Nov 2021 and

annual average of 95.9%, 97.2%, 97.8% & 97.6% in 2021, 2022, 2023 and 2024 respectively). This indicates that the absence of eHealth records with prompts for DVA coincided with a dip in screening rates.

CUMH screening rates were very low (30% on average from May 2021 to June 2024). Discussions with CUMH indicated that a move to telephone booking appointments, since 2020 because of the COVID pandemic, has severely impacted the *recorded* rate of screening at booking. Best practice recommendations advise against screening for DVA over the phone and so telephone booking appointments in CUMH typically skip DVA screening questions and women should instead be asked screening questions at their next in-person appointment. The DVA screening questions are on a different 'page' in the IT system than the page primarily used in the subsequent in-person appointment. CUMH Assistant Director of Midwifery indicated that it is likely that screening questions *have* been asked but responses not recorded in the booking record because the DVA screening questions only appear on one page in the system and staff are not going 'back' to record the responses. CUMH committed to investigate. The other hospital sites that use the same IT platform for screening data collection have not reported similar issues.

Disclosure of DVA at booking

Table 6: Percentage of Women disclosing DVA at booking

	NMH	Coombe	Rotunda	CUMH
2021 (May-Dec)	1.43%	0.90%	0.72%	2.14%
2022	1.73%	0.87%	0.74%	1.76%
2023	1.38%	0.83%	0.42%	0.91%
2024 (to July)	1.33%	0.96%	0.71%	0.55%

The expected rate of disclosure of DVA at booking appointment is unclear however research indicates that a conservative estimate of prevalence of DVA in the perinatal period is 3%[41, 4240]. Applying this conservative benchmark disclosure rates at booking appear to be very low, averaging at 1.1% across the four pilot sites during the study period, and a range of 0.4% and 2.1%. Additional data provided by NMH medical social work team indicated two thirds of women referred to MSW for DVA concerns did not disclose at booking, further evidence that screening at booking is insufficient to identify women subjected to DVA.

Rate of referral to MSW

If a woman makes a disclosure of DVA she should be referred to medical social work for support so the expected figure for referral of women who disclose DVA at booking should be 100%. Table 7 summarises

the average % of women referred following disclosure for the four pilot sites. The variability in the data (43% up to 206%) indicates that the data is capturing a more complex picture.

First, where referral falls below 100% it may be that women are not being referred when they should be, or women are already in contact with social work team in the hospital and therefore do not require a 'new' referral, or a referral was made for another 'primary' issue such as addiction. Conversations with data analysts and social work teams indicates that there is no way for data systems to distinguish between these two possibilities without manual review of MSW records. Women may be falling through the gaps and manual review of records where women have answered 'yes' to DVA screening questions would be needed to 'catch' cases where a referral was not made when it should have been. The Coombe indicated that they have such a system in place. The MSW team manually review booking screening questions and any woman who answered yes to any DVA screening questions would be contacted and offered support. This is unique to the Coombe maternity hospital.

> *As part of our process in The Coombe Hospital we review Booking History Data at 2 further points in the pregnancy to ensure that all women who answer yes to DVA are identified by the MSW department - As such we would expect that almost all women who answer yes are identified and triaged for support by MSW department. – The Coombe, medical social work team*

For the Coombe the data for 2023 is likely to be an underestimate. Amended data for 2024 was compiled following a manual review of records as the initial report indicated a large decrease in referrals in 2024 compared to previous years. Following manual review of records MSW department found that a larger number of patients than previously identified were referred to the Medical Social Work Department following a disclosure of DVA at booking however the referrer had noted a number of reasons for referral, including DVA, but the referral was identified only by the primary reason in the IT system i.e. patients may have disclosed active addiction and DVA. The primary referral reason is noted as Addiction on the MSW department IT System so that the patient can be appropriately allocated to the correct medical social worker. Similarly, patients may be under 18 years of age & disclosed DVA or present as Homeless & disclosed DVA. Again, the primary reason for referral would be teenage pregnancy/Inclusion Health so that the patient can be appropriately allocated to the correct medical social worker. Given the above, it would suggest that the previous years' data for The Coombe may also have a similar pattern, but the MSW department did not have the resources to manually review such a large volume of data, at the time of writing.

In NMH, referral data appeared to be very low at 22%, on average, over the study period. This prompted a thorough review of referral data and data recording practices by the head of medical social work and clinical informatics, as they felt the low rate of referrals was not reflective of actual practice. Following this detailed review NMH identified issues with staff entering data incorrectly regarding routine screening questions. This has led to an inflated number of women being recorded as making a DVA disclosure when none was made, consequently *lowering* the apparent rate of DVA referrals following disclosure. NMH have committed to address this issue.

Second, referrals to medical social work may take place at any point in the pregnancy or postnatal period if a woman discloses abuse. In this way, the referrals to social work may be a proxy indicator of disclosure at other timepoints outside of the booking appointment[72]. However, the hospital analysts cannot distinguish at what type of appointment or stage of pregnancy the disclosure was made. When referral rates to MSW are above 100% this indicates that referrals at any point in pregnancy are being counted in any given month, not just those following disclosure at booking. This makes it more difficult to identify women who do disclose at booking but are not referred. They also cannot distinguish whether the disclosure was made in response to being asked about DVA or whether the disclosure was made independently.

Table 7: Percentage of women disclosing DVA at booking referred to Medical Social Work

	NMH	Coombe	Rotunda	CUMH
2021 (May-Dec)	18%	87%	45%	unavailable
2022	24%	92%	93%	31%
2023	21%	69%	206%	62%
2024 (to July)	24%	81%	137%	80%

The evaluation team also noted the following gaps in the type of data that maternity services record about DVA:

- Women attending Termination of Pregnancy or Early Pregnancy Unit services within the four pilot hospitals may be asked about DVA by the healthcare professionals they meet at these services, but there is no specific place on the MN-CMS to record whether they were asked, or whether they disclosed abuse while attending[73].
- There is no record of selective enquiry about DVA on the hospital data systems. The only record of whether a woman is asked about DVA is the data that is recorded at the booking appointment.
- IT systems typically only allow one 'primary' reason to be coded for reporting purposes. Referrals made to medical social workers where DVA is a concern but not the 'primary' reason for referral can

[72] It should also be noted that the medical social workers who participated in the evaluation noted that they also sometimes receive referrals if staff are concerned about the possibility of abuse, based on their observations.
[73] The medical social workers have indicated to the evaluation team that they sometimes receive referrals for women who attend these services who are being subjected to DVA.

only be identified through manual review of records. Collating this data is a labour-intensive process and collation and reporting of this information is not currently routine practice.

- CUMH referral data was generally low and remarkably variable over time. Best practice standards are that 100% of women who disclose DVA would be referred to MSW. Month by month data on the % of women referred to MSW following a DVA disclosure from May 2021 to July 2024 in CUMH ranged from 18% to 100%. The ADOM indicated that this may be related to the IT system, but believed this was less likely than it was with the screening data, and committed to investigate the reason for this variability.

Screening and disclosure by care type

All four pilot sites offer women the option of paying for private care or semi-private care. Observations in focus groups indicated a perception that women in private care were much less likely to see awareness raising materials or be asked about DVA. In response to these observations, we asked hospitals to provide data on percentage of women screened and percentage of women making a disclosure of DVA by care type.

Data from NMH on differences in screening and referral by care type confirmed this pattern. In NMH 29% of women accessing private care were screened for DVA compared to 95% in semi-private care and 90% in public care. Additional data provided by NMH on women who were referred to MSW for DV concerns indicate that 90% of women in public care who were experiencing DVA were asked about DVA at booking compared to 50% in private/semi-private care.

Data from CUMH indicated that screening was extremely rare for private patients, 31% of women accessing public care were recorded as having been asked DVA screening questions compared to 0.1% of women in private care. Data on screening by care type was unavailable from The Coombe or The Rotunda at the time of writing.

Table 8: Percentage of women disclosing DVA by care type

	NMH	Coombe	Rotunda	CUMH
% in public care	1.60%	1.15%	0.70%	1.42%
% in semi-private care	0.50%	0.08%	1.10%	unknown
% in private care	1.80%	0.00%	0.40%	0%

Table 8 summarises the percentage of women who disclosed DVA at booking by care type. The percentage of women who disclose DVA at booking was substantially lower for women in private (0%-

0.4%) or compared to public care (0.7% to 1.42%) in the Coombe, Rotunda and CUMH. NMH data indicated that disclosure rates in private care were similar to public care but with lower rates of disclosure in semi-private care. Additional data provided by NMH on the point in pregnancy a woman disclosed (at booking vs another time) indicated that, of the women referred to MSW for DVA concerns roughly 30% of women in public care disclosed at booking while 10% of women in private or semi-private do. Indicating that there is a significant gap between public and private care in 'disclosure friendly' environments.

Recommendations relating to data and monitoring

The pilot Maternity Project did not employ an experimental design and therefore we are unable to make strong claims that any changes detected in the hospital data in relation to DVA are directly attributable to the project and have been cautious in our interpretation of this data in this report. However, the work involved in liaising with the hospitals about the routine data has helped identify gaps in what is recorded by maternity hospitals in relation to DVA and informed recommendations about data collection on DVA at maternity hospitals. We recommend that:

- hospitals continue to use computer aided data collection systems that provide prompts to support DVA screening and recording of screening.
- hospitals adjust their data capture systems to include the ability to differentiate between instances were DVA screening questions were not asked, asked but not recorded or asked but the women declined to answer.
- CUMH review their practice of telephone booking appointments and DVA screening and take appropriate action to address the very low recorded rates of DVA screening.
- MN-CMS and other data systems used by maternity hospitals nationally add a code for recording if DV enquiry has been made/prompt for DV enquiry at all appointments, not just booking.
- hospitals review their processes for monitoring and responding to DVA disclosures to ensure that every woman who make a disclosure of DVA is offered support.
- hospitals commit to supporting MSW team to review screening and referral data easily to identify any missed opportunities for support to be offered and ensure that all women who make a disclosure of DVA are referred to MSW.
- hospitals commit to ongoing monitoring of DVA disclosure and referrals.
- MN-CMS and other data systems used by maternity hospitals nationally use the codes outlined in the new National Clinical Guidelines on Screening and Managing DVA in pregnancy to enable adequate monitoring and evaluation of DVA disclosure or concerns about DVA. Auditable standards in the guideline include:
    - Number of women screened for DV at Antenatal booking appointment

    - Number of women with outcome of DV screening recorded on her chart
    - Number of women with a DV indicator recorded on her chart
    - Number of women referred to MSW
    - Types, severity and complexity as per MSW records
    - Number of presentations to maternity hospital/unit following disclosure of DV
    - Number of women with postnatal screening for DV
    - Number of cases of DV referred to GP and PHN following disclosure on discharge.
- hospitals review and adjust the IT systems so that ongoing monitoring of DVA disclosure and referral does not require manual review of individual cases.
- data recording systems include a way to capture at what point in pregnancy a referral was made to MSW so that monitoring of progress towards earlier identification of women in need of support can be undertaken more easily.
- hospitals monitor the rate of screening, disclosure and referral by care type to identify and act on any gaps in DVA practice.

Awareness-raising materials

Implementation of Awareness-raising materials

Awareness raising materials were co-designed with the four pilot hospitals. These materials were specific to maternity services. They aimed to raise awareness of the prevalence and impact of DVA in pregnancy as a public health issue. Women's Aid also wished to provide women and staff members with the ability to self-refer to specialist support and included helpline contact details in all materials. The presence of the materials in hospitals aimed to contribute to a disclosure friendly environment, where women feel safe to disclose DVA.

The materials[74] included posters, leaflets, and an animation for display screens in maternity hospitals. Specific materials were developed for a staff audience, including "16 facts for 16 days" posters along with leaflets providing information for staff on recognising DVA in women attending maternity services with advice to refer to medical social work team. The information/facts on the posters were designed to inform and educate both staff and women using the maternity services on the prevalence and impact of DVA in pregnancy, recognising signs of DVA, and how to respond.

In addition to the bespoke co-designed materials Women's Aid also distributed branded lanyards for staff during the 16 days campaigns.

Women's Aid Maternity Project Coordinator and representatives from the pilot sites worked together from September to October 2021 to develop the materials. The first set of materials were given to all maternity units in Ireland (19 in all including the four pilot sites) in November 2021, as part of the wider '16 Days of Action' international campaign to galvanise action on violence against women and girls (25th November to 10th December). Further rounds of distribution of awareness raising materials for the WA Maternity Project were disseminated to coincide with '16 days' in November 2022 and 2023, a final round of dissemination will take place in November 2024. The materials were primarily distributed by the medical social work team at each pilot site.

Hospital sites also produce their own materials and activities, especially during the 16 days campaign.

Acceptability

The extent to which people feel it is a good 'thing'

[74] Links to awareness raising materials: Maternity 16 Facts for 16 Days Poster (PDF), 10 Common Signs of Domestic Abuse during Pregnancy (PDF), Information Poster for Maternity Care Staff (PDF), Information Leaflet for Maternity Care Staff (PDF), Domestic Abuse and Pregnancy Animation (MP4 Video)

Staff comments and feedback throughout the co-design process confirmed the need for awareness raising materials that are specific to maternity services.

The materials developed were very well received with high levels of satisfaction and very strong agreement among staff and service managers/leaders that awareness raising materials should be in place year-round.

> *The awareness thing is very good, and we should have more of it - ADOM*

Appropriateness

The perception that the project is a good fit for the context

The fit was very good, and the co-design process enhanced the perceived fit of the materials with the needs of the services.

In the co-design process medical social workers and service leads made sure that the recommended referral pathway remained via MSW or if women self-refer directly to Women's Aid for support that Women's Aid would commit to making connection with MSW. This was to ensure that the hospital could fulfil its statutory duty of care and minimise the risk that women would 'fall though the cracks'. Agreeing to this referral pathway was vital to maintaining the maternity services continued support for the project overall.

There is still a need for continuous conversations about DVA to maintain awareness that DVA is an important and common issue in pregnancy. The materials were seen as very helpful prompts and supports for those conversations and interactions.

Awareness raising materials in the hospitals were indicated to be a mix of materials developed by Women's Aid and materials that the medical social work team at the hospitals had developed themselves, indicating an appetite to retain both.

Adoption

The extent of uptake and utilisation of the intervention within a service

Adoption of the materials appeared to be very strong.

> *"The whole hospitals absolutely plastered in posters we have there, and we all wear our lanyards as well" – Medical social worker interview*

> *"You can't sit on a toilet in this hospital without having a DV poster facing you" -Medical social worker interview*

This was especially true in areas where individual staff members, who championed the project, had influence.

Materials are most often present in bathrooms, staff notice boards and patient notice boards. Posters were most commonly and consistently in place in women's bathrooms, on the back of cubicle/toilet doors. This private space was seen as the ideal place for materials aimed at women and where women can spend time reading and processing the information without partners observing them.

Staff suggested that more video-based resources would be welcome for use on display screens in waiting areas in the hospitals.

As part of 16 days campaign pens and lanyards are distributed and staff use these year-round where they are permitted[75]. Lanyards in particular were seen as effective in creating a visibly disclosure friendly environment in the context of women interacting with individual staff members.

> *"[women] can see that you have that lanyard. I think it's really you know it's really important and it just reinforces that look you're safe here." – Medical social worker interview*

Staff indicated that there is much lower uptake of awareness raising materials in private/semi-private services compared to public services. The data provided by the hospitals also indicates that there is a large gap in screening and disclosure between women accessing private as compared to public care. Focus group participants reflected that there is less detection and referrals for DVA for women accessing semi-private and private care. This was further reflected in our survey of women's experiences where those experiencing DVA who attended private maternity services (over the previous 5 years) were less likely to see information materials about DVA than women accessing public services.

Progress towards the goal of making asking about DVA as normal as all other routine screening in pregnancy (e.g. urine testing, BP, growth monitoring, baby movement etc.) was made. However, there was evidence that this work needs to continue. We heard lingering concern from some staff that asking about DVA or talking about DVA "too often" is perceived to be unwelcome. This is at odds with our findings that women themselves are very supportive of being asked about DVA often.

Feasibility

'This was practical and feasible for us to do'

In general, the development and distribution of awareness raising materials in all pilot sites and nationally was eminently feasible. The points below highlight those few areas where improvements could be made.

Medical social workers spoke about the importance of interaction, physical presence *"having stands"* and conversations with colleagues in raising awareness of DVA. They felt that the 16 days campaigns created

[75]The project coordinator indicated that in some sites staff are required to wear hospital branded lanyards outside of the "16 days of action" period and could not therefore make use of the Women's Aid lanyards year-round.

the opportunity and impetus to talk about DVA with colleagues, making the distribution and 'refreshing' materials easier but they wanted more opportunities to bring focus to DVA.

> *"awareness raising is best done consistently through materials being available for women and staff as well as posters on display, as per our usual practice. Again the 16 days campaign is a great opportunity to raise awareness in a more targeted way on an annual basis."* - Medical Social Worker

One hospital noted some resistance to widespread distribution of resources by the hospital communications team, with a reluctance to highlight DVA. *"the 16 days of action we would have had, like Women's Aid created like images to be posted on the social media at the hospital, social media, all to do with messages around domestic violence and pregnancy and not all of them were shared at the time….because the hospital didn't want to like overload, the hospital social media site with too much information about domestic violence, which we were a little bit disappointed about."* This indicates that the wider hospital environment was not as strongly supportive of DVA awareness as those engaged in the project.

Reach across the full range of services that women access appeared to be patchy. There was evidence that reach into antenatal and postnatal spaces was very strong. Reach into other services, for example physiotherapy, phlebotomy, dietetics, fetal assessment and others was curtailed because the medical social workers championing materials did not have the autonomy or authority to place materials in these services' spaces. We heard one example of a physiotherapy service adopting the awareness raising materials as a result of attending training as part of the project.

Participants in the focus groups questioned the reach of materials into private care spaces and felt that there was much less uptake of materials, and less visibility of materials for women accessing private care.

Finally, the reach and impact of awareness raising materials on marginalised and ethnic minority women was unclear, but we did find evidence that language barriers are an issue that can be addressed through translation of materials into different languages. The project recognised the value in doing this but did not have sufficient funding available to cover the associated costs.

Sustainability

Can we keep doing this?

The 16 days campaign galvanized efforts and provided opportunities to focus on DV in that period, refresh posters, run events, talk about it at staff huddles and more. This was valued but staff felt it would be beneficial to have more campaigns throughout the year or other ways to create opportunities to focus on DVA.

At a practical level, staff said that posters do tend to stay in place once they are put up, especially in bathrooms. Leaflets appear to vary in their visibility and need to have someone responsible for restocking and ensuring they are visible year-round.

The data indicated the need for a person or team to champion the presence of materials and make sure they remain in place/are replaced as needed. In most cases the MSW team took on this role but their reach into the full range of services that women may access was limited. Identifying and empowering champions in each service is likely to be a fruitful route to sustaining the presence of materials throughout the year and leading campaigns periodically.

The delivery of this campaign to all 19 maternity hospitals in Ireland cost €10,000 for each year it was delivered. This cost was borne by Women's Aid at zero cost to hospitals in production and posting of materials. This cost does not include the cost of staff time invested in the co-design process or time needed for coordination and delivery of resources. At the time of writing there is no funding for this campaign after 2024.

Impact of the awareness raising materials

Disclosure friendly environment

Visible resources (posters, lanyards, videos etc.) do contribute to a disclosure friendly environment.

> *"If you feel like you have that right to seek help you will."* Medical social worker.
>
> *"I've had patients commending us on how we have the signs up in the bathrooms to say and they say like it's great, they feel they're somewhere safe somewhere safe to go with that issue"* Assistant Director of Midwifery.

Some Medical social workers felt the materials provided an opportunity to "normalise" the idea that DVA can be discussed at the maternity service. One of the social workers interviewed referred to a case where a woman told her that she had spoken about abuse because she saw a poster about DVA at the hospital.

Staff undertaking the training helped to increase the uptake of awareness raising materials – people began asking for materials to put them up in their services, indicating a wider reach as a result of the knowledge gained from training.

Awareness

Responses to the staff survey and focus groups indicated that awareness-raising materials did enhance staff awareness of DVA as a public health issue, its prevalence, and its impact on pregnancy, and contributed to a disclosure friendly environment.

Staff who responded felt that awareness raising materials also improved women's awareness of DVA and supports available. One respondent give a striking example of a women seeking help as a direct result of seeing a poster *"one woman told me recently, like, she feels like she would have been killed if she hadn't have seen the poster",* ADOM.

Medical social workers felt that putting the harm caused by DVA in the context of other common health issues in pregnancy was effective in sparking interest and increasing the perceived importance of

addressing DVA in pregnancy. These materials in particular were perceived to contribute to raising interest in training among staff. Conversely participation in training also improved uptake of materials across the hospital as staff became more aware of the impact of DVA and the relevance to their service.

Recognise

Staff felt that the awareness raising materials were effective in improving recognition of the more subtle signs of DVA

> *"(less experienced staff)… missed some of the signs and that's why the awareness thing does work very well in my opinion, especially that quiz. …They're the kind of things we're actually dealing with and looking for the subtle signs. And it makes you read into what people say and do and how they interact together, the patients, you know, with their partners. So I do think the awareness thing is very good and I think maybe there should be more of that"*

Referrals

Medical social workers in all sites perceived an increase in referrals following the 16 days campaign. The materials were perceived to give rise to more conversations about DVA and a greater willingness from staff to approach MSW for support.

> *"after 16 days we are seeing an increase in the referrals to our service (MSW) and in turn probably an increase (in referrals) to OW as well after those kind of more public campaigns take place in the hospital" - MSW*

We were unable to detect an increase in referrals in the data provided by the hospitals. This does not indicate a lack of impact, rather that we are unable to detect or disentangle any impact of awareness raising materials from other factors that may influence referrals.

Awareness Raising Materials Summary

To summarise, our review of national policies identified that the Third National Strategy on Domestic Sexual and Gender-Based Violence (DSGBV)[13], the National Standards for Maternity Services[14], and the Clinical Practice Guidelines from the Institute of Obstetricians and Gynaecologists[69] and the National Clinical Practice Guideline Screening and Management of Domestic Violence in Pregnancy and the Early Postnatal Period (May 2024)[8] all recommend the availability of information about local, specialist DVA services within maternity service settings. The awareness-raising intervention of the Maternity Project is aligned with these policies. Women find awareness raising materials to be helpful and welcome their presence throughout maternity settings.[7] **Error! Bookmark not defined.** They can prompt women to self-refer, contribute to a disclosure friendly environment, and improve women's recognition of abuse, particularly coercive control. There was a high level of support from maternity services staff, who agreed that awareness raising materials were needed and welcomed in their services. Co-design of materials with Women's Aid and maternity services led to greater adoption and reach of materials with greater impact. Early indications suggest that the awareness raising materials contributed to a disclosure friendly

environment and staff felt that they prompted more open conversations about DVA and more referrals to MSW.

Recommendations for awareness raising materials

We strongly recommend that awareness raising materials should continue to be distributed and displayed throughout all maternity settings, with supports in place to ensure materials are visible in all maternity settings year round and adequate funding provided to support the annual 16 days campaign.

Based on our findings we specifically recommend that:

- Women's Aid continue to provide high-quality co-designed awareness-raising materials to maternity services.
- Funding to continue to deliver this annual campaign should be made available to Women's Aid and extended to allow hospitals to work with Women's Aid to create more opportunities to bring focus to DVA in pregnancy, not limited to 16 days campaign. This can help to keep those championing DVA awareness remain energised and prompt a review of materials placement and distribution and provide *'an excuse'* to keep talking about DVA.

Co-design with services was very successful but survivors were not directly involved.

- We recommend that future review/co-design of new resources includes the perspective of survivors who have experienced DVA in the perinatal period.

Gaps also remain in the reach of awareness raising materials to all of the services a women may attend in the perinatal period and between types of care. Focus group and interview participants indicated that materials tend to be concentrated in antenatal and post-natal wards. We recommend that:

- Hospitals make a concerted effort to address gaps in the reach of awareness raising materials into private and semi-private maternity settings.
- All maternity hospitals disseminate and support the reach of materials into all services that women come into contact with throughout the perinatal period. The journey map highlights additional services where materials could be disseminated in hospitals (e.g. antenatal education materials, phlebotomy, physiotherapy, dietetics) and in community settings (GPs and other community health settings).
- Specific funding is provided to translate materials into different languages, tailored to the needs of the hospital/local catchment area.
- Hospitals to maintain year-round visibility of materials throughout all services.

- Hospitals commit to regular review of all services that women may be in contact with to ensure that services have the materials, that staff are aware of them, particularly in teams with high turnover of staff, and that materials are consistently on display and visible to women and staff members.
- Partner hospitals and Women's Aid identify, train and support champions within services to lead on maintaining year-round visibility of materials and creating more opportunities to focus on DVA, not limited to the 16 days campaign.
- Women's Aid and/or hospitals to consider developing and maintaining a repository of awareness-raising materials for the Maternity Project may be a useful way for new staff to access materials that are available to use. This could also contain ideas from across sites of ways that information has been shared with women, e.g., one hospital advocated including DVA awareness raising materials in the information folders at the booking appointments.

The materials produced were seen as very good already. Suggestions for further enhancement from maternity staff included:

- Create more awareness raising materials that focus on facts about DVA in pregnancy and postnatally as these were viewed as particularly useful for multiple audiences.
- Creating durable physical reminders/prompts such as credit card sized information or laminated prompts for screening questions or signs of DVA.
- Consider resources that could be safely included in information packs distributed at booking and at discharge. Suggestions include adding a QR code to link to information, resources and support for women.
- Create more video-based content is developed for display screens in hospital settings. This should be co-designed with maternity services and made available on a national basis.
- Focus on making materials even more visually engaging. Including women in co-design could support this.
- Ensure materials are regularly updated, incorporating feedback from both staff and patients and up to date evidence to enhance relevance and effectiveness.
- Continue to emphasise the non-physical signs of abuse, creating specific leaflets/resources to help women to recognise abuse that is not physical. This recommendation from staff echo the evidence that women were often unaware that their relationship was abusive and that it took them time and support to recognise coercive control.

The Women's Aid Outreach Support Service

The DVA Outreach Support Service was a new service, created by Women's Aid, for the three Dublin maternity hospitals taking part in the pilot. Throughout the pilot, it was resourced with one Outreach Worker (OW) who works full time across the three hospitals.[76] The OW receives referrals from the medical social work team within each of the maternity hospitals. The first OW began receiving referrals in May 2021 and was in post until September 2022, before leaving the role, she was replaced in November 2022.

To evaluate the Outreach Support Service as an intervention at the maternity hospitals, the CES evaluation team gathered data in a number of ways. This has included:

- Analysing the process data that Women's Aid capture about the Outreach Support Service. Women's Aid routinely collects data about the DVA Outreach Support Service, including information relating to the women who engage with the service, and the nature of support that is provided. This process data supplied by Women's Aid is summarised in Appendix B)[11].
- Capturing feedback from women who have engaged with the Outreach Support Service, via participation in an online, anonymous survey between August 2022 and June 2024 (n=24).
- Conducting interviews with (i) the OWs who have worked in the role to deliver the service (October 2022 and June 2023), and (ii) medical social workers who have worked with the OW at each of the maternity hospitals (1 DVA specialist medical social worker in December 2023, 4 x medical social workers, 2 x DVA specialist medical social workers in 3 sites in May 2023)
- (iii) Conducting focus groups with 2 hospital sites in May 2024 and (iv) a brief survey that was shared with staff involved in the design and/or roll out of the pilot to capture their views and experiences of all aspects of the Maternity Project, including the implementation of the Outreach Support Service, May/June 2024, 13 respondents.

A detailed overview of the approach to data collection (including recruitment of participants and methods of data analysis) is included in the interim report which was submitted to Women's Aid in September 2023[77].

Implementation of the Outreach Support Service

The data from all sources were in general very convergent, with sources tending to affirm and extend findings from the others. The key themes identified from the data were: the responsiveness of the Outreach Support Service; managing the capacity of the service (in terms of balancing caseload with a timely response); the importance of the social work role for DVA; the added value that the outreach service brings

[76] Women's Aid secured funding at the end of 2023 for a second outreach worker who had been in post since the end of July 2024
[77] Centre for Effective Services (2023), Interim report for the evaluation of the Women's Aid Maternity Project. Unpublished

for the support that the maternity service can provide for DVA; the support needs of the OW role; and the perceived need for wider rollout of the outreach service. These themes are contextualised using Proctors' implementation outcomes[11] and are outlined individually below.

Acceptability

The extent to which people feel it is a good 'thing'

Generally, there appears to be a high level of satisfaction with the Outreach Support Service among project partners who took part in the evaluation. Furthermore, feedback from the survey of women engaged with the outreach worker was overwhelmingly positive about the support provided, with 100% of the 24 women who responded indicating that they would recommend the service to other women for support.

Social workers from across all three hospitals and the OWs discussed a number of different ways that the Outreach Support Service was contributing to a broadening of support and greater efficiency in terms of how women engaged with maternity services can be supported with DVA, and how the social work teams also benefit from the outreach service. The specific components of the Outreach Support Service which were found to enhance acceptability of the intervention are outlined individually as sub-themes below.

Expertise of the Outreach Worker

The medical social workers valued the additional knowledge and expertise that the OW contributes to supporting DVA cases within the maternity services. They described using the OW as *"a sounding board"* for advice on cases, even cases that were not referred to the Outreach Support Service. The medical social workers felt the OW was knowledgeable about a range of complex issues and processes relevant to women subjected to DVA, including housing, technology safety, social welfare entitlements, and the law. It was also noted that the OW has connections with different refuges around the city.

> *"I had a really complicated coercive control one and she was just able to send me the details about the law that was being broken… …she gives good clarification on stuff if I'm querying it and she has that information quickly as well." (Medical Social Worker)*

> *"For me, it's always been quite a clear, distinct role. Like we're (social work team) supporting the lady in the hospital during her pregnancy, but anything else in relation to, you know, accessing refuge or what her options are around housing or social welfare. Then I would always sort of, you know, direct them to (OW). For that type of information. Because she's working in that area day-to-day and she's you know she's very familiar with it." (Medical Social Worker)*

The OW was perceived to have very specific knowledge and expertise around legal systems and processes as a consequence of their role in accompanying women at court:

> *"[OW's] in there a lot more often and has more experience in that. I'd often ask her if I wasn't sure if a person had grounds for a protection order or safety order, or whether this needed to be reported to the guards separately and seek a legal order. What's the best course of action? Those sorts of things. I think it's really good at helping or at providing advice and guidance on those kind of more complicated ones." (Medical Social Worker)*

Support with legal needs

Both OWs spoke about support with legal needs as a core feature of their work. The OWs also provide support to women making statements for the Gardai and follow up with the Gardai to serve court orders when these are delayed. The current OW referred to the need for her role to understand the legal "*nuances*" of complex cases (e.g., when a teenager has been abused by an adult) and described signposting these cases for further legal advice.

The ability of the OW to accompany women in court was highly praised by medical social work teams who acknowledged they would not have the resources available to do this for every woman. The OW was also seen to provide women with clear information about their options for court orders and what to expect from the process if they apply.

Connections to Women's Aid supports

The social workers who participated in interviews referred to benefits from the OW connecting women directly with resources and support from Women's Aid. This has included funding from the Women's Aid Emergency Fund and/ or Security Fund, which have allowed women to access safety features to enhance their home security. The OW also described being able to refer women on to other specific programmes such as vouchers and the High-Risk Support Project in Women's Aid.

Community-based work

Flexibility is a key aspect of the outreach service and the OWs described travelling around Dublin to meet with women in their local areas at a time and place that suits them. The medical social workers and OWs believed that a key benefit of the outreach service is the capacity to provide support in the community. This was seen as particularly beneficial for women with small babies, those who are isolated, and those who find it distressing to attend a hospital setting.

Continuity

The OWs spoke about developing trusting relationships with the women they work with, which enables them to provide support in complex and challenging situations. In cases where there is an issue that takes time to assist with, there is benefit in the woman receiving *"ongoing support throughout with the same person*". For women who re-enter an abusive relationship, the OW indicated a sense of reassurance that the relationship she has developed with the woman ensures that the woman are more likely to feel comfortable reconnecting for support at a later date.

> *"… but they'll always come back to you. So, I think that you're always just hoping that you have enough of relationship with the person that they go back into the relationship and it's a bit safer for them because they now know things that they didn't know, and that they'll come back to you when things get bad again." (OW)*

The consistency and continuity of the OW role was highlighted by the medical social workers. They noted that having one point of contact helps women to continue to engage with the service. In cases where homeless women may move around different refuges in the city, the OW is connected with the case throughout.

Reinforcing messages about DVA

Educating women about DVA was noted to be a feature of support provided by both the maternity outreach worker and the medical social workers. This overlap in support functions was framed as a strength that served to reinforce key messages about the nature of DVA and options for support. This was described as particularly useful for women who were unsure about whether their relationship was abusive. The medical social workers perceived great benefit in having another professional, especially one from Women's Aid, speak to the woman about DVA.

> *"Because some people often come in like, 'I don't know if this is abuse, but I seen a poster in the hospital, or someone said this'. And so we would do an education piece and then I think having someone back that up, like another professional back it up like [OW] do an education piece as well around it. That kind of is really helpful because they're going to hearing it from multiple angles." (Medical Social Worker)*

The social workers also commented on the consistency in the communication about DVA from the social work team and the OW, which was felt to enable women to build trust in the support received. One of the social workers commented that the OW's training and knowledge of the child protection system and processes means that the social work team can rely on the OW to provide accurate and consistent messaging to women, which is not always the case with other agencies:

> *"And I can kind of rely on that consistency in the messaging, which you can't sometimes with other community services, for example, like the Gardaí. Like I've often had patients come in, they've made a disclosure of an assault to the Gardaí and the Gardaí said, "well, unless you're going to pursue legal actions, I'm not going to refer to Tusla". Then they come to me, and I say, "Well that's actually incorrect and I will have to refer it". But, you know, I think [OW], she's on the same page cause she probably has a lot of similar training when it comes to the child protection piece." (Medical Social Worker)*

Independence from the hospital

Finally, the interviews identified benefit in the fact that the Outreach Support Service was provided by Women's Aid, an organisation independent of maternity services. This was particularly viewed as beneficial for women who might have a fear or mistrust of social workers and the involvement of statutory services:

> *"I do say to them that I don't work for the hospital. And I think it's actually really important that I say that because I think sometimes, they can get scared that you know… their GP will find out [or] their consultant. So, I do always say, you know, you were referred in from the hospital. I don't work for the hospital; you know Women's Aid is a separate service." (OW)*

Women's experience of the Outreach Support Service

Overall, there was a high level of support and an overwhelmingly positive response from the women who participated in the survey about their experiences with the Outreach Support Service. Women reflected:

> *"… The service was invaluable to me. It could not have worked any better as a service for me."*
>
> *"… my experience was extremely helpful and beneficial."*
>
> *"Maternity project outreach support service have given me support mentally and financially when I was alone .really I appreciate good work women protection team which have given me a confidence to survive in my situation and thanks a lot to support service and miss lucy"*
>
> *"The service, information and support I received was fantastic, I couldn't have done it on my own. Thank you so much again"*

Appropriateness

The perception that the project is a good fit for the context

Features related to the appropriateness of the Outreach Support Service are presented under a number of dominant themes which were identified in the data. These are: (i) perception of need (ii) flexibility in designing and implementing a referral pathway and (iii) the responsiveness of the Outreach Support Service.

Perception of need

An initial concern of the social work departments at the hospitals was the potential for role duplication. Despite this, all social workers who engaged with and referred to the Outreach Support Service reported that in practice, they found the OW role was distinct and complementary to the support provided by the maternity social work department. One social worker who participated in interview indicated that while they felt the role was valuable (i.e. acceptable), they did not feel it was an appropriate fit for their hospital setting owing to the fact that they had an existing social work department that was meeting the needs of women experiencing DVA. They felt, the role would be a much better fit in a hospital that did not have a social work resource:

> *"It was a post that… if there'd been consultation with the hospital, it wouldn't be something we'd recommend because it wasn't needed in Dublin city or it wouldn't be needed in Cork city because they have a CUMH but where there is no social worker, it's really really needed" (Medical Social Worker)*

This view however was the exception amongst those gathered, and other social workers from the same hospital spoke positively about the benefits of the Outreach Support Service.

Both OWs had previously worked in other support services for DVA, and they had noted in their previous roles that there was a *"massive gap"* for a support service that is specifically tailored to women who are subjected to DVA in pregnancy.

"And I suppose from working with women in a previous capacity, just in a general outreach role, every single woman mentioned how they were affected by either a stressful pregnancy, a concealed pregnancy, termination and miscarriage, a loss. And it's just such a huge theme" (OW)

Flexibility in designing and implementing a referral pathway

Much of the work that the medical social workers undertake to support women subjected to DVA is similar to the work of the outreach services- putting safety plans in place, supporting legal orders, providing information and education around DVA and its impact in pregnancy, and engaging with relevant community and statutory services. For this reason, at the outset of the Outreach Support Service's implementation, the social work teams were concerned that there would be duplication in the work carried out by the two roles. One of the social workers interviewed, who was a DVA medical social worker, felt that the social work service was already meeting the needs of the women at that hospital, and that the outreach service in that context, was generally not needed.

The medical social workers at the pilot hospitals were further concerned that medical staff would make referrals directly to the OW, which would obstruct the safeguarding work of the social work team.

Women's Aid, in response sought to engage and consult with maternity hospitals for feedback which resulted in the introduction of changes to the referral pathways that would help to alleviate concerns and secure buy in for the service. These changes included an agreed referral pathway through which hospital referrals to the Outreach Support Service would be made by medical social workers to avoid the risk that maternity staff would bypass the social work departments and make referrals to the Outreach Support Service directly. This engagement appeared to be highly successful with all but one of the medical social workers who participated in interviews indicating that their initial concerns around role duplication were addressed through engagement with and consultation about aspects of the service's design. For those who engaged in this process, the collaborative approach to implementation, and flexibility from Women's Aid to adapt and respond to the hospital context to ensure the fit and practicality (feasibility) of the service, served to enhance their perceptions of the service's 'appropriateness; overall.

Process data indicates that the proportion of referrals to the service from sources outside the hospital reduced substantially between 2022 and 2023 (from 19.5% to 2.5%) and appears to have remained relatively stable in the first half of 2024 (4%). The highest proportion of referrals outside of the hospitals was made by the Women's Aid National freephone helpline (n=12), followed by self-referral (n-8) and referrals from Women's Aid drop-in service (n=7). When a referral comes through another source (e.g., via the Women's Aid helpline, or self-referral) the current OW will only work with a woman who consents to be referred to a medical social worker at the hospital she is attending.

More recently the Outreach Support Service has begun receiving referrals from termination services, maternity drug treatment services, and nurses and doctors within the wider maternity hospital. In these cases, the OW directs the healthcare professional making the referral to first contact the medical social work team. The OW felt that the established referral process has built "*trust"* between her role and the

medical social workers, as they are reassured that they will continue to be involved with any DVA cases within the maternity service.

This flexibility in the design of aspects of the service – in this case the referral pathway – contributed to a sense that it was tailored to fit the hospital context, and this helped to increase stakeholders' perceptions of its acceptability:

> *I can't really speak to the setting it up… but obviously the implementation of that, that's been working really well. The referral process to the OW is... it's really kind of streamlined in the sense that I feel like she adapts it to each hospital depending on what works for the department, and we've got a really close relationship with her. (Site Focus Group)*

Findings from recent site focus groups found that the referral pathway that was developed at the early stages of the service's implementation is well established, is understood and continues to work well:

> *'I feel like that's been working really well. From the teams in the hospital, they understand that and they seem to know that that's the referral pathway' (Site Focus Group).*

Process data collected by the Outreach Support Service would also suggest that the referral pathway is established and working well, with the majority of referrals to the service coming from each of the 3 hospitals (93% of all referrals from May 2021-June 2024).

The responsiveness of the Outreach Support Service

The interviews with the OWs and medical social workers conveyed that responsiveness is a core component of the Maternity Project Outreach Support Service. This was discussed in relation to both the immediacy of response from the OW to women referred for support, and also the responsiveness of the service to women's individual needs.

Immediacy of response

The medical social workers noted that the referral process to the OW was "*informal*" and "*easy*". Once the woman has given consent for referral, the medical social workers just "*pick up the phone, you give her (OW) the details*". They spoke positively about the immediate nature of the response from the OW to women referred:

> *"(OW) always answers the phone straight away I don't know how she does it." (Medical social worker)*

The current OW explained that she aims to make a first call to a woman on the same day that the referral is received. In the first call, the OW typically introduces herself and explains that she will call the woman again the following day to talk further and plan a meeting. For some women, support with specific immediate issues is also needed in the first call and can require an in-person meeting that same day. The OW explained that the initial response from the Outreach Support Service must be as immediate as possible,

given the high-risk situations women are living with. This is also reflected in the literature, that prompt response is vital.

> *"If I was to put myself in the shoes of a woman and I was waiting for someone to call me, I would want it to be immediate. I would want it to be that day. Like if my life was turning upside down and I needed accommodation, I would want that person to ring me that day… … it is life or death stuff like it does have to be immediate and especially when they're pregnant". (OW)*

The current OW noted that the speed of response from the Maternity Project Outreach Support Service is much quicker than the response from general DVA outreach services, as indicated by service response time information that is monitored by Women's Aid.

> *"I think we're catching women that possibly we wouldn't have caught before". (OW)*

Process data supported this finding. The response time of the Outreach Support Service to referrals appears to have improved greatly between 2022 and 2023 (from 2 days to 3 hours). The Outreach Support Service manager has confirmed the service has managed to maintain a quick response to referrals in 2024, with women receiving a 'same day response' from the OW via telephone contact with her consent.

Responding to individual needs

The evaluation found that the OW takes a person-centred approach to delivering support which is in line with the evidence of best practice in advocacy work, as outlined in the Background and Context section. The interviews conveyed a sense of how the Outreach Support Service responds to the individual needs and preferences of the women referred. The medical social workers noted that the OW "*follows the lead*" of those referred and meets their needs "*where they're at, at the time*". The two OWs described the wide range of support that they have provided to women who engaged with the outreach service, as support is individually tailored to each woman's situation.

> *"The only thing I think that every single client has in common is their safety and risk. I think everything else, every client is just so different". (OW)*

The OWs spoke about working with women to understand and explore the nature of their relationship with the perpetrator, educate them about DVA and the cycle of abuse, and share information and guidance about safety planning. The current OW reported that women have told her they appreciate being able to speak to someone who understands the dynamics of DVA, as family members and others often do not understand. Both the OWs and the medical social workers referred to the harm reduction approach the OW adopts in cases where a woman remains in an abusive relationship.

> *"Even where the decision hasn't been made to leave, like I had a few cases where [OW] was linked in, where the patient wanted to remain in the relationship. So [OW] went with that. It wasn't the case where she was, you know, trying to convince otherwise. You know, she ran with that and provided the patient with … advice on how to keep herself safe within the relationship." (Medical Social Worker)*

The OWs reported that the most common areas of support women need from them are in relation to legal issues and housing. They also referred to providing support around visa applications, social welfare payments, and other issues that can prevent a woman from leaving an abusive relationship. The OWs indicated that the most immediate needs are prioritised for each case and other issues are then supported as the engagement continues.

The current OW also noted that the role involves working with women through different stages of the pregnancy journey, including pregnancy loss. There is therefore a "*fluidity*" required in the approach to each case, to respond to women's changing circumstances. The outreach service was described as continually adapting and expanding to meet the needs of those subjected to abuse in pregnancy, including working with pregnant teenagers and their parents. Ongoing learning and skill development for the OW was therefore seen as important for the role. While the Outreach Support Service is currently only available to those who live in Dublin, the OW noted that she telephones women from surrounding counties who need support but are not eligible for the outreach service, in order to signpost them to local DVA services in their area.

Adoption

The extent of uptake and utilisation of the intervention within a service

Findings for the outcome of 'adoption' are presented under the overarching themes of (i) rates of engagement (ii) perception of need and (iii) building relationships.

Rates of engagement

- There was a total of 278 referrals received from May 2021 to June 2024 inclusive.
- There has been a growing number of referrals to the Outreach Support Service each year.
- The proportion of referrals from each hospital is consistent with the hospitals size/number of births/women cared for indicating consistent uptake of the service across all three hospitals now that it has been established.

The percentage increase for average monthly referrals received from the three hospitals are outlined in the table 9, with names of hospitals removed to retain anonymity. Referrals from hospital A increased slowly at first but have more than doubled in the past year indicating an initial slower uptake of the service. Referrals from hospital B indicated swift uptake of the service at the outset with continued growth in referrals. Referrals from hospital C increased more slowly initially then more than doubled in 2023 indicating strong uptake of the service over time with continued growth in referrals into 2024.

Table 9; Increase in average monthly referrals to the outreach support service compared to the previous year

	2022	**2023**	**2024 (to June)**

Referrals from hospital A	66.67%	93.33%	103.45%
Referrals from hospital B	162.50%	30.16%	24.39%
Referrals from hospital C	53.33%	108.70%	38.89%

At the early stages of implementation, Women's Aid reported to be experiencing varying levels of 'adoption' (i.e. referrals to the Outreach Support Service) across the three Dublin hospitals and were concerned about the lower referral rates coming from hospital A. As noted earlier, the evaluation found that a small number of influential stakeholders within this hospital did not experience the co-design process as a positive one and this appears to have impacted early attitudes towards and uptake of the project overall. This initial slow uptake did not last and over time referrals to the service were in line with the other hospitals.

Most referrals come from hospitals, with few referrals from other sources direct to the service. Referrals from all hospitals increased over time, despite an overall decrease in women attending the hospitals/decrease in births over the same period.

There have been high levels of engagement with the Outreach Support Service from the women referred. Key points from the process data on who is engaging with the service are summarised below.

- 379 women engaged with the service between May 2021 and June 2024.
- There have been high levels of engagement with the Outreach Support service from the women referred with an average of 87% (94% in 2021; 79% in 2022; 88% in 2023; 93% in 2024).
- Most women are pregnant at the time of referral (58% average). Fewer post-partum referrals but still a large minority (32% average). Few women were referred following pregnancy loss (4% average) and termination of pregnancy (3% average).
- In the first year of the Outreach Support service, 2021, most referrals received were for women in the postnatal period (45%), but over the following three years this has reduced (between 30-33% between 2022 and Jan-June 2024) with a corresponding increase in referrals for women who are pregnant (60% in 2022, 59% in 2023 and 59% for Jan-June 2024).
- For each year, mental health issues were the most frequently recorded additional vulnerability for the women referred to the Outreach Support Service (39% in 2021, 24% in 2022, 48.5% in 2023 and 38.5% for Jan-June 2024), followed by homelessness (6% in 2021, 13% in 2022, 15% in 2023 and 9.5% for Jan-June 2024).
- Approximately 10% of the women referred to the service throughout the period were from a minority ethnic group.
- Tusla involvement upon referral was recorded for 19% of all women who engaged with the outreach support service throughout the pilot.

Perception of need

A significant factor that appears to have influenced rates of adoption among medical social workers is the 'perception of need.' The Maternity Project Coordinator reflected that at the early stages of implementation, when meeting with the social work departments, there was two broad responses:

> *'…some hospitals… welcomed it with open arms and were delighted…they were really overwhelmed in terms of the amount of you know support they needed, and they really needed the support and help you know in terms of what they were doing and others were kind of like well we're doing that work, why do we need you?' (Maternity Project Coordinator)*

There was a significant effort made at the early stage to build support for the project, with meetings held to outline the 'added value' of the specialist support the DVA outreach worker could provide and additional resources they could access through wider Women's Aid services and resource such as the Emergency Fund.

While overall these efforts appear to have established strong support for the Outreach Support Service, as reflected previously, there was one hospital where few influential staff did not feel the service was an appropriate fit for hospitals with a SW department and in this case, it appeared to have limited their uptake of the service:

> *"I think I referred two cases to her in a year" - Medical social worker.*

Building relationships

Building relationships and trust that the project would deliver was key to securing buy in for the project and increasing hospital engagement with the Outreach Support Service. Strong working relationships – which were eventually established with all Maternity social work departments appear to have resulted in increased hospital engagement and referrals to the service over time (i.e. adoption).

These working relationships also positively impacted the quality of the 'package' of support women received from the social work department and OW.

The social workers described the OW as approachable and responsive and commented that they had a "*great working relationship*" with her, which facilitates regular communication about DVA cases within the maternity services. The OW noted that there was "*mutual respect*" between the outreach service and the social work team, in terms of the work that each role does to support women on DVA cases. In the interviews, the OW and social workers described working together to manage the support provided. They communicate regularly about the work that has already been done on a case and what each role is going to contribute going forward, to reduce any potential for duplication of work. They also sometimes work jointly on cases that are particularly high risk or high need, e.g., both preparing letters to immigration services, or both advocating to Tusla for supports to be put in place.

The social workers noted that working together on a case with the OW made "*a big difference*" for their work, in terms of being kept informed about what is happening for a woman, with her consent, in between hospital appointments. Previously, they referred women to general community-based outreach services where they did not know the staff and they did not hear further updates on progress for women with these services. Furthermore, there is reassurance provided in having a wider support structure for each case; if the social worker or the OW is on leave, they know there is another source of support available for the woman.

Feasibility

This was practical and feasible for us to do'

Themes that relate to the implementation outcome of feasibility include (i) capacity of the Outreach Support Service and (ii) supports required for the outreach worker role.

Capacity of the Outreach Support Service

The Maternity Project outreach service was designed as a model of short-term support, to respond quickly to a woman's immediate needs and if required, connect her with longer term community supports. The OWs indicated that there was no specified timeframe for their engagement with women, which typically depends on need. The support provided can range from a very brief period to help with a specific issue (such as a letter to support a housing application), through to 8 to 12 weeks of support to address a number of objectives. There is also the possibility to provide extended support beyond 12 weeks for a specific issue, such as the time required to make a statement to Gardaí, or accompaniment to court proceedings at a later date. In cases of extended support, the input needed from the OW was indicated to be less intensive with telephone contact *'now and again'* in the run up to court accompaniment.

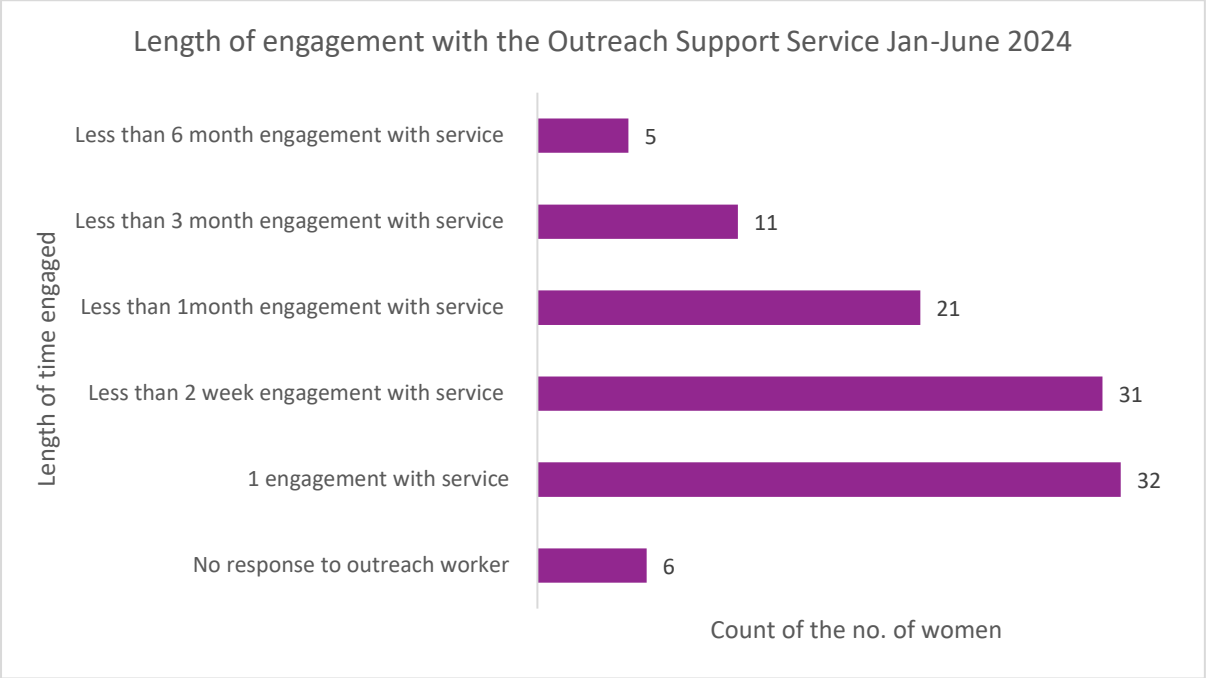


Figure 3: Length of engagement with the outreach support service (Jan-June 2024)

Recent data provided by the Outreach Support Service for Jan-June (see Figure 3[78]) indicates that in the majority of cases, women receive support for a period of 1 month or less. The OW reports that typically cases are closed when a client has been referred to longer term support or when they have not engaged with the service in longer than 1 month.

Both OWs discussed the implications of the service timeframe for managing the caseload and capacity of the role. At an earlier stage of the outreach service, the OW referred to the challenges she experienced in maintaining boundaries around the duration of the support provided when a relationship had been established with the woman:

> *"I've linked in with her, we've gone to court, we've done a plan around X, Y and Z, and then I'm linking her in with a new service where she has to, again, start from scratch. I don't feel like it's the most appropriate support."* (OW)

In some cases, women who had initially engaged with the service for short-term support returned to the OW for support a number of months later. This led to consideration of capping the number of cases for the Outreach Support Service in order to ensure that responsiveness could be maintained.

> *"There is no capacity and [manager] here was kinda saying, 'Look I think that we need to kind of cap the numbers here'. And I suppose… the way I envisaged the project was it was very important that …when you're like advertising something, say to … the medical social work team, you're offering the service that we're going to try and immediately respond as soon as possible. And then if*

[78] This figure reflects typical length of engagement with the outreach support service. It must be noted that a few women sometimes require support for longer than 6 months on a needs led basis. This represents a very small number of women and typically occurs when women require ongoing support, and it is not appropriate to refer their case on to another service.

> *we're capping numbers then they have to go back on to waiting lists and that was the gap that we were… trying to fill. So this is definitely something that I think needs to change moving forward … to be able to, you know to continue to deliver that service, or to maybe look at delivering another service with a cap on the numbers and maybe like a 12 week plan or you know something like I don't know something like that maybe." (OW)*

In the interview with the current OW about the more recent delivery of the Outreach Support Service, there was a stronger sense of confidence in the effectiveness of the short-term support model. While the OW acknowledged that the short-term nature of the work limited capacity to *"get to know women"*, the shorter duration of support enabled the OW to manage capacity and maintain the timeliness of the service response:

> *"If I was to keep clients longer term, I just wouldn't have that capacity to meet women as quickly. And that's kind of the nature of the service." (OW)*

The OW indicated that the responsiveness of the service is the key priority for managing service delivery. The workload is determined week by week and the OW tries not to book many engagements in advance. One day per week is typically set aside for court accompaniment, but new referrals needing immediate support take priority on those days. The OW also noted that she is careful to ensure that she only accepts referrals for cases requiring support relating to DVA and its impacts, rather than cases for other issues.

> *"I could give my life to court and I could give my life to doing housing pieces. So, I do just have to be careful, if it's not domestic violence, it's not for me." (OW)*

Some of the medical social workers expressed concerns about the future caseload of the OW if there is an increase in referrals, and how this may impact on the capacity to deliver a timely and responsive service:

> *"I just worry sometimes about [their] caseload, you know, because I think like we do refer quite a lot in and all of the hospitals are referring in as well like you know. Is there concern that that at some stage that might get unmanageable, and the responsiveness might not be there?"* (Medical Social Worker)

Feedback from the Outreach Support Service manager indicates that while providing such a *"highly responsive service"* was made possible *"due to the skill and dynamism of the worker,"* it has indeed put pressure on the outreach worker and would not have been possible to continue indefinitely with just one worker between the three Dublin Maternity Hospitals. As such, during the period of evaluation, Women's Aid secured core funding that enabled them to sustain the original outreach worker post and to recruit for a second outreach worker who started in post in July 2024.

Supports required for the Outreach Worker role

In exploring their experiences of the role, the OWs described a high level of risk, complexity, and trauma in the cases that they dealt with in their work; including image-based sexual abuse, teenage pregnancy, child protection concerns, and pregnancy loss suspected to be caused by DVA. One OW described feeling unprepared for the extent of loss and grief she had faced in the role, and the emotional impact she experienced from these traumatic cases.

> *"…it obviously is so rewarding. But I also don't think I was prepared for the amount of loss within the maternity outreach since I've started. There's been so much more loss in this project in terms of of babies, in terms of pregnancies, than I've ever experienced before in any of my my previous outreach roles… …It's a totally different level …of trauma and pain…It's absolutely heart breaking …I've had almost every month I've had at least one client whose baby has died as a result of physical assault. And so, I suppose that is something that …I have really struggled with." (OW)*

Both OWs commented that there was a sense of isolation with the role, due to the independent nature of the work, the movement between hospitals, and the absence of a wider team of other outreach workers.

> *"I think that this role is quite an isolated role… you don't have a team in any hospital. You're kind of outside all the time and it can be…quite isolating."* (OW)

To reduce this isolation, the OWs drew on a range of supports to help them navigate the complexity of cases and the emotional impact of the work. These supports included line management supervision, monthly clinical supervision (funded by Women's Aid), as well as opportunities for informal advice, guidance, and peer support from experienced colleagues in the wider Women's Aid team.

> *"…because I'm kind of out and about so much, it's actually more so me making, I have to make the effort to kind of ring someone if that makes sense. So I kind of have to make sure, and I am pretty good at it, you know that I sit down and say OK, I'm gonna text one of the girls that I work with to see are they in the office tomorrow just so I can, I can talk it through with them. Because like some of the women that have worked for Women's Aid, like they been there for like 30 years and like no matter what you've come up against, they know someone that can help".* (OW)

As noted previously, funding was secured to recruit a second Outreach Worker which has been noted by Women's Aid to be a *"very positive development*" that will provide access to peer support within the broader regional service and help to mitigate against feelings of isolation.

The working relationships between the OW and some social work teams were also described as a source of peer support. At one of the hospitals, the social work team often encourages the OW to join them for lunch and to feel connected to the team.

> *"…a lot of my more traumatic cases have been in (name of hospital). So myself and the social workers would have kind of dealt with those together. And it has been nice…" (OW)*

Both OWs reported a very supportive relationship with their line manager, who was approachable and knowledgeable about a range of issues that they encountered in the role. Supervision was used to access support and guidance to manage practice issues, ethical dilemmas, and the emotional impact of the work.

Sustainability

Can we keep doing this?

Findings which relate to the implementation's sustainability are presented under the themes (i) support for continuation of the pilot and (ii) considerations for wider rollout of the Outreach Support Service.

Support for the continuation of the pilot

There was clear support from all stakeholders for the continuation of the Maternity Project Outreach Support Service:

> *"…it will be really sad when we don't have that anymore."* (Medical Social Worker) [79]
>
> *"Keep the funding coming."* (Medical Social Worker)
>
> *'Keep Lucy (person who I was referred to) by all means…*' (Woman engaged with the outreach support service).
>
> *"…I highly recommend your service and everything that your team are doing is great…"* (Woman engaged with the outreach support service).

While it is still early in the pilot project's implementation, findings from the evaluation suggest that the outreach worker role is particularly *'bedded'* into the system and represents a service offer that complements the support provided by maternity services' social work departments to women experiencing DVA:

> *"I think that the key worker has been really successful and that's really now embedded almost to be part of our service which is great"* (Site Focus Group)

Considerations for wider roll-out of the Outreach Support Service

Stakeholders who participated in the evaluation were in support of the Outreach Support Service being rolled out more widely to other maternity services in Ireland. Many felt that the outreach worker role would be even more beneficial for maternity hospitals and units that do not have medical social workers within their services.

> *"I think the service will be hugely valuable particularly in those in those hospitals that don't have social workers who kind of have that kind of specialist knowledge or kind of additional knowledge". (Medical Social Worker)*
>
> *"The outreach worker should be in all maternity services throughout Ireland" (Woman engaged with the outreach support service)*

With that said, others acknowledge that in hospital settings where there is no or limited access to SW support, the implementation of the OW role could look very different. Two of the three Dublin hospitals that participated in the pilot of the Outreach Support Service employed SWs who specialised in domestic violence and all three had access to a SW department dedicated to Maternity services. Many stakeholders interviewed cautioned that not all hospitals have access to this level of support and expertise and in

[79] NB: at the time of interview, the Maternity Project was a pilot with no guarantee of core funding to sustain the outreach support service

maternity services that are not resourced with medical social workers in place, the workload of an OW may be greatly increased relative to the experience of the pilot:

> *"I think they could really do with it in other hospitals… Like I think they (OW) would be used so much in other hospitals. They would be very busy I would say in other hospitals because they'd…everything would go to them to do the whole piece of work…" (Medical Social Worker)*

In hospital settings such as this, there may be greater risk that the OW would get a higher number of referrals and without carefully considered resourcing, the Outreach Support Service may find it difficult to maintain the responsiveness of the service.

It must be noted that the Outreach Support Service has only been implemented in hospitals located in urban areas that have access to maternity specific medical social work departments and as such, the evaluation is unable to draw any conclusions as to how this service would operate in rural areas and/or hospital settings which have no or only 'generic' access to social work. Indeed, the evaluation has found that the OW's role is distinct from that of the SW department and the success of the Outreach Support Service was attributed in part to the strong working relationships between the OW and SWs so that women were provided with wraparound and complementary support. Any plans to implement or extend the service to settings with no or limited access to SW support may not operate in the same way or experience the same degree of success.

For the ongoing development and future rollout of the outreach service, some of the social workers interviewed made suggestions for more engagement with social work teams. One felt that the Maternity Project had not sufficiently engaged with the team at her service prior to its design and implementation. She emphasised the importance of consultation with key frontline stakeholders prior to any implementation of the outreach service at other maternity services. Another social worker suggested that the teams who have experienced the Outreach Support Service during the pilot ought to be brought together to share learning and ideas about how they could make best use of the outreach service going forward:

> *"The one thing I think would be helpful. It's not that this is missing, but we, I, would be really interested to see how the other maternity hospitals use the outreach service and if there's anything more that they're getting from it that we haven't thought of or like how it's working for them." (Medical Social Worker)*

Impact of the Outreach Support Service

While data gathered for the Outreach Support Service primarily focused on implementation outcomes, the evaluation does point to some early short term beneficiary outcomes, primarily through the survey of women engaged with the service and supported by stakeholder perceptions in interviews and focus groups. This section provides an overview of the reported benefits of the Outreach Support Service for women experiencing DVA.

Improved co-ordination of support

Overall, findings from the evaluation suggest that the Outreach Support Service contributed to a more 'joined up' approach to supporting the needs of women accessing maternity services and experiencing DVA. The medical social workers described previously linking in with and referring women to generic outreach support services and explained that in such cases, it was often difficult to get information and updates from community services about the woman's engagement. Having a ring-fenced community outreach service for women engaged with maternity services enabled strong working relationships to be developed and maintained between the Outreach Support Service and the social work department which worked to ensure women were well supported throughout their pregnancy.

A small number of women who participated in the survey about their engagement with the OW (n=2) did suggest that more interconnection between services could help to strengthen the support provided by the Outreach Support Service:

> *"Keep Lucy (person who I was referred to) by all means. More support maybe for those who are in need, connections for legal services like solicitors also might be helpful"*
>
> *"Yea maternity outreach support should interconnect with all department like garda station so that people can get help very well"*

Increased accessibility of support

Women's Aid's vision for the Outreach Support Service was that it would act as a *'direct referral pathway'* that was responsive and would serve *to 'increase accessibility for vulnerable women' to a specialist support service'* (Project Coordinator). Process data for the Outreach Support Service demonstrates that while initially during the early stages of implementation, response times for referrals to the service were generally responded to within 2 of days, over time, the service was able to provide and maintain a same-day response to referrals.

Findings from the survey of women who engaged with the Outreach Support Service indicate that women experienced the service as a helpful source of support:

- Twenty-three respondents (96%) rated the Outreach Support Service as 'very helpful' and one participant (4%) rated it as 'Somewhat helpful.'
- All participants Strongly Agreed or Agreed with the statement, *"I received information and support from the Maternity Outreach Support Worker about my rights and the options available to me".*
- All participants Strongly Agreed or Agreed with the statement, *"I received emotional support from the Maternity Outreach Support Worker during our meetings and conversations. (Emotional support might include feeling listened to, accepted, or encouraged)"*

- Twenty-three of the participants (96%) Strongly Agreed or Agreed with the statement, *"I felt stronger and more confident in managing my situation after my conversations /meetings with the Maternity Outreach Support Worker".* One respondent indicated 'Not Sure' in relation to this statement.
- All participants indicated that they would recommend the Maternity Project Outreach Support Service to other women who are in a similar situation.

Process data for the Outreach Support Service also indicates that in addition to direct support from the OW, many women accessing the service were also referred on to other community supports, where required. Twenty participants (83%) indicated that their contact with the Outreach Worker helped them in other ways, e.g., access to other services and supports. Fifteen participants provided free-text responses about the types of support provided, which included:

- Information and support with family law
- Help with legal aid
- Court accompaniment
- Access to the Freedom Programme (a free, online course for those who have been affected by the impact of an abusive relationship)
- Guidance about entitlements
- Assistance completing forms for social welfare payments
- Referral to support from the Society of St Vincent De Paul
- Support with increased home security
- Support with housing options

Increased safety

Both OWs and the medical social workers discussed how a quick response to disclosure of DVA is more likely to secure women's engagement and encourage them to take action for their safety. The Outreach Support Service as a ringfenced support for women accessing maternity services was reported to be more capable of responding to referrals and providing immediate access to support compared to generic outreach services. This echoes previous qualitative research which suggests that an immediate response helps prevent survivors from being lost in a 'standard' referral pathway.[80]

[80] Dheensa et al. (2020) "From taboo to routine": a qualitative evaluation of a hospital-based advocacy intervention for domestic violence and abuse.

An immediate response to referrals was also believed to validate the importance of the issue of DVA and give women more confidence in the availability of support.

> *"Because it is an urgent issue and like we find as well, people disclose, we try and catch them on the day because when they disclose, they're more open to telling you everything. Whereas they could say something and if you don't see them or deal with the issue then and there, they kind of retract... … but I think having that urgency and that availability of someone ready to support gives women that kind of feeling of like oh, yeah, this is important." (Medical social worker)*

There was a perception among stakeholders interviewed that the OW's ability to accompany women to court was helping to increase the number of protection orders that were sought:

> *"We get more results. You know, you get the protection order in place. You get all of that stuff because they feel like they're working with someone who isn't going to take their baby…." (Site Focus Group)*

Outreach Support Service Summary

The Outreach Support Service pilot project, implemented across three Dublin maternity hospitals, was evaluated to assess its effectiveness in addressing domestic violence and abuse among women engaged with maternity services. This service, which began in May 2021, provided support through an Outreach Worker who was integrated into hospital services, receiving referrals primarily from medical social workers with some women referring themselves to the service. Throughout the evaluation, data was collected through interviews with OWs, focus groups with maternity staff including medical social workers, and a survey of women who utilised the service. The evaluation noted that 278 referrals were received over the study period, with a high engagement rate among women. There was a substantial year on year increase in referrals, highlighting the time needed to embed the service *and* the growing demand for the service one it was embedded.

The OW's role was seen as complementary to the existing medical social work departments, offering specialised knowledge in DVA, especially in legal matters, housing, and safety planning. The evaluation found that the OWs were valued for their expertise, quick response times, and ability to offer community-based support. The OWs provided both emotional and practical support, such as court accompaniment and assistance with legal orders. Women accessing the service expressed overwhelmingly positive feedback, emphasising the value of the Outreach Support Service in improving their ability to manage their situations. Key challenges identified included managing the caseload and the emotional toll of dealing with complex and traumatic cases.

Overall, the Outreach Support Service had a significant impact, enhancing the support provided to women, ensuring timely access to expert community-based support. There was widespread support for the

continuation of the service, with recommendations for its expansion to other maternity services across Ireland. The success of the service was dependent on its integration with medical social work teams. Working in partnership to design and implement the service elsewhere to assess its feasibility and adaptations needed to fit in any new context would be needed before rolling out the service to other hospitals.

Recommendations for the Outreach Support Service

Continuation of the Outreach Support Service in Dublin hospitals.

- We strongly recommend that the Outreach Support Service be continued, and appropriate funding provided to Women's Aid to maintain this service by HSE/relevant state body. This should include sufficient resources to enable the service to maintain same-day response for women referred, manageable caseloads and the excellent quality of the service for women.

Maintaining the Outreach Support Service's responsiveness. This project, alongside other initiatives within maternity settings and nationwide is contributing to an increased awareness of the signs of DVA. Training delivered to the participating hospitals is reported to have enhanced staff understanding of the issue and capacity to respond. If this has the hoped for impact on rates of identification and disclosure, it could result in an increased number of referrals and a requirement for increased system capacity to respond and meet the needs of women experiencing DVA. To ensure the Outreach Support Service is adequately resourced to maintain the immediate response to referrals, we recommend:

- Women's Aid work with the MSW departments to analyse trends in rates of detection and referral to inform understanding of the demand for the Outreach Support Service and enable Women's Aid to seek out funding to meet resource requirements.

Support for the OW. The evaluation found that the OW role involves working with a high level of risk, complexity, and trauma and that this has an emotional impact on the worker. The role was also found to be at increased risk of isolation owing to it being a single post, although we recognise that funding has now been secured by Women's Aid for two permanent posts and that the recruitment of a second Outreach Worker in July 2024 has the potential to increase opportunities for peer support. To ensure OWs remain supported in the role, we recommend:

- Continued access for the OWs to Women's Aid line management as well as monthly clinical supervision

Ongoing review and improvement: to ensure the service continues to operate optimally within its current hospital settings we recommend:

- Women's Aid consider the suggestion from a MSW to bring the three Dublin hospitals together on a regular basis to share learning and ideas about how they could make best use of the Outreach Support Service.

Wider rollout of the Outreach Support Service - considerations & recommendations

As noted earlier, the Outreach Support Service has only been implemented in hospitals located in urban areas that have access to maternity specific medical social work departments and as such, the evaluation is unable to draw any conclusions as to how this service would operate in other contexts, nor can it definitively recommend that it should be rolled out to other settings. With that said, the evaluation did find that the OW and SW departments across the three hospitals worked well in partnership with one another to provide a complementary system of support for women experiencing DVA, and as such, we recommend further exploration around the feasibility of implementing the service in other hospitals. To ensure implementation is evidence based, we recommend:

- Women's Aid to secure funding to commission a feasibility assessment to determine if the Outreach Support Service model is transferable to other settings e.g. hospitals without a dedicated Maternity Setting, hospitals that lack maternity social workers or DVA specific social workers, smaller units in rural areas etc. and informed by an understanding of the wider policy context and existing initiatives (e.g. business case for medical social workers, plans to develop referral pathways to community social work support, training and existing processes and support for women subjected to DVA). This would require sufficient resource for Women's Aid and commitment from hospitals to engage in co-design of the service that could be implemented within each new service context.

Building relationships and buy in for the Outreach Support Service. It is very clear from the evaluation that the Outreach Support Service has developed excellent working relationships with the 3 Dublin hospitals and all social work departments who participated in the evaluation reflected that it served to complement, broaden, and enhance support for women accessing maternity services who are experiencing DVA. These relationships however were only built through concerted effort at the early stages of implementation to build buy in for the intervention, which was not co-designed with the maternity services. If considering wider rollout to other maternity services, we recommend:

- Women's Aid to factor into implementation plans the time required to build relationships and garner support for the Outreach Support Service in any future rollout of the service.
- Women's Aid ask for testimonials from existing social work departments to demonstrate to other hospitals the 'added value' of referring to the Outreach Support Service.

Managing capacity of the service: focus group participants acknowledged that while the role of the OW would be very valuable to hospitals that lack access to maternity SW departments, they also cautioned that

there is risk that implementation in such settings would lead to increased demand for the Outreach Support Service and this has the potential to reduce the service's ability to provide an immediate response to referrals. We also note that the evaluation found that the OW role is distinct from that of the SW (i.e. flexible and independent support in the community) and that both worked together to complement one another and offered an enhanced package of support. In addition to the above recommendation on a feasibility assessment we also recommend:

- ongoing review and evaluation of the implementation of the service in other contexts to inform an understanding of its impact.

The Maternity Project Training

Training design process

The training course was designed in collaboration with maternity services staff from multiple disciplines. Women's Aid undertook extensive engagement with services, first at senior leadership levels (hospital 'masters', clinical directors and directors of midwifery) to gain buy in and approval for the project. Next the maternity project coordinator met with medical social work leads and service leads to set-up training committees whose role was to co-design the training programme. The Women's Aid project coordinator facilitated seven design sessions, across four pilot sites involving 43 staff from multiple disciplines between December 2021 and March 2022. The key questions asked in these sessions assessed the desired learning outcomes, desired practice changes, who the target audience for training should be and how training should be delivered. Considerations for delivery included timing, how long sessions could be, mode of delivery (online or in-person, self-paced individual learning or interactive), location and potential barriers to training uptake to be overcome and facilitators to be leveraged. Women's Aid project coordinator then drafted the programme and worked with each partner hospital to secure sign off on the training programme design (April- May 2022) before the content was then developed and tested with hospitals (July- August 2022). The Maternity Project Coordinator was on maternity leave from September 2022 to September 2023 and during this time the eLearning module was developed and again this was in consultation with the four key partner hospitals. On the Project Coordinator's return to work in September 2023, the focus was on a training rollout plan and recruiting two regional sites to participate in the pilot training. The Coordinator met with the six pilot hospitals for discussion and agreement on the plan. Discussions were held on the timings of the training, ways to recruit participants and locations for the Gold Sessions. Eight meetings (1:1's & multidisciplinary) were held between October 2023 and November 2023 and included a Consultant Obstetrician from the three pilot hospitals; physiotherapy management, Midwife Management and Medical Social workers from six pilot hospital sites. This co -design process in its entirety was undertaken between December 2021 and October 2023 and led by Women's Aid Maternity Project coordinator. During the training delivery from November 2022 to July 2023, the Coordinator continued to meet with the key multidisciplinary contacts from each site updating them on the training progress and working together to promote the training. The Maternity project coordinator delivered the silver and bronze training sessions, offering continuity between training development and delivery.

Training structure and learning outcomes

The training was structured in three levels, with trainees having to complete the previous level in order to be eligible to progress to the next. The course was accredited for 4 RCPI CPD credits & 5 NMBI CEU's on completion of the 3 levels. The training levels were:

- Bronze level, *Recognising and understanding the impacts of domestic abuse on women, a* 45-minute self-paced eLearning, focused on recognising domestic abuse and signposting support options available.
- Silver level, *Enquiring about and responding to women subjected to domestic abuse*, a 1.5 hour, facilitated online multidisciplinary group training, addressing how to enquire about and respond to abuse.
- Gold level, *Skills workshop facilitating and managing disclosures of domestic abuse*, 1.5 hour facilitated in-person multidisciplinary group workshop using case studies and role plays to allow participants to practice skills in managing disclosures. Participants apply their knowledge gained at silver level through practical exercises such as case studies and role-plays, developing skills to facilitate and manage DVA disclosures in a clinical setting.

Learning outcomes were developed in partnership with hospitals using Blooms taxonomy[81] and the Knowledge, Skills and Attitudes (KSAs) framework.

Staff were consulted on the content of 'silver' training; 100% were very satisfied with the course content, format of delivery, quality of facilitation and length of the course. For 'Gold', 100% agreed that roleplays aided learning, were realistic and relevant and learning could be applied to their jobs. Bronze training content was then designed to provide a foundation knowledge on DVA, it's impact on health and framing as a public health issue, its prevalence, forms, risks and impacts and clinical signs. Bronze was designed as a pre-requisite for access to silver training to be accessed as online self-paced eLearning. It was not intended to be a stand-alone 'basic' training.

Roll out of training

The pilot hospitals were consulted on the plans for roll out through multiple meetings. The training roll out was expanded beyond the original pilot sites (Coombe, NMH, CUMH and Rotunda) to include University Hospital Kerry (UHK) and St Lukes Kilkenny.

Bronze training was launched in November 2023 as part of the 16 days campaign. Women's Aid project coordinator attended staff meetings and events to promote the training throughout November and December 2023. A variety of staff in each site led the promotion of the training and facilitated staff time to avail of the training including Medical Social Work Team leads, Directors and Assistant Directors of Midwifery and service leads in other services (e.g. physiotherapy). The first silver online interactive facilitated training was delivered in January 2023, the first Gold in-person training was delivered in May 2024. The training offer closed in early July 2024.

[81] Bloom (1956). Taxonomy of educational objectives: Cognitive and affective domains.

The number of trainees in each pilot site is outlined in Table 10: Number of trainees in each pilot site.

Table 10: Number of trainees in each pilot site

	NMH	Coombe	Rotunda	CUMH	UHK	St Lukes	Total
Pre-Training Evaluation	102	78	100	61	66	19	426
Bronze eLearning Module	79	61	80	48	63	14	345
Bronze Evaluation	78	57	78	48	62	14	337
Silver Online Zoom Training	33	35	39	18	33	8	166
Silver Evaluation	29	18	27	16	30	7	127
Gold in person workshop	11	14	17	12	12	1	67
Gold Evaluation	5	8	12	8	9	1	43

Training context

At the time the maternity project was operating there were also two other national training initiatives rolled out that maternity hospital staff had access to. One was an eLearning module, "HSE Domestic, Sexual and Gender Based Violence (DSGBV) Training Module 1 – Awareness"[82], developed by the HSE for all HSE staff and staff from funded services. This eLearning module focused on raising awareness by providing information about domestic sexual and gender-based violence (DSGBV), prevalence and impacts along with information on national policy and legislation. The HSE training covered all forms of DSGBV not DVA specifically, nor was it specific to maternity services. Three further planned HSE eLearning modules will focus on recognising, responding and referring victims of DSGBV respectively.

The National Women and Infants Health Programme (NWIHP) also commissioned Women's Aid to deliver training to all 19 maternity units with training subsequently commissioned for gynaecology services. The NWIHP training was commissioned to begin while the co-designed Maternity Project training was still in development. The training delivered was an adapted version of Women's Aids existing "Three R's"; Recognise, Respond, Refer training. The training was adapted based on the literature review prepared for the maternity project[7], and relevant national guidelines. Adaptations included:

- Including information about the intersection of DVA and pregnancy in context slides
- Integrating questions about DVA and pregnancy throughout trainer manual and programme to aid trainers in integrating maternity unit/gynaecology specific focus and content
- Developing a case study and practice questions set in maternity units
- Developing a case study and practice questions specific to gynaecology services

[82] Health Service Executive (2024) Domestic Violence and Abuse. Strengthening Understanding & Awareness

- For maternity unit training, flagging each local DV service particular to the hospital group area.

This NWIHP training was offered as a single 3 hour online facilitated session and was rolled out between October 2022 and March 2024.

The key features of the Maternity Project Training that differed from the HSE and NWIHP training offers available were:

1. The co-design process represented one of Women's Aid's most in-depth collaborations with organisations receiving training in an effort to build a programme to meet their specific needs. This co-design process led to the development of bespoke content and learning outcomes designed to meet the specific needs of the maternity services.
2. The tiered approach of Bronze, Silver and Gold.
3. The blended learning approach with eLearning, online and in person interactive workshops offering information, skill building and an opportunity to practice practical application through role plays respectively.
4. Flexibility with delivery of training outside of normal training hours, including early mornings and evenings to accommodate expressed preferences of maternity services involved in the pilot.

Sources of data

To evaluate the training, we drew on data from multiple sources, both quantitative and qualitative, gathered between October 2023 to July 2024:

- A pre-training questionnaire completed by all trainees (380 valid responses), providing baseline insights before the commencement of the training sessions.
- Post-training questionnaires assessing the impact of training (The Bronze Award Training n=289 valid responses/84% response rate; The Silver Award Training n=118/ 71% response rate, and the Gold Award Training n=41/ 61% response rate), with these surveys conducted from October 2023 through to July 2024. The questionnaires were anonymous. We were unable to track individual respondents as they progressed through the training levels.
- A follow-up questionnaire sent to all trainees between two and four months after they undertook any of the training (n=24). Initially we planned to issue follow up questionnaires 4 to 6 months post-training but this was not possible in the time available for evaluation.
- Focus groups with the key staff involved in the project at two of the pilot sites in May 2024. Initially four were planned, one with each site, but low uptake at two sites meant two of a planned four focus groups were feasible.

- A survey for staff involved in the project (n=13, 34% response rate) conducted between May and July 2024, to capture views of those unable to attend the focus groups.
- An interview with both the Maternity Project Coordinator and Women's Aid Training and Development Manager.

First, we present the findings on the implementation of training, using five selected outcomes drawn from Procter's implementation framework (Acceptability, Appropriateness, Adoption, Feasibility and Sustainability). Findings on the impact of training are presented under the section heading 'Training impact.'

Implementation of Training

Acceptability

The extent to which people feel it is a good 'thing'

Overall, multiple sources of data indicated that training was highly acceptable.

Satisfaction with all three levels of the training was high. For trainees, 92% were very satisfied with the course content describing it as "excellent" and highly relevant. There was almost unanimous agreement among trainees that the training was relevant to their professional roles (98%).

> *"The course content was excellent and invaluable to me in helping me to deal with such issues in my day-to-day role as a midwife"*

Trainees in Silver and Gold often noted the positive impact of role plays on their learning, despite initial trepidation and in some cases dread at the thought of doing role plays with other trainees:

> *"The role play was excellent. To take time as the woman, worker and observer really hits home the impact DV has on the woman, how important our reaction to a woman's verbal and nonverbal ques are. Not to be afraid to ask direct questions where appropriate or to challenge the narrative and point out what type of abuse it appears to be, to the woman, from what she may describe"*

This sentiment reflects the overall very positive reception to the training, with many staff members appreciating the depth and relevance of the material covered. Post-training feedback indicated that 97% of respondents felt the training either met or exceeded their expectations and very nearly unanimous agreement that trainees would recommend the course to colleagues at all three levels (99.5%).

Trainees valued the **multidisciplinary** approach to training. Participants who availed of silver and gold training valued the ability to train with staff from other disciplines and/or on occasion with staff from other hospitals, allowing sharing of experiences and practices.

> *"The interactive session was extremely helpful and addressed sensitive areas. The sharing of knowledge from different disciplines and workplaces was very beneficial and learning was supported".*

Additionally, there was a call from some, trainees and staff, for making the training mandatory. This reflects the participants' belief in the importance of the training, despite the logistical challenges. However, this call for mandatory training was not universal. The main concerns were; the care of staff who may not be in a position to cope with the emotionally demanding nature of the training; the additional bureaucracy that comes with mandated training; that training may become a 'tick box' exercise and demotivate staff from fully engaging with DVA training. It is Women's Aid's firm view, that DVA can happen to **any** pregnant woman and ensuring that **all** relevant staff, not just those already motivated to do training themselves, have at least some form of mandatory training relevant to this health setting.

Appropriateness

The perception that the project is a good fit for the context

The collaborative approach taken by Women's Aid in designing the training was particularly well-regarded, as it enhanced the perception that the training was meeting specific needs in the pilot hospitals.

Pre-training questionnaires indicated a need for DVA training as just over half (52%) had not accessed any DV training in the past despite the widespread recognition that DVA training should be universally available to maternity services. Of those who had accessed prior training on DVA, 18% (73) had accessed training commissioned by NWIHP and delivered by Women's Aid, and 43% (169) had accessed other training in the past, for this group of trainees the majority felt this training was worth their time despite already having accessed other training.

The training was widely recognised as being highly appropriate and relevant to the hospital setting. The overwhelming majority of respondents (99.31%) found the course to be directly relevant to their work, underscoring the strong alignment between the training content and their professional responsibilities.

> *"I'm more informed and more equipped to recognise concerning signs of domestic abuse and I'm in an education role with new staff so will use this as an opportunity to bring this subject to the foreground in all interactions with families within the service".*

The Maternity Project training was provided to both maternity staff and medical social work teams in pilot sites. Research points to the benefit of joint educational programmes for health and social care professionals to support communication and understanding between these groups, for example with regards to child protection and confidentiality considerations[83]. We found that trainees valued working with other professional groups and sharing learning and good practice.

Concerns were raised regarding the tiered design of the training. The Bronze level, which primarily focused on foundational knowledge and recognising signs of DV without offering detailed guidance on how to

[83] Kirk & Bezzant (2020). What barriers prevent health professionals screening for domestic abuse? A literature review.

respond or make referrals, was perceived as inadequate by some participants. There was a strong call to "close the circle" within that level of training by providing more comprehensive guidance so that participants felt equipped to handle DV cases from recognition to referral. This call appears to be at odds with the design of the tiered approach where bronze was deliberately conceived as a pre-courser to silver training with the goal of all clinical staff availing of bronze and silver at a minimum and staff with a particular interest in DVA or those whose role involves working with women at risk of DVA, would access the gold training. There were some calls to redesign the offer to have bronze as a basic level of training that covers the full circle, albeit in more limited depth while then combining silver and gold content to be pitched at a more 'advanced' level.

The pre-training questionnaire responses also indicated that trainees were primarily seeking to improve their ability to recognise signs of domestic abuse, increase their confidence in addressing the issue, and enhance their communication skills with women who may be experiencing DVA. Respondents expressed a desire to feel more assured when discussing or handling domestic abuse situations, aiming to better identify indicators and facilitate disclosures effectively. They are also keen on expanding their knowledge and awareness about domestic abuse, including up-to-date information and best practices, to provide appropriate support and interventions. Furthermore, participants want to understand the available support services and the correct procedures for referring women to these resources. There is a strong emphasis on learning about the management pathways and gaining practical skills that can be applied in real-world scenarios to help women in abusive situations. The achievement of these goals would only be possible through undertaking bronze and silver training at a minimum as currently designed.

The emotional impact of the training posed significant challenges, particularly for staff who had recently experienced traumatic events, highlighting the need for additional support mechanisms within the training framework.

The need for practical application tools was also highlighted, with participants suggesting the provision of pocket-sized cards to guide staff in asking sensitive questions about DVA. These resources would help to bridge the gap between training and real-world application, ensuring that staff can effectively implement what they have learned.

Overall, the training was considered a vital tool to empower healthcare professionals, especially midwives, by providing them with the necessary skills and knowledge to effectively support and manage cases of domestic abuse in their work environments.

Adoption

The extent of uptake and utilisation of the intervention within a service

Adoption of the training programme was bolstered by a co-design approach that facilitated buy-in and commitment from participants. Individuals that championed the project were also crucial, as they actively promoted the training and encouraged participation among their peers and wider professional network in

their hospital. These champions were found in both staff who were already keen to improve their service's approach to DVA and those who became champions as a result of engagement with the project in co-design or as a trainee. Champions' reach however is sometimes limited to the service they primarily work within.

Trainees valued the multidisciplinary approach to training however uptake of training varied by clinical role. Medical Social Workers were most likely to avail of training with 4 in 5 availing of the training offered. Midwives are a key professional group, with on average, 1 in 6 availing of the training. Doctors were least likely to avail of training. Hospital C was particularly successful in securing multidisciplinary engagement with the project overall, which resulted in greater uptake across all professional groups with notable success with 1 in 10 doctors engaging with the training offer compared with 1 in 50 in the other sites where data on staff numbers was made available.

Table 11: Percentage of staff in each role that accessed any training

	Hospital A*	Hospital B	Hospital C	Hospital D
Doctor (consultant/NCHD)	-	2%	10%	2%
Nurse	-	13%	6%	2%
Midwife	-		16%	16%
HCA	-	12%	9%	3%
Social Worker	-	86%	73%	100%
Other	-	2%	-	-

*Hospital A was unable to provide data on number of people in each role, so we were unable to calculate the percentage of staff in each role that attended training.

Despite the success of champions, the overall uptake of the training was lower than anticipated across all pilot sites by both Women's Aid and the maternity hospital staff involved in its development. Champions of the project were particularly disappointed by the low uptake despite significant effort being expended on training design and promotion. We identified three main barriers to more widespread uptake: time, staffing pressures, and the rollout of two other training offers on DVA during the maternity project (HSE Land online training on DSGBV and NWIHP commissioned training delivered by Women's Aid and rolled out between October 2022 and March 2024).

Time was seen as the most important barrier. The training was designed to try to make it as accessible as possible by developing some of content into online self-paced learning (bronze) to reduce the amount of scheduled training time required for silver and gold levels. Despite this, trainees still struggled to make time for training in a busy service, with just under half (47%) undertaking some online training in their personal time. Service managers also noted the difficulty of freeing staff to attend training, needing long lead time to release staff while maintaining safe staffing levels. They also noted the time cost associated with 'giving back' time off for time spent on training outside of normal shifts.

Towards the end of the project there was a notable increase in demand for training as those who intended to avail of it rushed to sign up before it was no longer available. This is at odds with comments from services that the roll out of training was too short and needed more time to build momentum and engage more staff. It may be that those who availed of training represent those keen early adopters, and more time and effort may be required to support a wider rollout.

The contemporaneous rollout of training via HSE Land and NWIHP commissioned training delivered by Women's Aid was believed to have had an impact on adoption. Multiple sources indicated that staff were confused about what training they should do, what they had already done and a sense that accessing one of these trainings was sufficient.

Some trainees noted practical challenges such as difficulties accessing the online training portal with a small minority reporting confusion over where to access online training (via hospital logins, HSE Land or via Women's Aid platform).

The idea of making DVA training mandatory also emerged in this context, with many respondents across all levels advocating for some DVA training to be compulsory for all maternity staff. This was seen as essential not only for ensuring widespread adoption but also for promoting a consistent and standardised approach to DV recognition and response across the hospital setting. Again, this was not a unanimous view and was largely limited to mandating 'bronze' level training or similar to equip staff with a basic level of knowledge and competence. One site expressed a view that DVA training should be mandatory within that hospital but not at a national level. This may be, in part, due to the perceived bureaucracy associated with a national mandate and the greater ability of individual hospital sites to manage competing demands to facilitate the hospital's own internal priorities for staff development. Another site felt the opposite, that training in DVA should be mandatory nationally but that their service already had sufficient staff trained that would not need to mandate training in their service.

There was also some disagreement regarding the optimal format for the training. While some participants advocated for a single, intensive full-day session, others preferred the current, more staggered approach, which they felt allowed for better management of the emotionally charged content.

Feasibility

'This was practical and feasible for us to do'

The feasibility of the training programme faced significant challenges, primarily due to the demanding schedules of hospital staff, many of whom work in shift patterns. While the content of the training was well-received, the timing and format of the sessions often posed significant barriers to participation. For example, feedback from the Gold-level training indicated that 41% of participants struggled to find the time to engage with the training. Some participants suggested that a more condensed training model might be more practical, allowing for greater flexibility and reducing the time commitment required.

The concept of mandatory training also posed feasibility concerns generating disagreement between different focus groups, particularly regarding how to accommodate such a requirement within the limited time slots available, especially for part-time staff. Participants suggested that offering more self-paced learning options and tailoring the training more closely to specific job roles could make it more accessible to a wider range of staff.

There was a recognised need for practical tools to assist in the application of the training amidst regular duties, ensuring that the learning could be feasibly integrated into the daily routines of hospital staff without causing significant disruption.

Sustainability

Can we keep doing this?

Sustainability emerged as a key concern for the future of the training programme. While there was a strong desire among participants for the training to continue, its long-term viability will depend heavily on embedding the practices learned into routine hospital operations *and* securing additional resources to enable Women's Aid to continue to deliver training, to invest time in promoting the training and to ensure it is kept up to date in collaboration with maternity services. Resources are also required to allow hospitals to release staff to attend training.

The proactive involvement of the Women's Aid Maternity Project Coordinator and the engagement of advocates for addressing DVA within the hospital were together deemed necessary for ensuring the sustainability of the programme. The project set up and co-design process would not be possible without a dedicated role/resource of a coordinator. The project coordinator role was funded by Women's Aid. Further roll out of training with a co-design approach to training development and implementation would require further funding for this role.

Ongoing support from the hospitals is needed to enable trainees to embed learning into routine practice, removing organisational and service level barriers. For example, a move to telephone-based booking appointments makes it impossible for DVA screening questions to be asked safely. Trainees indicated that a lack of private space and partner presence in busy clinical settings remains a barrier to implementing the learning. Trainees also indicated a need for prioritised time within appointments to enable screening conversations.

Persistent time constraints and variability in available resources were seen as potential threats to maintaining the programme without additional support. To counter these challenges, maternity staff recommended that efforts be made to secure funding through reviews of national strategies or by integrating the training costs into ongoing operational budgets. Ensuring that the necessary resources, such as practical tools and guidance, are readily available will also be crucial for sustaining the training's impact.

Incorporating DV training into early education for healthcare professionals was another suggestion from hospital staff to embed critical skills in addressing DVA from the outset of their careers, thereby contributing to the long-term sustainability of DV awareness and response within the healthcare sector. Similarly, hospital staff suggested that the induction of new staff may be an opportunity to embed DVA training and maintain high levels of staff knowledge over time. Trainees and clinical leads also called for periodic refreshers of training every 2-3 years to maintain standards and update on current guidelines and good practice in supporting women.

Training impact

The impact of training was assessed through questionnaires completed by trainees, focus groups and interviews as well as hospital data on screening and referrals.

Impact on staff

The training programme had a positive impact on the staff's preparedness to recognise and respond to DV cases within the hospital setting with evidence of a progression for the training cohort overall, through the three tiers of training in trainees self-rated preparedness to identify indicators of DVA, recognise DVA, ask about DVA, respond to disclosure, refer women to specialist support and refer women to support within the hospital.

> *"I feel more confident discussing domestic violence and informing women what domestic violence is and the support available from Women's Aid".*

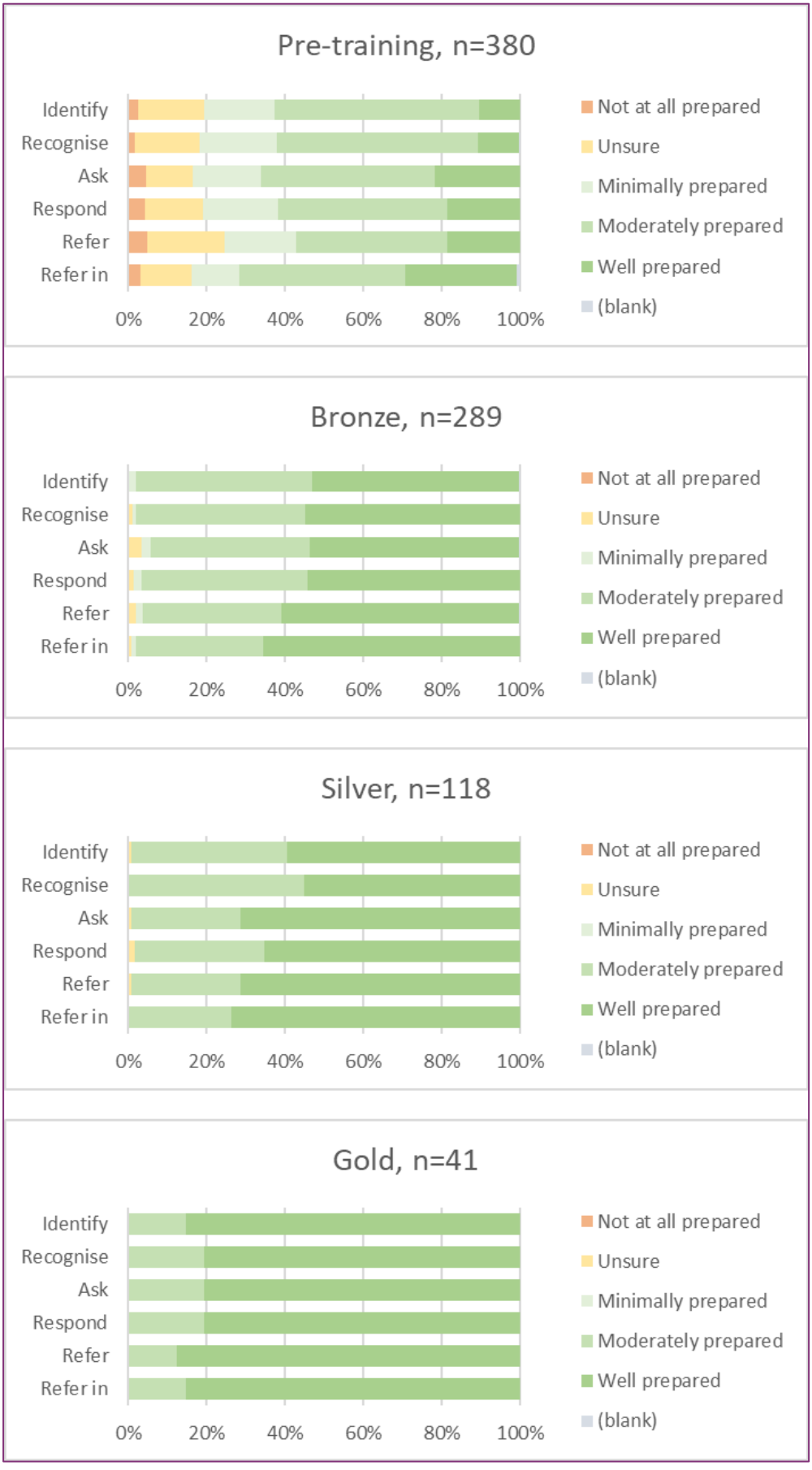
Trainees were asked to rate how prepared they feel to:

- identify indicators of domestic abuse based on a woman's history
- recognise when a woman attending the maternity service may be experiencing domestic abuse
- ask a woman attending the maternity service about domestic abuse
- respond to a woman who discloses domestic abuse while attending the maternity service
- refer a woman for specialist domestic abuse support
- refer a woman experiencing domestic abuse to support within the hospital

Error! Reference source not found. show the percentage of respondents who felt not at all prepared, u nsure, minimally prepared, moderately prepared, or well prepared in the pre training and post training questionnaires for the Bronze, Silver, and Gold. The figures indicate a marked positive progression for the training cohort overall through the three tiers of training. On average, prior to training 18% felt well prepared, this markedly improved with training to 57% following bronze, 66% following silver and 83% following gold.

We were unable to track individual progress through the training tiers. It may be that those who access higher tiers of training are a self-selecting group who already have greater preparedness, however examples of improved practice from training participants and observations of staff and service managers indicate that the apparent progression in preparedness is attributable to training. The strongest impacts emerging from the qualitative data was the increased awareness among staff, leading to quicker identification of signs and a more proactive approach to referrals. Participants reported a deeper understanding of the complexities surrounding DV, particularly the barriers that women face in accessing medical appointments. Staff felt that this heightened awareness translated into more empathetic and informed interactions with patients, allowing staff to better support and safeguard those at risk. Staff also expressed that the training empowered themselves/their trained colleagues to ask more direct questions about home situations.

Figure 4: Impact of training on preparedness to identify, recognise, ask about, respond to DVA and refer to support



This is reflected in the data from the follow-up questionnaire, indicating that 83% of participants agreed they have made noticeable positive changes in their approach to handling DV cases, noting greater confidence in discussing DVA, asking more direct questions, more often not just the mandatory screening questions at booking.

> *"I am more conscious asking about DV now and try not to quickly skim over it."*
>
> *"More aware of ongoing DV questioning, not just at first appointment."*
>
> *"Very aware of the importance of directly explaining and asking all women about domestic abuse."*

Many participants noted that they felt more equipped to recognise the signs of DV and to offer the necessary support and guidance to affected women. The training provided practical skills and knowledge that could be immediately applied in real-world settings, which was frequently highlighted as a key benefit. This immediate applicability underscores the training's effectiveness in not just educating staff but also in preparing them to take meaningful action to improve practice.

> *"I found the course very informative helpful and relevant to my work. I feel empowered to help women experiencing domestic violence as I am now fully aware of the services of Women's Aid".*

Service level

We found early indications that the training has had a positive impact on the relatively modest numbers of staff who availed of some training (an average of 8% of clinical staff, not including medical social workers where 86% accessed some training).

It is unrealistic to expect training to have created a major shift in service/organisational practices at this early stage but the overwhelmingly positive reception to the training by trainees and service managers is very encouraging.

We did find some evidence that the multidisciplinary nature of training led to improvements in how physiotherapy services in one hospital improved their processes for 'no shows' at appointments as a result of greater awareness of the possibility that DVA perpetrators may prevent women from attending appointments. This same service also adopted awareness raising materials in their spaces (waiting areas/clinical rooms/bathrooms) as a direct result of attending training with colleagues from other services.

The training was seen as so beneficial that there were calls from some trainees to extend its reach beyond maternity staff to include other healthcare professionals, such as general practitioners, practice nurses, public health nurses, and emergency department staff. This feedback indicates a perception of the broader applicability of the training. Hospital staff cautioned against moving too quickly to a wider rollout to other health care settings, suggesting that it would be better to 'get it right' in maternity settings first given the significant barriers to training uptake within maternity services. This reflects difficulty with implementation

within a busy hospital environment rather than issues with the training content or the approach to co-design training with services.

Reflections from staff involved in the rollout of the training indicated that they have observed some excellent examples of improved practice. There is a strong sense from medical social workers that staff are more willing to discuss DVA, are coming to them more often with queries and are having more conversations with women about DVA.

While the training supported important positive changes in individual staff approaches to DV, some challenges at a service/hospital level were noted that could hinder its long-term effectiveness. Issues such as insufficient time allocated for appointments and lack of private space need to be addressed to enable staff to apply their learning. Language barriers and occasional difficulty accessing translation services is an important barrier that is still present and affects some of the most marginalised women. Practices, such as telephone booking appointments, make screening at booking more challenging and has negatively impacted recorded screening rates.

Despite these challenges, the training was perceived as normalising discussions about DV within the hospital environment, contributing to a shift in culture that prioritises the safety and well-being of victims. Moving forward, it is crucial to build on the initial progress made, ensuring that all staff receive ongoing training and support, and that the hospital environment remains responsive to the needs of DV victims. Addressing these challenges will be essential to sustaining and enhancing the observed positive impact of the training.

Summary of training findings

The training programme for maternity services staff was developed collaboratively with input from healthcare professionals across various disciplines. It was designed to provide comprehensive knowledge and practical skills for recognising and responding to domestic violence and abuse within maternity care settings. The training was structured into three progressive levels: bronze, silver, and gold. The bronze level offered foundational knowledge through self-paced e-learning, the silver level included interactive online sessions on sensitive communication, and the gold level provided advanced in-person workshops focusing on practical application in clinical environments.

The training programme aligns with the policy landscape, particularly the **National Clinical Practice Guideline Screening and Management of Domestic Violence in Pregnancy and the Early Postnatal Period**[8]. This guideline underscores the importance of ongoing education and training for all maternity staff in recognising and responding to domestic violence. It mandates training on domestic violence awareness, screening, recognising signs, responding appropriately, and making referrals for all midwives, nurses, doctors, and healthcare professionals working in maternity settings.

The training improved participants' preparedness to recognise the signs of DVA, ask women about DVA, respond appropriately to a disclosure and refer to appropriate supports, with notable progress as staff advanced through the training tiers.

While the programme showed clear benefits, there were challenges in fully integrating it into hospital operations, such as ensuring the availability of private spaces and adequate scheduling for staff to apply their training.

Participant feedback was highly positive, particularly regarding the interactive elements such as role-plays, which were seen as effective in enhancing learning. However, despite the strong positive reception, uptake was slow, largely due to time constraints and other demands on hospital staff. Despite the challenges in availing of the training posed by time constraints, the training was still deemed highly acceptable, indicating that the primary issue was not with the quality of the content but rather with the feasibility of participation given the demanding schedules of the staff.

The programme's success was also seen to be dependent on ongoing support and sufficient resources within the maternity hospitals and from Women's Aid to maintain its implementation.

There was a growing call for the training to be made mandatory, although there was not a consensus on this point.

At the time of writing this training programme has ended and there is no funding in place to continue its roll out.

Training Recommendations

Based on our findings we recommend that:

- This training be rolled out further with adaptations to the structure and delivery to improve feasibility and adoption and in continued partnership with hospitals. Consider the balance needed between appropriateness (training that is excellent, in-depth) and feasibility (accessible for large numbers of maternity staff in the context of time and staffing pressures).
- Sufficient funding is provided to Women's Aid to deliver an adapted programme of work and resourcing provided to maternity services to enable staff to be released for training.
- Senior leaders in partner maternity hospitals commit to working with Women's Aid to address the barriers to training uptake and application of learning identified in this evaluation.
- Hospitals identify, resource and support champions to lead the adoption of training across all services, roles/disciplines and types of care to address the gaps in training uptake.
- Any further roll out should include monitoring and evaluation of its impact within services. The evaluation of this pilot provides evidence that the training content is excellent, and early indications

suggest that it has had a positive effect on individual trainees' practice. Impact at a service level is not yet evident given the short time the training was available for.

- HSE/NWIHP provide funding to support further roll out and evaluation of the training in partnership with Women's Aid, building on the existing resources and insights gained through Women's Aid's and pilot partner hospitals investment in the co-design and delivery of this high-quality training. This is in line with National Clinical Practice Guidelines that there should be mandatory training for all Midwives, Nurses, Doctors and Health and Social Care Professionals and students working in maternity settings.
- Any rollout of training retains the multidisciplinary approach to training different professional groups together, potentially jointly delivered with MSW where feasible.
- Hospitals and Women's Aid consider adopting a training model similar to the 'Children First' approach, which provides a basic but comprehensive training programme that is widely accessible, potentially through online self-directed learning, and mandatory for all staff. This could be supplemented with more detailed training for those in direct contact with women and advanced training for individuals with designated responsibility for DVA.
- Realistic timelines and allocation of resources are adopted for any further rollout of training. Those who availed of training to date may represent keen early adopters and more time and effort may be required to support a wider rollout to those with more pressing priorities.

Training on DVA can be emotionally and psychologically challenging for trainees. Care needs to be taken when rolling out DVA training that time is allocated to after training to deal with this emotional impact, and appropriate support and care for staff is in place, particularly for those who may have personal histories or current experiences of DVA.

It is crucial to consider the needs of staff with personal experiences of domestic violence and abuse. However, the risk of triggering staff should not be a reason to avoid mandatory training. In fact, mandatory training could provide a valuable opportunity to support and empower employees, providing them with information and referral pathways for themselves, particularly given the new statutory provisions for domestic violence leave. Given the high prevalence of DVA among healthcare professionals, providing this training may help with self-identification of abuse and ensure staff are equipped to support others appropriately. While exceptions should be available for those in the midst of a domestic violence situation, this process should also open a pathway for employers to provide support to affected staff.

- Consider the emotional and psychological impact of DVA training on trainees and ensure appropriate support and exemptions are in place for those who need it.

Training content was consistently deemed to be excellent. Suggested enhancements included:

- Continue to include practical, scenario-based learning and role-plays

- Review the duration and frequency of training sessions, to balance comprehensive coverage with feasibility for staff to access training.
- Address challenges related to finding time and private space for eLearning and online training
- Provide ongoing support and resources, including continuous professional development and refresher courses.
- Consider incorporating content on any new screening questions adopted in response to new clinical guidelines on screening and managing DVA[8] and the importance of adequate coding of responses in electronic health systems.

Asking about DVA in pregnancy is viewed as acceptable by most women, but research has indicated low rates of DVA screening by GPs and public health nurses, despite their key role in antenatal and postnatal care pathways. If policy objectives for perinatal DVA are to be met, these other healthcare professional groups will need to be involved in receiving similar training to those working in maternity hospitals and units.

- HSE/NHWIP to consider commissioning the roll out of this training to other health professionals who are in contact with women during pregnancy. Any further roll out beyond maternity hospitals should include funding for co-design/adaptations to training to fit within each new service context/needs/constraints.

Overarching recommendations

The evaluation of the implementation and impact of Women's Aid Maternity Project has identified learning that will inform the future of the project itself and has wider implications for the approach to DVA in maternity settings. Here we summarise recommendations for the future of the project and its components based on a combination of the existing research evidence and national and international policy and guidelines[7], the data gathered for this project and specific recommendations shared by maternity staff as experts in their own needs and those of the service they work within.

- Any future development or rollout of the Maternity Project should be informed by the policy context. For example, there are a range of relevant deliverables that are being progressed through the implementation the National Domestic, Sexual and Gender-Based Violence Strategy 2022-2026[4] (e.g. the roll out of a Make Every Contact Count (MECC) training programme for all staff in maternity hospitals/units, the development of a business case for a minimum of 1 dedicated SW in maternity hospitals/units etc)[84] which may present opportunities for Women's Aid and the Maternity Project to work with policy makers to deliver on these objectives, drawing on their experience, investment, products and learning from the Maternity Project.

HSE policy is that all women are screened for DVA during the recording of their history ('the booking visit') with the maternity service. Hospital data obtained in this evaluation indicates that this is not consistently occurring.

- All maternity hospitals to review their practices in screening and recording of screening for DVA to identify any barriers to asking about DVA and recording that screening has taken place. This is in line with auditing requirements outlined in the National Clinical Guidelines[8].

The focus of DVA screening in maternity services is at the booking appointment, but some women may not be ready to disclose at this first appointment. Maternity care staff need to be trained to recognise signs of DVA and to ask about it at other timepoints in women's antenatal or postnatal care pathways. Our survey respondents were strongly in favour of women being asked about DVA frequently at their appointments with maternity services.

- Expand DVA screening beyond the booking appointment.

Our survey findings indicated that women attending private maternity services are less likely to be asked about DVA. Our survey numbers were small, and caution must be taken in generalising from the survey data but focus group participants expressed similar concerns about the lack of identification and referrals of DVA in these settings. Data from hospitals also indicate that screening and referral from private and semi-

[84] See the Overview of the Policy Context section for details of deliverables relevant to the Maternity Project

private services is extremely low and data collection in these services is poor. DVA does not discriminate, any woman can be subjected to DVA by a perpetrator. It appears that work is still needed to dispel the myth that those who can afford private care are 'somehow immune' to DVA.

- Hospitals to work to close the gap in DVA awareness, identification and support for women attending private services.

Women subjected to perinatal DVA may be dealing with multiple and complex adversities and maternity care professionals need to be able to recognise risk for, and indicators of, DVA in situations where women may be experiencing challenges around mental health issues, substance use, disability, or other stressors. There remain structural barriers to accessing support for women from minority ethnic communities; including discrimination and poor treatment from healthcare staff; language and communication barriers, and economic, housing, and legal insecurities. While these structural barriers are outside of the remit of the Maternity Project, healthcare staff need to be aware of the multitude of challenges that some women may face in accessing support for DVA, and how services can enhance their response (e.g., ensuring accessible interpretive services in appointments, staff training in intercultural awareness and inclusive practices).

- Maintain awareness and understanding among staff of the complex adversities and structural barriers women subjected to DVA may face and the impact of these on their ability to access care and support

While psychological abuse is the most prevalent type of abuse, the indicators of psychological abuse can be difficult for healthcare professionals to identify and for women themselves to recognise. Qualitative responses to our survey and evidence from existing research, recommended that staff in maternity services are trained to recognise signs of psychological abuse and improve understanding of coercive control and the behaviours that constitute domestic abuse.

- Focus on improving awareness and understanding of coercive control and non-physical abuse.

In our survey, fear and shame appeared to be key factors preventing disclosure (including fear about the involvement of child protection services), along with a belief that the service would not know how to help. When asking questions about DVA, staff may need to explain to women about the support options available, and to communicate sensitively about the role of social workers (and the Outreach Support Service where available) in providing support for the impacts of DVA and for protection of the unborn baby and other children. Training needs to help develop and enhance practice, where possible, in building trust and empathic support between maternity care professionals and the women in their care. The research literature indicates that disclosure is more likely to be supported when healthcare professionals use a non-judgmental tone and sensitive language when screening for DVA[85]. Women may also need to be reassured

[85] Creedy et al. (2020) A cross-sectional survey of pregnant women's perceptions of routine domestic and family violence screening and responses by midwives: Testing of three new tools.

about confidentiality when questions about DVA are being asked. Our survey indicated that the strongest encouraging factor for disclosure was respondents' belief that their information would be kept confidential.

- Continue to work to remove or reduce barriers to screening and disclosure identified (see Table 1) and enhance enablers at system, organisation, staff and individual levels.
- Develop a specific care pathway for Traveller and Roma women in the maternity service, with staff who are trained to support Traveller and Roma women.

Sustaining improvements brought about by the maternity project in the approach to DVA requires institutional support for ongoing training, workplace champions, flexibility with appointment times, opportunities for debrief sessions with colleagues, and updated service protocols and guidelines in line with changes to the law and policy context.

- Hospitals to commit to building on the enablers and strengths already in place while also addressing structural barriers to improving the approach to DVA at service and organisational level. This will require senior leadership to prioritise DVA, lead and support this work.
- Maternity hospitals to address the specific barriers identified that removes the ability to safely discuss DVA with women; a lack of private space, partner presence and language barriers including access to translation services when needed.

Throughout this evaluation it was evident that co-design was a powerful route to creating interventions that were acceptable, appropriate and impactful.

- Integrate co-design approaches into any wider rollout of the project, in whole or in part, to other maternity services or into other healthcare settings, including the perspective of survivors.
- Funders to acknowledge the value of co-design and provide specific funding to enable this resource intensive approach, including a dedicated coordinator role to lead and manage the process.

Summary of recommendations

HSE/State bodies/ funding bodies

The project overall

- Funding to continue the project and build on the resources developed should be made available to Women's Aid and participating hospitals by HSE or relevant state bodies.
- Funders to acknowledge the value of co-design and provide specific funding to enable this resource intensive approach, including a dedicated coordinator role to lead and manage the process.
- Any future development or rollout of the Maternity Project should be informed by the policy context. For example, there are a range of relevant deliverables that are being progressed through the implementation the National Domestic, Sexual and Gender-Based Violence Strategy 2022-2026[4] (e.g. the roll out of a Make Every Contact Count (MECC) training programme for all staff in maternity hospitals/units, the development of a business care for a minimum of 1 dedicated SW in maternity hospitals/units etc)[84] which may present opportunities for Women's Aid the Maternity Project to work with policy makers to deliver on these objectives, drawing on their experience, investment, products and learning from the Maternity Project.
- Any extension of the project to other health settings (GPs, emergency departments, public health nursing) should build on the resources developed and the learning generated.
- Any extension of the project should first consider the feasibility of implementation in new contexts or services.

Awareness Raising

- Funding to continue to deliver the annual 16 days campaign should be made available to Women's Aid and extended to allow hospitals to work with Women's Aid to create more opportunities to bring focus to DVA in pregnancy, not limited to 16 days campaign. This can help to keep those championing DVA awareness remain energised and prompt a review of materials placement and distribution and provide *'an excuse'* to keep talking about DVA.
- Specific funding is provided to translate materials into different languages, tailored to the needs of the hospital/local catchment area.

Outreach Support Service

- The Outreach Support service should be continued, and appropriate funding provided to Women's Aid to maintain this service by HSE/relevant state body. This should include sufficient resources to

enable the service to maintain same-day response for women referred, manageable caseloads and the excellent quality of the service for women.

- Support a feasibility assessment to determine if the outreach support service model is transferable to other settings e.g. hospitals without a dedicated Maternity Setting, hospitals that lack maternity social workers or DVA specific social workers, smaller units in rural areas etc. and informed by an understanding of the wider policy context and existing initiatives (e.g. business case for medical social workers, plans to develop referral pathways to community social work support, training and existing processes and support for women subjected to DVA). This would require sufficient resource for Women's Aid and commitment from hospitals to engage in co-design of the service that could be implemented within each new service context.
- ongoing review and evaluation of the implementation of the service in other contexts to inform an understanding of its impact.

Training

- Sufficient funding is provided to Women's Aid to deliver an adapted programme of work and resourcing provided to maternity services to enable staff to be released for training.
- HSE/NWIHP provide funding to support further roll out and evaluation of the training in partnership with Women's Aid, building on the existing resources and insights gained through Women's Aid's and pilot partner hospitals investment in the co-design and delivery of this high-quality training. This is in line with National Clinical Practice Guidelines that there should be mandatory training for all Midwives, Nurses, Doctors and Health and Social Care Professionals and students working in maternity settings.
- HSE/NHWIP to consider commissioning the roll out of this training to other health professionals who are in contact with women during pregnancy. Any further roll out beyond maternity hospitals should include funding for co-design/adaptations to training to fit within each new service context/needs/constraints.
- Any further rollout should include a robust evaluation adopting an experimental design.

Maternity Data systems

- MN-CMS and other data systems used by maternity hospitals nationally add a code for recording if DV enquiry has been made/prompt for DV enquiry at all appointments, not just booking.
- MN-CMS and other data systems used by maternity hospitals nationally use the codes outlined in the new National Clinical Guidelines on Screening and Managing DVA in pregnancy to enable adequate monitoring and evaluation of DVA disclosure or concerns about DVA. Auditable standards in the guideline include:

    - Number of women screened for DV at Antenatal booking appointment
    - Number of women with outcome of DV screening recorded on her chart
    - Number of V1 responses
    - Number of women referred to MSW
    - Types, severity and complexity as per MSW records
    - Number of presentations to maternity hospital/unit following disclosure of DV
    - Number of women with postnatal screening for DV
    - Number of cases of DV referred to GP and PHN following disclosure on discharge.
- data recording systems include a way to capture at what point in pregnancy a referral was made to MSW so that monitoring of progress towards earlier identification of women in need of support can be undertaken more easily.

Maternity hospitals

- All maternity hospitals to review their practices in screening and recording of screening for DVA to identify any barriers to asking about DVA and recording that screening has taken place. This is in line with auditing requirements outlined in the National Clinical Guidelines8.
- Expand DVA screening beyond the booking appointment.
- Hospitals to work to close the gap in DVA awareness, identification and support for women attending private services.
- Maintain awareness and understanding among staff of the complex adversities and structural barriers women subjected to DVA may face and the impact of these on their ability to access care and support
- Focus on improving awareness and understanding of coercive control and non-physical abuse.
- hospitals monitor the rate of screening, disclosure and referral by care type to identify and act on any gaps in DVA practice.
- hospitals continue to use computer aided data collection systems that provide prompts to support DVA screening and recording of screening.
- hospitals adjust their data capture systems to include the ability to differentiate between instances were DVA screening questions were not asked, asked but not recorded or asked but the women declined to answer.

- CUMH review their practice of telephone booking appointments and DVA screening and take appropriate action to address the very low recorded rates of DVA screening.
- hospitals commit to ongoing monitoring of DVA disclosure and referrals.
- hospitals review and adjust the IT systems so that ongoing monitoring of DVA disclosure and referral does not require manual review of individual cases.
- hospitals review their processes for monitoring and responding to DVA disclosures to ensure that every woman who make a disclosure of DVA is offered support.
- hospitals commit to supporting MSW team to review screening and referral data easily to identify any missed opportunities for support to be offered and ensure that all women who make a disclosure of DVA are referred to MSW.

The project overall

- The project should continue with adaptations to respond to the learnings from this evaluation.
- Any continuation of the project should include monitoring of uptake and impact by both Women's Aid and partner hospitals.

Awareness Raising

- Hospitals make a concerted effort to address gaps in the reach of awareness raising materials into private and semi-private maternity settings.
- All maternity hospitals disseminate and support the reach of materials into all services that women come into contact with throughout the perinatal period. The journey map highlights additional services where materials could be disseminated in hospitals (e.g. antenatal education materials, phlebotomy, physiotherapy, dietetics) and in community settings (GPs and other community health settings).
- Hospitals to maintain year-round visibility of materials throughout all services.
- Hospitals commit to regular review of all services that women may be in contact with to ensure that services have the materials, that staff are aware of them, particularly in teams with high turnover of staff, and that materials are consistently on display and visible to women and staff members.
- Partner hospitals and Women's Aid identify, train and support champions within services to lead on maintaining year-round visibility of materials and creating more opportunities to focus on DVA, not limited to the 16 days campaign.
- Women's Aid and/or hospitals to consider developing and maintaining a repository of awareness-raising materials for the Maternity Project may be a useful way for new staff to access materials that are available to use. This could also contain ideas from across sites of ways that information has

been shared with women, e.g., one hospital advocated including DVA awareness raising materials in the information folders at the booking appointments.

Training

- Senior leaders in partner maternity hospitals commit to working with Women's Aid to address the barriers to training uptake and application of learning identified in this evaluation.
- Hospitals identify, resource and support champions to lead the adoption of training across all services, roles/disciplines and types of care to address the gaps in training uptake.
- Any rollout of training retains the multidisciplinary approach to training different professional groups together, potentially jointly delivered with MSW where feasible.
- Hospitals and Women's Aid consider adopting a training model similar to the 'Children First' approach, which provides a basic but comprehensive training programme that is widely accessible, potentially through online self-directed learning, and mandatory for all staff. This could be supplemented with more detailed training for those in direct contact with women and advanced training for individuals with designated responsibility for DVA.
- Consider the emotional and psychological impact of DVA training on trainees and ensure appropriate support and exemptions are in place for those who need it.
- Continue to work to remove or reduce barriers to screening and disclosure identified (see Table 1) and enhance enablers at system, organisation, staff and individual levels.
- Develop a specific care pathway for Traveller and Roma women in the maternity service, with staff who are trained to support Traveller and Roma women.
- Hospitals to commit to building on the enablers and strengths already in place while also addressing structural barriers to improving the approach to DVA at service and organisational level. This will require senior leadership to prioritise DVA, lead and support this work.
- Maternity hospitals to address the specific barriers identified that removes the ability to safely discuss DVA with women; a lack of private space, partner presence and language barriers including access to translation services when needed.

Women's Aid

The project overall

- The project should continue with adaptations to respond to the learnings from this evaluation.
- Any continuation of the project should include monitoring of uptake and impact by both Women's Aid and partner hospitals.

- Integrate co-design approaches into any wider roll-out of the project, in whole or in part, to other maternity services or into other healthcare settings, including the perspective of survivors.
- Women's Aid continue to provide high-quality co-designed awareness-raising materials to maternity services.
- Future review/co-design of new resources includes the perspective of survivors who have experienced DVA in the perinatal period.

Awareness raising

- Partner hospitals and Women's Aid identify, train and support champions within services to lead on maintaining year-round visibility of materials and creating more opportunities to focus on DVA, not limited to the 16 days campaign.
- Women's Aid and/or hospitals to consider developing and maintaining a repository of awareness-raising materials for the Maternity Project may be a useful way for new staff to access materials that are available to use. This could also contain ideas from across sites of ways that information has been shared with women, e.g., one hospital advocated including DVA awareness raising materials in the information folders at the booking appointments.

The awareness raising materials produced were seen as very good already. Suggestions for further enhancement from maternity staff included:

- Create more awareness raising materials that focus on facts about DVA in pregnancy and postnatally as these were viewed as particularly useful for multiple audiences.
- Creating durable physical reminders/prompts such as credit card sized information or laminated prompts for screening questions or signs of DVA.
- Consider resources that could be safely included in information packs distributed at booking and at discharge. Suggestions include adding a QR code to link to information, resources and support for women.
- Create more video-based content is developed for display screens in hospital settings. This should be co-designed with maternity services and made available on a national basis.
- Focus on making materials even more visually engaging. Including women in co-design could support this.
- Ensure materials are regularly updated, incorporating feedback from both staff and patients and up to date evidence to enhance relevance and effectiveness.
- Continue to emphasise the non-physical signs of abuse, creating specific leaflets/resources to help women to recognise abuse that is not physical. This recommendation from staff echo the evidence

that women were often unaware that their relationship was abusive and that it took them time and support to recognise coercive control.

Outreach support service

- Women's Aid work with the MSW departments to analyse trends in rates of detection and referral to inform understanding of the demand for the outreach support service and enable Women's Aid to seek out funding to meet resource requirements
- Continued access for the OWs to Women's Aid line management as well as monthly clinical supervision
- Women's Aid consider the suggestion from a medical social worker to bring the three Dublin hospitals together on a regular basis to share learning and ideas about how they could make best use of the outreach support service.
- Women's Aid to secure funding to commission a feasibility assessment to determine if the outreach support service model is transferable to other settings e.g. hospitals without a dedicated Maternity Setting, hospitals that lack maternity social workers or DVA specific social workers, smaller units in rural areas etc. and informed by an understanding of the wider policy context and existing initiatives (e.g. business case for medical social workers, plans to develop referral pathways to community social work support, training and existing processes and support for women subjected to DVA). This would require sufficient resource for Women's Aid and commitment from hospitals to engage in co-design of the service that could be implemented within each new service context.
- Women's Aid to factor into implementation plans the time required to build relationships and garner support for the outreach support service in any future roll out of the service.
- Women's Aid ask for testimonials from existing social work departments to demonstrate to other hospitals the 'added value' of referring to the outreach support service.

Training

- This training be rolled out further with adaptations to the structure and delivery to improve feasibility and adoption and in continued partnership with hospitals. Consider the balance needed between appropriateness (training that is excellent, in-depth) and feasibility (accessible for large numbers of maternity staff in the context of time and staffing pressures).
- Any rollout of training retain the multidisciplinary approach to training different professional groups together, potentially jointly delivered with MSW where feasible.
- Hospitals and Women's Aid consider adopting a training model similar to the 'Children First' approach, which provides a basic but comprehensive training programme that is widely accessible, potentially through online self-directed learning, and mandatory for all staff. This could be

supplemented with more detailed training for those in direct contact with women and advanced training for individuals with designated responsibility for DVA.

- Realistic timelines and allocation of resources are adopted for any further rollout of training. Those who availed of training to date may represent keen early adopters and more time and effort may be required to support a wider rollout to those with more pressing priorities.

Training content was consistently deemed to be excellent. Suggested enhancements included:

- Continue to include practical, scenario-based learning and role-plays
- Review the duration and frequency of training sessions, to balance comprehensive coverage with feasibility for staff to access training.
- Address challenges related to finding time and private space for eLearning and online training
- Provide ongoing support and resources, including continuous professional development and refresher courses.
- Consider incorporating content on any new screening questions adopted in response to new clinical guidelines on screening and managing DVA8 and the importance of adequate coding of responses in electronic health systems.

References

An Garda Síochána (2021) Annual Report 2020.

Bacchus L, Bewley S, Torres Vitolas C, Aston G, Jordan P, Murray SF. (2010). Evaluation of a domestic violence intervention in the maternity and sexual health services of a UK hospital. *Reproductive Health Matters*; 18(36): 147-157.

Baird, K. (2021) Intimate Partner Violence in Pregnancy and the Post-partum Period: A Research and Practice Overview. In: Bradbury-Jones, C., Isham, L. (eds) *Understanding Gender-Based Violence (pp.115-132).*

Baird K, Creedy DK, Branjerdporn G, Gillespie K. (2021). Red flags and gut feelings – Midwives' perceptions of domestic and family violence screening and detection in a maternity department. *Women and Birth*; 34(5):e468-e474

Bloom, B. S. (1956). Taxonomy of educational objectives: Cognitive and affective domains. New York: David McKay.

Bradbury-Jones C, Appleton JV, Watts S. (2016). Recognising and responding to domestic violence and abuse: the role of public health nurses. *Community Practitioner*; 89(3); 24-28.

Bunting, L., Davidson, G., McCartan, C., Hanratty, J., Bywaters, P., Mason, W., & Steils, N. (2018). The association between child maltreatment and adult poverty–A systematic review of longitudinal research. Child abuse & neglect, 77, 121-133.

Bywaters, P., Bunting, L., Davidson, G., Hanratty, J., Mason, W., McCartan, C., & Steils, N. (2016). The relationship between poverty, child abuse and neglect: An evidence review. York: Joseph Rowntree Foundation.

Centre for Effective Services (2023), Perinatal Domestic Violence and Abuse, Review of Evidence and Policy for the Women's Aid Maternity Project. Unpublished

Centre for Effective Services (2023), Survey of Women's experience of maternity services while subjected to DVA. Interim report for the evaluation of the Women's Aid Maternity Project. Unpublished

Chisholm CA, Bullock L, Ferguson JE. (2017) Intimate partner violence and pregnancy: epidemiology and impact. *American Journal of Obstetrics & Gynecology;* 217(2): 141-144.

Cleaver K, Maras P, Oram C, McCallum K. (2019) A review of UK based multi-agency approaches to early intervention in domestic abuse: Lessons to be learnt from existing evaluation studies. *Aggression and Violent Behaviou; 46:* 140-155.

Council of Europe (2011). *Convention on preventing and combating violence against women and domestic violence.* CETS No. 210.

Craig, P., Dieppe, P., Macintyre, S., Michie, S., Nazareth, I., & Petticrew, M. (2008). Developing and evaluating complex interventions: the new Medical Research Council guidance. *Bmj*, *337*.

Creedy DK, Baird K, Gillespie K. (2020) A cross-sectional survey of pregnant women's perceptions of routine domestic and family violence screening and responses by midwives: Testing of three new tools. *Women and Birth;* 33(4): 393-400.

Department of Health (2021). *National Maternity Strategy: Revised Implementation Plan 2021-2026.*

Department of Health (2016). *National Maternity Strategy – Creating a Better Future Together 2016-2026.*

Department of Justice (2022) *National Strategy on Domestic, Sexual and Gender-Based Violence 2022-2026*.

Department of Justice (2022) *Third National Strategy on Domestic, Sexual and Gender-Based Violence Implementation Plan.*

Dheensa S, Halliwell G, Daw J, Jones SK, Feder G. (2020) "From taboo to routine": a qualitative evaluation of a hospital-based advocacy intervention for domestic violence and abuse. *BMC Health Services Research;* 20(129).

Doyle, J., Ashe, S., Lawler, L., (2021) Addressing domestic, sexual and gender-based violence Part One: Overview. Houses of the Oireachtais Library and Research Service Note

Forde C, Duvvury N. (2021) Assessing the Social and Economic Costs of DV: A Summary Report. Ireland: Safe Ireland & NUI Galway.

Geraghty R, Morgan, M. (2022) *Access Evidence: Intimate Partner Violence*. Centre for Effective Services.

Hall M, Chappell LC, Parnell BL, Seed PT, Bewley S. (2014) Associations between intimate partner violence and termination of pregnancy: a systematic review and meta-analysis. *PLOS Medicine;* 11(1): e1001581.

Halliwell G, Dheensa S, Fenu E, Jones SK, Asato J, Jacob S, et al. (2019). Cry for health: a quantitative evaluation of a hospital-based advocacy intervention for domestic violence and abuse. *BMC Health Services Research;* 19(718).

Health Information and Quality Authority (2016) *National Standards for Safer Better Maternity Services*.

Health Service Executive (2010) *HSE policy on domestic, sexual and gender-based violence.*

Higgins A, Carroll M, Downes C, Monahan M, Gill A, Madden D, et al. (2017) *Perinatal mental health: an exploration of practices, policies, processes and education needs of midwives and nurses within maternity and primary care services in Ireland*. Health Services Executive.

Health Service Executive & Institute of Obstetricians and Gynaecologists RCPI (2014) *Clinical Practice Guidelines for Antenatal Routine Enquiry Regarding Violence in the Home*.

Irish Statute Book (2018) *Domestic Violence Act 2018.*

Katz, E., Nikupeteri, A., & Laitinen, M. (2020). When coercive control continues to harm children: Post-separation fathering, stalking and domestic violence. *Child abuse review*, *29*(4), 310-324.

Kirk L, Bezzant K. (2020). What barriers prevent health professionals screening for domestic abuse? A literature review. *British Journal of Nursing;* 29(13): 754-760.

Mojahed, A, Alaidarous N, Kopp M, Pogarell A, Thiel F, Garthus-Niegel S. (2021) Prevalence of intimate partner violence among intimate partners during the perinatal period: A narrative literature review. *Frontiers in Psychiatry;* 12: 601236.

Mueller I, Tronick E. (2019). Early life exposure to violence: Developmental consequences on brain and behavior. *Frontiers in Behavioural Neuroscience;* 13(156).

NICE Clinical Guidelines. (2010). *Pregnancy and Complex Social Factors: A Model for Service Provision for Pregnant Women with Complex Social Factors.* UK: National Institute for Health and Care Excellence.

Normann AK, Bakiewicz A, Madsen FK, Khan KS, Rasch V, Linde DS. (2020) Intimate partner violence and breastfeeding: a systematic review. *BMJ Open;* 10: e1034153.

O'Doherty , Hegarty K, Ramsay J, Davidson LL, Feder G, Taft A. (2015) Screening women for intimate partner violence in healthcare settings. *Cochrane Database of Systematic Reviews, Issue 7.*

O'Reilly R, Beale B, Gillies D. (2010) Screening and Intervention for Domestic Violence During Pregnancy Care: A systematic Review. *Trauma, Violence, & Abuse;* 11(4): 190-201.

O'Shea MT, Collins C, Ni Riain A, Daly M. (2016) *Domestic Violence During Pregnancy- GP Survey Report*. Ireland: Irish College of General Practitioners.

Pallitto CC, Garcia-Moreno C, Jansen HAFM, Heise L, Ellsberg M, Watts C. (2013) Intimate partner violence, abortion, and unintended pregnancy: Results from the WHO Multi-Country Study on Women's Health and Domestic Violence. *International Journal of Gynecology & Obstetrics;* 120(1): 3-9.

Pastor-Moreno G, Ruiz-Perez I, Henares-Montiel J, Escriba-Aguir V, Higueras-Callejon C, Ricci-Cabello I. (2020) Intimate partner violence and perinatal health: a systematic review. *BJOG: An International Journal of Obstetrics & Gynecology;* 127(5): 537-547.

Proctor, E., Silmere, H., Raghavan, R., Hovmand, P., Aarons, G., Bunger, A, Griffey, R. & Hensley, M. (2011). Outcomes for implementation research: conceptual distinctions, measurement challenges, and research agenda. Administration and policy in mental health and mental health services research, 38, 65-76.

Reisenhofer S, Taft A. (2013) Women's journey to safety – The Transtheoretical model in clinical practice when working with women experiencing Intimate Partner Violence: A scientific review and clinical guidance. *Patent Education and Counselling;* 93(3): 536-548.

Rivas C, Ramsay J, Sadowski L, Davidson LL, Dunne D, Eldridge S, et al. (2016) Advocacy Interventions to Reduce or Eliminate Violence and Promote the Physical and Psychosocial Well-Being of Women who Experience Intimate Partner Abuse: A Systematic Review. *Cochrane Database of Systematic Reviews, Issue 12.*

Rivas C, Vigurs C, Cameron J, Yeo L. (2019) A realist review of which advocacy interventions work for which abused women under what circumstances. *Cochrane Database of Systematic Reviews, Issue 6.*

Robinson A, Payton J. (2016) Independent advocacy and multi-agency responses to domestic violence. In S Hilder & V Bettinson (eds.) *Domestic Violence: Interdisciplinary Perspectives on Protection, Prevention & Intervention.* (pp. 249-271).

Salmon D, Baird KM, White P. (2013) Women's views and experiences of antenatal enquiry for domestic abuse during pregnancy. *Health Expectations;* 18(5): 867-878.

Tarzia L, Bohren MA, Cameron J, Garcia-Moreno C, O'Doherty L, Fiolet R. (2020). Women's experiences and expectations after disclosure of intimate partner abuse to a healthcare provider: A qualitative meta-synthesis. *BMJ Open;* 10: e041339.

Vicard-Olagne M, Pereira B, Rouge L, Cabaillot A, Vorilhon P, Lazimi G, et al. (2022) Signs and symptoms of intimate partner violence in women attending primary care in Europe, North America and Australia: a systematic review and meta-analysis. *Family Practice;* 39(1): 190-199.

Webster, J., Lawlor, S., Kavanagh, D., Breen, A., Sheil, O., McCarthy, AM., O'Brien-Green, S., Kirby, F., & Leahy M. (2024) *National Clinical Practice Guideline: Screening and Management of Domestic Violence and Abuse in Pregnancy and the early postnatal period.* National Women and Infants Health Programme and The Institute of Obstetricians and Gynaecologists.National Clinical Practice Guideline.

World Health Organisation. (2011) *Intimate partner violence during pregnancy: Information sheet.*

World Health Organisation. (2016) *WHO recommendations on antenatal care for a positive pregnancy experience*

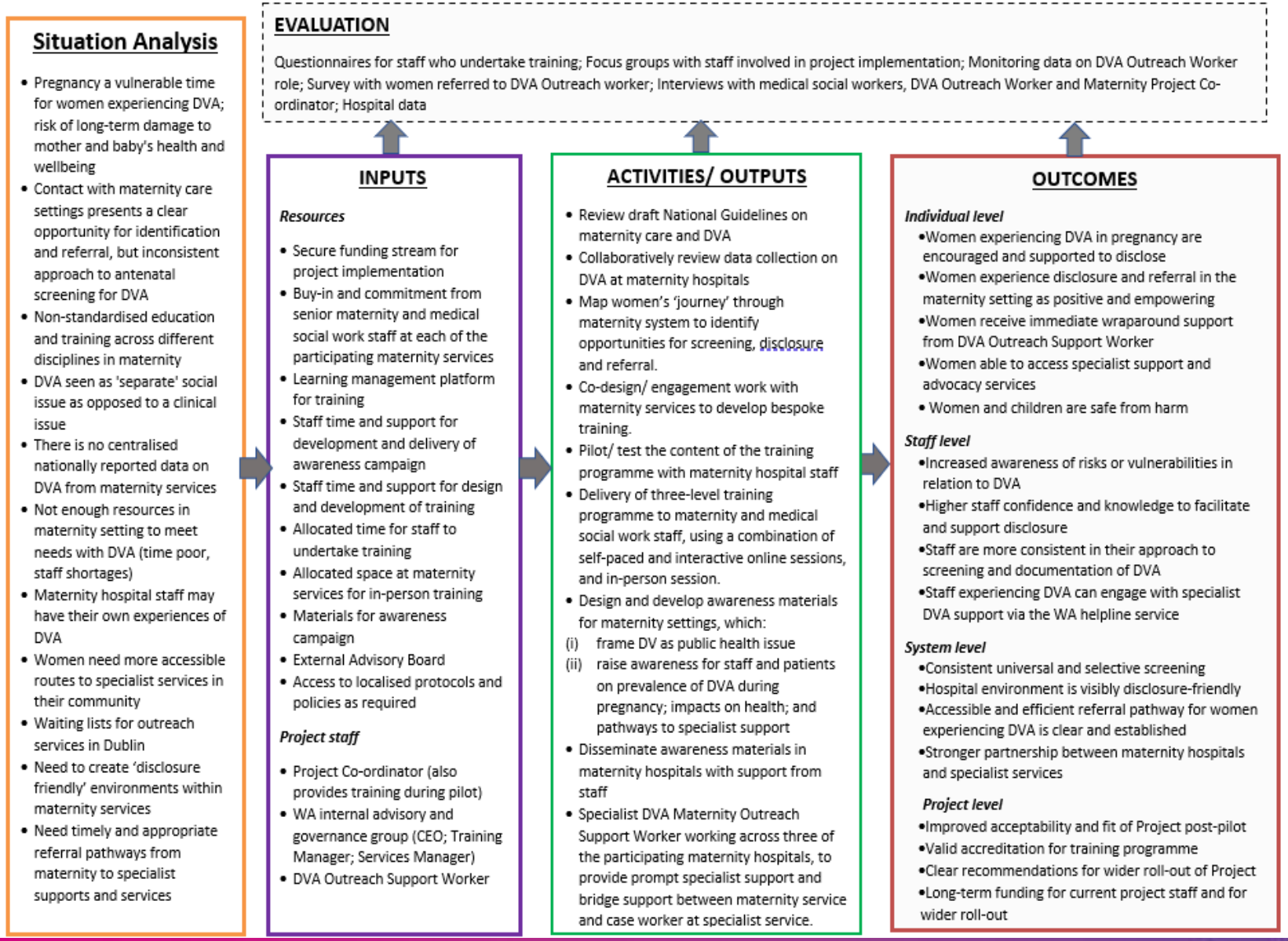
Women's Aid. (2022) *Annual Impact Report 2021.*

Women's Aid. (2022) *Femicide in Ireland: Femicide Watch.* Accessed May 2022.

World Health Organisation (2024) Violence against women factsheet.

Appendices

Appendix A Logic model for the Maternity Project



Appendix B Process data on Outreach Support Service

Table 12 Process data on Outreach Support Service

	2021 (*May-Dec*)	**2022** *(excl. Oct)*	**2023** *(Jan-Dec)*	**2024** *(Jan- Jun)*
Total number referrals	**33**	**67**	**146**	**107**
Referral source				
Hospital A	6 (18%)	10 (15%)	29 (20%)	27 (25%)
Hospital B	8 (24%)	21 (31%)	41 (28%)	23 (21.5%)
Hospital C	15 (45%)	23 (34%)	72 (49.5%)	53 (49.5%)
Self-referral	1 (3%)	3 (4.5%)	1 (0.5%)	2 (2%)
Via Women's Aid helpline	3 (9%)	5 (7.5%)	1 (0.5%)	2 (2%)
Via Women's Aid Drop-in Service	-	5 (7.5%)	2 (1.5%)	-
Age of women referred (years)				
18-30	15 (45%)	19 (28%)	51 (35%)	25 (23.5%)
30-40	13 (39%)	28 (42%)	64 (44%)	31 (29%)
40-50	1 (3%)	2 (3%)	10 (7%)	2 (2%)
50-60	1 (3%)	-	1 (0.5%)	-
Unknown	3 (9%)	18 (27%)	20 (13.5%)	49 (46%)
Maternity status at referral				
Pregnant	14 (42%)	40 (60%)	86 (59%)	63 (59%)
Pregnancy loss	1 (3%)	2 (3%)	5 (3.5%)	5 (4.5%)
Termination of pregnancy	-	1 (1.5%)	4 (2.5%)	4 (3.5%)
Postnatal	15 (45%)	22 (33%)	44 (30%)	35 (32.5%)
Maternity hospital staff [86]	3 (9%)	1 (1.5%)	-	-
Unknown	-	1 (1.5%)	7 (5%)	-
Additional vulnerabilities at referral				
Homelessness	2 (6%)	9 (13%)	22 (15%)	10 (9.5%)
Immigration	1 (3%)	8 (12%)	6 (4%)	4 (3.5%)
Addiction	1 (3%)	3 (4%)	7)5%)	2 (2%)
Mental health	13 (39%)	16 (24%)	71 (48.5%)	41 (38.5%)
Disability	-	-	4 (2.5%)	2 (2%)
Other	-	3	8 (5.5%)	4 (3.5%)
Minority groups				

[86] This relates to staff in the hospital looking for support for themselves or a friend/ family member.

Traveller	-	-	3 (2%)	2 (2%)
Refugee	-	-	6 (4%)	3 (3%)
Disability			4 (2.5%)	2 (2%)
Asylum seeker	-	-	4 (2.5%)	1 (1%)
Roma	1 (3%)	1 (1.5%)	-	1 (1%)

Table 13 Information on nature of abuse within referrals

	2021 (*May-Dec*)	**2022** *(excl. Oct)*	**2023** *(Jan-Dec)*	**2024** *(Jan- Jun)*
Relationship to perpetrator				
Spouse	4 (12%)	12 (18%)	47 (32%)	33 (31%)
Ex-spouse	6 (18%)	11 (16%)	48 (33%)	23 (21.5%)
Male dating	6 (18%)	12 (18%)	6 (4%)	9 (8.5%)
Ex male dating	17 (52%)	24 (36%)	32 (22%)	14 (13%)
Unknown	1 (3%)	8 (12%)	7 (5%)	24 (22.5%)
Other	-	-	10 (7%)	4 (3.5%)
Type of abuse				
Emotional	28 (85%)	49 (73%) [87]	75 (51.5%)	90 (84%)
Physical	14 (42%)	25 (37%)	48 (33%)	40 (37.5%)
Financial	17 (52%)	28 (42%)	36 (24.5%)	17 (16%)
Sexual (including rape)	5 (15%)	6 (9%)	18 (12.5%)	11 (10.5%)
Social[88]	*Data not collected*	8 (12%)	26 (18%)	4 (3.5%)
Verbal	*Data not collected*	16 (24%)	34 (23.5%)	32 (30%)
Stalking	*Data not collected*	5 (7.5%)	7 (5%)	6 (5.5%)
Coercion	*Data not collected*	9 (13%)	8 (5.5%)	8 (7.5%)
Control	*Data not collected*	12 (18%)	40 (27.5%)	36 (33.5%)
Tech/ social media	6 (18%)	9 (13%)	11 (7.5%)	8 (7.5%)
Use of access[89]	*Data not collected*	2 (3%)	-	-
Other	*Data not collected*	4 (6%)	-	-

[87] The percentages in the Types of Abuse columns will total higher than 100% as many of the women referred will have been subjected to multiple different types of abuse.
[88] Social abuse is either when a person is denied opportunities to engage in friendships or other social relationships, or when an abuser attempts to harm the person's relationships or reputation.
[89] Post-separation abuse, where the abuser uses their access visits with a child as an opportunity to verbally, emotionally, or physically abuse or threaten the woman.

Table 14 Information on support provided by Outreach Support Service

	2021 (*May-Dec*)	**2022** *(excl. Oct)*	**2023** *(Jan-Dec)*	**2024** *(Jan- Jun)*
Average time from receiving referral to contacting woman	-	2 days	3 hours	
Number of women who engaged with the service	31 (94%)	53 (79%)	128 (88%)	100 (93%)
Referrals from Outreach Worker to external supports				
Legal aid	11 [90]	23	45	31
Court orders	11			13
Solicitor	8	21	32	16
Gardai	7	26	73	44
Housing/ local authority	9	20	31	19
Social welfare/ community	5	28	11	3
Counselling	-	2	5	4
Residency[91]	1	4	0	0
Refuge	3	6	18	8
Medical social worker	1	2	9	4
Other	0	14	0	15
Referrals to sources of support within Women's Aid				
High Risk Support Project	1	6	5	4
Drop-in service Dolphin's House	1	2	7	2
Emergency fund	26	22	4	2
Security fund	2	1	1	3
Legal fees	3	0	1	0
Court accompaniments	14	30	41	21
Modes of engagement				
Face to face contact	*Data not collected*	29 women (198 times)	71 women (210 times)	46 women (95 times)
Video call	*Data not collected*	3 women (3 times)	-	1 woman
Telephone call	*Data not collected*	42 women (574 times)	140 women (958 times)	107 women (554 times)
Email	*Data not collected*	19 women (35 times)	71 women (139 times)	68 women (104 times)
Letter	*Data not collected*	12 women (20 times)	12 women (19 times)	3 breakdown unavailable
Text message	*Data not collected*	43 women (306 times)	98 women (669 times)	479 breakdown unavailable

[90] Percentages are not provided for the onward referrals as we do not have data on whether some women received multiple referrals.
[91] This relates to support with permissions for residency for those who are immigrants.

Appendix C Maternity Project Training Programme

Surveys: Pre-Training Questionnaire

1. Have you previously undertaken training for recognising, asking, and responding to domestic abuse in pregnancy? [92]
   - Yes -> *Please specify when and where it took place, and who provided the training:*_____
   - No

2. How would you rate your current awareness of domestic abuse as an issue in pregnancy?
   - Not at all aware
   - Slightly aware
   - Somewhat aware
   - Moderately aware
   - Extremely aware

3. Knowledge check about DVA in pregnancy. *This has not been finalised as it will be the same questions as the knowledge checklist on the training course that will be used for the certificate of Bronze/ Level 1 training (in order to compare pre- and post-training knowledge)*

4. Please rate how prepared you feel for the following:

I feel prepared to	**Unsure**	**Not at all prepared**	**Minimally prepared**	**Moderately prepared**	**Well prepared**
Identify indicators of domestic abuse based on a woman's history					
Recognise when a woman attending the maternity					

[92] Amended to ask specifically whether they did the NWHIP training

service may be experiencing domestic abuse					
Ask a woman attending the maternity service about domestic abuse					
Respond to a woman who discloses domestic abuse while attending the maternity service					
Refer a woman for specialist domestic abuse support					
Refer a woman experiencing domestic abuse to support within the hospital					

5. To what extent do you agree with the following statement?

	Strongly Agree	Agree	Unsure	Disagree	Strongly Disagree
Asking about domestic abuse and responding to a disclosure is an important aspect of my job					

6. What do you hope to gain from the training?

Appendix D Maternity Project Training Programme

Surveys: Post-Training Questionnaire for Bronze

1. To what extent did training meet your expectations?
   - Not at all
   - Partially
   - Completely
   - Exceeded

If it did not completely meet your expectations, can you explain why?
_____

2. Please rate how you felt about the following aspects of training:

	Very satisfied	Somewhat satisfied	Not satisfied
Course content			

Further comments: _____

	Very satisfied	Somewhat satisfied	Not satisfied
Format of delivery			

Further comments: _____

	Very satisfied	Somewhat satisfied	Not satisfied
Length of the course			

Further comments: _____

3. What did you think about the amount of information that was provided?
   - Too much
   - Too little
   - About the right amount

   Additional comments _____

4. When did you engage with the training?
   - During working hours
   - Partially in working hours and partially in my free time
   - In my free time

   Additional comments _____

5. Were there any challenges for you in finding time to engage with the training?
   - Yes
   - No

   Additional Comments _____

6. Were there any I.T. issues (with the training software, or with your equipment) that affected you being able to engage with it?
   - Yes -> Please explain_____

- No

7. Do you think the course was relevant to your work?
   - Yes
   - No

   Additional Comments _____

8. Is there anything that you learned from the course that you will be able to apply in your role?
   - Yes
   - No

   Please explain _____

9. Please rate how prepared you feel for the following:

I feel prepared to	**Unsure**	**Not at all prepared**	**Minimally prepared**	**Moderately prepared**	**Well prepared**
Identify indicators of domestic abuse based on a woman's history					
Recognise when a woman attending the maternity service may be experiencing domestic abuse					
Ask a woman attending the maternity service about domestic abuse					
Respond to a woman who discloses domestic abuse while attending the maternity service					
Refer a woman for specialist domestic abuse support					
Refer a woman experiencing domestic					

abuse to support within the hospital					

10. Are there any other areas of learning that you would like to see included in the course?

    _____

11. Would you recommend this training to a colleague?
    - Yes
    - No

12. To what extent do you agree with the following statement?

	Strongly Agree	Agree	Disagree	Strongly Disagree
Asking about domestic abuse and responding to a disclosure is an important aspect of my job				

13. Would you like to make any other additional comments on the training?

Appendix E Maternity Project Training Programme

Surveys: Post-Training Questionnaire for Silver

1. To what extent did training meet your expectations?
   - Not at all
   - Partially
   - Completely
   - Exceeded

   If it did not completely meet your expectations, can you explain why?

   _____

2. Please rate how you felt about the following aspects of training:

	Very satisfied	Somewhat satisfied	Not satisfied
Course content			

Further comments: _____

	Very satisfied	Somewhat satisfied	Not satisfied
Format of delivery			

Further comments: _____

	Very satisfied	Somewhat satisfied	Not satisfied
Quality of facilitation			

Further comments: _____

	Very satisfied	Somewhat satisfied	Not satisfied
Length of the course			

Further comments: _____

3. Did the activities and exercises used in the course aid your learning?
   - Yes
   - No

   Do you have any comments on any particular exercise/activity?
   _____

4. What did you think of the pace at which the information was provided?
   - Too fast
   - Too slow
   - Right pace

   Additional comments _____

5. Were there any challenges for you in finding time or a private space to take part in the training?
   - Yes -> *Please explain*_____
   - No

6. Were there any I.T. issues that affected you being able to engage with the training?
   - Yes -> *Please explain*_____
   - No

7. Did you feel you were given enough opportunity to interact with the trainer and other participants?
    - Yes
    - No

    Additional comments_____

8. Do you think the course was relevant to your work?
    - Yes
    - No

    Additional comments_____

9. Is there anything that you learned from the course that you will be able to apply in your role?
    - Yes
    - No

    Please explain _____

10. Is there any further support that you might need to apply what you have learned from the training?
    - Yes -> *Please explain*_____
    - No

11. Please rate how prepared you feel for the following:

I feel prepared to	**Unsure**	**Not at all prepared**	**Minimally prepared**	**Moderately prepared**	**Well prepared**
Identify indicators of domestic abuse based on a woman's history					
Recognise when a woman attending the maternity service may be experiencing domestic abuse					
Ask a woman attending the maternity service about domestic abuse					

Respond to a woman who discloses domestic abuse while attending the maternity service					
Refer a woman for specialist domestic abuse support					
Refer a woman experiencing domestic abuse to support within the hospital					

12. Are there any other areas of learning that you would like to see included in the course?
    - Yes -> *Please explain*_____
    - No

13. What did you like most about this course?

14. What would you like to improve on this course?

15. Are you motivated to go on to complete the Gold session?
    - Yes
    - No

    Please state your reasons _____

16. Would you recommend this training to a colleague?
    - Yes
    - No

17. To what extent you agree with the following statement?

	Strongly Agree	Agree	Disagree	Strongly Disagree
Asking about domestic abuse and responding to a disclosure is an important aspect of my job				

18. Would you like to add any additional comments?

    _____

Appendix F Maternity Project Training Programme

Surveys: Post-Training Questionnaire for Gold

1. To what extent did training meet your expectations?
   - Not at all
   - Partially
   - Completely
   - Exceeded

   If it did not completely meet your expectations, can you explain why?
   _____

2. Please rate how you felt about the following aspects of training:

	Very satisfied	Somewhat satisfied	Not satisfied
Course content			

Further comments: _____

	Very satisfied	Somewhat satisfied	Not satisfied
Quality of facilitation			

Further comments: _____

	Very satisfied	Somewhat satisfied	Not satisfied
Role play exercises			

Further comments: _____

	Very satisfied	Somewhat satisfied	Not satisfied
Length of the course			

Further comments: _____

3. Were there any challenges for you in finding time to take part in the training?
   - Yes -> Please explain_____
   - No

4. Did you feel there was enough opportunity in the session to interact with the facilitator and others taking part?
   - Yes
   - No

5. Do you think you've gained or improved existing skills as a result of participation in the training?
   - Yes
   - No

   Additional comments _____

6. Do you think you will be able to apply what you have learned to your work?
   - Yes
   - No

   Additional comments _____

7. Is there any further support that you might need to apply what you have learned from the training?

   _____

8. Please rate how prepared you feel for the following:

I feel prepared to	**Unsure**	**Not at all prepared**	**Minimally prepared**	**Moderately prepared**	**Well prepared**
Identify indicators of domestic abuse based on a woman's history					
Recognise when a woman attending the maternity service may be experiencing domestic abuse					
Ask a woman attending the maternity service about domestic abuse					
Respond to a woman who discloses domestic abuse while attending the maternity service					

Refer a woman for specialist domestic abuse support					
Refer a woman experiencing domestic abuse to support within the hospital					

9. Are there any other areas of learning that you would like to see included in the course?

   _____

10. What did you like most about this course?

    _____

11. What would you like to improve on this course?

    _____

12. Would you recommend this training to a colleague?
    - Yes
    - No

13. To what extent do you agree with the following statement?

	Strongly Agree	Agree	Disagree	Strongly Disagree
Asking about domestic abuse and responding to a disclosure is an important aspect of my job				

14. Would you like to add any additional comments?

    _____

Appendix G Maternity Project Training Programme Surveys: Post-Training Questionnaire Follow up

1. Since completing the training with Women's Aid, have there been any noticeable changes for you in how you manage domestic abuse in your work?
   - Yes

- No

  -> Please explain _____

2. Please rate how prepared you feel for the following:

I feel prepared to	**Unsure**	**Not at all prepared**	**Minimally prepared**	**Moderately prepared**	**Well prepared**
Identify indicators of domestic abuse based on a woman's history					
Recognise when a woman attending the maternity service may be experiencing domestic abuse					
Ask a woman attending the maternity service about domestic abuse					
Respond to a woman who discloses domestic abuse while attending the maternity service					
Refer a woman for specialist domestic abuse support					
Refer a woman experiencing domestic abuse to support within the hospital					

3. Have there been any barriers for you in being able to apply the learning and skills from training in your work?
   - Presence of partners
   - Language barriers
   - Lack of private space
   - Time constraints during appointments
   - Women's reluctance to disclose

- I don't remember what I learned
- I have too many other things to do
- It is too difficult to apply
- Other (please explain) _____

Additional comments ….....

4. Are there any further supports/ resources you need in your work environment to apply what you learned from the training?
   - Prioritised Time
   - Physical space
   - Help from my co-workers
   - Help from my immediate supervisor
   - Formal or informal recognition for my efforts
   - My own efforts and discipline to apply what I learned
   - Referring back to the course materials
   - Additional training
   - Other_____

5. On reflection, was there anything missing from the training programme that would have been helpful for you in your work?
   - Yes
     - ➔ *Please explain* _____
   - No

6. To what extent you agree with the following statement?

	Strongly Agree	Agree	Disagree	Strongly Disagree
Asking about domestic abuse and responding to a disclosure is an important aspect of my job				

7. Do you have any additional comments?

Appendix H Interview Schedule: Outreach Worker

- Can you tell me a bit about your **background** and how you came into this role?

- Can you describe **what the DVA Outreach worker role involves**?

Prompts-

- Who do you receive referrals from?
- What happens when you receive referrals?
- Can you describe the **kind of engagement** you have with women?
    - Where do you meet with women? (or what form is the contact- phone/ text/ in person?)
    - How often are you in contact?
    - How long are you typically engaging with women? (what happens after this?)
    - What kind of support is provided?

- Can you think of any examples where you were not able to engage with women referred?
    - What do you think were the **barriers to engagement** for women in those instances?

- Could you describe some examples of successful engagement and the **outcomes** of that for women?

- What do you think are the differences between your role and the role of an outreach support worker in WA?

- What do you think is **working well** with the role?
    - What's helping to get the work done?

- What do you think are the main **challenges** with this role?

- How did you find working across **three different hospitals**?
- What has your working relationship been like with the **medical social work teams** at the different hospitals?

    Prompts
    - How do you think the medical social workers perceive your role?
    - Do you think they have been supportive of the DVA Outreach worker role?

- Has there been any difference in your experience of the role at each of the three different hospitals where you've been working?

- What benefits do you think this role brings for women, that they would not receive otherwise from the usual support pathways at maternity hospitals?

- What kind of **management and support** for you was needed for this role from Women's Aid?

- If the Maternity Project was rolled out more widely and there were more DVA Outreach workers connected to maternity hospitals around the country, are there any **changes** that you would make to improve the role and the work that could be done?

    - Or **any further supports** needed for the role?

Appendix I Interview Schedule: Medical Social Workers

1. Can you say a bit about how you and your team are involved in supporting the needs of pregnant women impacted by domestic violence and abuse? ***Potential prompt for additional services/supports women are referred out to by medical SW teams.***

2. Can you tell me about how the *(name of hospital)* first became involved with the Women's Aid Maternity Project?
    - To what extent were you involved in the design or planning of the Project?
    - What were the expectations for the Project here at (*hospital)*?

3. How in your view is the **DVA outreach worker role** working at (hospital) for women impacted by domestic violence and abuse?
    Prompt for:
        - What has your working relationship been like with the DVA outreach worker?
        - Are the referrals being responded to by the Outreach Worker in a timely way? Are there any issues/challenges with the referral pathway into the Outreach service?
        - Are there benefits for you in having the Outreach Worker in post? (What are they?)
            - Has the DVA Outreach Worker role been helpful for you in managing your workload?
    - Has there been any overlap between your work and the work of the Outreach Worker?

- Have there been any challenges for the service with the introduction of the Outreach Worker role?

- In your view, is the role of the DVA outreach worker working effectively for women impacted by domestic violence and abuse?

- Do you think the role of DV outreach worker brings any benefits for women, that they would not receive from the usual support pathways at maternity hospitals? ***Potential prompt: what are the 'usual support pathways' for women engaging with the medical SW teams.***

- Would you welcome the continuation of Outreach Worker role beyond the lifetime of the pilot?

- Would you support the idea of having DVA outreach worker roles for maternity hospitals at a national level?

If there is time, could then go on to ask about:

- Were you involved in putting up the **information and awareness raising materials** from Women's Aid around the (hospital) for the Maternity Project? *(Prompt that it was posters, leaflets, video if needed)*
    - Do you think these kinds of materials make a difference for staff in terms of awareness of domestic abuse in pregnancy?
    - Was there a sense from staff that women had noticed the materials?
    - Are there any changes you'd recommend to improve the information that's provided at the (hospital) for staff and women about domestic violence and abuse?

- Is there anything else you would like to add from your experience with the Maternity Project at (hospital)?

Appendix J Interview Schedule: Site Focus Groups

4. Can you tell me about how [your hospital] first became involved with the Women's Aid Maternity Project?

5. *Describe the collaborative ethos of the project;* Does that reflect your experience?

6. What were the expectations for the Project at [hospital]?

7. *The maternity project consisted of an outreach worker, a collaborative approach to design and implementation, awareness raising materials (posters, leaflets, videos) and training for staff.* How well did the project as a whole package work for your hospital?

8. Has the Maternity Project influenced the (hospital's) ways of working around the issue of DVA? In what way?

9. In your experience, what are the *least effective* and *most effective* aspects of the Maternity Project?

10. If the project was being rolled out to **other maternity services** around the country, what do you think would need to be addressed, or changed, to make it more effective/give it the best chance of having a positive impact for services and women?

11. Thinking about any things that may have affected how the Maternity Project was able to be delivered *in your hospital* – how might these things be avoided/addressed in future if the project continues?

12. How do you think the Maternity Project fits with the National Maternity Strategy and/or the National Women and Infants Health Programme?

*Next were going to talk about each element individually, starting with the **training** that was provided by Women's Aid to staff as part of the Maternity Project, even if you didn't take part in the training yourself.* Note: The training consisted of Bronze: Online self-paced, Silver; interactive via zoom with women's aid trainer, Gold: In-person training.

13. Did the training reach the people who need it most (those reluctant to engage)? Should it be mandatory – who decides if it's mandatory or not?

14. Were you aware of any challenges for staff in taking part in the **training** and how were these addressed/could they be addressed in future?

15. Overall, does the (hospital) feel that staff benefitted from the training?

16. Should the training be rolled out/retained after this pilot ends in July? If so, who needs it most?

17. Have you noticed any differences in how staff at [hospital] have been managing the issue of domestic violence and abuse since the training?

18. Is there anything you'd recommend for staff training around domestic violence and abuse? (that was not included in the Maternity Project training)?

Awareness raising materials

19. What did you think about the **information and awareness raising materials** that Women's Aid have supplied to (hospital) the past two years as part of the Maternity Project? Prompt for:
- Can and should the materials be on display in maternity settings permanently? Why/why not?
- Are there any changes you would recommend to improve the information that is provided at the (hospital) for staff and women about domestic violence and abuse?

20. As part of the Pilot project, a dedicated Outreach Worker was employed by Women's Aid to take referrals directly from the three Dublin Hospitals. How well, in your view, is the **DVA outreach worker role** working for women impacted by domestic violence who are using your hospital? Prompt for:
    - What are the benefits for (hospital) in having the dedicated Maternity Outreach Worker available to refer women to? (What are they?)
    - Have there been any challenges for the service with the introduction of the Maternity Outreach Worker role?

19. If the project was rolled out more widely, ***beyond maternity services***, what are the priority areas? How could the offer (awareness raising materials, training, outreach worker role) be improved/adjusted to make it suitable for implementing in other settings?

Appendix K Interview Schedule: Women's Aid Project Coordinator

1. Thinking about the project overall: how did it first come about and what was the vision for it? What were the expectations for the Maternity project?

2. Describe the work that went in to developing the collaborative design of the project. How important was the collaborative approach to the project?
   (Was it collaborative? How well was that done? What prevented collaboration? What was the benefit of collaborative?)

3. What were the key challenges along the way and what helped to overcome these?
    a. Have there been any challenges with the introduction of the Maternity Outreach Worker role and how accepted that was by hospitals?

4. What were the key enablers that helped with the development and rollout of the project?

5. What changed/ how did your thinking and planning develop through that development and refining of the project?

a. as a result of the collaborative approach?
b. as a result of external influences (NWHIP, HSE Land training)?
c. as a result of learning from outreach officer?
d. as a result of the evaluation process?

6. After rolling out the project what have you learned and what might you have done differently?
    a. In your experience, what are the least effective and most effective aspects of the Maternity Project? Has anything surprised you about what was effective and what wasn't?
    b. If the project was being rolled out to **other maternity services** around the country, what do you think would need to be addressed, or changed, to make it more effective/give it the best chance of having a positive impact for services and women?

7. From the NWHIP national rollout – what have WA as an org learned about rolling out DV training nationally? Was there any learning for WA as an organisation on what worked well? What didn't? The impact of 'generic' training.

8. How well do you think the project worked as a whole package work?

9. What is the overall vision for the project and what happens next? (National rollout, changes to the offer, extending/transferability of training to different departments). Ask about each aspect individually:
    - Outreach worker role
    - Training
    - Awareness raising

10. How do you think the Maternity Project fits with the National Maternity Strategy and/or the National Women and Infants Health Programme?

11. If the project was rolled out more widely, **beyond maternity services**, what are the priority areas? How could the offer (awareness raising materials, training, outreach worker role) be improved/adjusted to make it suitable for implementing in other settings?

Appendix L Online Survey of maternity hospital staff

Q1. If you would like to complete the questionnaire, please tick Yes to confirm that you understand that it is an anonymous questionnaire and that you are taking part voluntarily.

- ☐ Yes
- ☐ No

Q2. What is your professional role? (Tick box)

- ☐ Midwife
- ☐ Nurse
- ☐ Healthcare Assistant
- ☐ Social Worker

- Doctor
- Prefer not to say
- Other (please specify)

Q3. Which hospital do you primarily work in?

- Coombe Women's Hospital
- National Maternity Hospital, Holles Street
- Rotunda Hospital
- Cork University Maternity Hospital
- Kerry General Hospital, Tralee
- South Tipperary General Hospital
- St Luke's General Hospital Kilkenny
- Waterford Regional Hospital
- Wexford General Hospital
- Galway University Hospitals
- Letterkenny General Hospital
- Mayo General Hospital Castlebar
- Portiuncula Hospital, Ballinasloe
- Sligo General Hospital
- University Maternity Hospital, Limerick
- Cavan/Monaghan Hospital Group
- Our Lady of Lourdes Hospital, Drogheda
- Midland Regional Hospital Portlaoise

Q4. Before the pilot began, was there a need to (Definitely yes, probably yes, probably not, definitely not)

Improve how your hospital approaches DVA overall?
Raise awareness of the prevalence of DVA in the perinatal period?
Raise awareness of the impact of DVA in the perinatal period?
Build staff capacity (knowledge, confidence, preparedness) to identify women subject to DVA?
Build staff capacity to respond to women subject to DVA?
Build staff capacity to refer to appropriate support for DVA?

Q5. One stated aim of the project was to collaborate with maternity services in the design and roll out of the project. (Yes, very much so/ Yes somewhat/ No, not really/ No, definitely not/ Not applicable)

Did the collaborative approach matter to you?
Did you have opportunities to provide feedback and/or influence its delivery over time?
Did you engage with the design/development of the awareness raising materials
Did you engage with the design/development of the training programme?
Dublin hospitals only, did you engage with the design/development of the referral pathways for the outreach worker role?
Did you support the delivery of the project, for example support recruitment to training, endorse the awareness raising materials etc.?

Q6. Did you support the delivery of the project e.g. recruitment, endorsing awareness-raising materials? If so, in what ways? If not, why is/was this the case?

Q7. In your opinion, what was most successful about the pilot project?

Q8. In your opinion, what was least successful about the pilot project?

Q9. Has the Maternity Project influenced the hospital's approach to DVA in terms of …(much improved, improved, no change, worsened, don't know)

Acknowledging DVA as an important public health issue?
Staff attitudes towards supporting women subject to DVA?
When/how often women are asked about DVA?
How women are asked about DVA?
Recognition of the signs of DVA?
Response to women when they disclose DVA?
Referral to support within the hospital?
Referral to support outside of the hospital?
How data are collected or recorded around domestic violence and abuse?

Q10. How has the maternity project impacted the approach to DVA in your hospital/service?

Q11. In your opinion, did the awareness-raising materials have an effect on …(much improved, improved, no change, worsened, don't know)

Staff awareness of DVA as a public health issue?
Staff awareness of prevalence of DVA in pregnancy in Ireland?
Staff awareness of the impact of DVA on health in pregnancy?
Women's awareness of DVA?
Women's awareness of support available?
Contributed to a 'disclosure friendly' environment for DVA in your hospital?
Contributed to normalising discussion of DVA in your hospital?

Q12. Should DVA awareness materials for women be in place permanently in maternity settings? (Definitely yes, probably yes, probably not, definitely not)

Q13. What would you recommend to improve the impact of the awareness-raising materials?

Q14. Do you think that training has … (much improved, improved, no change, worsened, don't know)?

Raised staff awareness of DVA as a public health issue?
Raised staff awareness of prevalence of DVA in pregnancy in Ireland?
Raised staff awareness of the impact of DVA on health in pregnancy?
Contributed to a 'disclosure friendly' environment for DVA in your hospital?
Contributed to normalising discussion of DVA in your hospital?
Built staff capacity (knowledge, confidence, preparedness) to identify women subject to DVA?
Built staff capacity to respond to women subject to DVA?
Built staff capacity to refer to appropriate support for DVA?
Improved practice in screening for DVA?
Improved practice in the overall approach to DVA?

Q15. Should the training be... (Definitely yes, probably yes, probably not, definitely not)

rolled out further for clinical staff?
rolled out further for non-clinical staff?

mandatory for all clinical staff in your hospital?
mandatory for all non-clinical staff in your hospital?
mandatory for all clinical staff in maternity services nationally?
mandatory for all non-clinical staff in maternity services nationally?

Q16. How could the training offer be improved to make it more effective, in its impact and implementation at scale?

Q17. How well did the outreach worker role work for your service, and how could it be improved? Note: Only relevant for Coombe Women's Hospital, National Maternity Hospital, Holles Street, and the Rotunda Hospital.

Q18. Is there anything else you'd like to say about the Women's Aid Maternity Project?

Appendix M Online survey of women referred to DVA Outreach worker

The Maternity Outreach Support is a new service at Women's Aid and we would like to ask you for your feedback. It is important that we learn whether women have found the service helpful, so that we can make any improvements needed in the future.

This is a short survey (approx. 5- 8 mins). It is anonymous, so we will not ask you any personal information about yourself, or your name. Please do not include your name in any of your responses.

You do not have to take part in this survey, it is your choice.

If you would like to take part, please tick this box to confirm that you understand that it is an anonymous survey and that you are taking part voluntarily. [Tick Box]

1. How would you rate the Maternity Outreach Support in terms of **how helpful it was for you**?
   - Not helpful
   - Somewhat helpful
   - Very helpful

2. Below are a number of sentences about your experience with the Maternity Outreach Support Worker. Please let us know to what extent do you agree with each of them (response options: Strongly agree. Agree, disagree. Strongly disagree).

Statement
I received information and support from the Maternity Outreach Support Worker about my rights and the options available to me.
I received emotional support from the Maternity Outreach Support Worker during our meetings and conversations. (Emotional support might include feeling listened to, accepted, or encouraged)
I felt stronger and more confident in managing my situation after my conversations /meetings with the Maternity Outreach Support Worker

3. Did your contact with the Maternity Outreach Support Worker help you in other ways? For example, access to other services and supports.
    - No
    - Yes, please specify_____

4. Would you recommend the Maternity Outreach Support service to other women who are in a similar situation?
    - No
    - Yes
    - Not sure

5. Please let us know if you have any other comments or suggestions from your experience with the Maternity Outreach Support Service:

Appendix N Maternity Project External Advisory Group

The External Advisory group (EAG) 1st Meeting was held in September 2021 and agreed Terms of Reference. The group then met twice a year from 2021-2024, a total of 8 meetings.

Purpose of the EAG:

- Advise and support the success of all aspects of the Maternity Pilot Project.
- To provide a diverse range of expert voices to advise and support on the implementation of the Maternity Project
- Provide ongoing guidance and advice on the most effective development of different strands of the work as they evolve
- Assist with program evaluation if and as deemed appropriate
- Develop awareness, understanding and support for the project, and represent strategically to the wider public and other stakeholders
- Advise on, and support opportunities for mainstreaming any components of the project based on concluding evaluation recommendations.

Membership by invite only and included the following:

- Academic and midwife Jeanine Webster
- HSE National Women and Infant Health Programme (NWIHP)
- HSE Office of Nursing and Midwifery Services Director (ONMSD)
- HSE National Social Inclusion Office
- Department of Health Women's Health taskforce
- Irish Nurses and Midwives Organisation
- TUSLA Domestic Sexual and Gender Based Violence Programme and later to be CUAN as the representative organisation
- Association for Improvements in Maternity Services (AIMS)
- Cairde
- Pavee Point

- Four partner hospital represented: Rotunda, Coombe, National Maternity Hospital and Cork University Maternity Hospital. Including Directors of Midwifery, a Consultant in Obstetrics and Gynaecology and Principal Medical Social Workers.

Women's aid would like to thank advisory group members for their commitment to the EAG work over the lifetime of the pilot project.

Produced by Centre for Effective Services, 2024.

27 Fitzwilliam Street Upper,
Dublin 2,
D02 TP23