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The Role of Simulation-Based Education for Domestic Violence Management

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Abstract

Domestic violence (DV) is a significant public health issue, which is a barrier to societal development as a complex healthcare burden. Historically, DV has been ignored and tolerated in many parts of the world. Certainly, the time to affect a change in this epidemic problem is now. The health care system is an essential setting for victim of DV to be provided supportive practices. Nowadays, sensitivity is a requisite for quality health care. Yet, routine DV screening is not regularly performed in health care settings. Especially, DV screening questions need added to the patient files as a part of hospital procedures. This patient-centered approach contributes positively in conducting the identifying of DV. Thus, all women are encouraged to disclosure about violence. Additionally, ongoing training for staff has become an essential component of the hospital process to enhance their competency/skill and confidence for DV screening. Further, to increase patient safety and to achieve quality of care, simulation based education model (SBE) is offered as a new approach with supportive care and accompanying protocols to victim of DV. Ultimately, this model may even more effective changing practices than conventional model of education. The objective of this review is to emphasize the importance of well organized the SBE in screening of DV and appropriate responding to women who experience DV.

Keywords

Domestic Violence, Screening, Simulation Based Education, Heath-Care Staff

1. Introduction

DV is defined by World Health Organization (WHO) as "any act of physical, sexual, or emotional abuse by a current or former partner, whether cohabiting or not". DV is based on gender stereotypes and it is perpetrated against women in

most cases as compared to those against man (WHO, 2021). Domestic violence (DV) is learned behavior and a violation of women's human rights DV against women is a violation of their fundamental human rights (Zaher et al., 2014; Miller & McCaw, 2019). Overall, DV is a major public health issue with substantial social, financial, mental, sexual and physical health problems for women including death, serious injury, sexual transmitted disease, acute or chronic pain, drug-alcohol abuse, perinatal complications, post-traumatic stress syndrome, fear, anxiety, depression, suicide acute and chronic poor health outcomes (Rosen et al., 2017; Yılmaz & Oz, 2019; Sohal et al., 2020; Spangaro et al., 2020; Azad, 2021). Besides, it is stated that women are highly anxious about being subject to DV. On the other hand, many survivors of DV tend to avoid reporting having suffering DV because of the fear of violence from their spouses or family members and lack of economic power. Many women are also advised to return home from their local authority (Musa et al., 2019; Krull et al., 2019; Sauber & O'Brien, 2020).

According to WHO (15 - 59 years old women population-based survey data from 2000-2018 across 161 countries), DV has reached (15% - 71% of women) epidemic ratio in various countries. DV was found to be most widespread form of abuse reported (with around 800 million women). In the twenty-first century, at least one in three women is still abused by their intimate partners or family members in their lifetime worldwide (Western Pacific 20%, Europe 22%, USA 25%, Asia 33%, Eastern Mediterranean and Africa 36% - 38% etc.)—a number that has remained highly unchanged over the past decade. Referring to these analyses, women at risk from DV than from cancer, accidents or other diseases (WHO, 2021).

In recent years, considerable efforts have been made to increase to develop strategy for the preventative measures to abuse. Nevertheless, despite all the national or international progress DV remains a widespread problem. In this regard, DV needs urgent attention globally (Devine et al., 2012; Mancheno et al., 2020; Miller & McCaw, 2019). To dealt with DV, it is recommended to establish some practices such as strengthened accountability, coordination, consultancy, leadership, legal, policy, proactive prevention, care plan, healing, support, response, vigorous surveillance, and information system by way of a multi-sectoral service (O'Campo et al., 2011; Moyer, 2013). Amongst the government sectors, the health sector has an important role to play to provide comprehensive care and appropriate referral for these women. Especially, emergency departments (EDs) are one of the first application centers and have an extremely important role in providing the necessary holistic treatment, long-term protection and support to women who are victims of DV. The fact that the EDs are accessible 24 hours a day, responding as soon as possible and having many sub-units (laboratory, imaging, etc.) are key points in terms of detection and management of DV. Therefore, ED workers also play a vital role to contribute to the prevention, identification and management of DV (Yonaka et al., 2007; Olive, 2007; Natan & Rais, 2010). Certainly, in order to provide an effective EDs for the solution of the

problems, it is very important to eliminate the educational and the institutional gaps, to provide a suitable room in the EDs where the privacy of women can be ensured, to provide the necessary documents, and security personnel in sufficient number and equipment. Unfortunately, progress in the healthcare community to DV has been slower (Boursnell & Prosser, 2010; Wong et al., 2018).

Although the general consensus of the WHO is to detect for DV, the prevalence of DV screening among health providers remains limited. Furthermore, it is reported that when women disclose DV health providers hesitate to get involved to support victims because DV is culturally not frequently considered a health issue (Wong et al., 2018; Mitchell et al., 2020). Consisted with current study indicates barriers involving screening women for violence (Natan & Rais, 2010; Kaplonyi et al., 2017). As mentioned, most health workers are confused about recording criminal context in medical files. Instead of being advocates of women, many health providers may prefer to remain "neutral" or "blind-eye" to problem of DV because of the cultural ignorance, and this approach amplifies DV (Wood, 2016; Sharma et al., 2018; Hegarty et al., 2020). As a result of the failure of society response, physical abuse is considered "real" abuse, which stems from visible injuries. In medical terms, this situation constitutes poor prevention medicine. In many countries, DV is often justified as a private family matter. Many barriers to collaboration based on these misperceptions. According to the several studies, most health providers are still not routinely screening cases for DV due to fear of offending patients, lack of appropriate training or confidence, lack of skills in responding to DV disclosures, lack of time for optimal care because of heavy workloads, lack of funding to improve new strategy, and lack of system-based scrutiny to identify victims of abuse. Therefore, professionals, institutional and national authorities need to be better educative actions for closer attention and awake to a strategic approach based on DV situations (Nicolaidis et al., 2005; Davila, 2006; Wong et al., 2015). As a point of all studies, by making DV more visible with ongoing personnel training, inter-sectorial study, and institutional protocol to guide for clinicians can be improved women's quality of life. Despite this recommendation, there are not so much effective training practices. Although it is stated that the DV trainings given using in-service work-shops are impressive in improving the knowledge and attitudes of health workers for managing victims of DV (Nicolaidis et al., 2005; Papadakaki et al., 2013). However, it is also emphasized that its effectiveness is not sufficient in the long term and there are limitations in reflecting it in practice (Zaher et al., 2014).

Simulation-based education (SBE) model may help to improve satisfaction from educational outcomes. SBE promotes peer-to-peer interaction with experiential team-based learning and creates behavior change to address issues surrounding patient abuse (Shefet et al., 2007; Bryant & Benson, 2015; Jeong & Lee, 2020). SBE also provides a realistic, cost effectiveness, innovative, secure, effective, and interactive learning setting for health workers SBE is essential to develop clinical skills without generating any risk to patients. SBE with variety of complex scena-

rios, different simulators and multimedia technology includes competency, critical thinking, clinical reasoning, judgment skills, knowledge retention, and cognitive reflection for screening of DV (Braude et al., 2015; Bryant & Benson, 2015). In this model, measurement outcomes associated with the training session evaluation include pre test and post test. After evaluation process, a change in knowledge and attitude scores is noted. However, the SBE yields additional data on staff performance for screening and managing of DV. Briefly, after all of these improvement, the patient will be cared safely, and also sustainable referral information will be offered (Wood, 2016; Devine et al., 2012).

2. Aim

This paper focused on the utility of the SBE on DV screening applied by health professionals.

3. Theoretical Framework for SBE

According to the Miller et al. (2021), properly administering training program on DV screening may be part of the solution. SBE model indicate a social constructivist theory of knowledge which stipulates that all cognitive functions through social interaction. This model on DV screening is particularly novel, as prior studies have not considered clinical adverse or good outcomes. Therefore, the SBE model included a silver code (in hostage position) simulation training with multidisciplinary team and it provides a better understanding of effective way of administering DV screening and properly response practices by health providers in the clinical setting (Heron et al., 2010; Braude et al., 2015). In addition, SBE model can lead to effective intervention to improve women's health in a safe environment as a gold standard. The SBE allows providers learn technical and non-technical skills from abuse scenarios. These learned skills could be used in both personal and professional life. The lack of continuity between simulation training programs is the biggest problem. Indeed, this unique experience is could not be achieved through traditional training program (Davila, 2006; Zaher et al., 2014; Wood, 2016; Jeong & Lee, 2020).

In a study indicated that a model of staff (consisting of a physician, nurse, social worker, psychologist, and hospital administer) training (with check list, posters, brochures, regular routine care and mandated DV tool) that emphasizes system change could be effective in improving the DV-related "culture" of the ED and provider attitudes and knowledge toward survivors of DV. Patient satisfaction was also affected positively (Devine et al., 2012; Wong et al., 2018; Sohal et al., 2020). Based on all these positive results, this kind of studies are urgently needed in other settings as well. Continued management support is required to increase lasting system change (Natan & Rais, 2010; Spangaro et al., 2020; Mitchell et al., 2020). In a different study performed by Shefet et al. (2007), SBE program for health workers was found highly effective in enhancing self-confidence, competences and skills regarding DV screening. In the prior studies, health personnel's knowledge, skills and advocate actions for responding DV cases im-

proved successfully with statistical significant (Wood, 2016; Kaplonyi et al., 2017; Sharma et al., 2018; Jeong & Lee, 2020). Similarly, correlation between overall provider's awareness of abuse, empathic communication skill, comfort, self-defense skills, and professionalism competency were positive (Heron et al., 2010; Zaher et al., 2014; Krull et al., 2019).

The SBE model includes some goals (Murphy et al., 2016; Kim et al., 2016; Kuliukas et al., 2017; Sharma et al., 2018).

- To increase the awareness of health workers about DV and to define their responsibilities in service.
- To improve the existing knowledge of health workers on DV and gender equality.
- Ensuring that health workers can use appropriate communication techniques within the framework of the DV problem of the woman applying to the institution.
- To ensure that healthcare professionals have the skills to identify the problem of DV, implement care, training and consultancy initiatives, and refer them to the right units when necessary.
- To create an improvement team among the service workers who were trained in developing the DV diagnosis form in order to help healthcare professionals include DV services within the scope of their care, and to share how to fill out this form.
- To develop the "DV" service quality and perspective of health professionals in their institutions and to enable them to develop an attitude towards enabling the applicant to benefit from this service.

In the SBE model, interdisciplinary partnership forms, tools and pre-post test (knowledge-attitude-belief) can be used to collect data or to evaluate outcomes; (Levett-Jones & Lapkin, 2014; Haan et al., 2016; Kuliukas, 2017; Krull et al., 2019).

- Individual identification Form
- DV Knowledge Scale
- Education Evaluation Form
- Attitude Scale towards Violence
- Attitude Scale of Health Staff's Occupational Roles Against DV
- Physical and Emotional Examination Form
- DV Screening Tool
- Epicrisis Report Form
- Lecture DV Workshop Presentation
- Pre-simulation Discussion Form
- Observed Structured Clinical Examination Form-OSCE
- Simulation Model Evaluation Form
- Simulation Debriefing Form
- DV Diagnosis-Flow chart-Protocol Form
- Education curriculum
- Video-CD, Computer, Brochure, posters
- Crisis Response Clinical Case Scenarios
- Standardized patients, Facilitator, Coordinator
- Patient chart, photographs, body maps of injury
- Informed Consent Form
- Criminal Proceeding Form
- Electronic medical records

4. Simulation Sessions

After didactic training, there is a preparation about the simulation case scenario and techniques or approach to the DV screening. Participants watch a brief 5 minutes video of an example DV screening by health personnel in a clinic. Instructors organize pre-simulation briefing of the participants. At this time, facilitators should be prepared some forms, organizational protocols or mock documents about the definition of DV scenario. Participants are encouraged to discuss to reference DV screening and to recognize the red flags during the video scenario by facilitators. Facilitators may want to rethink this exercise to explore participant's understanding of a victim of DV by pulling from personal experiences. To engage in discussion facilitators may propose some questions using the brainstorm technique. After the discussion, participants should be divided into pairs and they are given scripts (user-friendly) with scene description (Wong et al., 2015; Kim et al., 2016; Jeong & Lee, 2020).

A Sample Agenda for SBE (Shefet et al., 2007; Haan et al., 2016; Battista, 2017; Kuliukas et al., 2017; Mitchel et al., 2020)

- Warm Down Activity-Ground Rules
- Defining DV/Form of Violence
- Understanding/Measuring DV
- Wheel of DV Power & Control, Approaches/Models/Theories for DV
- Legal aspects of DV
- Effects of DV, Consequences of DV
- Risk factors with victims of DV
- Protection/Dealing with DV/Prevention Techniques
- Supportive resources for DV, Women Against Activity
- DV Crisis Response/Management/Reporting and Documentation Role Plays
- Elaboration and Development of Protocols
- Legal Perspectives/Procedures
- General Guidelines for Referral Process
- Conclusion-Wrap up Activity, Take-Away Points

Finally, participants have role-playing opportunity with standardized patient (SP) to maximize fidelity during simulation scenario using an environment set-up such a real clinic patient room. SP and participants should be knowledgeable and comfortable to perform their role in simulation environment. Apart from SP, this model may also comprise different simulators (low, medium, and high fidelity) according to scenario (Heron et al., 2010; Wood, 2016). The simulation scenarios are examined, trialed and validated by faculty member prior implementing the simulation. In this learning experience, the functions of the team leader (attending, resident, physician etc.) are; assign roles & responsibility, maintains situational awareness throughout to emergency response code or directive promotes communication and controls practices during simulation, monitors safety of group during simulation. Generally two bedside workers provide basic care to the patient. And one physician, one security staff and one social worker include

into the scenario (Levett-Jones & Lapkin, 2014; Murphy et al., 2016; Haan et al., 2016, Battista, 2017).

The simulation scenario requires the participant to focus on SP with visible bruises and history of poor health outcomes for DV screening. Each participant introduces the victim of DV with the SP (professional actor, instructor or health staff). SPs are recruited from department to act in the scenario and they are trained in conjunction with scenario. The instructors in the team monitor each scenario from the control room. At the end of session, instructors present a debriefing session and they evaluate each participant's perception and performance of their preparedness when managing victims of DV in the scenario. The further scenario is designed to be more complex than to first. Therefore, the level of difficulty can be escalated with the simulated patient instructed to react to staff interventions in a more aggressive style (Wong et al., 2015; Kim et al., 2016; Jeong & Lee, 2020). Scenario is also designed to enable staff to focus on managing therapeutic communication skills to recognize early warning signs of problems in the hospital setting. Each simulation session usually last 10 minutes, but debriefing session includes 30 - 40 minutes. Participant watched the simulation via live video stream in a room. After simulation, immediately participants view the feedback and reflected on their performance during debriefing session in a safe nonjudgmental manner. Overall participants share individual accounts of the simulation. This part is guided to reflect on effectiveness of various approaches (Heron et al., 2010; Papadakaki et al., 2013; Wood, 2016).

A Sample DV Visit Tool (Nicolaidis et al., 2005; Davila, 2006; Shefet et al., 2007; Haan et al., 2016; Battista, 2017; Kuliukas et al., 2017, Sharma et al., 2018).

- Identification of patient history; name, age/birth date, time, education, employment etc.), health habits, health condition, risk assessment or family history
- Identification of open ended questions and guidelines
- Identification of relationship to abusive person
- Identification presence of abusive partner during visit (description of abusive person)
- Identification victim's statements and behaviors regarding violence and screening questions (onset or regularity of abuse, detail description of DV etc.)
- İdentification of DV evidence/indicate suspicion of DV despite patient's denial of abuse (review notes from previous visits, unclear statements, body examining such as fractured, bruised, injured, slapped, kicked, choked, punched, shot findings on a body map; indicating size, type, location, shape, color, degree or healing process, especially injury body photos, drawings or some lab tests)
- Identification safety assessment, using of protective resources
- Identification of intervention strategies and follow up plan by health staff involved in treatment and all referrals
- Identification of rules for protecting patients' privileged relationship with staff

Participant's performance is assessed using a form complied by the observer instructors. In evaluation section; participant need to complete some surveys; a pre-training test, post-training test, self-evaluation form (observed structured clinical examination-OSCE), and a follow-up test to determine self-perceived le-

vels of self efficacy, competence in managing DV cases. A follow-up survey is sent to staff as online after 3 - 6 months post-simulation training to assess their continued knowledge, skills and perceptions of the training in the workplace. Participants have opportunity for skill maintenance is for simulation experiences to be followed by refresher courses. Briefly, SBE can be replicated in various clinical fields to achieve larger scientific evidence in terms of clinical issues (Nicolaidis et al., 2005; Shefet et al., 2007; Haan et al., 2016; Battista, 2017; Kuliukas et al., 2017).

5. Conclusion and Recommendations

In the light of previous literature, DV is increasing dramatically in society and many cases of DV remain unnoticed within the health sector due to lack of awareness. SBE is an acceptable model because it allows respond to realistic complex or crisis situations with uncompromising ethical principles in the clinical setting. SBE may also provide significant changes in health staff's knowledge, skills, ability, satisfaction, and confidence to handle women who experience DV. Integrating simulation into a comprehensive DV screening program is an effective method for preventing of DV. Sustainable SBE should be given as a routine practice of health clinic. This review can inform future efforts to improve new research on DV screening programs in clinical areas to ensure that victims of DV have achieve to suitable counseling, multidisciplinary supportive resources, and referral services. Consequently, for future intervention regarding prevention DV include the following;

- There is a need comprehensive expertise of professionals (screen, counsel, refer and follow-up on women who endorse DV) to solve problem and to change behavior with periodic fidelity training session.
- There is still a need for government and institutional involvement and support to protect women from DV. Psychosocial care to reduce anxiety and enhance quality of life should be given as a routine practice of clinics, also in the healthcare curriculum, nationally.
- There is a need for community awareness. Cultural sensitivity approach might have positively affected victim's outcomes and to eliminate the major barriers of DV.
- There is a need for evidence-based studies and safety planning strategies in this area. Further long-term patient-center studies are required for assessing the efficacy of simulation in the different clinical fields regarding screening DV.
- There is a need improving interdisciplinary cooperation and improving medical record documentation.

Conflicts of Interest

The author declares no conflicts of interest regarding the publication of this paper.

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