



See no evil, Hear no evil, Speak no evil

Studying the facilitating and impeding factors regarding the use of the
meldcode among maternity nurses

Bachelor Thesis

Faculty of Behavioural Sciences
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Dorothee Loch
s1122576

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1st Supervisor

Marcel Pieterse

2nd Supervisor

Annemieke Konijnendijk

UNIVERSITY OF TWENTE.

Abstract

Domestic violence is a persistent and complex problem. Professionals in the health care sector experience several barriers when dealing with it. The meldcode is a guideline that aims to support professionals in handling domestic violence. It will be implemented July 1st 2013 and from then all professionals, working with children and families, are obliged to use it. However, many innovations, such as guidelines, fail because the characteristics of the users were not taken into account. This research focuses on the barriers and facilitators that maternity nurses experience regarding the adoption of the meldcode. The results of this project can support health care organizations in the successful implementation of the meldcode. Since many maternity nurses do not work with the meldcode yet, their intention to do this in the future forms our most important dependent variable. The second dependent variable is the past behavior of maternity nurses regarding their use of the meldcode.

The goal of this study is to give concrete recommendations regarding the successful implementation of the meldcode among maternity nurses. The ASE-model helps us to operationalizes factors, that influence their intention to use the meldcode and their eventual behavior. It consists of the three determinants attitude, social norm and self-efficacy. We study if their attitude, social norm and self-efficacy predict their intention to use the meldcode. Additionally, the relation between past behavior regarding the meldcode and the ASE-model is studied. Furthermore, the role of the background factors work experience, experience with domestic violence, knowledge of the meldcode and the organization size are investigated.

An online survey was carried out among 124 maternity nurses from the area of Twente in the Netherlands.

Results indicate, that the perceived social norm and a high self-efficacy of the maternity nurses facilitate their intention to work conform the meldcode. The social norm plays a key role, since it predicts the intention but also the eventual behavior of the maternity nurses. Additionally, the knowledge about the meldcode is an important predictor of the intention and the behavior. The more knowledge a maternity has over the meldcode, the higher is her intention to use the meldcode and the higher is her performance of the steps when she has a suspect. Work experience, experience with domestic violence and organization size do not have an impact on the intention or the behavior.

The general lack of research about the implementation of the meldcode to maternity nurses can be reduced by the results of this research.

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Chapter 1

Introduction

1.1 Domestic violence

Prevalence and seriousness Domestic violence is a complex and persistent problem which can have terrible consequences for the victim and its environment. Van Dijk, van Justitie, Preventie, en Reclassering, and Criminaliteitspreventie (1997) conducted a study about the rates of domestic violence in 1997. 516 men and 489 women aged between 18 and 70 were asked about their experiences with domestic violence. The results suggest, that 45 % of Dutch people have been victims of domestic violence. The violence lasted for longer than 5 years in 21 % of these incidents. In 30 % of the cases the victims suffered from psychological after effects including anxiety, depression or divorce. Of all victims in this study, 83.8 % were female. The study “Met de deur in het huis” by Ferwerda (2007) analyzed the relationship between victims and offenders. This study suggests, that most of the domestic violence happens between partners (37.1 %) and ex- partners (35.3 %). Elderly and children younger than 18 years formed 10% of the victims in this study. About 100 000 children witness domestic violence between their parents per year. More than half of the children who witness violence between their parents become a victim themselves (Lamers-Winkelmann, Slot, & Bijl, 2007).

The consequences of domestic violence can be devastating. The intensity of the abuse, the age at which abuse began, the length of abuse and the personality of the victim influence the consequences (*Nederlands Jeugd Instituut*, n.d.). Movisie (2009) gives examples for consequences. Psychological consequences of abuse include depression, anxiety and sexual problems. Physical consequences include wounds, miscarriage or fractures. Addiction, eating disorders and headaches are only a few of the psychosomatic problems after the abuse. The effects of children’s exposure to domestic violence differ but are also related to problems in social, emotional, behavioral, cognitive, and general health functioning (Wolfe, Crooks, Lee, McIntyre-Smith, & Jaffe,

2003). The financial consequences of domestic violence were also identified by Movisie (2009). There are three kinds of costs: Costs for the usage of services such as police and health care, cost for intervention and costs of personal suffering for the victims themselves. It is difficult to calculate the amount of money spent on these three aspects. An English/Welsh study indicated that reduced productivity and human suffering as a result of domestic violence cost the UK approximately 28.6 billion€ per year.

Definition According the definition of the “Justitie-Dienst Preventie, Jeugdbescherming en Reclassering” domestic violence is a “violation of the personal integrity of the victim committed by someone from the victim’s family” (Van Dijk et al., 1997). This includes (ex-) partners, family members and family friends. This definition does not focus on the place where the violence is committed but on the relation between victim and offender. The violence does not have to happen at home but has to be carried out by a relative. The term domestic violence acts like a catch-all term in the Netherlands and includes physical, psychological and sexual violence (Movisie, 2009). Common forms of domestic violence are child abuse and violence between (ex-) partners (*Advies- & Meldpunt Kindermishandeling*, n.d.).

Child abuse is a specific form of domestic violence. It receives special attention within the framework of this study since maternity nurses form our target group. The term “child abuse” describes treatment of children that threatens their well-being and development and abuses their human rights (Lamers-Winkelmann et al., 2007). Witnessing domestic violence between parents is also harmful for the child and makes them to victims of domestic violence. They are indirectly affected through their exposure. The *Wet op de Jeugdzorg* (2013) states, that child abuse includes any physical, psychological and sexual contact with a minor which has the potential to cause physical or psychological damage. Maternity nurses are in the position to observe violence against children but also between the parents. Therefore, children and their parents together form the victim group.

1.2 The meldcode

Reporting domestic violence is important since it promotes early intervention and prevents re-victimization (Pietrantonio et al., 2013). Professionals in the health sector see their clients regularly and can investigate their physical and emotional state, which puts them in a unique position to identify early symptoms of domestic violence. The Ministry of Health and Sport (2012) has been working on the implementation of a domestic violence and child abuse protocol (Dutch: Meldcode voor huiselijke geweld en kindermishandeling) since 2004. The meldcode provides professionals with a 5-step guideline of what they have to do when they suspect domestic violence and where they

can get advice. At the present time, the government recommends the usage of the meldcode but it is not compulsory yet. The law of the meldcode will be implemented July 1st 2013 from which professionals in the sector health care, education, day nursery, community work, youth work and justice are obliged to follow it (*Kadera Aanpak Huiselijk Geweld, Over de Meldcode*, n.d.). A basic model of the meldcode is available and can be rewritten and adapted to different professional settings (Ministry of Health & Sport, 2012).

The five steps

1. Identifying the signs: When a professional identifies signs of domestic violence or child abuse, he is expected to make a record of the signs, the conversations about them, the steps taken, and the decisions he has made.
2. Peer consultation and, if necessary, consultation with the Advice and Reporting Centre for Child Abuse and Neglect or the Domestic Violence Advice and Support Centre.
3. Interview with the client: The client is confronted with the suspect of domestic violence and gets the chance to react. After this conversation, the allegation of domestic violence is either rejected or supported. If the allegation is rejected no further steps are necessary.
4. Assessing violence and child abuse: The professional now has to estimate the type, risk, and severity of domestic violence.
5. Reaching a decision: organizing or reporting assistance: The professional, if necessary assisted by experts, will decide whether to organize assistance himself or to file a report.

Role of the meldcode in health care organizations Until now, there is little known about the possessing and use of the meldcode among maternity nurses. The study of Doeven (2008) estimated whether professionals conform to the meldcode. The groups under investigation were professionals from the health sector, education, sport groups, youth care and the legal system. A closer look is taken on the health care organizations. Results show, that about 43 % of the studied health organizations stated to be in the possession of the meldcode. Of the maternity nurse organizations almost half indicated to have the meldcode (48 %).

Furthermore, amongst the professionals in the health care sector who have the meldcode, 70 % actually understood what it is about. Among the health care professionals who kept a copy of the meldcode, 64 % reported that they use it each time they suspect a case of child maltreatment. The professionals who used the meldcode were satisfied and described it as a helping tool for

dealing with domestic violence. They also filed more reports of suspected child abuse and judged their skills at identifying domestic violence higher than professionals without one. The intention of the health care professionals to use the meldcode was low. Only 27 % of the professionals who did not have the meldcode planned to implement it next year (Doeven, 2008).

A closer examination of the actions that professionals took when assuming domestic shows, that some stages of the meldcode were carried out less than other. Talking with the victim (stage 2) and getting advice from the AMK (stage 5) were often not done when dealing with domestic violence. Additionally, in 64 % of the cases professionals made the decision to not organize aid.

The study of Doeven (2008) reveals good information regarding the use of the meldcode but displays gaps that need to be filled. First of all, it is outdated and the results can therefore not simply be transferred to the present situation. Secondly, the questions about the use of and the attitude towards the meldcode were vaguely operationalized. This makes it hard to evaluate the concrete meaning of the results. Because no other studies about the meldcode exist so far we take the results of Doeven (2008) as indication but treat them with caution.

1.3 The innovation process and determinants

It is important to understand the process behind the development of an innovation, like the meldcode, to implement it successfully and make effective dealing with domestic violence more likely (M. Fleuren, Wiefferink, & Paulussen, 2004). Choi (2009) defines an innovation as “an idea, practice or object that is perceived as new by an individual or other unit of adoption”. The goal of the implementation process is, that the professionals use the innovation independently in their daily practice.

In this study, we follow the framework by M. Fleuren et al. (2004) to structure the innovation process. It contains the four stages of the implementation process (dissemination, adoption, implementation and continuation) and related factors in innovation processes (as can be seen in Figure 1.1). In this study, the focus lays on the adoption stage and the implementation stage. The adoption stage is translated into the intention to use the meldcode. The implementation stage is translated into the performance of the steps of the meldcode when there is a suspect of domestic violence. Knowing the factors that facilitate or impede the adoption of the meldcode supports the successful implementation mapping. Furthermore, it promotes the development of effective innovation strategies that are matched to the needs of the user. The determinants that influence the transition between the four stages of the innovation process are described as the characteristic of the 1) socio-political context, 2) organization, 3) adopting person and the 4) innovation.

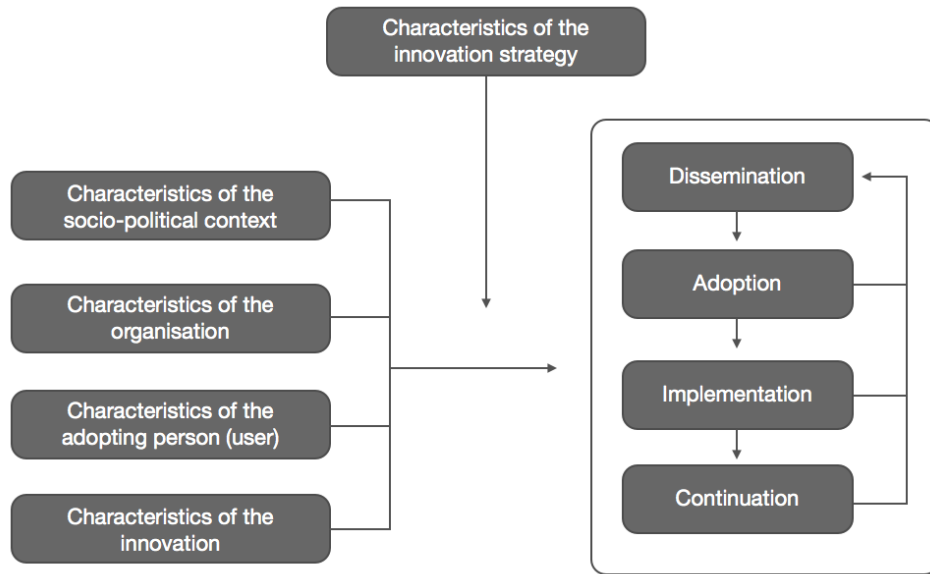


Figure 1.1: *Innovation process and related categories of determinants (M. Fleuren et al., 2004)*

Professionals experience barriers when dealing with domestic violence and using a guideline. We will now discuss these barriers based on the four determinants of the innovation-model. We study the maternity nurse's perception of the meldcode. Therefore, the characteristics of the innovation, the socio-political context and the organization are described out of the subjective perspective of the maternity nurses self.

Innovation The determinants of the innovation describe characteristics of the innovation that can be perceived and described objectively. But the user perceives these determinants in a subjective light. Therefore, it is possible that the objective determinants of the innovation and the users subjective perception of them do not overlap. Examples of these determinants are the *complexity of an innovation*, the *visibility of the results* and its *relevance for the client*. Furthermore the *difficulty in using* and the *clarity of the guideline's structure* also influence the diffusion of the innovation. Finally, the *fit between theory and practice* is identified as an additional important characteristic of the innovation (Evanson, 2006).

Adopting person The determinants of the adopting person include aspects related to the unique professional, like personal advantage/disadvantage, subjective norm and the knowledge about the innovation.

Identifying signs of domestic violence is complex because it requires *knowledge* about the forms of maltreatment and the *skills* to actually identify them (Lamers-Winkelmann et al., 2007). With regard to the skills, the inability to identify signs of domestic violence (Kenny & McEachern, 2002) and the unfamiliarity with the legal and technical aspects of filing a case and conducting conversations with the family over the suspect (Evanson, 2006) are important factors.

Subjective believes of professionals are also an important factor. Research shows, that nurses believe that the intrapartum period and the first weeks with the newborn child have to be a happy time for the family. They may think, that questions about suspects of domestic violence are not appropriate in this period (Furniss, McCaffrey, Parnell, & Rovi, 2007). Prejudicial beliefs like: “Victims can always leave the perpetrator if they want to” are identified as personal barriers in dealing with domestic violence (Sunborg, Saleh-Stattnin, Wändell, & Törnkvistl, 2012). Additionally, the feeling of loyalty towards the family (Vulliamy & Sullivan, 2000) and the belief to not have control over the situation (Natan & Raisl, 2010) impede them in handling domestic violence. An evaluation of an evidence-based best-practice guidelines for public health nursing prevention of violence against women and children by Lia-Hoagberg, Schaffer, and Strohschein (1999) reveals, that the belief that the guideline would improve practice and that using it is important are important factors regarding the success of the guideline.

The *perceived disadvantage for the family* resulting from reporting the violence is another reason why professionals often fail to report a suspect. Professionals who do not report child maltreatment often neglect to do so in the interest of the child (Wilson & Gettinger, 1989). They fear that reporting will result in further harm to the child (Alpert & Paulson, 1990) and will make an unstable family structure worse (Steinberg, Levine, & Doueck, 1997). The possibility of stigmatization of the family, and the long lasting psychological damage this can have, are additional aspects that professionals fear (Hutchison, 1993).

In the study by Vulliamy and Sullivan (2000) the main reason physicians were reluctant to report child abuse was due to an overall negative perception of the CPS (Child Protective Service). Warner-Rogers, Hansen, and Spieth (1996) found that experienced professionals who had previously filed a report were less likely to report again because of the *inadequate feedback* they received and the *delayed investigations* from the CPS. Furthermore, some professionals, such as doctors, believed they can intervene more effectively than CPS (Flaherty et al., 2013).

There may also be *negative consequences for the professional*. They fear physical retaliation from the perpetrator (Badger, 1989), the client

terminating the professional relationship (Tilden et al., 1994) and that the family will take legal action against them if the allegations of abuse turn out to be false or inaccurate (Abrahams, Casey, & Daro, 1992).

Evanson (2006) and Ajzen (2002) state, that the *social norm* is an important factor regarding to the use of the innovation. Receiving a positive social norm facilitates the use of the innovation.

Work experience is related to the development of knowledge, skills, motivation, attitudes and values that influence the behavior of the professional (Morrison & Brantner, 1992). The more often a task has been performed and the longer the length of time spend in a job, the higher are knowledge and skills (Lance, Hedge, & Alley, 1989). McCauley, Ruderman, Ohlott, and Morrow (1994) state, that challenging job situation, like experience with domestic violence, enhance the motivation to reach a desired level of job competency and get better at handling the situation.

Organization The determinants about the organization include the support of management, time resources, information about the innovation and feedback of the organization to the professional. Evanson (2006) identified a lack of time in schedule and lack of encouragement or expectations from the agency director and staff as barriers in dealing with domestic violence and using an innovation.

The *organization size* has been found to have a positive influence on the adoption behavior (Rogers Everett, 1995). A study of Teo, Wei, and Benbasat (2003) shows that large organizations are more likely to adopt innovations than small organizations because they have the resources and the skills necessary to assimilate the innovation effectively. This aspect needs to be taken into account because it is important that the innovation is carefully and specifically targeted to the potential adopters since this can facilitate the acceptance in the market (Easingwood & Beard, 1989).

The *work setting* of maternity nurses is characterized by little privacy. It is difficult for the professional to get time alone with the victim because other family members are often also present. Therefore, it is challenging to conducting conversations with family members about the suspect of domestic violence (Evanson, 2006).

Social-political context The determinants that target the socio-political environment include the laws and the cooperation with other institutions (e.g., the AMK and the SHG) (Doeven, 2008).

1.4 Aim of this study

This study investigates the factors that facilitate and impede maternity nurses from working with the meldcode. The term maternity nurse is a translation of the Dutch term “Kraamverzorger” and is an essential and integrated part of the (post)-natal care in the Netherlands (Lamkaddem & Wiegers, 2004). In 2004, Lamkaddem and Wiegers published the report “Monitoring Kraamzorg” which describes maternity nursing as the professional care for mother and child in the home environment during the first seven to eight days after birth. This level of care puts them in the unique position to observe the family in private situations, identify warning signs of domestic violence and respond to them. The tasks of the maternity nurses include among others education of the mother and support of the family with the household (Lamkaddem & Wiegers, 2004).

In this study, we focus on the characteristics of the adopting persons. In this case maternity nurses, because they are the ones who work with the meldcode. We study their subjective perception of the meldcode. The eventual aim is to develop generalizable results over the group of maternity nurse at large by mean of scientific methods (use of the ASE-model and the MIDI). All categories of determinants that M. Fleuren et al. (2004) mentioned in the model were integrated. But since our measurement instrument is a survey filled in by maternity nurses, all these determinants are studied out of the subjective perspective of the maternity nurses.

The determinants from Figure 1.1 are assigned to the ASE-model by de Vries, Dijkstra, and Kuhlman (1988) to predict the intention of maternity nurses to work conform the meldcode and their eventual behavior.

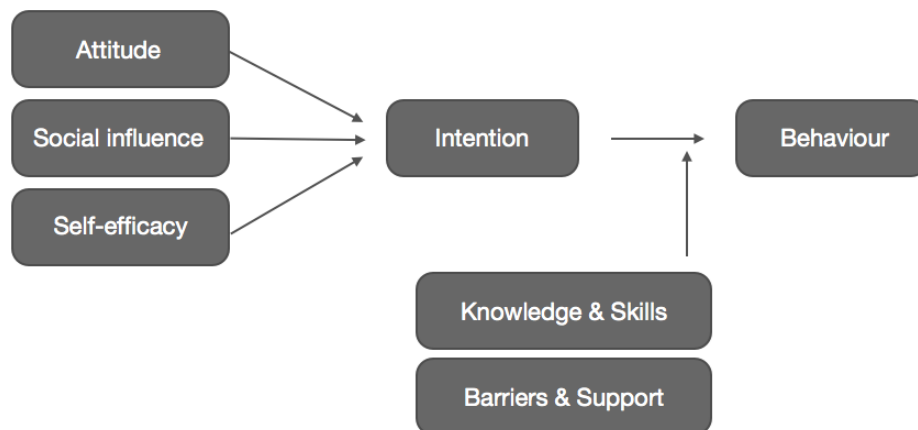


Figure 1.2: *The ASE model of de Vries et al. (1988)*

Its three main components, attitude, social norm and self-efficacy, are assumed to determine the intention. Fig. 1.2 shows that the eventual behavior of a person is determined by this intention. Translated to our context, the intention of maternity nurses is influenced by their attitude towards the meldcode, the social influence they experience through for instance colleagues and their feelings of self-efficacy to perform certain steps. The knowledge and skills of the person and the experienced barriers and support moderate the relation between the intention and the eventual behavior of the professional.

Research questions The aim of this research was to study facilitating and impeding factors regarding the (intention to) use of the meldcode. This study has an explorative character. Therefore, a general research question was formulated to keep all possible analyses open. First of all, the influence of the ASE determinants on the intention and the behavior of the maternity nurses was investigated. Hereafter, it was studied how 1) work experience, 2) experience with domestic violence, 3) knowledge of the meldcode and 4) organization size contribute to the intention to use the meldcode. Therefore, the following research question has been formulated:

- What factors hamper and facilitate the intention of maternity nurses to use the meldcode?

Chapter 2

Methodology

2.1 Participants

In total, 124 maternity nurses from seven organizations in the area of Twente (Netherlands) participated in this study. Due to missing data, 33 maternity nurses were excluded from the study. The participating organizations and their locations were:

- RST Zorgverleners (Barneveld)
- Lancelot Kraamzorg (Zwolle)
- Zorggroep Sint Maarten (Oldenzaal)
- Zorgbureau Excellent (Almelo)
- Attend Zorg (Nijverdal)
- Naviva Kraamzorg (headquarter situated at Deventer and other locations in Almelo, Apeldoorn, Borne, Bronckhorst, Dinkelland, Emmeloord, Enschede, Haaksbergen, Hardenberg, Heerde, Hengelo, Hof van Twente, Hoogeveen, Losser, Nijverdal, Oldenzaal, Ommen, Steenwijk, and Tubbergen)
- VVT Zorgverleners (headquarter situated at Almelo, with other locations at Enschede and Hardenberg)

In Table 2.1 "Percent total" shows how the participating number of maternity nurses (MN) per organization stands in proportion to the total amount of respondents in this study.

Table 2.1*Numbers and percentages of maternity nurses (MN)*

Organization	Total amount MN	Participating MN	Percent per organization	Percent total
RST	11	2	18.2 %	2.2 %
Lancelot	15	8	53.3 %	8.8 %
Sint Maarten	29	6	20.7 %	6.6 %
Excellent	11	6	54.5 %	6.6 %
Attent	12	1	8.3 %	1.1 %
Naviva	248	56	22.6 %	61.5 %
VVT	60	11	18.33 %	12.1 %
None		1		1.1 %
Total		91		100 %

2.2 Measurement instrument

The data was collected by means of an online survey containing 37 questions. Most of the items were based on the MIDI (Meetinstrument voor determinanten van innovatie) of Fleuren, Paulussen, van Dommelen, and van Buuren (2012). The MIDI contains 29 factors that may influence the use of an innovation. These factors are subdivided into four categories: *Characteristics of the user*, *characteristics of the innovation*, *characteristics of the organization* and *characteristics of the socio-political context*. The MIDI gives an example item for each factor of the four categories. These example items were eventually used in our questionnaire. Additional questions were derived from a concept version of a questionnaire that was constructed at the Twente University concerning a youth healthcare Guideline Secondary Prevention Child abuse (JGZ-richtlijn “Secundaire preventie kindermishandeling”). The final questionnaire can be found in the appendix.

Innovation-model On the basis of the classification in the four determinants of Fleuren et al. (2012) it was analyzed, whether there was a correlation between these determinants and the intention of maternity nurses to use the meldcode as well as their behavior. The socio-political context contained item number 35. This item covers difficulties in cooperation with professionals outside the own organization. The characteristics of the organization included items 33 and 34. They asked about feedback and trainings/education given by the organization. The items regarding the adopting person (#7–9, 12–16, 18–21, 23–27) were concerned with the user’s knowledge about the meldcode, perceived personal advantage/disadvantage, perceived social support et cetera. Items 28–32 formed the characteristics of the innovation. Topics were the perceived clarity, complexity and completeness of the meldcode.

Except from the demographical questions and three others (#24, 36, 37) participants answered these questions on a 5-point Likert scale, ranging from “I do not know this activity at all–I know this activity exactly”, “Strongly disagree–Strongly agree”, “None of my colleagues–All of my colleagues”, “Absolutely not–Absolutely” and “Clearly not enough–Clearly enough”.

The original five steps of the meldcode were sub-divided into nine steps, based on the action plan for maternity nurses (*V & VN meldcode kindermishandeling en huiselijk geweld*, 2011). Several steps have been subdivided, for example consulting the AMK apart from consulting the SHG. Additionally, a step about “actively asking for feedback, concerning the results of reporting” has been added.

Four Cronbach Alpha values were calculated to analyze the reliability of the determinants of the innovation-model of Fleuren et al. (2012). The *characteristic of the user* had a strong internal consistency ($\alpha = .91$). The Cronbach alpha of the *characteristic of the innovation* was raised by excluding the item complexity from a Cronbach alpha value of $\alpha = .77$ up to $\alpha = .90$. The *characteristics of the organization* revealed an internal consistency of $\alpha = .72$. The items of the *characteristic of the socio-political context* had a high internal consistency ($\alpha = .84$).

Structure of the questionnaire Because the ASE-model by de Vries et al. (1988) guided our analyses, we assigned each items of the questionnaire to one of the three factors of the ASE-model. Right at the beginning of the questionnaire the participants were informed about the study, their anonymity and where they can obtain the results. Afterwards, the participants were asked about their gender, work experience, work-place, experience with domestic violence, whether they have a part-time job and in how many families they have worked in the last 12 months (#1–6). This information helped to study the influence of personal factors on the performance of the steps of the meldcode. Furthermore, it allowed to test and formulate concrete recommendations for employees with certain personal characteristics. After collecting the demographic information, 31 questions regarding the meldcode followed. Since we analyzed the data according to the ASE-model by de Vries et al. (1988), this classification is used in the following to describe the questionnaire.

Attitude The determinant *attitude* consisted of 15 items (#12–19, 22, 23, 28–32). Participants answered on a 5-point Likert scale, ranging from “Strongly disagree–Strongly agree“. Example items of this determinant are: “The meldcode greatly supports me regarding the handling of my suspects of domestic violence and/or child abuse“ and “I think the meldcode is a useful instrument for my work as a maternity nurse“. The Cronbach alpha of this construct amounted $\alpha = .85$.

Self-efficacy The determinant *self-efficacy* contained two items (#9, 27). Participants answered on a 5-point Likert scale, ranging from "Strongly disagree–Strongly agree". The questions were "I have enough knowledge to use the meldcode" and "If I wanted, I would be able to perform the following steps". The internal consistency of this construct was very strong with a value of $\alpha = .89$.

Social norm The determinant *social norm* included five items, which covered the subjective norm, social support and the descriptive norm (#16, 20, 21, 24, 25). Example items are "How many of the colleagues in your organization use the meldcode?" and "To what extend to you think that the following persons expect you to use the meldcode?". Participants answered on different 5-point Likert scales ("Strongly disagree–Strongly agree"; " no colleague–all colleagues"; "surely not–for sure") and on a multiple-choice question. The Cronbach alpha of this construct amounted .75.

Distal factors Besides the three determinants attitude, self-efficacy and social norm there are also two distal factors (Knowledge and Skills, Barriers and Support) included in the ASE-model. The factor *knowledge* was included in our questionnaire (#7, 8). Participants answered on a 5-point Likert scale ("I absolutely do not know this activity–I exactly know what this activity includes") and on a 4-point Likert scale ("I do not know the meldcode–I know the meldcode and have read it thoughtfully"). An example question is: "To what extend do you know the meldcode?". The Cronbach alpha of this factor was with $\alpha = .91$ very high.

Dependent variables The most important dependent variable in this study was the intention of the maternity nurses to use the meldcode. The factor intention is a single part of the ASE-model. Question 36 asked the maternity nurses to rate their intention to use the meldcode on a 10-point Likert scale. The second dependent variable in this study was the behavior regarding the steps of the meldcode they take when they suspect domestic violence. The factor behavior is studied by question eleven ("In how many families where you suspect domestic violence and/of child abuse do you perform the following activities?"). Participants answered this question on a 5-point Likert scale ("In no family–In all families").

Others It was not possible to assign all items of the questionnaire to one of the constructs of the ASE-model (#10, 33–37). Item 10 asked whether the maternity nurses ever had a suspect of domestic violence with a yes/no question. Question 33–36 covered questions about the organization and were scored on a 5-point Likert scale ranging from "strongly disagree to strongly

agree”. Question 37 was an open question and gave the chance to provide further comments to the topic.

2.3 Procedure

We contacted the administrations of the seven organizations two weeks before we planned to start the data collection. We introduced ourselves, explained the goal of the study and asked them to support their willingness to participate. Two weeks later we sent them an email which included a brief motivation letter addressed to the maternity nurses and a web link to our questionnaire. We asked them to forward it to all their employed maternity nurses in the area of Twente. One week later, we sent a reminder to the administration and asked them again to forward it to the maternity nurses. After two weeks, 124 maternity nurses participated. We included those participants who revealed enough information for our analyses but excluded the ones who only filled in a couple of questions. Missing values were treated with the option ”exclude cases pairwise“. One participant claimed to have had 256 suspects of domestic violence in the last 12 months. We excluded this participant because this information seems unlikely to us. Finally, we used 91 participants in our study.

2.4 Analysis

This research investigated factors that support and impede the intention of maternity nurses to use the meldcode. Furthermore, we wanted to gain knowledge over factors that influence the eventual behavior. Thus, the performance of the steps of the meldcode when there is a suspect of domestic violence. This section presents the conducted analyses.

Descriptive statistics To get an overview about the sample, descriptive statistics analyses with the demographic information about the participants and their general attitude towards the meldcode were conducted.

Bivariate correlation analysis The correlations between the ASE constructs, the innovation-model constructs, the intention and the behavior of the maternity nurses were calculated using a *two-sided bivariate correlation analysis*. With a one sided correlation analysis we studied if the intention to use the meldcode predicted the behavior.

Hierarchical regression analyses Two *hierarchical multiple regression analyses* were performed to examine the influence of the ASE-model on the intention and the behavior when controlling for background variables. Variables that explain the intention were entered in two steps. Variables

that explain the behavior were entered in three steps. The ASE-model was entered as independent variable in step two of both analyses. Regarding the first analysis, the intention to use the meldcode was the dependent variable. The background factors work experience, experience with domestic violence and knowledge of the meldcode were entered in step one as the independent variables (model 1). Regarding the second analysis, the behavior of the maternity nurse when she has a suspect of domestic violence served as the dependent variable. The independent variables in step one were work experience and knowledge of the meldcode. Experience with domestic violence was not entered, since only maternity nurses who had experience with domestic violence answered the question over the behavior. In step 3 the intention was added.

Independent samples t-test for intention To get more detailed information about the prediction of the intention three *independent samples t-test* on item level were conducted. The dataset was divided via a median split in one group with a high intention (≥ 8) and one group with a low intention (< 8). These groups served as the grouping variable. The items of the three constructs of the ASE-model were separately studied as the fixed variables in one independent samples t-test each.

Analyses with organization size Hereafter, we divided the dataset according to the organization size (Small organizations ≤ 50 employees; Big organization > 50 employees). A *multivariate analysis* with the two organization groups as independent variable and the ASE-model as dependent variables was conducted. The idea behind this was, that the organization size influences the scores of the ASE constructs, which hereafter influence the intention. As for the intention, three independent samples t-test analyses with the organizational size as grouping variable were conducted.

Mediation and moderation The relationship between an independent variable and the dependent variable does not have to be direct but can also go via a mediator or a moderator variable. Therefore, two *mediation and moderation analyses* were conducted. The interaction between background factors of the maternity nurses and constructs of the ASE-model to predict the maternity nurse's intention was studied.

The first mediation analysis studied if self-efficacy has a mediating effect on the relationship between the work experience of a maternity nurse and her intention to use the meldcode. Secondly, it was studied if the relationship between the knowledge of the meldcode and the intention gets mediated by the social norm. The Sobel test (Sobel, 1986) was conducted for these mediation analyses.

Regarding the moderation analyses, it was studied if the feedback a maternity nurse receives regarding her report moderates the relationship between her attitude and intention. Lastly, it was studied if the cooperation with other institutes, like the AMK, moderates the relationship between the attitude and the intention.

Chapter 3

Results

This chapter presents the results that are necessary to answer the research question. Results regarding the analysis of the sample are reported first. Hereafter, the relationships between the models and the dependent variables are addressed. Lastly, the influence of background factors (experience with domestic violence, work experience, knowledge of the meldcode, organization size) on the intention are reported.

3.1 Description of the sample

In total, 91 female maternity nurses participated in this study. Their work experience ranged from 1 to 40 years ($M = 14.3$; $SD = 15.52$). The participants reported between 0 and 6 suspects of domestic violence in the last 12 months ($M = 0.43$; $SD = 0.98$). The number of families in which the maternity nurses worked in the last 12 months varied between 0 and 50 single families ($M = 19.7$; $SD = 9.2$). 67 % of the participants stated to have had prior experience with domestic violence in their working career.

Regarding the knowledge of the meldcode, 19.8 % of the maternity nurses did not know the meldcode at all and 24.2 % knew the meldcode but hadn't read it until now. In total, 42.9 % has read it superficially and only 13.1 % has read the meldcode completely and thoughtfully. On a 5-point Likert scale, 63.8 % rated the meldcode as an useful instrument (Agree: 41.8 %; Strongly agree: 22 %).

Regarding the dependent variables, the mean score on the 10-point Likert scale of intention was 7.7 with a standard deviation of 1.77. The participants were asked in how many families they perform the steps of the meldcode when they suspect domestic violence. The mean score of this question on a 5-point Likert scale ("In no family-In all families") was 2.99 with a standard deviation of .99.

3.2 Bivariate correlation analyses between the models and the dependent variables

A bivariate correlation analysis with the three determinants of the ASE-model, the four determinants of the innovation-model, the intention and the behavior was conducted. A significance level of .05 for all statistical tests was used. Table 3.1 displays the correlation coefficients and the level of significance for all factors correlated to intention and behavior.

Intention significantly correlated with all constructs of the ASE-model and the constructs of the innovation-model ($p < .05$). Additionally, the intention significantly predicted the eventual behavior (one-sided $p = .011$). All the correlations between the behavior and the constructs were significant except for the correlations with attitude ($p = .145$), self-efficacy ($p = .467$) and the characteristics of the innovation ($p = .100$). According to the numbers, the eventual behavior of the maternity nurses correlated stronger with the factors of the innovation-model than with the factors of the ASE-model. Possible explanations for these findings are given in the discussion.

Table 3.1

Bivariate correlation between the ASE-model, the innovation-model, intention and behavior

	Intention		Behavior	
	r	Sig.	r	Sig.
Attitude	.42**	.000	.19	.145
Social norm	.52**	.000	.35**	.006
Self-efficacy	.46**	.000	.10	.467
User	.54**	.000	.34**	.008
Innovation	.60**	.000	.21	.100
Organization	.45**	.000	.33	.010
Socio-political context	-.22*	.036	-.24	.068
Intention			.32*	.021

**Correlation is significant at the .01 level (2-tailed).

*Correlation is significant at the .05 level (2-tailed).

Note: Intention N = 89, Behavior N = 61.

3.3 Regression analyses

A multiple regression analysis with the ASE-model as independent variable and the intention as dependent variable was conducted. It showed, that there is a linear relationship between the ASE-model and the intention ($F(3, 85) = 17.17; p < .000$). The ASE-model explained 37.7% of the

variance in the dependent variable. To expand these results, a two-stage hierarchical multiple regression analysis with intention as the dependent variable was conducted. The background factors work experience, experience with domestic violence and knowledge of the meldcode were entered at stage one of the regression (model 1). The ASE-model was entered at stage two (model 2). At stage one, the background factors accounted for 9.6 % of the variation in intention and this model was significant^a. By adding the ASE-model, the predictive power increased up to 39.6 % and this model was also significant^b.

Model 2 shows, that self-efficacy and the social norm were unique predictors of the intention to use the meldcode. The beta value of knowledge was the only significant factor of model 1 with a $p < .05$. The beta value of knowledge became non-significant after adding self-efficacy and social norm, suggesting a mediation. Table 3.2 displays the results of this hierarchical regression analysis.

Table 3.2

Hierarchical linear regression analysis with intention as dependent variable and as independent variables in step one: Work experience, suspicion yes/no, knowledge meldcode and in step 2: Work experience, suspect ever, knowledge meldcode, ASE-model

	Model 1		Model 2	
	β	p	β	p
Work experience	.13	.226	.07	.452
Knowledge MC	.30	.005*	.10	.290
Suspicion yes/no	.03	.805	-.05	.598
Attitude			.13	.204
Self-efficacy			.25	.010*
Social norm			.35	.003*
R^2	.096		.397	
F	3.02		8.96	
ΔF	3.02		13.56	
Sig.	.034		.000	
ΔR^2	.096		.301	
Sig. ΔF	.034		.000	

a. Model 1: $F(3, 85) = 3.02$; $p < .034$

b. Model 2: $F(6, 82) = 8.96$; $p = .000$

A three-stage hierarchical multiple regression analysis was conducted with behavior as the dependent variable. The entered background factors at stage one were knowledge and experience with domestic violence. The ASE-model was added in stage two. The intention to use the meldcode was added at stage three. The hierarchical multiple regression revealed that at

stage one, the background factors contributed significantly to the regression model. They accounted for 11.9 % of the variation in the behavior^a. The knowledge of the meldcode is a unique predictor of the behavior in model 1. Introducing the ASE-model increased the predictive power up to 19.4 % with the two unique predictors knowledge and social norm. This change in R^2 was significant^b. The predictive power rose up to 21.7 % by adding the intention in step 3. This change in R^2 was significant^c. The beta values of knowledge and social norm got non-significant predictors of the behavior after adding the intention.

Table 3.3 displays the results of this hierarchical regression analysis.

Table 3.3

Hierarchical linear regression analysis with the behavior as the dependent variable and as independent variables in step one: Work experience and knowledge of the meldcode, step 2: Work experience, knowledge meldcode, attitude, social norm and self-efficacy and in step 3: Work experience, knowledge meldcode, attitude, social norm, self-efficacy and intention

	Model 1		Model 2		Model 3	
	β	p	β	p	β	p
Work Experience	-.00	.983	-.02	.869	-.04	.762
Knowledge MC	.35	.008*	.28	.039*	-.25	.057
Attitude			-.02	.884	-.05	.746
Self-efficacy			-.09	.529	-.14	.340
Social norm			.32	.046*	.25	.132
Intention					.20	.211
R^2	.119		.194		.217	
F	3.87		2.59		2.45	
ΔF	3.87		1.66		1.60	
Sig.	.027		.036		.036	
ΔR^2	.119		.076		.024	
Sig. ΔF	.03		.19		.21	

a. Model 1: $F(2, 57) = 3.87$; $p < .027$

b. Model 2: $F(5, 54) = 2.59$; $p < .036$

b. Model 3: $F(6, 53) = 2.45$; $p < .036$

3.4 T-tests with the items of the ASE-model as independent variable and the intention as dependent variable

Three independent sample t-test were conducted to study differences on item level. The single items of the ASE constructs were chosen as test variables and the intention groups (High intention ≥ 8 ; Low intention < 8) as grouping variable. Regarding the 14 items of attitude, the item fear of reaction, $t(87) = -.59$; $p = .276$, relation with client, $t(87) = -.10$; $p = .460$, time disadvantage $t(87) = .15$; $p = .441$ and personal attitude towards domestic violence, $t(87) = .55$; $p = .293$ did not show a significant difference between the intention groups. The high intention group scored significantly higher on the other ten items than the low intention group ($p < .05$). Table 3.4 displays the means, standard deviations, t-values and p-values for the two intention groups based on their score on the 14 items of attitude.

Table 3.4

Independent samples t-test between attitude and high/low intention on item level

Attitude	Low		High		<i>t</i>	Sig.
	\bar{m}	<i>SD</i>	\bar{m}	<i>SD</i>		
Support	2.71	1.15	3.98	.88	-5.87	.000*
Self-confidence	2.66	1.16	4.02	1.04	-5.77	.000*
Fear of reaction	3.11	1.39	3.28	1.17	-.59	.276
Relation w.client	2.97	1.36	3.00	1.26	-.10	.460
Time disadvantage	2.24	1.29	2.70	1.16	.15	.441
Responsibility	3.51	.57	4.01	.63	-3.81	.000*
Personal attitude DV	2.66	.91	2.54	1.08	.55	.293
Fear impact family	3.06	.97	2.69	1.06	1.67	.049*
Attitude over MC	2.97	1.20	4.11	.84	-5.27	.000*
Expectation effect	3.17	1.29	4.31	.74	-4.74	.000*
Clarity MC	2.91	.78	3.96	.75	-6.33	.000*
Visible results	3.11	.93	3.93	.89	-4.13	.000*
Triability	2.60	.74	3.69	.91	-5.92	.000*
Completeness	2.57	.95	3.80	.79	-6.62	.000*

a. Dependent Variable: Intention high/low

b. Note: one-sided p-value ($< .05$)

The construct social norm included the descriptive norm, satisfaction of the family, cooperation of the family, social support and subjective norm. The factor satisfaction of the family did not reveal a significant difference between the two intention groups, $t(87) = -1.56$; $p = .062$. Maternity nurses

with a high intention scored significantly higher on the other four factors ($p < .05$) than maternity nurses with a low intention. The values for the five items of the social norm can be found in Table 3.5.

Table 3.5

Independent samples t-test between social norm and high/low intention on item level

Social norm	Low		High		<i>t</i>	Sig.
	\bar{m}	<i>SD</i>	\bar{m}	<i>SD</i>		
Satisfaction family	2.54	.85	2.83	.86	-1.56	.062
Cooperation family	2.43	.74	2.72	.86	-1.66	.049*
Descriptive norm	2.63	.88	3.33	1.23	-3.15	.001*
Social support	2.11	1.09	3.13	1.30	-3.83	.000*
Subjective norm	3.07	1.45	3.96	.84	-3.96	.000*

a. Dependent Variable: Intention high/ low

b. Note: One-sided p-value ($< .05$)

The independent samples t-test with self-efficacy as independent variable showed, that the high intention group scored significantly higher on their knowledge to use the meldcode, $t(87) = -2.24$; $p < .014$ and the self-efficacy item, $t(87) = -4.71$; $p = .00$. The means, standard deviations, t-values and p-values are displayed in Table 3.6.

Table 3.6

Independent samples t-test between self-efficacy and low/high intention on item level

Self-efficacy	Low		High		<i>t</i>	Sig.
	\bar{m}	<i>SD</i>	\bar{m}	<i>SD</i>		
Knowledge to use MC	2.66	1.11	3.24	1.26	-2.24	.014*
Self-efficacy item	3.49	.59	4.06	.51	-4.71	.000*

a. Dependent Variable: intention high/ low

b. Note: One sided p-value ($< .05$)

3.5 Analyses of the organization size

The organizations were divided in two based on the number of maternity nurses they employ (Small organization ≤ 50 ; Big organization > 50). 23 maternity nurses stem from small organizations whereas 67 stem from big organizations. A multivariate analysis of variance with the ASE constructs as dependent variables and the two organization groups as fixed factors was conducted. This model did not reveal a significant result^b. Because this

study has an explorative character, further analyses for this non-significant model were conducted. Nevertheless, it is important that the results and conclusions about the organization size are treated with caution. Table 3.7 displays the means, the standard deviations, F-values, p-values and the R^2 of the ASE constructs on the organization size. Self-efficacy was the only significant construct ($p = .04$) and explained 4.76 % of the variance in the organization size. There was no significant difference found between attitude and social norm regarding the organization size ($p > .05$).

Table 3.7

Multivariate analysis with smaller/larger organizations as fixed factors and the ASE-model as dependent variables

	Small		Large		F	R^2	Sig.
	\bar{m}	SD	\bar{m}	SD			
Attitude	3.21	.72	3.27	.53	.21	.002	.645
Social norm	2.98	.74	2.94	.59	.05	.001	.820
Self-efficacy	3.14	.87	3.54	.76	4.36	.047	.040*

a. Note: Small: N = 23; Large: N = 67

b. Model: $F(3, 86) = 1.99$; $p < .121$

Three independent samples t-test with the three constructs of the ASE-model as testing variable and the organization size as grouping variable were conducted. They revealed, that the item of the construct attitude did not differ between maternity nurses of big organizations and of maternity nurses of small organizations ($p > .05$). Regarding social norm, the only item that differed significantly between the small and the big organizations was social support, $t(88) = 2.98$; $p < .001$. Regarding self-efficacy, maternity nurses from larger organizations scored significantly higher on knowledge to use the meldcode, $t(88) = -2.47$; $p < .008$. There was no significant difference between the organization size regarding the general factor self-efficacy ($p = .254$). The results of this t-test are displayed in Table 3.8.

Table 3.8

Independent samples t-test between self-efficacy and smaller/larger organizations on item level

Self-efficacy	Small		Big		t	Sig.
	\bar{m}	SD	\bar{m}	SD		
Knowledge to use MC	2.52	1.38	3.22	1.10	-2.47	.008*
Self-efficacy item	3.76	.65	3.86	.59	-.662	.254

a. Dependent Variable: organization big/small

b. Note: one sided p-value ($< .05$)

3.6 Mediation and moderation analyses

Several mediation and moderation analyses were conducted to study the role of additional distal determinants (e.g., knowledge, work experience, feedback and the cooperation with other institutions) in predicting the intention. The first mediation analysis studied if the relationship between work experience and intention is mediated by the ASE-construct self-efficacy. We suspected that the more work experience a maternity nurse has, the more self-effective she feels, which eventually leads to a higher intention to use the meldcode. The conditions to conduct a mediation analysis were not given since the relationship between work experience and intention ($p = .39$) and between work experience and self-efficacy ($p = .45$) were not significant.

The second mediation analysis revealed a complete mediation of the relationship between knowledge and intention via the mediator social. The relationship between knowledge and intention got insignificant when entering the mediator social norm. Thus, the more knowledge a maternity had, the higher were her scores on social norm, which eventually lead to a higher intention to use the meldcode. 3.1 displays this mediation and gives the standard regression coefficients for the relationship between knowledge and intention in becoming mediated by the social norm.

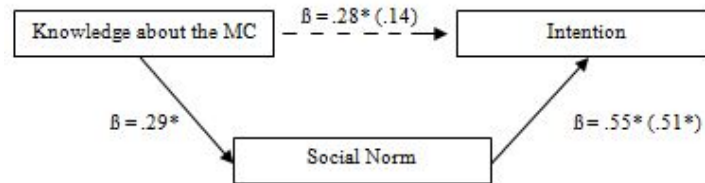


Figure 3.1: A complete mediation between the knowledge about the meldcode and the intention via the social norm ($p^* < .05$)

Hereafter, it was studied if the relationship between the attitude and intention is moderated by the cooperation with other institutions like the AMK. This moderation analysis did not yield any significant results. Finally, it was studied if the relationship between the attitude and the intention is moderated by the feedback the maternity nurse receives regarding her report. This moderation analysis did not yield a significant result.

Chapter 4

Discussion

This study investigates facilitating and impeding factors regarding the use of the meldcode by maternity nurses. The relationships between the ASE-model, the innovation-model, the intention and the eventual behavior are evaluated. Furthermore, the impacts of the background factors organization size, knowledge of the meldcode, experience with domestic violence and work experience are discussed. Additionally, the practical implications and limitations of the study and a list of recommendations are reported.

The majority of the maternity nurses (63 %) describe the meldcode as an useful tool in combating domestic violence, as was expected from the study of Doeven (2008). In contrast, 86.9 % of them do not know the meldcode or has only read it superficially. The conflict between these numbers underlines the importance of research concerning the successful implementation of the meldcode.

The intention of maternity nurses to use the meldcode correlates significantly with the ASE-model and the innovation-model. This supports the predictions of de Vries et al. (1988) and Fleuren et al. (2012). A perceived social norm and high self-efficacy are facilitating factors to adopt the meldcode for maternity nurses. The social norm is the strongest predictor of the intention and the eventual behavior regarding the meldcode. Therefore, this construct deserves special attention. Regarding the innovation-model, the characteristics of the user and the organization influence the behavior of the maternity nurses. Knowledge about the meldcode facilitates the intention and also the eventual use of it. This is an important result, since knowledge is a characteristic than can be directly influenced by interventions of the organization. But it must be mentioned, that the influence of the knowledge on the intention is mediated by the social norm. Regarding the role of the organization size, no conclusions can be made. Work experience and experience with domestic violence do not have an influence on the intention of the maternity nurses. The following sections discuss these results and compared to earlier studies.

4.1 Items that influence the intention

After discussing the overall effect of the ASE-model on the intention, the role of the items of the three ASE constructs are addressed now. Maternity nurses with a more positive attitude over the meldcode also have a stronger intention to use it, as was expected by Evanson (2006). They perceive the meldcode as better aiding tool and feel more self-confident to use it, as was expected from the study of Doeven (2008). Furthermore, they feel more responsible to actively deal with suspects of domestic violence. The feeling of responsibility may create an open attitude regarding tools that aid one in fulfilling this responsibility. This may results in a high intention. Regarding the characteristics of the innovation and in accordance with Evanson (2006), maternity nurses with a higher intention, expect more visible results and effects from working with the meldcode. They also perceive it as more clear, complete and congruent with their current working method (Evanson, 2006). Maternity nurses with a low intention worry more about the possible negative consequences their behavior could have on the family situation, as was expected by Alpert and Paulson (1990) and Steinberg et al. (1997).

Furniss et al. (2007) and Sunborg et al. (2012) state that personal prejudices towards domestic violence inhibit effective responding. Therefore, we expected maternity nurses with a low intention to score higher on this item. However, on a 5-point Likert scale the mean of this item was 2.59 with a standard deviation of 1. This results did not support our expectation. It is possible that this item was vaguely formulated and therefore all participants scored somewhere in the middle of the scale. Additionally, having prejudices is often rated negatively from people. Therefore, the prejudices often get suppressed if they contradict the self concept (Crandall & Eshleman, 2003). This could explain why people from both intention groups score somewhere in the middle of the scale and no significant difference could be found. In discordance with Badger (1989), Tilden et al. (1994) and Evanson (2006) the intention is not influenced by the fear about the reaction of the client, the fear about the negative consequences of the reporting and the possible time disadvantage that the use of the meldcode can create. We expected that the maternity nurses with a low intention score higher on these items.

It stands out that all items about concrete characteristics of the innovation, like its clarity or completeness, yield significant results. The maternity nurses do not have to have experience with domestic violence to have an expectancy on these items. In opposite, to make statements about the expected reaction of the client or the influence the reporting may have for the relation with the client, experience with domestic violence may be necessary. Most of the maternity nurses have only little or none experience with domestic violence. This lack of experience possibly made it hard for them to answer these items and therefore no significant difference between the groups was found.

The social norm has a strong influence on the intention and the behavior.

Maternity nurses are part of a organizational culture and are less autonomous like for instance doctors. They are integrated in a team and make decisions together with colleagues. The *V & VN meldcode kindermishandeling en huiselijk geweld* (2011) addresses nurses and caregiver. It underlines the importance that maternity nurses contact colleagues regarding decisions about domestic violence. This integration in the organization and cooperation with colleagues explains the importance of the social norm in this profession. Maternity nurses with a high intention to use the meldcode score significantly higher on the descriptive norm, the social support and the subjective norm. This result is in accordance with the findings of Evanson (2006) and Ajzen (2002).

Maternity nurses with a high intention to use the meldcode feel significantly more self-efficient to work conform the meldcode. This is in accordance with Kenny and McEachern (2002) and Evanson (2006) who underline the importance of feeling self-efficient to identify signs of domestic violence. They also mention the legal and technical aspects of filing a report.

4.2 Background factors

The hierarchical regression analysis reveals that the ASE-model contributes significantly to the prediction of the intention since it explains 30 % of the variance in the intention. In contrast, it only explains 7.6 % of the variation of the behavior. This difference was expected, because the ASE factors are directly related with the intention and only indirectly related with the behavior. The background factors work experience, knowledge of the meldcode and experience with domestic violence were entered in the above mentioned hierarchical regression analyses. According to Lance et al. (1989), Morrison and Brantner (1992) and McCauley et al. (1994) it was expected, that the more work experience and experience with domestic violence a maternity nurses has, the stronger her intention to use the meldcode will be. Furthermore, Ajzen (1991) states that knowledge influences the intention via the attitude. Therefore, a relation between the knowledge of the meldcode and the intention to use it was expected. These background factors significantly explain 9.6 % of the variance in the intention and 11.9 % in the behavior. Knowledge significantly predicts the intention, as was expected by Ajzen (1991).

In addition, a mediation analysis shows that the relationship between the knowledge and intention is mediated by the social norm. Therefore we can conclude, that the knowledge about the meldcode influences the intention to use the meldcode only indirectly via the social norm. In opposite to our expectations, work experience and experience with domestic violence show no significant results on the intention or the behavior. It is possible that people with a lot work experience have developed their own working routine

and reject new ways of problem solving. Similarly, maternity nurses with little work experience may want to develop their own working method before following a guideline. Therefore, intention is not influenced by the amount of work experience. From the participating maternity nurses, 76.9 % did not experience a single case of domestic violence in the past 12 months. This little experience with domestic violence makes finding a difference on this factor additionally difficult.

The quality of cooperation with other organizations, like the AMK, has no influence on the relationship between the attitude and the intention. This is in contrast to our expectation after reading Vulliamy and Sullivan (2000). We based our expectations on an American study over the CPS (Child protective service). It is possible that the attitude of maternity nurses over the Dutch versions of this institution (AMK and the SHG) are different to the attitude over the CPS. This could be a reason why there was no significant result found. The amount of feedback a maternity nurse receives regarding her report does not influence the relationship between the attitude and the intention. This is in discordance to Warner-Rogers et al. (1996). Analyses display that the majority of the maternity nurses either does not ask about feedback or even does not know the possibility to ask for feedback. This can explain why the factor feedback does not play an important role in this study.

Literature of Rogers Everett (1995), Teo et al. (2003) and Easingwood and Beard (1989) shows, that the organizational size plays an important role in predicting the success of implementing an innovation. Teo et al. (2003) states, that larger organizations are more likely to adopt innovations than small organizations because they have the resources and the skills necessary to assimilate the innovation effectively. Maternity nurses from larger organizations score higher on self-efficacy than maternity nurses from smaller organizations, which is in accordance with Teo et al. (2003). The social norm and attitude do not show differences between the big and small organizations. The multivariate analysis with the organizational size as grouping variable and the ASE-model as fixed factors reveals no significant result. No reliable statements can be made about the influence of the organization size on the ASE-model. Therefore, all following conclusions about the impact of the organizational size must be treated with caution.

4.3 Differences between the two models

Both models are appropriate for predicting the intention but show weaknesses in predicting the eventual behavior. The determinants attitude and self-efficacy are not significantly correlated with behavior. Additionally, the correlation of the four determinants of the innovation-model with the eventual behavior is weaker than the one with the intention. This was expected since

the determinants of both models influence the behavior indirectly via the intention. Furthermore, since most maternity nurses did not work with the meldcode until now, their reported behavior was partly past behavior. This makes it also more difficult to relate their behavior with the models than their current intention.

The determinants of the innovation-model correlate stronger with behavior than the determinants of the ASE-model do. This was not expected since the ASE-model has a stronger empirical basis than the innovation-model. A possible explanation can be found in the theoretical background of the questionnaire. Most of the items stem from the innovation-model of Fleuren et al. (2012) and have been originally distributed over the four determinants of this model. To use the ASE-model of de Vries et al. (1988), the original distribution was reversed and the items were allocated among the three ASE determinants. This allocation was less clear and distinct as the original allocation among the determinants of the innovation model. This can explain the stronger correlation of the innovation model with the behavior. Furthermore, the items of the two models partly overlap. But not all items of the MIDI were allocated to the ASE-model. Therefore, the innovation-model contained more items than the ASE-model. This is another explanation for the stronger prediction of the behavior through the innovation-model.

4.4 Further work

The allocation of the items of the MIDI to the ASE-model results in reliable constructs for measuring the intention to use the meldcode. Unfortunately, the relationship between the ASE-model and the behavior was weak. Therefore, further research could investigate better methods to study the actual behavior of maternity nurses regarding their use of the meldcode. A longitudinal study would allow to investigate in how far the intention to use the meldcode leads to actual behavior.

One conclusion from this study is, that the social norm strongly predicts the intention and the eventual behavior. Therefore, this factor deserves more attention by further research. Interviews with maternity nurses over the perceived social norm could be a possible direction. These interviews could give more detailed information about the perceptions and needs of the maternity nurses. The organizations could consider results of such a study in their implementation strategy and improve implementation mapping.

This study moves beyond general descriptions by making specific statements about factors that influence the intention of maternity nurses. The way the meldcode is written and presented seems to strongly predict the intention to use it. The clarity and completeness for instance influence the intention. Further research could address the unique needs of maternity nurses regarding the concrete characteristics of the meldcode. With this

knowledge the meldcode could be specifically targeted to maternity nurses.

Furthermore, the knowledge about the meldcode seems to play an important role regarding the performance of the steps. This is an important results since organizations can directly influence the knowledge, by giving information for example. Further studies could investigate how the information needs to be presented to maternity nurses that they understand and memorize it.

Our analysis about the influence of the organizational size did not reveal significant results. This is in contradiction to the literature of Rogers Everett (1995), Teo et al. (2003) and Easingwood and Beard (1989). The distribution of participants over the two organization groups was not equal. Only 23 maternity nurses stemmed from small organizations whereas 69 stemmed from big ones. Therefore, further research could resume this background factor and try to study it with different methods and a better distribution. Knowing more about the influence of the organization size would make it possible to give specific recommendations to differently sized organizations.

4.5 Limitations

The focus on the subjective attitudes and perceptions of the maternity nurses is the primary limitation of this study. On the one hand, this was done deliberately to study their personal barriers and facilitators. On the other hand, we must be cautious with the interpretation and generalization of the results. This must be taken into account when interpreting the results of this study.

The second limitation is that we did not study actual behavior but only intention. Since not all participating maternity nurses have the meldcode and since the law that makes the meldcode mandatory begins not until July 2013, we could only measure the intention. According to de Vries et al. (1988) the attitude, social norm and self-efficacy predict the intention, which here after predicts the behavior. This assumption is the reason why we assume that measuring the intention also warrants conclusions about the behavior.

Three limitations regarding the representativeness of the study should be mentioned. First of all, all participants stem from the region of Twente. This selection was done by purpose to make specific statements about maternity nurses from this region. But this fact limits the representativeness since regions may differ on the measured factors. Secondly, the data was collected by means of an online survey. This involves the risk that only maternity nurses with internet access could participate. Thirdly, in total 124 maternity nurses participated in our study from which we used 91. 33 respondents were excluded because they didn't answer the questions that we identified as key items. It is possible that the excluded participants and the non-respondents differ from the used ones in their attitude towards the meldcode.

4.6 Recommendations

The most important results of this study are summarized in four recommendations. These recommendations should support the successful implementation of the meldcode among maternity nurse and increase its enduring usage.

- Maternity nurses need to be more educated regarding domestic violence and the meldcode. Firstly, most maternity nurses experience only little domestic violence in their working career. For that reason, they know little about the symptoms and effects of domestic violence from their own experience. The education about domestic violence could lead to greater awareness of the problem and increased knowledge about it. Secondly, this study shows that the majority of maternity nurses has not read the meldcode thoughtfully. Therefore, it is important to introduce each step of the meldcode to the maternity nurses and explain what it includes. This ensures, that they know the meldcode entirely and know their responsibilities. In addition to this education, it is important that the gap between theory and practice is reduced. Presenting and discussing practical examples of situations where the meldcode must be used could help hereby.
- The social norm fulfills an important role for maternity nurses. It predicts the intention to use the meldcode but also the eventual behavior. Therefore, it is important that the maternity nurses experience a positive social norm from their professional network regarding the meldcode. All workers of the organization have to support each other and show a positive attitude towards the use of the meldcode. Talking about domestic violence and the meldcode and radiating openness and interest to each other are important.
- It is important, that the basic characteristics of the meldcode are matched to the needs of the maternity nurses. The meldcode must appear clear and complete to them. They must know, that working conform the meldcode will change the family situation. Therefore, visible effects resulting from following the meldcode, for example an improvement of the family situation, support the use of it. Additionally, it is important that working with the meldcode matches with the current working methods of the maternity nurses. They have to feel that the meldcode supports them in combating domestic violence. Lastly, the feeling that they are able to perform the actions of the meldcode can support their use if it.
- Knowledge over the meldcode is an important predictor of the behavior. Therefore, organizations need to make sure that their employees have enough knowledge over the meldcode and the use of it.

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Appendix A - Questionnaire

Beste kraamverzorg(st)ers,

het volgende onderzoek gaat over het basismodel van de Meldcode Huiselijk Geweld en Kindermishandeling. De overheid stelt vanaf 1 juli 2013 het handelen volgens de Meldcode landelijk verplicht.

>> Waarom dit onderzoek? <<

Kraamverzorg(st)ers kunnen in de dagelijkse praktijk verschillende knelpunten en belemmeringen ervaren waardoor niet altijd volgens de stappen van de Meldcode wordt gewerkt. Met dit onderzoek willen we hier beter zicht op krijgen. Hierdoor hebben wij de mogelijkheid om jullie in samenwerking met uw organisatie beter te ondersteunen en een betere houvast te geven bij het omgaan met vermoedens van huiselijk geweld en/of kindermishandeling.

>> Volledig anoniem <<

Dit onderzoek is geheel anoniem. Uw gegevens worden strikt vertrouwelijk door de onderzoekers van de Universiteit Twente verwerkt en bewaard.

>> BELANGRIJK! <<

Wanneer u de Meldcode niet of in beperkte mate kent, vragen wij u toch **alle** vragen in te vullen. Vul de vragen dan in naar uw verwachting over (het gebruik met) de Meldcode.

>> Hoe wordt u geïnformeerd over de resultaten? <<

De belangrijkste uitkomsten van het onderzoek zullen in vorm van een fact-sheet via de kraamzorg organisaties worden verspreid. Dit gebeurt naar verwachting in juli 2013.

Het invullen van de vragenlijst neemt rond 20 minuten in beslag.
Alvast hartelijk bedankt voor uw medewerking!

Achtergrondvariabelen

1. Wat is uw geslacht?
 - a. man
 - b. Vrouw
2. Hoeveel jaar werkt u als kraamverzorg(st)er in de kraamzorg? jaar
3. Bij welke organisatie bent u op dit moment werkzaam?
 - ☐ RST Zorgverleners
 - ☐ Lancelot Kraamzorg
 - ☐ Zorggroep Sint Maarten
 - ☐ Zorgbureau Excellent
 - ☐ Attent Kraamzorg
 - ☐ Naviva Kraamzorg
 - ☐ BTK Zorg

- ☐ VVT Zorgverleners
- ☐ Ik wil hier geen antwoord op geven

4. Hoe vaak heeft u binnen de afgelopen 12 maanden in uw werkomgeving een vermoeden van huiselijk geweld en/of kindermishandeling gehad?

keer

5. Bij hoeveel gezinnen heeft u in de afgelopen 12 maanden als kraamverzorg(st)er gewerkt?

gezinnen

6. Voert u naast uw werk als kraamverzorg(st)er nog een van de volgende nevenfuncties uit?

- ☐ Intaker
- ☐ Bereikbaarheidsdienst
- ☐ Planning
- ☐ Geen van deze functies

Bekendheid met de meldcode

7. In hoeverre bent u bekend met de inhoud van de meldcode?
- ☐ Ik ken de meldcode niet
 - ☐ Ik ken de meldcode wel maar heb hem (nog) niet doorgelezen
 - ☐ Ik ken de meldcode en heb hem oppervlakkig doorgelezen
 - ☐ Ik ken de meldcode en heb hem volledig en grondig doorgelezen

Gebruik van de meldcode

Het volgende deel gaat over uw gebruik van de meldcode als u vermoedens van huiselijk geweld en/of kindermishandeling heeft. Als u tot nu toe nog geen gebruik van de meldcode hebt gemaakt, dan gaat het om uw verwachte gedrag hiermee.

8. In hoeverre kent u de volgende activiteiten van de meldcode?
1 (Ik ken deze activiteit helemaal niet) – 5 (Ik weet wat deze activiteit precies inhoudt)
- a. In kaart brengen van signalen die een blijvend vermoeden van kindermishandeling of huiselijk geweld bevestigen of ontkrachten
 - b. Signalen vastleggen in het verpleegkundig of zorgdossier
 - c. Bespreken van de signalen met een deskundige collega, of een leidinggevende
 - d. Advies vragen bij het Advies- en Meldpunt Kindermishandeling (AMK) en/of het Steunpunt Huiselijk Geweld (SHG)
 - e. Bespreken van de signalen met de ouders
 - f. Op basis van de verzamelde informatie wegen van het risico op kindermishandeling en/of huiselijk geweld
 - g. Hulp organiseren

- h. Het vermoeden bij het AMK en/of SHG melden
 - i. Actief navraag doen of de behandeling van het gezin begonnen is
9. Ik beschik over voldoende kennis om de meldcode te kunnen gebruiken
1 (Helemaal mee oneens) – 5 (Helemaal mee eens)
10. Heeft u ooit een vermoeden van huiselijk geweld en/of kindermishandeling gehad?
Ja (→ vraag 11 / Nee → vraag 12)
11. Bij welk deel van de families bij wie u een vermoeden heeft van huiselijk geweld en/of kindermishandeling voert u de volgende activiteiten uit?
1 Bij geen enkel familie / 2 Een minderheid van de families / 3 Bij sommigen wel, bij sommigen niet / 4 Een meerderheid van de families / 5 Alle families
- a. In kaart brengen van signalen die een blijvend vermoeden van kindermishandeling of huiselijk geweld bevestigen of ontkrachten
 - b. Signalen vastleggen in het verpleegkundig of zorgdossier
 - c. Bespreken van de signalen met een deskundige collega, of een leidinggevende
 - d. Advies vragen bij het Advies- en Meldpunt Kindermishandeling (AMK) en/of het Steunpunt Huiselijk Geweld (SHG)
 - e. Bespreken van de signalen met de ouders
 - f. Op basis van de verzamelde informatie wegen van het risico op kindermishandeling en/of huiselijk geweld
 - g. Hulp organiseren
 - h. Het vermoeden bij het AMK en/of SHG melden
 - i. Actief navraag doen of de behandeling van het gezin begonnen is

Kenmerken van de kraamverzorg(st)er

Geef bij de volgende uitspraken aan in hoeverre ze bij u passen. Als u de meldcode nog niet hebt gebruikt dan geef uw verwachtingen aan.

1 (helemaal mee oneens) - 5 (helemaal mee eens)

- 12. De meldcode geeft mij grote houvast bij het omgang met vermoedens van huiselijk geweld/kindermishandeling.
- 13. Door de meldcode te gebruiken voel ik mij zekerder over de te nemen stappen bij een vermoeden van huiselijk geweld/kindermishandeling.
- 14. Ik ben bang voor de reactie van het gezin als ik de stappen van de meldcode volg.
- 15. Ik ben bang dat ik het contact met het gezin verlies als ik bij een vermoeden van huiselijk geweld/kindermishandeling de stappen van de meldcode volg.
- 16. Het kost mij veel tijd om bij een vermoeden van huiselijk geweld/kindermishandeling de stappen van de meldcode te volgen.
- 17. Ik vind de meldcode een nuttig instrument voor het werken als kraamverzorg(st)er.

18. Ik verwacht dat het toepassen van de meldcode een bijdrage levert aan het vroegtijdig signaleren en vroegtijdig stopzetten van huiselijke geweld/kindermishandeling.
19. Ik vind dat de volgende activiteiten tot mijn functie behoren
- a. In kaart brengen van signalen die een blijvend vermoeden van kindermishandeling of huiselijk geweld bevestigen of ontkrachten
 - b. Signalen vastleggen in het verpleegkundig of zorgdossier
 - c. Bespreken van de signalen met een deskundige collega, of een leidinggevende
 - d. Advies vragen bij het Advies- en Meldpunt Kindermishandeling (AMK) en/of het Steunpunt Huiselijk Geweld (SHG)
 - e. Bespreken van de signalen met de ouders
 - f. Op basis van de verzamelde informatie wegen van het risico op kindermishandeling en/of huiselijk geweld
 - g. Hulp organiseren
 - h. Het vermoeden bij het AMK en/of SHG melden
 - i. Actief navraag doen of de behandeling van het gezin begonnen is
20. Gezinnen waarin een vermoeden van huiselijk geweld/kindermishandeling bestaat, zijn over het algemeen tevreden als ik de stappen van de meldcode volg.
21. Gezinnen waarin een vermoeden van huiselijk geweld/kindermishandeling bestaat, werken over het algemeen mee als ik de stappen van de meldcode volg.
22. Ik heb een persoonlijke mening over het onderwerp “huiselijk geweld” en deze beïnvloedt mijn houding tegenover de familie.
23. Ik ben bang dat door mijn handelen volgens de meldcode de situatie in de familie slechter wordt.
24. Ik krijg bij het werken volgens de meldcode voldoende ondersteuning als ik die nodig heb van ...
- ☐ Collega's in mijn team
 - ☐ Verloskundigen
 - ☐ Direct leidinggevende
 - ☐ Het Advies- en Meldpunt Kindermishandeling (AMK)/Steunpunt Huiselijk Geweld (SHG) voor *advies*
 - ☐ Het AMK/SHG bij het *melden* van kindermishandeling/huiselijk geweld
 - ☐ Geen van de bovenstaande
25. Hoeveel collega's in uw organisatie maken volgens u gebruik van de meldcode?
1 (geen enkele collega) – 5 (alle collega's)
26. In hoeverre denkt u dat de volgende personen van u verwachten dat u de meldcode gebruikt:
1 (zeer zeker niet) – 5 (zeer zeker wel)
- a. Cliënten
 - b. Collega's

- c. Leidinggevende
- d. Management

27. Indien u dat zou willen, lukt het u dan om de volgende stappen uit te voeren ...

- a. In kaart brengen van signalen die een blijvend vermoeden van kindermishandeling of huiselijk geweld bevestigen of ontkrachten
- b. Signalen vastleggen in het verpleegkundig of zorgdossier
- c. Bespreken van de signalen met een deskundige collega, of een leidinggevende
- d. Advies vragen bij het Advies- en Meldpunt Kindermishandeling (AMK) en/of het Steunpunt Huiselijk Geweld (SHG)
- e. Bespreken van de signalen met de ouders
- f. Op basis van de verzamelde informatie wegen van het risico op kindermishandeling en/of huiselijk geweld
- g. Hulp organiseren
- h. Het vermoeden bij het AMK en/of SHG melden
- i. Actief navraag doen of de behandeling van het gezin begonnen is

Meldcode

Geef bij de volgende uitspraken aan in hoeverre ze bij u passen.

1 (helemaal mee oneens) - 5 (helemaal mee eens)

Indien u helemaal niet bekend bent met de meldcode, sla dan de vragen 28 t/m 33 over

- 28. Ik vind dat de meldcode helder aangeeft welke stappen ik moet uitvoeren.
- 29. Ik verwacht dat het werken volgens de meldcode bij een vermoeden van huiselijk geweld/kindermishandeling zichtbare uitkomsten binnen het gezin oplevert.
- 30. De meldcode is te ingewikkeld voor mij.
- 31. De meldcode past goed bij mijn manier van werken.
- 32. De meldcode biedt alle informatie en materialen die nodig zijn om er goed mee te kunnen werken.

Organisatie

Geef bij de volgende uitspraken aan in hoeverre ze bij u passen.

- 33. In mijn organisatie vindt regelmatig terugkoppeling plaats over de meldingen die zijn gemaakt.
1 (helemaal mee oneens) - 5 (helemaal mee eens)
- 34. In hoeverre vindt u dat er voldoende mogelijkheden (trainings, educatie enz.) zijn om goed met de meldcode om te kunnen gaan?
1 (helemaal niet voldoende) – 5 (absoluut voldoende)

35. In welke mate ervaart u knelpunten in de samenwerking met professionals buiten uw organisatie bij een vermoeden van huiselijk geweld/kindermishandeling?

1 (helemaal niet) – 5 (helemaal wel)

- a. Advied- en Meldpunt Kindermishandeling
- b. Steunpunt Huiselijk Geweld
- c. Leidinggevende
- d. Verloskundige
- e. Andere instanties

36. Ik ben van plan om volgens de meldcode te gaan werken/te blijven werken.

1 (helemaal mee oneens) – 10 (helemaal mee eens)

37. Wat zou u bij het werken met de meldcode ondersteunen (Suggesties, tips, ideeën)

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Einde vragenlijst

Hartelijk bedankt voor uw medewerking.