Midwives
Recognize & Respond
to Family Violence

# Recognizing and Responding to Family Violence

## KNOWLEDGE ASSESSMENT SURVEY REPORT

MAY 2021

CAM ACSF
Canadian Association of Midwives
Association canadienne des sages-femmes

NACM
NATIONAL ABORIGINAL COUNCIL OF MIDWIVES

Public Health Agency of Canada

## Acknowledgements

This research was funded by the Public Health Agency of Canada (PHAC) as part of its strategy to support projects that aim to prevent gender-based violence, and its impacts, from a health perspective. The Canadian Association of Midwives (CAM) and the National Aboriginal Council of Midwives (NACM) are grateful to PHAC for making this research possible.

This research project was reviewed and approved by the Community Research Ethics Board.

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# Knowledge Assessment Survey: Recognizing and Responding to Family Violence

## Summary of Goals and Rationale of the Research Project

The Canadian Association of Midwives (CAM) and the National Aboriginal Council of Midwives (NACM) have partnered with McMaster University on a project to build the capacity of midwives to recognize and respond to family violence. This is a three-year project to support non-Indigenous and Indigenous midwives to recognize and respond safely to child maltreatment, children's exposure to intimate partner violence, and intimate partner violence (IPV). Through this program, we aim to reach thousands of midwives and their clients, with the potential of reaching up to 18,000 people per year. The project is funded by the Public Health Agency of Canada.

One of our program activities is to adapt family violence education resources developed by McMaster University with multidisciplinary professionals. The VEGA (Violence, Education, Guidance, Action) on-line platform is intended for all health care and social service providers but does not specifically target midwives.

The goal of the the Knowledge Assessment Survey was to assess midwives' current knowledge and skills in recognizing and responding to child maltreatment and intimate partner violence. This assessment was designed to identify gaps in knowledge and skills, which will in turn help us adapt and develop resources to meet midwives' needs. The survey was available in English and French.

For this survey, we sought to find out:

- Demographics of midwives and midwifery students who responded to the survey
- Current knowledge of midwives and midwifery students in recognizing signs of family violence
- Practicing midwives' current attitudes, barriers, and practices in responding to family violence
- How practicing midwives describe best practices in recognizing and responding to family violence
- Preferred learning styles, methods of accessing resources and topics of interest for continued education

## Methodology

The survey was distributed to all CAM and NACM members, as well as to students in the seven university-based Midwifery Education Programs running at the time of the survey, and five Indigenous community-based Midwifery Education Programs across Canada. Through newsletters, email lists and social media channels, we reached approximately 1900 midwives and 600 students. The average open rate for survey outreach emails was 47.1% and the average click through rate was 14.95%. According to the email marketing platform, Constant Contact, these are far better rates for the non-profit sector than the average open and click through rates of 21.07% and 10.07% respectively.

Survey responses were collected on SimpleSurvey, a cloud-based data collection and analysis tool. Results were tabulated for all, non-Indigenous and Indigenous respondents. Qualitative responses were analyzed to identify patterns and themes. Respondents granted explicit permission to be quoted in this survey report.

## The Team

The Project Lead, Knowledge Translation (Gender-Based Violence Prevention) from the Canadian Association of Midwives was the main researcher in the design and analysis of the survey. She worked in collaboration with the Community Engagement Lead from the National Aboriginal Council of Midwives. Midwives were also consulted in the survey design, including other CAM staff and midwives who serve communities disproportionately impacted by family violence and/or were involved in the creation of the VEGA family violence education resources.

## Who Responded?

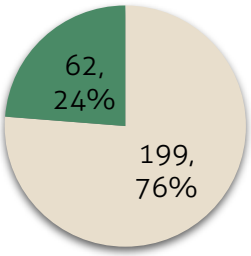
A cross-section of Registered Midwives, Indigenous midwives, Aboriginal Midwives[1] and midwifery students responded to the Knowledge Assessment Survey on Family Violence.

Responses reflect the geographic representation of midwives across Canada, with the largest number of responses from Ontario, followed by British Colombia, Quebec, and Alberta. Midwives in Manitoba, New Brunswick, Nova Scotia, Newfoundland, Nunavik, Nunavut, Northwest Territories, and the Yukon also responded to the survey.

In total, 395 people responded to the survey (16% of CAM members), and 261 completed the survey. Of these, 230 identified as non-Indigenous people and 29 as Indigenous peoples – namely First Nations, Inuit, or Métis communities. Indigenous respondents represent 17% of NACM membership. Survey response rates are similar to other surveys conducted by CAM and NACM and indicate a typical response rate for our issue-specific surveys.

Overall, about three-quarters of all respondents were midwives and one quarter were students. The breakdown was similar for non-Indigenous and Indigenous respondents.

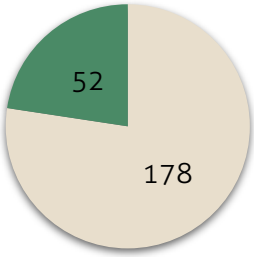
All Respondents




Registered Midwife, Indigenous, Aboriginal Midwives

Midwifery Students

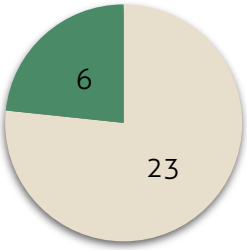
Non-Indigenous Respondents




Registered Midwife, Indigenous, Aboriginal Midwives

Midwifery Students

Indigenous Respondents




Registered Midwife, Indigenous, Aboriginal Midwives

Midwifery Students

The 63 students who completed the survey said they were enrolled in Midwifery Education Programs at Université du Québec à Trois-Rivières, University of British Colombia, Ryerson University, Mount Royal University, McMaster University, and Laurentian University. One student was studying with the Onkwehonwe Midwives Collective, an Indigenous community education program.

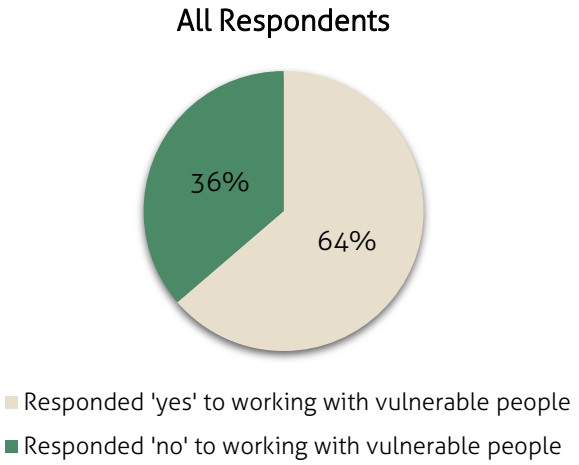
[1] In Ontario, Aboriginal midwives providing care to Indigenous communities are exempt from the Regulated Health Professions Act. The Ontario Midwifery Act allows Indigenous midwives who provide traditional midwife services to use the title 'Aboriginal Midwife'.

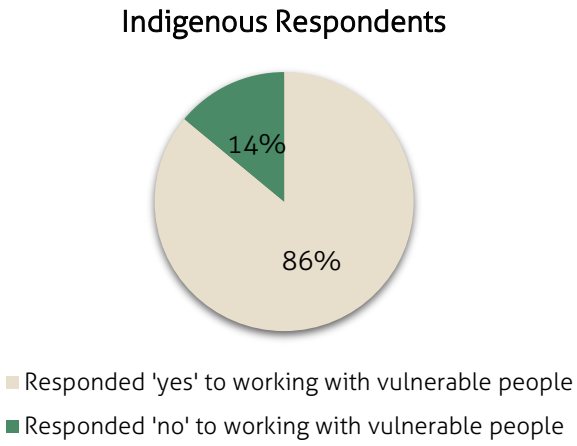
# Results Summary

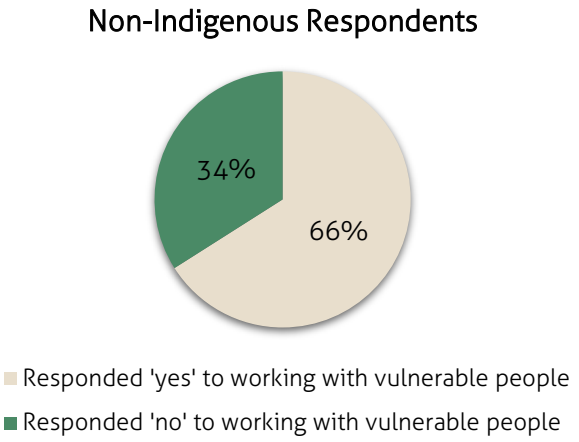
## Working with Vulnerable Communities

**Most respondents work with people who are vulnerable to family violence, however they are more likely to work with people vulnerable to intimate partner violence compared to child maltreatment.**

Overall, Indigenous midwives and midwifery students reported being more likely to work with people vulnerable to family violence compared to non-Indigenous respondents.



A breakdown in numbers:

- Most respondents (76.83% or 199 of 259) indicated they provided care to someone they suspected to be experiencing IPV. This rate was even higher for Indigenous respondents:
    - 27 out of 29 respondents (93.10%) reported caring for someone they suspected or had reasonable grounds to believe was experiencing intimate partner violence.

The likelihood of caring for a person with children suspected of experiencing child abuse was much lower than caring for someone they suspected to be experiencing IPV:

- 108 out of 258 respondents (41.55%) indicated they provided care to a person with a child they suspected was experiencing child maltreatment.

## Recognizing Family Violence

We were interested in understanding the current knowledge of midwives and midwifery students in recognizing signs and symptoms of family violence. Our findings indicate that non-Indigenous and Indigenous midwives and midwifery students who responded have a good *general* understanding of the signs and symptoms of family violence, including IPV and child maltreatment. *See Tables 1- 3 for survey responses on signs and symptoms.*

An overwhelming majority of respondents named physical injuries (90.38%) and mental health disturbances (96.92%) as indicators of family violence. Seventy-eight percent of all respondents named chronic pain as evidence of family violence. These results are consistent with evidence-based signs and symptoms referred to in VEGA resources. Chronic pain can be attributed to many causes which may account for fewer respondents naming this sign as an indicator of family violence.

Many respondents pointed to 'other' indicators of IPV or child maltreatment such as behaviour or physical/psychological issues. When referring to children, respondents also named 'not meeting developmental milestones' as an indicator.

**In general, respondents felt more certain about their ability to recognize indicators of IPV compared to indicators of child maltreatment.**

Notably, the large number of qualitative comments related to recognizing family violence points to how these indicators are context specific and rely on midwives' assessment.

### Risk Factors

The large majority of 260 respondents named financial strain/recent job loss (97.69%) and alcohol/drug misuse (96.92%), high family stress (96.15%), recent separation (83.08%) and expressing harmful gender norms (80.77%) as risk factors for family violence.

'Other' risk factors mentioned were socio-economic, and/or connected to community and individual histories. These included: poverty, immigration status, racism, mental health, disability, history of family violence, intergenerational trauma, colonial impacts, and pregnancy.

### What are other risk factors of family violence?

In their own words:

> *Trauma/PTSD. Children's Aids Society apprehending previous child. Precarious housing. Limited access to food and basic resources for humans to thrive. Impacts colonialism has on Indigenous families. Limited resources on her reserve.*
>
> *Racism against the family, family member with disability and lack of support, upset family members.*
>
> *Experiencing extreme poverty, familial and personal boundaries not respected, intergenerational trauma and learned behaviours.*

## Responding to Family Violence

### Midwives are more likely to observe for signs and symptoms of IPV compared to children's exposure to IPV or child maltreatment.

- Most respondents or 226 of 260 (86.92%) routinely observe for signs and symptoms of IPV or ask about IPV. Only 2 of 260 respondents said they *do not* observe for signs and symptoms.
- Comparatively, 61.24% or 158 of 258 respondents reported routinely observing for children's exposure to intimate partner violence or child maltreatment.

When observing for signs and symptoms, people who reported using or not using a particular protocol fall across a spectrum:

- 41.38% (96 of 232) said they use a particular protocol
- 47.41% (110 of 232) report they do not follow a particular protocol

Examples of protocols used:

- Screening questions/tools as part of intake health history (examples of forms/screening tools mentioned: provincial antenatal records, Routine Universal Comprehensive Screening Protocol, Women Abuse Screening Tool (WAST), provincial protocols)
- Trauma-informed care
- Mix of direct, open-ended and closed-ended (standardized) questions to create a dialogue
- Observation of appearance and behaviour
- Make sure client is alone
- Ask at least twice during pregnancy

**What does the particular method or protocol look like?**

In their own words:

> *Follow provincially recognized screening tool, use personal intuition/observance/experience to guide additional screening.*
>
> *Home visits for most appointments, antenatal and postnatal, detailed observation of interactions within the family, building trust by being open-minded and non-judgmental, waiting with more intimate questions until trust has been developed, etc.*

## Gaps and Opportunities

In general, survey results suggest that midwives use a client-centered approach to responding to family violence. How they respond depends on the individual and community context, as well as midwife knowledge and safety concerns.

Many indicated they use screening tools with standardized questions, others use their judgement and open-ended questions. Notably, according to the VEGA Handbook on IPV, universal screening for IPV (asking everyone, regardless of signs and symptoms) is not considered evidence-based.

The most common practice is to ask about safety concerns. Several people commented it is difficult to assess for violence virtually.

Yet not all midwives reported routinely observing for indicators of family violence. Referring to *Table 4*, the biggest reason for not observing for family violence is that midwives could not ask questions at the time of their visit because of a potential risk to the client. Other reasons include not knowing what to say or being afraid to offend clients.

The gaps in knowledge, safety concerns, and inconsistent protocols for responding to family violence present opportunities to create midwife-specific resources and continuing education training on best practices, especially for child maltreatment.

## Attitudes and Barriers in Responding to Family Violence

### Attitudes

A sign of how complex it is to practice midwifery, relatively few midwives feel *strongly confident* in their ability to recognize and respond to family violence in a trauma-informed way.

- Only 7.51% or 19 of 255 respondents feel *strongly confident* in their capacity to recognize family violence while 49.60% are *somewhat confident*.
- Similarly, 10.63% of all respondents are *strongly confident* in their capacity to respond to situations of family violence in a trauma-informed way while 42.91% are *somewhat confident*.

**Compared to non-Indigenous respondents, Indigenous respondents are generally more confident in both recognizing and responding to situations of family violence.**

- 74.07% of Indigenous respondents described themselves as somewhat or strongly confident in their capacity to recognize family violence compared to 58.48% of non-Indigenous respondents.
- 70.37% of Indigenous respondents describe themselves as somewhat or strongly confident in their capacity to respond to family violence compared to 54.47% of non-Indigenous respondents.

The majority of respondents agreed that responding to family violence reflects the continuity of care principle in the midwifery model and reflects the midwifery scope of practice. Most respondents also agreed that responding to family violence does not remove the systemic/structural causes of violence.

### Barriers

Non-Indigenous and Indigenous respondents agreed that insufficient training, insufficient knowledge of how to advocate for clients and their children in situations of family violence, logistical barriers (related to access to services, finances, geography, culture, language, etc.) were *major* or *somewhat major* barriers to responding to family violence.

*Trust in the system*

- 61.54% of Indigenous respondents agreed that they sometimes report to institutions that they know could create more harm. This compares to 44.04% of non-Indigenous respondents.
- All Indigenous midwives agreed to some extent that their clients would not get the help they needed when they made a referral.

- More than half or 54.98% (138) of all respondents agreed that the boundaries around professional obligations to disclose child abuse, neglect, or the possibility of bodily harm to a client are not always clear.

### Making referrals

When assisting someone in a situation of family violence, respondents were most likely to refer clients to social workers, shelters, and child protection services.

When considering referrals, many respondents indicated they feel bound by systems that create more harm than good. Challenges with child protection agencies and systemic barriers such as racism, discrimination, and access to adequate services were mentioned. Some commented on the cycle of violence and that interventions are made progressively, with impacts seen over time. Others named relationship-building and using a trusted circle of referrals as examples of effective interventions.

Putting these challenges into context, only 36% of 236 respondents said they considered their referrals/interventions effective *all of the time*. At the same time, about two thirds of respondents or 62.29% said they perceive their interventions/referrals are effective *some of the time*.

### Involvement and Impact

**Many midwives stay actively involved with clients after making a referral to services. However, proportionally more Indigenous midwives (62.96%) reported staying actively involved compared to non-Indigenous midwives (43.25%).**

All midwives are impacted by exposure to family violence, but Indigenous midwives appear more personally impacted by this work. More Indigenous respondents experience vicarious trauma, are re-traumatized and suffer mental health impacts from exposure to family violence compared to non-Indigenous respondents. This is likely due to the ongoing impacts of colonialism and intergenerational trauma experienced by Indigenous peoples. *See Table 5 on the Impact of Exposure to Family Violence.*

Despite this impact, more Indigenous midwives (69.23%) compared to non-Indigenous midwives (53.77%) report that exposure to situations of family violence has motivated them to continue to do this important work.

## Best Practices and Challenges

We asked practicing midwives to describe their best practices and challenges for recognizing and responding to family violence.

One hundred and forty-five midwives named the following best practices:

- Routine/universal screening, follow provincial guidelines, follow Duty to Report
- Practice trauma-informed care that respects informed choice
- Prioritizing continuity of care
- Building relationship/rapport: ask questions, create a safe space for open communication, make observations, use instincts
- Connect with local support systems to ensure a team response
- Offer awareness-raising resources to client; some mentioned posting resources in clinics as well as offering referrals to services such as social workers, children's aid services, lawyers, and shelters

In their own words:

> *My practice is guided by community standards, community resources, and my own lived experience.*
>
> *Asking direct questions, using validated screening tools, practicing trauma-informed care (always asking consent before any touching, being aware of certain procedures' likelihood of being triggers, being gentle, etc. with everyone including colleagues/students), working in a midwifery care model that prioritizes continuity of care, following Duty to Report, not making referrals to Children's Aid Society and potentially harmful organizations without a significant and plausible reason.*
>
> *Using a rights-based approach, focusing interventions on safety, having a team approach with other care providers involved to update the care plan and ensure all persons' needs are being met.*
>
> *I follow a trauma-informed care approach where I create a safe place, invite people to share without having to describe. Only ask what will assist me with providing care. Always have time and resources on hand if the answer is yes. I am not aware of any best practice protocols.*

## Challenges

One hundred and fifty-eight midwives described their challenges in recognizing and responding to family violence and how they address these challenges. Their qualitative responses reflect a number of themes:

- Limited or lack of resources/services
  Several people mentioned difficulties in accessing appropriate, adequate, community, local or qualified resources or services, especially during the COVID-19 pandemic. Several people mentioned collaboration with other professionals and a coordinated team approach/response as both a challenge and a need.

- Systemic/societal challenges
  The following systemic challenges were named by several people:
  - Issues with children's aid services in Indigenous communities
  - Lack of protection from child services
  - Lack of safe housing
  - Patriarchy, gender inequalities
  - Racism

- Lack of training/knowledge
  Several people mentioned insufficient training or knowledge about all forms of family violence. Two people also mentioned the lack of clarity around the Duty to Report/Warn.

- Fear of causing harm
  Several people named the fear of causing harm to clients or oneself due to gaps in knowledge or distrust in the system, especially regarding the protection of children.

- Limited scope of practice
  A few people mentioned that midwives are part of a larger systems response to family violence and have a limited direct role in addressing family violence.

## Addressing challenges

Various people named maintaining rapport/relationship-building with clients as a means to create a safe space. This was considered especially important for vulnerable communities. In general, the importance of protecting client relationships and staying connected to community services are considered priorities.

However, while developing trusting relationships is seen as a key to recognizing and responding to family violence, there can be barriers to building rapport:

- Having time with the client alone
- Cultural barriers (religious practices, gender norms)
- Client readiness to disclose due to fear, distrust of systems or inability to leave the situation

In their own words:

These responses provide particular insights on systemic and professional challenges as well as best practices:

> *Clients' inability/unwillingness to leave situations of violence, health/economic system inability to meet clients' needs (insufficient low-cost housing and shelter, poor quality and expensive mental health services that prioritize clients of high socioeconomic status), racism and discrimination by Children's Aid Services, difficulty of identifying child maltreatment versus differences in cultural and family parenting styles, miseducation of colleagues (i.e. considering use of cannabis in pregnancy as maltreatment or indication for children's service involvement). I address these challenges by being updated on current research and best practices, trying to provide cultural safety, listening to my clients, and establishing a relationship of trust and rapport, being active in my community meetings with Children's Aid Society through research/stakeholder discussions.*
>
> *I just don't feel like I am prepared well enough, and it feels overwhelming to deal with this issue when midwives deal with so much already in terms of client care. I realize that we are in a position as primary healthcare providers to identify IPV and child maltreatment, but I also think managing it is outside of our scope. It should be managed by and in conjunction with professionals in this field.*
>
> *Unless clients admit to violence, it is often so hidden. We can suspect but never confirm with enough to make referrals. We are only a part of their care team for a finite amount of time and even with longer appointments we don't have enough exposure to determine if suspicions are supported by evidence or build enough of a relationship that the client will admit violence is occurring.*

In summary, the responses to questions related to attitudes, barriers, challenges, and responses provide important insights on the need to increase knowledge and provide tools and resources to build confidence and capacity to recognize and respond. At the same time, while midwives can play an important role in mitigating violence within families, responding to family violence does not remove systemic/structural causes of violence. Systemic change is necessary to reduce the impacts of family violence on society.

## Learning and Engagement

We asked respondents to identify their existing knowledge of VEGA resources as well as resources available on federal and provincial health sites. We were also interested in finding out about preferred learning styles, methods of accessing resources and topics of interest for continued education.

### Knowledge of existing resources

Many respondents reported not being aware of the existing resources mentioned. This was most significant for VEGA resources compared to federal or provincial health websites.

- 86.05% of 259 respondents are **not aware of VEGA**, 58.14% or 150 respondents are not aware of federal health websites, 43.02% or 111 are not aware of provincial health websites.

Respondents are more likely to use provincial health sites compared to federal sites or VEGA resources.

- Only 5.81% or 15 respondents reported using VEGA resources, some 22.48% or 58 respondents use federal health websites, and 42.64% or 110 use provincial health websites.

Significantly, many respondents reported they are aware but do not use the resources.

- 8.14% or 21 of all respondents reported knowing about VEGA but not using it as resource, 19.38% or 50 respondents know about but don't use federal health websites, and 14.34% or 37 know about but don't use provincial health websites.

- Notably, Indigenous respondents were more likely to be aware but not use VEGA. This was reported by 24.14% or 7 of 29 of Indigenous respondents.

### Gaps and Opportunities

Gaps in knowledge point to opportunities to raise awareness about existing resources, especially VEGA. At the same time, the significant number of people who are aware but who do not use the mentioned resources points to an opportunity to develop more midwife-specific resources and learning opportunities.

In their own words:

> *I have not had need to use these websites in the past, have not heard of VEGA and don't think the federal government offers anything useful. I would naturally first start closer to home, municipal, and then provincial resources.*
>
> *Government stuff is useless except for the phone numbers. Only became aware of VEGA recently; use an Indigenous framework and teachings.*

## Preferred resources

We asked midwives and midwifery students to identify what kind of information or resources they would find helpful to assess and support someone in a family violence situation.

The following are the most preferred resources:

- Downloadable and printable (posters, pamphlets, guides, tip sheets)
- Checklists (e.g., indicators or cues of family violence, considerations for trauma-informed care)
- Flowcharts (e.g., pathways to available services)
- Infographics (e.g., statistics on intimate partner violence, children's exposure to intimate partner violence, child maltreatment, role as a midwife)
- Awareness-raising resources to share with clients

Various people named additional suggested resources targeted to clients or midwives.

| For clients: | For midwives: |
|---|---|
| • Zine with resources<br>• Harm-reduction resources (safety-plan)<br>• Apps<br>• Infographics that explain IPV (all forms)<br>• Cultural-specific resources<br>• Available in multiple languages | • Follow-up protocol<br>• Information on local supports (both client/midwife)<br>• Resources to navigate access to social services such as housing, income, food access, and wrap-around service supports<br>• Awareness-raising resources for sharing with colleagues |

Regarding how they access information, respondents prefer accessing shareable resources such as images, infographics, and videos, as well as interactive resources such as webinars and teaching modules.

## Professional Development

About 90% or 257 respondents are interested in participating in professional development workshops on family violence. The following table summarizes the five professional development topics with the highest level of interest. These are categorized by all respondents, non-Indigenous and Indigenous respondents. Notably, compared to non-Indigenous respondents, Indigenous respondents have a significantly greater interest in building capacity on how to recognize family violence, how to respond to intergenerational trauma, and how to advocate for clients.

| Preferred Topics (all respondents) | Non-Indigenous | Indigenous |
|---|---|---|
| 1. Violence and trauma-informed care 80.93% | 81.14% | 89.66% |
| 2. Recognizing intimate partner violence, children's exposure to intimate partner violence, child maltreatment 77.87% | 77.68% | 92.5% |
| 3. Conducting safe clinical assessments in the home 69.17% | 67.86% | 69.23% |
| 4. Client advocacy (to access psychosocial supports) 67.45% | 69.16% | 81.48% |
| 5. Inter-generational trauma, colonization and their effects on family wellbeing 62.20% | 62.83% | 75.00% |

People were given the opportunity to suggest other topics they would like to see addressed in professional development trainings.

The following is a list of suggested topics:

- Safety (midwife/client)
- Co-morbidity of mental health and addiction
- Substance use in pregnancy
- Specific challenges in Indigenous communities (access to resources limited)
- Clear referral process and navigating child protections services when there is a lot of distrust in the system
- Coordinating an effective team approach
- Flowcharts to document physical injury (resource)
- Role-playing scripts
- List of national and local resources
- Recognizing all forms of violence, including non-physical; working with vulnerable populations
- Suggested speaker on trauma-informed care: Jodi Hall
- Stories of survival

**What other topic would you like addressed through professional development?**

In their own words:

> *Post-traumatic resilience - how people with a history of violence go on to find their strength and be badass people who shed the mantle of victim. More stories of triumph because I need a way to deal with the tightness I get in my chest after all these checklists.*

## Situations of Violence Described by Respondents

Midwives who have provided care to people in situations of family violence were given the opportunity to describe the situation(s). Fifty midwives shared experiences that reflect a number of community, relationship and individual patterns.

**Patterns:**

- Controlling partners, isolation
- Traditional gender norms, especially with newcomers
- Most describe situations of physical violence, including rape leading to pregnancy, sexual trauma, there was one case of sex trafficking described
- There were also situations of psychological abuse, emotional abuse
- Situations involving vulnerable communities: newcomers, sex workers, people living with disabilities, addictions, or people facing poverty, and overcrowding

A few survey responses poignantly demonstrate the role of midwives in situations of family violence, the difficulty of the work, as well as the impact of violence and systemic challenges.

In their own words:

> *A client always seemed like something was off but did not disclose despite repeated attempts to get her to confide and offer her assistance. She ended up having a triggering moment during labour when she needed an operative delivery and had to have general anesthesia for her Cesarean section. It was very traumatic for everyone involved, especially for her, I imagine. I felt unprepared to deal with this situation and that I had somehow let her down when I truthfully did all that I knew to do. I just wish I knew more.*
>
> *One of my clients was trafficked and re-victimized by a perpetrator who was released from prison in March 2020 due to COVID restrictions in prisons. She'd spent two years fighting to put him behind bars to protect her daughter. After he was released, he forced her back into sex work and then used her involvement in sex work to remove their daughter from her care. She was an outstanding mother. She's been unable to visit with her child due to staffing and COVID restrictions. Child protection services won't return the child to her care while she is involved with sex work. The child resides with her pimp's own mother, and he has access despite being convicted on 21 counts. She's been treated repeatedly at the hospital for violent injuries resulting from rape.*

People were also given the option to share anything else they would like to say about midwives working in a context of family violence.

### A number of recurring themes emerged:

- Midwives are uniquely positioned to do this work; however, the work comes with huge responsibility. They are in a position of privilege where their actions can help or create more harm.
- Midwives may have an impact on individual lives, but systems change is needed to address the root causes of violence and to ensure proper supports.
- There is a need for more formal training on identifying all forms of violence, and there is a need to address the safety concerns of midwives as well.
- Knowing that reporting can create more harm, there is a need for good judgement when making decisions on the Duty to Report.
- There is general distrust in the system that causes more harm than good. This points to the need for systemic change, including more referral pathways.
- There is a big personal impact of doing this work and some question whether it should be within their scope of practice.
- Better community supports are a priority, and this needs to be addressed at a systems level.

In their own words:

> *My daughter was a victim of coercive control. I learned about it and now it's alarming to me how often I have seen it in my work. I really believe that we as midwives have a unique opportunity to recognize this and plant seeds with our clients because of the nature of our relationships with them. But if we don't even know what it is how can that happen? Just because there are no bruises does not mean there is no abuse. Please, can we design some educational resources around this?*
>
> *Midwives have a lot of power and clients do not always feel empowered. In the context of family violence, midwives' actions (or lack of action) can have serious impacts if the care does not have the client at the centre.*
>
> *We can identify and provide some support, but it is a huge societal issue and we are small cogs in the wheels of the system. I think we can offer some help and develop trusting relationships with our clients in a micro/individual way but there needs to be macro changes.*

*Midwives can and do have a vital role to support their clients, to educate and promote safe futures for women and their children, and to break the cycle of family violence. As midwives we play crucial roles in supporting and protecting families. We hold such incredible privilege as midwives. Through longer appointment times, focus on social determinants of health, mental wellbeing, and home visits, we have a deep view into the window on a family's dynamics and wellbeing in this vulnerable time. We owe it to families to use that privilege to serve their safety and wellbeing as best we can.*

## Demographics

Survey respondents practice in Ontario (129), British Colombia (50), Quebec (30), Alberta (15), Manitoba (5), Northern Canada (6), and the Maritimes (5). This distribution is consistent with the geographic representation of midwives across Canada. Most (61%) midwives who responded to the survey practice in urban areas. The remaining survey respondents practice in sub-urban areas (28.79%), rural areas (30.35%), remote (6.61%) and Northern communities (6.23%). The majority (83%) of people who responded are between 25-54 years of age. There was a similar number of midwives with considerable years of midwifery experience compared to those with five years of experience or less.

Based on the way the question on communities served was designed (*Table 9*), we cannot infer which communities are most served. However, it is clear midwives serve a range of communities including Indigenous, immigrant, racialized and LGBTQ2S+ communities.

Respondents could select among the list of communities mentioned, as well as the category 'other'. They were given the option of providing more information. Those who selected 'other' or provided more information stated they served Caucasian/white people, religious-cultural groups (Mennonites, Amish, Evangelical), low-income, middle class, privileged, and non-status populations[2]. *See Tables 6 – 9 for more detailed information on demographics.*

Notably, there were two key differences between non-Indigenous and Indigenous responses.

- 78.57% of Indigenous midwives serve Indigenous communities compared to 52.05% of non-Indigenous midwives.
- 66.21% of non-Indigenous midwives serve immigrant communities compared to 50.00% of Indigenous midwives.

*See Tables 6 – 9 for more detailed information on demographics.*

[2] Some people who provided more information mentioned serving communities already listed in the question, namely Indigenous, racialized and immigrant, LGBTQ2s+ communities. Only responses that were different than the listed choices are described as 'Other' answers.

## Key Takeaways

1. Survey respondents represent a good cross-section of the midwifery population in Canada.
2. Knowledge gaps were identified related to recognizing and responding to family violence, especially around child maltreatment. The need for formal training on trauma-informed best practices also emerged. There is a need to pay particular attention when making service referrals given the possibility of creating more harm. This applies especially for referrals among communities with higher/disproportionate rates of violence who face the ongoing legacies of colonialism, racism, and systemic discrimination—namely, Indigenous peoples, racialized, immigrant and LGTQ2S+ communities.
3. Systemic barriers to preventing and addressing violence were named repeatedly in survey responses. While midwives acknowledge they can play a role in mitigating family violence, long- term solutions require addressing systemic/structural causes of violence.
4. There is an expressed interest in practical and dynamic resources as well as interactive learning opportunities on how midwives can support clients in situations of family violence. Notably, very few respondents are aware or use existing VEGA resources; most respondents do not rely on government websites for information on family violence.
5. The stakes in doing this work are higher for Indigenous peoples—they are more likely to work with people vulnerable to family violence, more likely to be confronted with systemic barriers, and more likely to be impacted personally by this work. These tendencies point to the need for all midwives working with Indigenous communities to be informed about the legacies of colonialism and avoid perpetuating harm.
6. Midwives are very engaged in the well-being of their clients. The hundreds of qualitative comments in the survey illustrates the passion of midwives to support clients in situations of family violence. At the same time, midwives acknowledge it is very difficult work that takes a toll on them professionally and personally.

## Conclusion

While family violence can happen to anyone, we acknowledge that some people are more likely to experience family violence due to socio-economic inequalities. We know systemic barriers drive disparities, especially for people facing the impacts of colonialism, racism, sexism, classism, able-ism, xenophobia, and homophobia. We also acknowledge that family violence can start or escalate during pregnancy.

Continuity of care is a foundational principle of midwifery practice in Canada. The ability to build trusting relationships with clients and their families, and to be actively involved in the community, uniquely positions midwives to recognize and respond to family violence. Having access to tools and resources, including knowledge of trauma-informed care will enable midwives to recognize and respond to family violence in a constructive and socially responsive way.

Indigenous midwives have an intimate knowledge of their communities, and the systemic roots of violence. This project aims to enable midwives to harness their knowledge and expand their capacity to address the harms of colonial violence by working with clients who are living its reality.

It is important to centre the knowledge of Indigenous communities. It is also important to acknowledge the responsibility of CAM and all midwives in supporting NACM's goal to restore Indigenous midwifery to Indigenous communities as a crucial step in addressing systemic colonial violence.

Through this project, we are hoping that early intervention can mitigate the devastating impact of family violence on physical, psychological, and social health, for all communities. The findings in the Knowledge Assessment Survey will inform our work towards this goal.

# Tables

### Table 1: Signs and Symptoms of Family Violence

*6. Which of these signs and symptoms do you believe may be related to intimate partner violence, children's exposure to intimate partner violence and child maltreatment? Check all that apply:

Respondents: 260

| Choice | Percentage | Count |
|---|---|---|
| a) Physical injuries | 90.38% | 235 |
| b) Mental health disturbances (depression, post-traumatic stress) | 96.92% | 252 |
| c) Chronic pain | 78.08% | 203 |
| d) Other – please specify: | 41.92% | 109 |
| e) Not sure | 3.46% | 9 |
| Total | 100% | 260 |

### Table 2: Signs and Symptoms of CE-IPV and Child Maltreatment

*7. Which of these behaviours or cues do you believe may be related to children's exposure to intimate partner violence and child maltreatment? Check all that apply:

Respondents: 260

| Choice | Percentage | Count |
|---|---|---|
| a) Fearful | 90.38% | 235 |
| b) Oppositional behaviour | 79.23% | 206 |
| c) (Parent/Caregiver) Fails to follow-up on treatment | 82.31% | 214 |
| d) Other - please specify: | 20.00% | 52 |
| e) Not sure | 11.15% | 29 |
| Total | 100% | 260 |

Table 3: Signs and Symptoms of Intimate Partner Violence

*8. Which of these behaviours or cues do you believe may be related to intimate partner violence? Check all that apply:

Respondents: 260

| Choice | Percentage | Count |
|---|---|---|
| a) Repeatedly cancelling visits | 91.15% | 237 |
| b) Increased use of health services | 65.77% | 171 |
| c) Deferring to partner in visit | 94.23% | 245 |
| d) Partner is always present | 94.62% | 246 |
| e) Partner answers for pregnant client | 98.46% | 256 |
| f) Other controlling behaviour: please explain | 36.15% | 94 |
| g) Other - please explain: | 15.38% | 40 |
| h) Not sure | 4.23% | 11 |
| Total | 100% | 260 |

*Indicators of IPV, child maltreatment and children's exposure to child maltreatment included as options were based on evidence-based indicators in VEGA resources.

Table 4: Not Observing for Family Violence

13. If you do not routinely observe for signs and symptoms or ask about family violence, which of these scenarios best describes why? I have had worries about family violence but didn't say anything because (Check all that apply):

Respondents: 73

| Choice | Percentage | Count |
|---|---|---|
| a) I didn't know what to say | 27.40% | 20 |
| b) I couldn't ask at the time (potential risk to client) | 68.49% | 50 |
| c) I didn't want to offend my client | 23.29% | 17 |
| d) I was afraid to find out more because then what... | 19.18% | 14 |
| e) Other - please specify: | 31.51% | 23 |
| Total | 100% | 73 |

Table 5: Impact of Exposure to Family Violence

22. How has exposure to family violence impacted you? Check all that apply:

| Choice | Indigenous Percentage | Count | Non-Indigenous Percentage | Count |
|---|---|---|---|---|
| a) I have experienced vicarious trauma due to my exposure | 46.15% | 12 | 22.61% | 45 |
| b) It has re-traumatized me | 26.92% | 7 | 14.57% | 29 |
| c) My mental health has suffered | 42.31% | 11 | 22.61% | 45 |
| d) It has made me question my motivation to continue to practice | 19.23% | 5 | 6.03% | 12 |
| e) It has motivated me to continue to do this important work | 69.23% | 18 | 53.77% | 107 |
| f) I have not noticed a significant impact | 11.54% | 3 | 30.15% | 60 |
| g) Other - please specify: | 11.54% | 3 | 16.58% | 33 |
| Total | 100% | 26 | 100% | 199 |

Table 6: Age

35. What is your age?

Respondents: 259

| Choice | Percentage | Count |
|---|---|---|
| Under 25 | 1.93% | 5 |
| 25-34 | 30.50% | 79 |
| 35-44 | 28.96% | 75 |
| 45-54 | 23.94% | 62 |
| 55-64 | 11.97% | 31 |
| Over 65 | 2.70% | 7 |
| Total | 100% | 259 |

Table 7: Years of Midwifery Practice

37. How long have you been practicing midwifery?

Respondents: 259

| Choice | Percentage | Count |
|---|---|---|
| 5 years or less | 26.25% | 68 |
| 6-10 years | 17.37% | 45 |
| 11-15 years | 13.51% | 35 |
| 16-20 years | 10.04% | 26 |
| More than 20 years | 15.44% | 40 |
| N/A | 17.37% | 45 |
| Total | 100% | 259 |

Table 8: Practice Catchment Area

38. Describe your practice catchment area. Check all that apply:

Respondents: 257

| Choice | Percentage | Count |
|---|---|---|
| Urban | 61.09% | 157 |
| Suburban | 28.79% | 74 |
| Rural | 30.35% | 78 |
| Remote | 6.61% | 17 |
| Northern | 6.23% | 16 |
| Other - please specify: | 3.11% | 8 |
| N/A | 7.39% | 19 |
| Total | 100% | 257 |

Table 9: Communities Served in Midwifery Practice

39. Describe the communities you serve in your practice. Check all that apply:

| Choice | Non-Indigenous Percentage | Non-Indigenous Count | Indigenous Percentage | Indigenous Count |
|---|---|---|---|---|
| Indigenous peoples (First Nations, Inuit, Métis) | 52.05% | 114 | 78.57% | 22 |
| Immigrant communities | 66.21% | 145 | 50.00% | 14 |
| Racialized communities | 53.88% | 118 | 50.00% | 14 |
| LGBTQ2S+ communities | 48.86% | 107 | 42.86% | 12 |
| (Optional) Provide more information: | 14.61% | 32 | 17.86% | 5 |
| Other - please specify: | 14.16% | 31 | 7.14% | 2 |
| N/A | 8.22% | 18 | 3.57% | 1 |
| Total | 100% | 219 | 100% | 28 |

# Midwives
# Recognize & Respond to Family Violence

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