

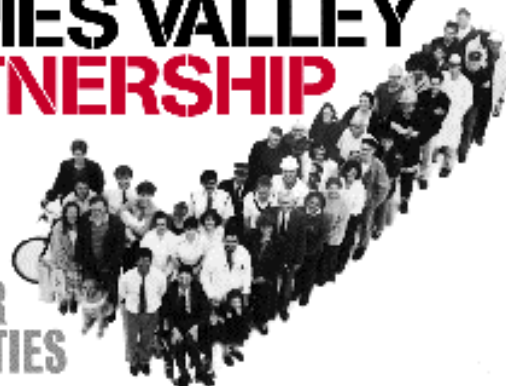
Domestic Violence and Health

An audit of PCT practice
in the Thames Valley

By Julia Worms
March 2004

**THAMES VALLEY
PARTNERSHIP**

WORKING
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Foreword

Domestic violence is an issue for the National Health Service. One in four women will experience violence from a partner at some stage in their lives. The health consequences include serious injury, the exacerbation of other medical conditions, stress and mental illness. Recent research by the Home Office shows that opportunities within the NHS to identify domestic violence are often missed.

In the Thames Valley, and as elsewhere, practitioners such as health visitors and midwives increasingly recognise the importance of domestic violence in their work. They have been working with multi-agency groups in their local area, and raising awareness amongst their own colleagues. But domestic violence is not seen as a priority for Primary Care Trusts or the NHS in general.

The Thames Valley Partnership has undertaken this Audit of activity in Primary Care Trusts in order to support the development of good practice and promote the importance of this work within PCTs more generally.

This work has coincided with research conducted by the Home Office on four projects tackling domestic violence and led by the NHS. The findings from both pieces of work are complementary in stressing the importance of asking women about their experiences of domestic violence. Professor Taket's work is summarised in Appendix 4 and is included in the list of general resources on page 38.

The Thames Valley Partnership also hosts network meetings and seminars where practitioners from a range of agencies come together to hear of national and local developments and to strengthen their own networks of support. If you or anyone within your organisation is interested in being kept informed of these opportunities please contact Julia Worms at the Thames Valley Partnership.

Finally I would like to take this opportunity of thanking Julia for her work on the completion of this Audit and commend it to you as another milestone in improving the way in which, we as a society identify and respond to those who are experiencing violence at home.

Sue Raikes
Chief Executive
Thames Valley Partnership

Executive Summary

Background

In 2002 an unsuccessful bid for funding to the Department of Health by the Thames Valley Partnership identified the need to review the ways in the NHS interacted with domestic violence and to link this with emerging findings, which were encouraging a more proactive response. The audit was undertaken to establish existing services and procedures, identify current practice and initiate a network to share best practice and take this work forward.

The effects of domestic violence on health are wide-ranging and complex and are an ongoing drain on health service resources. In recent years research has highlighted a variety of best practice in this field, which has been acknowledged by the health service.

Methodology

A series of structured questionnaire interviews were undertaken with both frontline practitioners and health executives from all fifteen PCTs in the Thames Valley. The responses to these were analysed and compiled into this audit document. The draft document was put out to consultation prior to release of the final version. The audit reviewed a variety of aspects of the health service's interface with domestic violence including strategic objectives, policy and procedures, current practice, multi-agency working, training, data collection, local initiatives and mental health.

Results and Evaluation

Policy & Procedures

Domestic violence was not directly specified in strategic objectives, but was included in more general community objectives. The policies and procedures which did exist related usually to health visitor guidelines. There was a difference in views regarding policy between frontline practitioners and executives. Only 35% of respondents felt that their PCT were meeting Department of Health objectives in this field.

The importance of specific strategic objectives was identified to demonstrate long-term commitment, initiate policy and to address the issue of resources. Domestic violence should be viewed as an issue for the whole Primary Care Trust, not just health visitors and specialist nurses. The direct effects of domestic violence on health and the indirect effects on homelessness, drug and alcohol abuse, teenage pregnancy etc needs to be more widely acknowledged. Frontline staff often have a clear perspective of the issue, but need increased resources and support for a more proactive response.

Awareness Raising

Awareness raising of the issue has been addressed in relation to the public, but amongst health professionals it is frequently limited to health visitors and specialist nurses. There were wide variations in the availability and quality of resources for victims, signposting information and best practice. There were little or no referrals of perpetrators or involvement with work with them.

The audit identified a lack of awareness across all PCT personnel, especially GPs in relation to the issue. The full costs and health implications of domestic violence were not fully appreciated and there is a need to provide more effective resources and referrals for victims. The importance of the health service to engage with other agencies to promote work with perpetrators as a preventative strategy was highlighted.

Data Collection

There were a wide variety and no standardisation of methods of recording domestic violence data both across the region and within PCTs. There was minimal evidence of data being aggregated to provide statistics or show prevalence. A great deal of confusion existed around issues of patient safety, confidentiality, data protection and the implications of evidence gathering. Any data sharing with other agencies was usually at individual case level and often related to child protection.

The majority of respondents to the audit called for clearer data recording guidelines and for the issues of confidentiality and patient safety to be clarified. Confidentiality is often used as a barrier to prevent effective data recording and there is a need to promote the collection of robust statistics and safe information sharing. It is important to address the requirements of recording routine screening information and review the considerations of evidence gathering.

Routine Screening and 'Asking The Question'

There was a range of responses demonstrated among health service personnel when abuse is either disclosed or suspected among patients. Proactive asking about domestic violence was usually dependent on individual judgement, the existing relationship between practitioners and victim and the perceived severity of the abuse. Only two PCTs had any form of routine screening, which had been started as part of health visitor checks. There was a general lack of confidence demonstrated in relation to routine screening.

Research shows that systems of routine screening can have beneficial outcomes both in terms of earlier intervention and because the majority of victims would have welcomed being asked. Systems of routine screening and proactive 'asking' could be implemented in line with specialist training for practitioners, more consistent risk assessment and efficient sign posting.

Multi-Agency Working

The majority of PCTs had links with local domestic violence forums, generally at frontline practitioner level. There was evidence of multi-agency initiatives especially with the Police and Social Services. Multi-agency work was generally confined to training, referrals and education programmes. There was a lack of resources to pursue this work, although most respondents appreciated the benefits of increased multi-agency working.

Domestic violence forum membership should be by designated individuals to ensure resources are available and at a more strategic level of input and not reliant on 'interested individuals'. Many good local initiatives would benefit from wider adoption and it should be appreciated that effective co-working is reliant on clear information sharing procedures.

Training

The majority of PCTs had undertaken some domestic violence training, usually for health visitors and specialist nurses. The training was only an on-going commitment for 35% of PCTs and domestic violence was not included in induction training. Buckinghamshire has a pool of domestic violence trainers and Oxon has a planned multi-agency training schedule.

85% of respondents felt that standardised structured training would be beneficial. Training needs to be provided across PCTs, not just to health visitors and should be included in induction and medical training. Expert training will engender more confidence in a more proactive response.

Recommendations & Suggested Areas of Work

The audit identified a variety of areas where PCTs could focus future work in relation to their response to domestic violence. The main recommendations included: -

- Domestic violence should be identified specifically within strategic objectives, local delivery plans etc.
- A designated domestic violence lead should be identified within PCTs as part of the public health agenda.
- DOH guidelines should be fully implemented in all PCTs
- Domestic violence should be seen as an issue for all health service providers – not just health visitors.
- A wider acceptance is needed of the prevalence and detrimental effects of domestic violence.
- A broader, committed programme of domestic violence awareness and specialist training should be undertaken.
- A review of methods of recording and sharing domestic violence data should be undertaken.
- Routine screening and proactive 'asking' about domestic violence should be encouraged.
- Health service support for community based perpetrator programmes.
- An engagement with multi-agency working at a more strategic level.

1. Introduction

Domestic violence is and continues to be a major health issue. In addition to having significant health impacts on victims, it can also have a direct effect on the health and well being of children. Research into the effects of violence; clearly show that it is an on-going and significant drain on health service resources.

'Intimate violence is one of the principal factors resulting in health inequalities across gender specifically, and forms a significant barrier to women receiving effective and equal health care'

UNICEF (1997) & WHO (1997)

In recent years there has been a raising of awareness and an increase in multi-agency working in relation to domestic violence across much of the statutory sector. Within this framework there has been a developing recognition nationally of the important role that the health service can play, as identified in the Department of Health's own guidelines.¹ The Home Office recognised the vital role of the health service and under the auspices of their wider crime reduction strategy funded several health based pilot projects, which have sought to establish best practice within primary care and to demonstrate a more effective response. The evaluations of these are just being released and we are now far more aware of the effects of domestic abuse and of some of the ways in which more effective interventions can be made. The principle recommendations of the Department of Health's guidelines are reproduced in Appendix 1.

In July 2002 the Thames Valley Partnership applied to the Department of Health to fund a post, intended to encourage a more proactive and innovative response within the health service in the region. The application was unsuccessful, but the Partnership felt that the work was too important to ignore and therefore provided funds for the initial stages to continue. It is important that the opportunity for health to interface with community safety and engage with the crime reduction strategy is not missed and that the restructuring of Primary Care Trusts (PCTs) does not interrupt future planning and service provision in this field. The essential first stage was to analyse and review the current interface between the health service and domestic violence issues.

The intention was to undertake an audit of the health service's involvement with domestic violence, within all the PCTs in the Thames Valley, and relate this to emerging good practice. The aims of the audit were to identify existing provision and procedures, reveal variations across the region, establish a network to share best practice, engage management more fully and raise awareness within the health service. The outcome was to produce an audit document detailing both current and planned activity. Topics addressed would include strategic aims, current practice, level of involvement in local domestic violence forums, and training. A comparison would then be made between local objectives and actual practice and current National Health Service recommendations. These findings were then to be disseminated to inform and promote future good practice and encourage a more proactive response among health professionals to domestic violence. This document is the result of that audit.

2. Research Background

In recent years a great deal of research has been undertaken into the implications for health of violence in general and specifically domestic abuse. It is beyond the scope of this document to review all of this research, but a selection has been highlighted here with references for further reading identified.

2.1 Prevalence

Domestic violence occurs within all strata of our society, a finding that is supported by a range of research data and surveys. Each year some 45% of female homicide victims are killed by present or former partners - on average two per week, with domestic violence accounting for one quarter of all violent crime.²

In general the majority of surveys support the view that one in four women will have suffered domestic violence at some time in their lives.² Locally in Buckinghamshire, the Sunlight Project found that 33% of women respondents at GP practices had or were experiencing domestic abuse, whilst their supermarket survey identified that 41% of women had experienced some type of abuse (threatening behaviour, physical or sexual assault or bullying) of which 24% reported that it was by someone close to them.³

Surveys within general practices in Hackney found that 41% of respondents had experienced physical violence from a partner or former partner, with some 17% within the past year. The study concluded that with this 'high prevalence, health professionals should maintain a high level of awareness of the possibility of domestic violence'.⁴

N.B. This document is focussed on female victims of domestic abuse, but that is not to say that there are not many other victims including children, men, the elderly and those in single sex relationships, who's needs also have to be met by service providers.

2.2 Impact Of Domestic Violence on Health

The effects of domestic violence on health are diverse, and can be classified as both direct and indirect.

'In addition to direct physical injury, victims of violence are at increased risk of a wide range of psychological and behavioural problems'

World Report On Violence & Health – World Health Organisation 2002 ⁵

There has been a great deal of research, summarised for example in the Lancet (2002)⁶ which itemises and demonstrates these effects. Broadly they are divided into physical and mental effects, both of which have a wide range of outcomes, these have been listed below but are not intended to be comprehensive.

Physical Health Effects: -

Low health status, poor quality of life, direct injuries of a wide range of type and severity, mortality (murder and suicide), chronic pain, headaches, central nervous

system disorders, gastrointestinal disorders, hypertension, immune system suppression, gynaecological problems, miscarriage, foetal distress, still birth, pre-eclampsia etc.

Mental Health Effects: -

Depression, post traumatic stress disorder, stress, suicidal tendencies, drug and alcohol abuse, anxiety, insomnia, social dysfunction, eating disorders, panic attacks, self harm, etc.

Research by the Sunlight Project in Buckinghamshire among attendees at GP surgeries found that there was a difference between how those who had suffered abuse and those who had not, rated their own health. 27% of respondents with no experience of abuse rated their health as poor or fair, whilst 47% of those reporting abuse (a third of total respondents) rated their health as poor or fair.³

It is estimated that women who have experienced violence from a known man are fifteen times more likely to abuse alcohol, nine times more likely to abuse drugs, three times more likely to be diagnosed as depressed or psychotic and five times more likely to attempt suicide.

A study of the use of the health service by domestic violence survivors found that 18% go to a physician in the first year of abuse, 56% in the second year and 31% during the third year.⁷

A range of authorities have acknowledged the significant impact of domestic abuse on health, and identified the scope and range of these impacts. For example: -

'Domestic abuse may have a damaging, sometimes even life-threatening impact on the physical and mental well-being of a woman and her baby. Conclusive evidence has demonstrated that pregnancy, far from being a time of peace and safety, may trigger or exacerbate male violence in the home.'

Domestic Abuse In Pregnancy – Royal College of Midwives Position Paper 19⁸

'Domestic Abuse is a frequent cause of significant injury, mental health difficulties and chronic health problems among women'

Women At Risk – Stark & Flitcraft 1996⁹

'Domestic Violence is a frequent cause of injury and emotional trauma to women and accounts for a substantial proportion of health service use'

What Works In Reducing Domestic Violence – Julie Taylor Browne¹⁰

2.3 Indicators of Best Practice

There is an increasing amount of research related to best practice for all agencies in relation to domestic violence. These have been summarised in the publication 'Domestic Violence – Good Practice Indicators'¹¹ and most identified in the Department of Health's own guidelines.¹

The practice indicators relate to: -

- Usage of clear definitions and parameters.
- Monitoring and screening to establish the extent of the problem.
- Development of strategies and policies.
- Safety orientated practice.
- Training to raise awareness and develop skills.
- Evaluation to ensure effective response.
- Multi-agency working.
- Work with women and children

Research increasingly shows that women expect health professionals to include domestic violence as a health care issue, which they expect to be asked about and to be offered support and appropriate referral and advice.¹⁰ Current recommendations broadly include:-

- The responsibility of all health professionals to be aware of the importance of domestic violence.
- The development of local strategies and guidelines for the identification and support of women victims, including multi-agency working.
- The provision of information about sources of help for victims.
- Routine questions about violence should be included in taking social history and that obstetricians and gynaecologists should ask all women about violence.
- That all women are seen at least once on their own during antenatal care.
- Routine questioning must be accompanied by training for professionals and provisions for referrals.

2.3.1 'Asking The Question'

One of the key current areas of thinking centres on proactively asking patients about domestic violence and routinely screening women. The benefits of this approach are numerous including identification of victims, the ability to intervene earlier, reduction of the stigmatisation of domestic violence, provision of an opportunity for the victim to discuss the issue, reduction of self-blame and assistance in the realisation of abuse. It should be emphasised that for this approach to be beneficial those asking the question need to be sufficiently trained, considerations of safety and confidentiality must be taken into account and adequate referral and support services must be in place.

A review of research projects related to screening for domestic violence in primary care found that half to three-quarters of women patients thought that screening was acceptable, with a higher proportion among women who had experienced abuse.¹²

Similarly the Sunlight Project found that 69% of those reporting abuse stated they would have liked to have been asked.¹³ The main reason cited was that it would have raised awareness of their own situation.

A study in Ireland among women attending general practices concluded that some two fifths of women had experienced domestic violence but few recalled being asked about it. Most women favoured routine questioning by their practitioner about such violence.¹⁴ A study undertaken at Guy's and St Thomas' Hospitals concluded that women were six times

as likely to disclose domestic violence during pregnancy when asked specific questions, than when left to disclose themselves.¹⁵

'A sensitive enquiry about domestic violence should be routinely included when taking a social history... sought in the absence of the woman's partner'
'Why Mothers Die' Report Into Maternal Deaths 1994 – 1996¹⁶

'The links between domestic abuse and adverse pregnancy outcomes suggest that midwives should assume a greater role in its detection and management.'
Domestic Abuse In Pregnancy - Royal College of Midwives Position Paper 19⁸

3. Methodology

The information for this audit was obtained via a series of structured, personal, questionnaire interviews with health professionals within each PCT. The researcher compiled the initial questionnaire and a full copy is attached in Appendix 2. The questionnaire consisted of thirty questions, requiring an initial yes/no response, followed by back up questions and further opportunities for comment.

The questionnaire was designed to address a range of aspects of the health service's interaction with domestic violence and was intended not only to promote discussion with the individual around current practice, but also to identify local differences in response, personal opinions and their own experience in the field.

The researcher approached each of the fifteen PCTs, as listed, between April and July 2003.

Berkshire: –

Bracknell, Newbury, Reading, Slough, Windsor & Maidenhead and Woking.

Buckinghamshire: –

Chiltern & South Bucks, High Wycombe, Milton Keynes and Vale of Aylesbury.

Oxfordshire: –

Cherwell, North East Oxon, Oxford City, South East Oxon and South West Oxon.

(It should be noted that all five PCTs were approached and interviewed, although policy for domestic violence is now shared in the southern and northern PCTs).

Each PCT was invited to recommend two people to be interviewed one at a strategic / executive level and a front line practitioner. It was felt that by interviewing two representatives more comprehensive details of the involvement of the PCT would be gathered and that both strategic and frontline experience would contribute to the audit. Details of the background to the audit were distributed; see Appendix 3, to assist in their recommendation. The decision as to who undertook the interview was taken by the PCT and not directed by the researcher. In many instances the researcher had to make several approaches to the PCT before relevant contacts were provided, often because it was not immediately clear who held responsibility for domestic violence issues.

The researcher undertook the structured interviews between May and August 2003. A total of twenty-six interviews were completed, with every PCT in the Thames Valley represented. Care was taken by the researcher to explain the purpose of the interview and to make it clear that the intention was to undertake a fact-finding audit. The confidentiality of individual's responses was guaranteed to ensure a free discussion and it was not intended that any individual PCT would be mentioned or analysed, but that a broad perspective and conclusions were drawn. It was impossible in practice for complete verbatim responses to be recorded during the interviews, but the researcher endeavoured

to accurately record all the salient points, and during the course of the interview re-checked with the interviewee, where there was any areas of misunderstanding, whilst endeavouring not to direct or lead actual comments.

A range of health service professionals were interviewed including health visitors (some with special responsibility for child protection, homelessness or local refuges), public health, directors of nursing and clinical services, directors of primary care, directors of strategy and clinical managers. The majority of frontline practitioners interviewed were health visitors.

The questionnaires were then collated and analysed to produce this document. A wide range of comments were recorded on all aspects of the audit, but it is beyond the scope of this document to analyse each individual response, a more general overall view has been taken within each category and a generalised range of responses recorded.

The draft audit document was presented at a seminar at the Partnership in February 2004 and issued for consultation within the health service, prior to its final release in March 2004.

4. Audit Results

The direct results of the answers and comments made during the audit interviews have been summarised and reported in this section, with resultant analysis, conclusions and commentary included in sections 5 and 6. The results are outlined and recorded below in the format and order of the questionnaire. (Appendix 2)

4.1 Policy & Procedures (Questionnaire - Section 2)

Questions in this section related to strategic objectives, the application of the Department of Health's Domestic Violence Resource Manual recommendations, current practice around domestic violence cases and whether current policy met with perceived Department of Health objectives in this field.

4.1.1 Strategic Objectives (Question 7)

Whilst some 50% of respondents felt that domestic violence was directly included in PCT strategic objectives, no written strategic plans which identified domestic violence were actually provided to the researcher. Where policy or procedures were stated to exist they related in the majority of cases to health visitors guidelines, procedures and protocols or were mentioned in relation to child protection policy. In one PCT it was specifically included in the targeted work of the health visitor.

Several PCTs noted that as a result of new organisational structures, objectives may be included in the future as part of public health agendas, local delivery plans, future business plans, crime and disorder responsibilities, drug and alcohol abuse strategies or new strategy documents. There was uncertainty expressed as to where, within these strategies domestic violence would be placed and how the implementation work required for more proactive interventions would be achieved.

A variety of reasons why specific strategic objectives were thought to be desirable by the respondents were recorded and included: -

- A more beneficial 'top down' approach.
- A wider acceptance of the detrimental effects of domestic violence on health and welfare.
- Practical work on the 'frontline' would not need to rely on local 'champions' and there would be a continuity of policy.
- The need for a more proactive approach.
- The need for an overarching PCT policy.
- More effective joint objectives with those involved with social care and education.
- Resources would be more easily available.
- An identified lead within PCTs would be appointed.
- Proper procedures would be identified across all levels of the PCT.

4.1.2 Domestic Violence Resource Manual (Questions 8 & 9)

Respondents were shown a copy of the Department of Health's – 'Domestic Violence: A Resource Manual for Health Care Professionals'.¹ This document was published and distributed within the Health Service in March 2000.

Some 70% were aware of this document and all respondents were able, when prompted through the seven main objectives, to comment on the implementation of any of these practices within their PCT. (The main recommendations from this report, regarding policies, responses, activity and protocols are reproduced for information in Appendix 1). It should be noted that there were differences recorded between the views of frontline practitioners and managers within PCTs as to the extent to which these recommendations had been introduced.

Awareness Raising

Nearly all the PCTs had undertaken some form of awareness raising, directed towards the public, which included the display of posters and leaflets, awareness training for health visitors and some practice or community nurses. In a couple of PCTs a designated frontline practitioners had been identified as the lead on domestic violence and were responsible for awareness raising locally. Some noted that a more proactive response was now being undertaken.

It was recorded that general awareness training for all practitioners had not been undertaken, so there was limited group awareness and often work in this field was prompted by a personal interest rather than being part of designated work roles.

Staff Support

There was a diverse range of responses regarding the availability of support for either those personnel who were experiencing domestic violence or those who were dealing with it as part of their caseload. Support, where perceived as available, was generally through normal clinical supervision, the informal support of colleagues or via external independent counselling/support services.

Views expressed included that there was little specific support, no guidelines for support, no structure of support for staff as victims and that the implications of a more proactive response by the Health Service had not been fully considered with regard to the impact on staff.

It was generally noted that where domestic violence was identified as falling within child protection policies and procedures, a more structured support was available.

Zero Tolerance

All the PCTs had a campaign related to violence in the workplace demonstrated by posters, leaflets and procedures for reporting incidents. Some respondents had been trained to deal with challenging behaviour and felt that incidents were treated seriously. Whilst these procedures related to violent or abusive incidents in the workplace, it was not clear whether these policies included references to possible

domestic violence implications or whether awareness around these specific issues had been discussed with personnel.

Information Gathering

There was a wide spectrum of replies regarding the recording of domestic violence data and there was a clear lack of guidelines as to how this information should be recorded and collected especially with regard to patient safety, confidentiality and accessibility of documentation.

Methods of recording included separate domestic violence records maintained by health visitors, diary sheet recording, coded triggers on patient records, simple codes on patient record, details of accounts of injuries on patient record - without domestic violence being officially stated, direct recording on notes, personal separate records for sharing with colleagues, 'high dependency' client records, the recording of the results of routine questioning, recording as part of child protection requirements etc. In itself domestic violence was not always perceived as a reason for starting a special record although child protection would be, as would severe illness for example depression.

No PCT had developed methods of aggregating information for statistical analysis or as a means of ascertaining prevalence. Many of the data recording processes that related to coding were however seen to be adaptable to further aggregation and analysis and were viewed as a means of ascertaining need and influencing service provision. There was limited evidence of a domestic violence audit in two PCTs but no formal information was either available or provided to the researcher.

Many respondents acknowledged the need for clearer guidelines for data recording especially if a more proactive response was anticipated. It was noted that if information was aggregated and more accurate details of prevalence maintained it might impact service provision and resource availability.

Multi-Agency Working

The majority of PCTs had links with or were represented on local domestic violence forums. Attendance at forum meetings was variable and often linked to whether the representative had domestic violence as part of their designated job description, which allowed time for multi-agency working.

Beyond attendance at forum meetings, there was less involvement in actual multi-agency working (Refer to section 4.2.2 on specific multi-agency working), although there were direct links with the Police and social services.

It was noted that usually membership of the forum was left to frontline practitioners and did not engage senior health service staff or it was not perceived to be a need for the PCT.

Resources & Services

The availability of resources and services for victims varied widely and ranged from minimal contact lists for Police and Women's Aid through a full range of literature and comprehensive sign-posting registers to the provision of a support group for women. It should be noted that Buckinghamshire generally had a much more comprehensive range of resources available for supporting victims.

In terms of resources for perpetrators, these were either non-existent or minimal. A few were referred to anger management courses, which had no specific provision for work around domestic violence, some to alcohol and drug abuse programmes, and some were referred to mental health teams. Some interaction with perpetrators was recorded via other community programmes e.g. parenting classes. It was often viewed that this was solely a Police matter.

In those PCTs where many of the above recommendations had not been addressed there was some commitment by participants to review the literature and look at the possibility of further training and changes in practice.

4.1.3 Current Practice Around Domestic Violence (Question 10)

There was a wide range of responses recorded relating to the procedures adopted when domestic violence was felt to be an issue in a family. The response selected depended in most cases on the perceived severity of the incident or situation, the perceived status of the individual involved, the relationship with the health practitioner and any considerations of confidentiality. In many cases it was left to the judgement of the individual practitioners as to the action taken.

Actions taken included: -

- Referral to social services if child protection was an issue.
- Referral to Women's Aid or Police with victims permission (generally in perceived severe cases).
- Advice sought from Police.
- Domestic violence guidelines followed.
- A relationship established with the victim.
- Support, opportunity to talk and advice offered.
- Signposting information provided.
- Help given with action plans.
- Discussion undertaken regarding the effects on children.
- Referral to the GP.
- Information recorded on notes.
- Discussion of the situation with colleagues.
- Discussion with colleagues regarding issues of staff safety.
- Referral to other services with victim's permission.
- Report to line manager.
- Assessment of the needs of the family.

It was sometimes noted that the increasing severity of incidents might trigger a more proactive response.

4.1.4 'Asking The Question' (Question 11)

The term 'asking the question' refers to proactive domestic violence enquiries by health professionals or routine screening for domestic violence as outlined in section 2.3.1. Recent research has highlighted the benefits of this type of approach.

Respondents were asked as to whether health practitioners would directly ask about domestic violence. 80% of respondents stated that their colleagues would ask, in the right circumstances or if there were sufficient concern about the client, but only two PCTs had any form of routine screening as part of their health visitor checks.

Whilst a high proportion of health practitioners appeared to proactively ask, there were many barriers to this process and often it was left to an individual's choice and the type of relationship that existed between client and practitioner. There was a range of attitudes expressed among frontline practitioners about actively asking. Some felt reluctant or were in disagreement with such a proactive policy, others thought it would be a good idea but felt a lack of the correct expertise, whilst some were more confident to ask and appreciated the benefits of such a response. Often the response given related to the level of training that an individual had received. There was a general acceptance that both appropriate training and peer support would be essential for such a policy to work effectively. Support currently available included others in the primary care team, clinical supervision, colleagues, line managers and confidential counselling services. The majority of respondents were unaware of any plans to introduce routine screening.

4.1.5 Department of Health Strategy & Current Policy (Question 12)

35% of respondents felt that the current policy of the PCT met with Department of Health objectives in this field, 30% were unable to comment and 35% felt that it did not meet these objectives. A higher proportion of managers (75%) felt that they did meet the objectives, but only 30% of frontline practitioners agreed. The majority of respondents felt that improvements could be made, whilst some felt that some progress had been made more recently.

Improvements that could be made, suggested by respondents included: -

- The need to establish long-term commitment to this work in a preventative way.
- Overcoming the difficulty of allocating resources where there were difficult to measure targets.
- Linking domestic violence work to Health Promotion strategies.
- Making the case under pressure from competing resources.
- The need for a clear strategy, which identified the issue and took the work forward.
- Specialist training for all practitioners.
- Training to improve confidence to handle disclosure.
- Increase awareness raising.
- Develop reporting and monitoring systems – as statistical input would be useful.
- Provide clearer reporting structures and systems to aid the collation of data.
- Adopt a more proactive policy.
- Include domestic violence considerations in a variety of procedures.
- Utilise risk assessment techniques.
- Introduce routine screening.

- Provide support groups for victims.
- Provide more direct support for staff encountering domestic violence.
- Improve liaison with mental health teams around domestic violence.
- Make similar progress with domestic violence as has happened with child protection.
- Apply guidelines to all those in primary care including GP's and A & E departments.
- Apply local good practice to entire PCT.
- More co-ordinated response across the PCT.
- Establish a better working relationship with the Police.

4.2 Multi-Agency Working (Questionnaire - Section 3)

Respondents were asked in detail about their interaction with other agencies, both statutory and voluntary in the field of domestic violence.

4.2.1 Domestic Violence Forum (Question 13)

Over 90% of respondents stated that their PCT was involved with the local domestic violence forum. Barriers to membership appeared to be that it was not a designated role for anyone within the PCT and therefore there were time and resource issues. The majority of the membership (70%) was by health visitors or specialist child protection nurses, only a few managers attended.

4.2.2 Multi-Agency Working (Question 14)

77% of respondents felt that their PCT was engaged in some form of multi-agency working and all respondents identified the importance and benefits of such working.

Initiatives varied widely across the region and other agencies identified were Police, Social Services, Women's Aid, Community Safety Partnerships, Multi-agency Public Protection Panels, Education, housing departments, the Sunlight Project (Bucks), Citizens Advice etc.

The main areas of work included training initiatives, referral networks, women's support, child protection procedures and educational programmes. There were several examples of excellent joint working and good practice initiatives, with the majority of working revolving around the links with the forum and undertaken at a local level. It was noted that it would be beneficial if this type of work were assigned to designated individuals to allow for extra resources to develop these initiatives, enable them to reap their full potential and to develop these links further.

4.2.3 Shared Information (Question 15)

Over 75% of PCT practitioners shared information related to domestic violence. In general specific case information would be shared when there was a child protection issue, staff safety issue or with the permission of the victim. The agencies involved with information sharing were the Police, Women's Aid, Social Services, housing and other members of the PCT team. No anonymous aggregated data was shared, mainly because there was none available, with the exception of two PCTs who were involved with new initiatives with the

Sunlight Project and the Police. Some respondents raised concerns regarding confidentiality, client safety, human rights, and evidence gathering.

4.2.4 Local Domestic Violence Initiatives (Question 16)

Over half of the respondents stated that their PCT was involved with local domestic violence initiatives, these included education in schools, training events, domestic violence 'weeks', work with refuges, publicity, data gathering, awareness sessions and action plans.

4.2.5 Information Available (Question 17)

65% of respondents felt that there was inadequate information available relating to domestic violence. It was generally felt that the domestic violence forums provided good access to information, but that often it was only the health visitors that held this information and it was not available elsewhere in the PCT. Much information was held on an ad-hoc basis or merely by those who were highly motivated. Another concern expressed, was that there was an overload of information generally, in relation not only to medical research but also concerning best practice and as a result important information was often overlooked.

There were several areas where gaps in available information were identified:

- Good quality statistical information and research.
- The impact on health of domestic violence.
- The work of agencies in the voluntary sector.
- Details of protocols and procedures in other agencies.
- Documented information on specific cases.
- The domestic violence awareness of health professionals.
- Lack of feedback within PCTs from the forum representative.
- The role of local government in initiatives.
- Points of contact and their availability in other organisations.
- Information beyond the immediate locality.
- Research on specialist expertise and best practice.

4.3 Training (Questionnaire - Section 4)

Respondents were asked about all aspects of domestic violence training that had been undertaken or was planned in their PCT.

4.3.1 Training Undertaken (Question 18)

The majority of PCTs had undertaken some specific domestic violence training with only three where there had been none known to date or undertaken recently, generally because it was not seen as a priority.

The majority of the individuals trained were health visitors, school and district nurses and midwives. In one or two areas there had been training for A & E departments and GPs. Over 50% of the training had been provided externally (usually by the Police or domestic violence co-ordinators) with only 35% undertaken as an on-going commitment. In some cases the training was only attended by the domestic violence lead in the practice. In no

PCTs was domestic violence included in induction training and only a few GPs had been included in the awareness training. The majority of the training undertaken was general awareness, with some related to signposting and 'asking the question'. These responses are supported by the Sunlight GP practice research, which identified that some 37% of practice staff had received specific domestic violence training.³

4.3.2 Training - Planned (Question 19)

The majority of PCTs had some future domestic violence training anticipated, although much was in the early planning stages and not an immediate prospect. Future training was intended to address increased awareness raising, training a wider spectrum of health professionals, support work for women, 'asking the question' and induction and refresher training.

It should be noted that Buckinghamshire now has a pool of domestic violence trainers under the auspices of the Bucks Domestic Violence initiative and Oxfordshire has a planned multi-agency training schedule under the auspices of the county domestic violence co-ordinator.

4.3.3 Standardised Thames Valley Training (Question 20)

Most respondents (85%) felt that a standardised regional training initiative would be beneficial. The rest were unsure because there were considerations of the type of training to be offered, who the training would be for, the importance of local knowledge and networks and the need for training to be locally delivered.

The benefits of such a regional standard approach recorded, included: -

- The sharing of good practice and network links with other practitioners.
- The acceptance of domestic violence as a public health issue, which has been too easy to ignore to date.
- A structured, consistent multi-agency response.
- The provision of support and supervision to tackle this issue.
- The provision of an over-arching service agreement.
- An equality of service such as that provided by child protection.
- A means of ensuring that policy is carried through and it is not just treated as a training issue.
- An engagement at an executive level with the issue.
- A standard approach, which would be more cost effective.
- A method of building the issue into all agencies strategies.
- A means of linking multi-agency approaches, especially that of the Police.
- Providing a clearer message to perpetrators and victims.
- A reduction in the duplication of effort and resources across the region.

4.4 Domestic Violence – General (Questionnaire - Section 5)

Respondents were asked to address general questions about domestic violence and given an opportunity to make their own comments.

4.4.1 Is Domestic Violence An Issue For This PCT? (Question 21)

Over 95% of respondents felt that domestic violence was an issue for their PCT. The reasons expressed varied and are summarised as follows: -

- Not enough is known, both in terms of prevalence and the response needed.
- We know that we have a fair number of cases.
- Locally it must be the same as national statistics - therefore it must be here.
- Many of our patients will be victims.
- The involvement with and impact on child protection needs to be made clearer.
- It impacts on the mental health of the community and has secondary effects in education and anti-social behaviour – it affects the stability of the community.
- It affects all aspects of health.
- Impacts on homelessness.
- Impacts on drug and alcohol abuse.
- As a result of awareness raising our referrals have increased.
- It is a public health issue.
- There are cultural and ethical considerations.
- Dealing with domestic violence is part and parcel of improving the health of the population.
- A more proactive response is needed.
- Impacts on the high teenage pregnancy rate.
- It is more hidden in rural areas.
- It is a major drain on our resources treating victims.

4.4.2 Could A Proactive Response Have Cost Savings Benefits? (Question 22)

There were mixed views among the respondents about the cost savings benefits of a proactive response, with 58% in agreement, 27% unsure and 15% disagreeing.

The prevailing view was that there would be increased costs short term due to higher levels of support being needed, higher caseloads being uncovered and that despite a proactive response there would still be long-term support issues for some families. The shorter-term costs of working with perpetrators, implementing training and support networks would initially be high. However there would be important savings long term including reducing future use of the health service, reducing the long term impact on children, preventing the escalation of longer term mental health problems (e.g. depression), allowing earlier preventative intervention and the reduction of medical outcomes. The view that 'prevention is better than cure' was frequently expressed and that the health service should take a longer-term view of this issue, as one of their key aims is to improve the general health of the population. The major problem expressed was that the benefits are difficult to measure in the shorter term.

4.4.3 Health Improvement Plans (Local Delivery Plans) (Question 23)

Domestic violence was directly or indirectly included in the Health Improvement Plan of four PCTs, although some 35% of respondents were not sure. The reasons as to why it was not included were pressures of other targets, because it is not currently a government health target, it is not directly a medical target and that although not mentioned

specifically it would be included in other targets e.g. mental health. Views were expressed that it may be useful if it was directly included as more resources may be allocated locally.

4.4.4 Women's Mental Health Into The Mainstream (Question 24)

Respondents were shown a copy of 'Women's Mental Health Into The Mainstream' (Department of Health)¹⁷ which states that: -

'there is a substantial body of research which links women's experience of child sexual abuse and domestic violence with long-term mental illness and also with physical and sexual health problems'

and that important issues are that: -

'violence and abuse are more common than generally realised, have a significant impact on physical and mental health and are often not disclosed'.

This document identifies domestic violence as a risk factor for mental health.

Only one respondent was aware of this publication and the rest stated that such documents would normally be sent to Mental Health Teams or Health Care Trusts.

Issues raised included the problems of cross linking with mental health teams, the fact that this type of information would not necessarily be disseminated within PCTs and that increased joint working with mental health maybe beneficial.

4.4.5 General Comments (Question 25)

Respondents were given the opportunity to make any extra comments they felt were relevant. The following are a representation of those made: -

- Despite local commitment domestic violence cannot be taken forward as an issue, because of the pressure of other objectives.
- Domestic violence is not always identified as an issue and taken seriously because of a lack of awareness.
- Multi-agency working is essential.
- There should be a more integrated approach - not dealt with as a separate issue.
- Need to do more work with domestic violence and drug and alcohol abuse teams.
- Need more specialist training to deal confidently with the issues.
- A total response to community safety is required.
- Specialist information is required to deal with the issue in ethnic communities.
- Need robust procedures to deal with recording data and documentation.
- Need to address men as victims as well.
- The best way to address the problem is through public health.
- There is a need to intervene early to be more preventative.
- Need information sharing protocols.

5. Evaluation of Results

In recent years there have been many changes undertaken in the structure and organisation of PCTs and the results of this audit should be seen against a background of organisations which are newly emerging and still endeavouring to 'find their feet' to some extent. This reorganisation has impacted on the handling of community safety issues and domestic violence specifically, as many PCTs are still unsure as to where this agenda stands and there is a lack of a designated authority within PCTs or comparability across them as to where this brief rightly belongs.

The effects of domestic violence are well known not only directly on individuals and their children's health and well-being but also in other areas including teenage pregnancy, homelessness and drug and alcohol abuse. Currently there is no strategic acknowledgement of these impacts and the associated costs to health services. Domestic violence remains something of a 'hot potato' with a subsequent lack of strategy, resources and internal structures to deal with the problem.

Within the health service domestic violence is often viewed as a more vague community objective rather than a truly operational health improvement one. The reduction of domestic violence and the subsequent health benefits should be clearly stated as with any other public health issue, for example smoking, alcoholism or heart disease.

The interaction on the frontline, by health visitors in domestic violence issues and the consequent impact on work or caseload are not fully appreciated for several reasons. Domestic violence is not directly reported and statistical information is not routinely kept or presented, so prevalence is not identified. Confidentiality among health visitors tends to keep information within 'ranks' and many doctors and other health professionals are not fully aware or sufficiently engaged with these issues.

5.1 Strategic Objectives

The consensus view of most of those participating in the audit was that domestic violence was covered in strategic objectives or guidelines. The reality appeared to be that it was included in much broader non-specific objectives and not directly identified or mentioned within these. As a result it was all too easy to ignore the issue at strategic level and there was a subsequent lack of allocation of resources or the allocation of the task to a designated individual at a managerial level.

The first approaches made by the researcher for participants in the audit clearly demonstrated a lack of defined lead within PCTs and general confusion as to who or where responsibilities may lay. In many instances several approaches were made to the PCT before a designated individual was allocated. The range of personnel interviewed at strategic level showed a lack of alignment or consistency among PCTs as to where and how the issue was handled.

In terms of frontline practitioners interviewed, nearly all were health visitors, thus tending to support the view that this was solely seen as an issue for them and not for all areas of the PCT or indeed for all health service providers. In most cases the only policy or

procedure in place were health visitor guidelines thus adding further emphasis to this view.

In practice it was often the case that health visitor guidelines were not adhered to operationally for a variety of reasons including lack of resources, lack of adequate training, uncertainty about a more proactive agenda, lack of support for staff, movement away from a public health role for health visitors to a purely medical function and a perceived lack of managerial or strategic lead and support.

The researcher's view on completion of the audit was that health visitors were not only dealing with the majority of the interface with the issue directly on the frontline, often adding hugely to their workload, but also responsible for dealing with all aspects of the issues within the PCT, whether that related to 'championing' the cause, undertaking new initiatives, attending forums, organising training, altering practice or seeking funding for new initiatives. The results are that they often felt isolated with the issue, unable to undertake new practice due to time and financial resources and felt a lack of both strategic support and general support within practices.

The need for strategic objectives within this field are clearly underpinned by the benefits of this approach recorded in section 4.1.1. by participants. It is evident that many frontline health visitors and child protection nurses have a clear perspective of the problem and the impact that this has on their work and are endeavouring to improve practice locally but are currently lacking resources and direction.

5.2 Department Of Health Guidelines

The majority of participants were aware that there have been recent guidelines issued by the Department of Health and that these had implications on practice. There was more limited in-depth knowledge of these recommendations and to what extent they had been adopted within PCTs.

Awareness raising had generally been addressed by all PCTs, some more proactively than others. Health visitors, directly in relation to the public, largely undertook this role. There was a general lack of awareness raising among health service personnel within the PCT especially GPs, practice staff and at a managerial level.

Support for staff either engaged in dealing with the issue or as victims was inconsistent across the region. Support structures were in place for general employment considerations, but it was not clear whether this support would have the specialist knowledge to deal with the implications of domestic violence or have the expertise to support a 'proactive' response to domestic violence. The support was in place for child protection issues but not for domestic violence cases.

All PCTs had a proactive 'zero tolerance' response to violence in the workplace, but there was a lack or awareness of how this interfaced with domestic violence and the impact of specific power and control issues.

There was a complete lack of consistency regarding the recording of data related to domestic violence, not only between PCTs but within them. This directly impacts on a wide range of issues, including patient care, but the researcher found no evidence of a

systematic method of recording information. It is essential if PCTs are to engage with this issue directly that consistent, comparable methods of data recording are undertaken, not only to establish prevalence and ensure appropriate allocation of resources, but also to facilitate patient safety, allow information sharing, enable the adequate recording of routine screening information, protect client confidentiality, address evidence gathering considerations, facilitate a consistent, coordinated response and support child protection procedures. The lack of any aggregated statistical information within PCTs meant that none were aware of the extent of domestic violence in their workload and were unable to share this data with other agencies to contribute to the development of services.

The confusion expressed around the sharing of information due to considerations of confidentiality, victim and personnel safety, human rights, data protection and ethical issues regarding the impact of evidence gathering as a result of a more proactive Police pro-arrest policy, clearly demonstrates a need for a defined, clear policy and guidelines and protocols for data sharing. The issue of confidentiality has often prevented the collection of statistical information that could be utilised to establish prevalence and impact on service provision. Distinctions need to be made between individual and de-personalised data so that sound data can be employed to raise awareness about the issue and service provision can be justified

5.3 Multi-Agency Working

The membership of domestic violence forums by health personnel was perceived as desirable, but the bulk of that membership was undertaken by frontline practitioners which reinforces the view that domestic abuse is only the concern of the health visiting / child protection teams. The networks of these teams are often very localised and thus there was an immediate barrier to the effective dissemination of information across the PCT. Frontline practitioners are unable to make a strategic contribution to the work of these forums and as such resultant changes in practice are difficult to establish or influence.

Far too often involvement with multi-agency working was reliant on an interested individual or a local 'champion' and not backed by strategy, resources and designated structures. The lack of the inclusion of this work in job descriptions and designated tasks leads to an 'ad-hoc' approach which erodes commitment to such work. It seems that often when an individual leaves, with their specific interest, the majority of the good work is lost with them.

The benefits of multi-agency working beyond forum meetings was appreciated by respondents, but in practice this was often limited to direct referrals, joint training and child protection. True multi-agency working is reliant on joint working procedures, information sharing and a higher awareness of the roles of other agencies. There is much scope for the development of this approach, but it needs to be included in mainstream provision, rather than rely on good local initiatives, pilot projects and local personal contacts.

Effective multi-agency working relies on clear information sharing procedures if it is to succeed. Currently within health little information regarding domestic violence is shared beyond individual case referral and then often only in extreme cases or as a result of child protection procedures. There is no doubt that issues of patient safety, patient

confidentiality, human rights and data protection need to be addressed, but within these there is far greater scope than is being currently utilised to share information both individually and as anonymised aggregated statistics. A clear framework and the necessary protocols are needed to address this requirement, so that information can be shared in an appropriate, safe and realistic way.

5.4 Resources & Services

The availability of appropriate resources and services was inconsistent across the region. In many cases the provision of good resources, effective signposting information and services for victims emerged as a result of the working of an external domestic violence co-ordinator or an active forum, rather than as an internal requirement of the health service. This leads to inconsistent availability and pockets of good practice that were not adopted elsewhere.

Domestic violence is a crime and the interface with perpetrators is seen as the role of the criminal justice system. In reality though the Police do not charge or convict the majority of perpetrators and an essential part of any effective domestic violence strategy must include intervention and work with perpetrators. Currently there are very limited options in the Thames Valley for the referral of perpetrators, outside of the Probation Service, and those that exist are often inappropriate. It is vital that the health service engage with this issue, in conjunction with other agencies to ensure there are other available appropriate options, with the resultant beneficial impact on children and victims.

A variety of information gaps were identified in relation to domestic violence, often in relation to good practice, appropriate research and contacts and details of other agencies involved in this field. The health service needs to ensure access to relevant information and that frontline practitioners have appropriate contacts, signposting registers and relevant research and best practice.

5.5 Current Practice

The individual response of health practitioners to domestic violence varied widely across the region and in many cases was left to personal choice or discretion. Many positive proactive responses were undertaken, but inconsistently and without any methodical consideration of risk or within a framework of accepted practice and procedures.

There are many occasions when the health service has the opportunity to intervene at an earlier stage or identify cause for concern, but all too often events have to become critical for a more proactive response to be undertaken.

It was found that many practitioners stated they would undertake to ask directly about domestic violence but in practice there were many barriers to this process and routine screening was minimal. Research shows that systems of routine screening for domestic violence can have beneficial outcomes in terms of earlier intervention, but also that most victims would have welcomed being asked directly as it provides an opportunity to talk, reduces self blame by increasing awareness and offers a path for help in the future.

It is interesting that whilst many felt that there had been improvements recently in the health service response to domestic violence only a third felt their policy matched

Department of Health objectives. A greater proportion of managers felt they had met these objectives and there was clear mismatch between their views and that of frontline practitioners. It is clear from comments made to the researcher that much innovative and recent thinking about responses to domestic violence are known to practitioners (Refer section 4.1.5) but that these have yet to be translated into practice. The audit identified two examples of much closer working namely a Police/Health data sharing initiative and co-operation in a 'one-stop shop' approach. A wider participation in these initiatives would not only reduce duplication of effort, but allow a more efficient response with immediate cost saving benefits for those agencies involved.

5.6 Training

Basic domestic violence awareness training had been undertaken by many of the PCTs, but was limited often to health visitors, nurses and midwives and undertaken as a one-off programme. In practice this means that new employees have no exposure to the training, there is no general awareness across all health professionals and there is no 'on-going' review of best practice. It is essential that if new practice relating to domestic violence is to be incorporated into working procedures that full training and support is provided on an 'on-going' basis. If a consistent, effective, knowledgeable response is to be maintained it is vital that all the complex related issues are fully understood by health professionals.

The benefits of a more structured training provision across the region were identified by respondents (Refer section 4.3.3), not only revealing the need for a new approach, but also that there is an awareness of the gaps in current response.

5.7 Domestic Violence As A Health Care Issue

The vast majority of respondents saw domestic violence as an issue for the PCT, not only because of its prevalence, but because of the clear links with and effects on poor health. There is no doubt that there are huge cost implications for health services because of such violence, but these are not readily identified, measured or allocatable to domestic violence directly. Research shows that dealing more directly with the issue of domestic violence can and will have long term cost saving benefits not only in the direct medical treatment of individuals, but also in terms of mental health improvements, long term effects on children, alcohol and drug abuse and improved perceptions of better health. The challenge for the health service is to find innovative ways of evaluating and justifying initial short term costs, in terms of these long term savings so that resources can be allocated in an effective way, within an environment of many competing needs.

The links between mental illness and domestic violence need to be more clearly stated and demonstrated by mental health teams. They need to proactively engage with the new mental health agenda and become more clearly involved with joint working with PCTs on this issue, addressing both the requirements of the victims and perpetrators.

There is no doubt than many health professionals clearly identify the needs of the domestic violence agenda and daily deal with the effects on health, but currently have difficulty aligning the needs of this agenda with current working practice.

6. Recommendations

In the Thames Valley there is evidence of good practice regarding domestic violence, but there is a need for the health service to more proactively engage with the community safety agenda and with domestic violence specifically.

There is a broad range of both specific and procedural changes, backed by recent research, which could be identified and incorporated into best practice, but the intricate detail of these is beyond the scope of this document.

The recommendations identified here relate to the specific areas dealt with by the audit and are intended as indicators of areas of interest for health executives to engage on a broad level, with a view to influencing practice within the Thames Valley.

6.1 Policy & Procedures

- Domestic Violence should be identified in specific objectives, targets, local delivery plans and work plans for each PCT.
- An identified lead in Community Safety and specifically domestic violence should be appointed in each PCT as part of the public health agenda.
- Domestic violence should not just be seen as an issue for health visitors, but for all health service providers, especially GPs.
- Domestic Violence should be clearly identified as a Public Health issue.
- Department of Health best practice and guidelines in this field should be adopted by each PCT and translated into action plans with implications for all service providers.
- A wider acceptance of the prevalence and detrimental effects of domestic violence on all aspects of health should be incorporated into PCT strategy.
- Overarching policy and procedures related to domestic violence should be adopted throughout the PCT.
- There should be movement away from considering domestic violence purely as a health visitor issue.

6.2 Training

- More general awareness raising of the issues related to domestic violence across all personnel within PCTs.
- On-going rolling programme of domestic violence training amongst all service providers, possible as part of induction training or as part of initial medical training.
- Specialist training for those proactively 'asking the question' or involved in routine screening for domestic violence.

6.3 General

- Review of staff support procedures both for those dealing with disclosures and for staff as victims of domestic violence.
- Review of methods of recording domestic violence data and adoption of a standard approach with approved guidelines.

- Commitment to domestic violence forum membership at a more strategic level and designated routes for information to be disseminated to involved personnel.
- Active involvement and commitment to a true multi-agency response and aligning of consistent responses and procedures.
- Adoption of routine screening for domestic violence against a background of support for those screening, adequate training and availability of adequate resources for dealing with disclosure.
- Support and commitment to community based perpetrator programmes as a preventative measure.
- Review of resources and sign-posting information held by individual surgeries etc.
- Inclusion of more formal risk assessment procedures upon disclosure.

6.4 Summary

This audit clearly demonstrated that domestic violence is an issue for all PCTs, but despite much interaction and awareness of good practice at a local level, the issue has still not been fully integrated into the public health agenda. There is often a mismatch between the views of the frontline practitioners and those at a more strategic level, with a resultant lack of clear guidelines and effective procedures.

Any more proactive response must be supported by a named lead and designated workers, the provision of domestic violence training, consistent data recording, awareness of recent good practice, support in the workplace, active multi-agency working and the availability of good resources and sign-posting information. Within this background routine screening, support for work with perpetrators and the opening up of this agenda will have direct benefits for health of the local population, both in the short and long term.

For domestic violence and other community safety issues to be truly addressed by the health service, health objectives should be included in Community Safety strategies and community safety objectives in health improvement plans and health professionals should be fully engaged and involved with these forums.

'Generally speaking, the response of the health sector to violence is largely reactive and therapeutic. Because that response tends to be fragmented into areas of special interest and expertise, the wider picture and the connections between different forms of violence are often ignored. Violence, however is a complex phenomenon and needs to be addressed in a more comprehensive and holistic manner.'

World Report On Violence & Health – World Health Organisation 2002 ⁵

'Priority is usually given to dealing with the immediate consequences of violence – providing support to victims and punishing offenders. While such responses are important and should be strengthened – there needs to be much greater investment in primary prevention of violence.'

World Report On Violence & Health – World Health Organisation 2002 ⁵

7. References

- 1 Domestic Violence: A Resource Manual for Health Care Professionals
Department of Health March 2000
- 2 Women's Aid Fact Sheet – Radford, Hester & Pearson 1998
- 3 The Sunlight Project – Exit Report March 2003
- 4 'Identifying Domestic Violence: Cross Sectional Study In Primary Care
British Medical Journal 2002 – Richardson et al
- 5 World Report On Violence & Health – World Health Organisation 2002
- 6 Health Consequences of Intimate Partner Violence
Lancet 2002; 359:1331-36
- 7 Domestic Violence – A Health Response: Working In a Wider Partnership
Conference Report Department of Health 2000
- 8 Domestic Abuse In Pregnancy
Royal College of Midwives Position Paper 19 – November 1997
- 9 Women At Risk – Stark & Flitcraft 1996
- 10 What Works In Reducing Domestic Violence – Julie Taylor Browne Whiting & Birch
- 11 Domestic Violence Good Practice Indicators
Humphreys, Hague, Hester & Mullender University of Warwick 2001
- 12 Should Health Professionals Screen Women For Domestic Violence? – Review
British Medical Journal 2002 - Ramsey, Richardson Carter et al
- 13 Research Into The Views of Women Living with Violence
Sunlight Project 2003
- 14 Reported Frequency of Domestic Violence: Cross Sectional Survey of Women Attending
General Practice.
British Medical Journal – Bradley et al 2002
- 15 An Exploration of The Prevalence, Nature & Effects of Domestic Violence in Pregnancy
Economic & Social Research Council – Mezey & Bacchus
- 16 Why Mothers Die – Report on Confidential Enquiries into Maternal Deaths in UK 1994 –
1996 – Executive Summary & Key Recommendations.
Department of Health 1998

- ¹⁷ Women's Mental Health – Into The Mainstream – Strategic Development of Mental Health Care For Women
Department of Health December 2002

8. General Resources

8.1 Web Sites

www.barnados.org.uk
www.bbc.co.uk
www.bmjournals.com
www.camden.gov.uk
www.citizensadvice.org.uk
www.cps.gov.uk
www.domesticviolencedata.org
www.dvintervention.co.uk
www.dvip.org
www.elderabuse.org.uk
www.homeoffice.gov.uk/violenceagainstwomen
www.lgbt-dv.org
www.met.police.uk
www.nacro.org.uk
www.respect.uk.net
www.samaritans.org.uk
www.stopitnow.org.uk
www.sunflower-centre.org
www.survivors.org.uk
www.suzylamplugh.org
www.thamesvalleypartnership.org.uk
www.thamesvalley.police.uk
www.thamesvalleyprobation.gov.uk
www.thelancet.com
www.victimsupport.org.uk
www.womensaid.org.uk

8.2 Publications and Literature

Abuse & Harassment of Women – Action Against Abuse 1994
Abuse of Older People – Action on Elder Abuse 1998
Bitter Legacy – The Emotional Effects of Domestic Violence on Children - Barnados 2002
British Crime Survey 1996
Care for Women – Department of Health 2003
Domestic Violence – Changing Direction – Thames Valley Partnership 2003
Domestic Violence – A Health Response – Stevens – Department of Health 2000
Domestic Violence – A Health Response – Dr J Cold – Department of Health 2000
Domestic Violence in Pregnancy – Bewley 1997
Domestic Violence Sourcebook – D B Berry – Lowell House 2000
Elder Abuse – Tonks & Bennett – British Medical Journal 1999
Enough Is Enough – Domestic Violence Strategy – Metropolitan Police 2001
Forced Marriages Abroad – Your Right To Choose – Foreign & Commonwealth Office
It Hurts – A Survey of Recent Findings on The Effects of Violence on Children
Bracknell Forest Borough Council & Thames Valley Partnership 2001

Loves Me Loves Me Not - Home Office 2002
Living Without Fear – Cabinet and Home Office -June 1999
Multi-Agency Guidance For Addressing Domestic Violence - Home Office 1998
NCH The Hidden Victims 1994
Pakistani Women's Experience of Domestic Violence in Great Britain
Home Office Research Findings No 43 1996
Primary Care Trusts as Responsible Authorities
Nacro Community Safety Practice Briefing 2003
Research Study on The Extent & Nature of Stalking – Home Office 1998
Respect – Statement of Principles & Minimum Standards of Practice – Respect 2000
Routinely Asking Women About Domestic Violence in Health Settings
British Medical Journal – A. Taket September 2003
Safe – The Domestic Abuse Quarterly – Women's Aid 2003
Stop It Now – Preventing Abuse Among Children & Young People – Stop It Now
Stop The Violence – A Guide To Keeping Children Safe – NSPCC
The Crown Prosecution Service Code of Practice on Domestic Violence - November2002
The Protection of Vulnerable Adults – Department of Health 2000 HMSO
Understanding Family Violence – V.R. Wilde Sage 1998
Violence at Home – A Guide for Teachers - Thames Valley Partnership 2001

'In all contacts with those who have disclosed domestic violence, or where it is suspected that there may be experience of domestic violence, health professionals must ask the question "will my intervention leave this patient and her children in greater safety or greater danger?" This requires health professionals to:

- Ensure that the safety of the person (and of any dependant children) is the paramount consideration in deciding on a particular intervention.
- Treat people with respect and dignity; listen to what they are saying, and not be judgemental.
- Seek to empower people to make informed choices about their lives, and not try to make decisions on their behalf.
- Respect confidentiality, especially in minority, ethnic communities and recognise the real dangers, which may be created if this is breached.
- Recognise the skills and contributions that other agencies are able to make and co-operate with them appropriately
- Ensure that they do not place themselves or their colleagues at risk in a potentially violent situation.

These key principles should underpin local policies and protocols developed by Health Authorities, Trusts and Primary Care Groups.

In addition these protocols and policies, backed up by appropriate training, supervision and support, need to address and take account of:

- Awareness raising about the nature and prevalence of domestic violence.
- Supporting staff in their personal reactions to encountering domestic violence and helping them to deal with issues when they have personal experience of being abused.
- Demonstrating zero tolerance for perpetrators of violence in the workplace of the NHS.
- How information gathered from individual record keeping should be aggregated and monitored and feedback provided to inform practice and help shape local service provision.
- The need to clarify responsibilities for inter-agency working (such as through domestic violence fora) and promote co-operation
- All available local resources and services to support victims of domestic violence and to address treatment of perpetrators'

QUESTIONNAIRE

The questionnaire consists of six sections and has thirty questions in all; most of the answers require a yes/no response and then a follow up descriptive answer depending on that response. Please ask if you require any further explanation of any of the questions and give as full an answer as you wish. Please feel free to make any additional comments that you feel may be relevant at any time during the interview.

Section 1 – Contact Information (Confidential):

1. Contact Details:

Name _____
 Position/Title _____
 PCT _____
 Address _____
 Telephone _____
 Email _____

2. Are you happy for your contact details to be added to our mailing list?
YES / NO
3. Are you happy for your contact details to be available to other PCTs associated with this research/audit?
YES / NO
4. Are you happy for details of any of your domestic violence initiatives to be publicly attributed to this PCT.
YES / NO
5. Have you seen the briefing providing background details of the audit?
YES / NO
 If NO please read now
6. Any comments or questions about the audit before we continue?

Section 2 – Policy & Procedures Relating to Domestic Violence

7. Does this PCT have specific strategic objectives directly related to domestic violence?
YES / NO
- If YES what are they?
- If YES are there specific policies & procedures - may we have a copy?

- If NO do you think they are needed and why/why not? YES / NO
YES / NO
- If NO are there any plans to introduce specific policies & procedures?
YES / NO
8. Are you aware of the Department Of Health – Domestic Violence Resource Manual for Health Care Professionals (March 2000)? YES / NO
9. Have any of the recommendations in this strategy been implemented in this PCT? YES / NO
If YES which ones?
If NO why not and are there any plans to implement them?
10. What is the current practice if practitioners feel that domestic violence is an issue in a family?
11. Would practitioners in this PCT directly ask patients whether they were suffering domestic violence/abuse i.e. 'asking the question'? YES / NO
If YES do they have support in this area – what support is available?
If NO – are there any plans for this practice to be more widely adopted?
12. Do you feel that your current policy meets with the Department of Health strategy and objectives in this field? YES / NO
If YES are there areas where policy could be improved?
If NO how could your policy be improved? When is this likely to take place?

Section 3 – Multi-Agency Working

13. Are you or any representatives of this PCT, members of the local domestic violence forum? YES / NO
If YES who are they?
If NO why do you feel this is not important?
14. Are you or any representatives of this PCT involved with any multi-agency working in the field of domestic violence? YES / NO
If YES in what way?
If NO do you feel that this is important in the future?

15. Is any information related to domestic violence shared with other statutory or voluntary organisations? YES / NO

If YES is this aggregated information or at specific case level?

If YES what agencies do you share this information with?

If NO do you think this might change in the future and why?

16. Has this PCT been involved with any local domestic violence initiatives? YES / NO

If YES what were they?

If NO do you think that this would be beneficial in the future?

17. Do you feel there is adequate information available regarding domestic violence referrals and the services other agencies offer? YES / NO

If NO what would be useful

Section 4 – Training

18. Has any specific domestic violence training been undertaken in this PCT? YES / NO

If YES who has been trained?

If YES was the training internal or external – who provided it?

If YES was this training one-off or an on-going programme?

If NO why not?

19. Is any future training planned in relation to domestic violence? YES / NO

If YES who will be trained?

If YES what type of training will they attend?

If YES who will provide this training?

If NO why not?

If NO are you aware that domestic violence awareness training is available?

20. Do you think that a standardised Thames Valley wide training initiative in relation to domestic violence would be beneficial? YES / NO

If NO why not?

Section 5 – General

21. Do you think that domestic violence is an issue for this PCT?
YES / NO
If YES in what way?
22. Do you think that a more proactive response to domestic violence could have cost savings benefits within PCTs?
YES / NO
If YES in what way?
If NO why not?
23. Is domestic violence identified in you Health Improvement Plan?
YES / NO
If YES in what capacity?
If NO do you think that this would be beneficial in the future why/why not?
24. Are you aware of the Department of Health document 'Women's Mental Health Into The Mainstream', where domestic violence & sexual violence are identified as risk factors for mental health?
YES / NO
If YES what implications do you think this will have for mental health teams?
If YES what changes in practice do you envisage?
If NO will action be taken to review this documentation with a view to altering practice in this PCT?
25. Are there any other comments you would like to make?

Section 6 – Follow Up & Feedback

26. Do you feel that the information collected in this audit will be of use to you?
If NO
why not?
27. Would you like to receive a copy of the completed audit? YES / NO
28. Would you be interested in being involved in a seminar on the implications of this audit on health service practice across the Thames Valley? YES / NO
29. Is there anyone else who you think it would be important to involve in a seminar on the implications of this audit on health service practice across the Thames Valley?
YES / NO
If YES who?

Contact Details:

30. Is there any other information or services regarding domestic violence, which would be beneficial to you in the future? YES / NO

If YES what would that be?

Thames Valley Partnership
Domestic Violence & Health Audit

April 2003

The Thames Valley Partnership is a charity, which seeks to reduce crime and the fear of crime across Buckinghamshire, Berkshire and Oxfordshire. Their work includes identifying local need and crime trends, researching and evaluating best practice, stimulating partnership working, promoting innovative crime prevention and managing integrated projects. Domestic violence has been one of its specialist fields of work over the past ten years and this audit will form part of its domestic violence intervention programme.

It is clear that when domestic violence occurs, it has a significant impact directly and indirectly on the health of victims and their families. The health service provides essential support and contact, but also has an opportunity to interface with community safety and crime prevention, which has important implications for future health and well being. In an effort to evaluate this interface the Partnership is undertaking a Thames Valley wide audit of all PCTs and their current involvement within the field of domestic violence.

It is intended that the audit will consist of structured questionnaire based personal interviews with PCT executives, public health representatives and frontline practitioners within each PCT. Questions will relate to current practice and procedures, related training, examples of proactive responses and future changes in practice. The results of this audit will be utilised to inform future best practice, encourage multi-agency working, promote co-ordinated health and domestic violence strategies across PCTs and improve community safety. An audit document of results is planned, together with a seminar to discuss findings, encourage feedback and promote multi-agency working. The document and seminar will be available to all those participating.

The confidentiality of individual PCTs will be maintained, with the purpose of the audit to evaluate the current picture across the entire Thames Valley, and whilst quantitative and qualitative assessments will be made, individual PCTs will not be named in relation to any particular findings. The only exception to this would be the citing of examples of best practice with the individual permission of the PCT.

Julia Worms an associate of the Thames Valley Partnership will be undertaking this research and producing the audit document. She agrees to maintain the confidentiality of those individuals taking part and will seek permission regarding reference to any individual PCT and the recording of any contact details.

If you have any further questions, please contact the researcher at Thames Valley Partnership.

Ann Taket, London South Bank University is the Home Office evaluator for the domestic violence and health funded projects and the slides below record the presentation she made at Community Safety & Health seminar held at the Thames Valley Partnership – February 2004.

Exploring the health service contribution to tackling domestic violence

Ann Taket
Professor of Primary Health Care
London South Bank University



Domestic violence

- Affects between one in four & one in three women at some time during their adult life
- Affects all age groups, all ethnic and religious groups, all income levels
- Major health impacts
 - physical and mental health
- Impacts on children

'Mary' - a case study

- In her early fifties
- No children
- Emotional abuse for over 20 years
- Intensified over time
- Physical abuse started 3 years ago
- Enters refuge after contacting Samaritans

'Mary' – Missed opportunities

- Abortion counselling
- Visits GP with psychological distress
- Psychiatric inpatient
- Police
- Visits GP for help for husband

'Nicki' – a second case study

- In her early 30s
- 2 children
- Relatively long history (years) of abuse
- Initially kept isolated at home
- Once children were at school realised “something was wrong”

'Nicki' - effective signposting into services

- Visits GP about injuries
- Told about specialist outreach worker
- Saw outreach worker next day
- Enters refuge with children few days later
- Offered suitable property by council
- Leaves refuge for new home after 3 months

Routine enquiry - I

- Highly acceptable to majority of women
- Uncovers previously hidden cases
- Repeat enquiry increases likelihood of disclosure
- Many women will not disclose without being asked directly
- Trained staff find routine enquiry acceptable and helpful
- Time required is not long in most cases

Routine enquiry – II – advantages over selective enquiry

- Contributes to changing social attitudes about abuse
- Less likely to make women experiencing abuse feel stigmatised
- Less likely to compromise the safety of women experiencing abuse
- Health professionals report that their perceptions about which women were free from abuse were often incorrect

Training

- at least one day in length
- Covering:
- nature and extent of health problem represented by domestic abuse
 - asking direct questions about abuse
 - responding appropriately to disclosure
 - local availability of specialised services
 - safety planning
 - safe documentation of abuse

On training - I

“I think (the training) gave me insight into why people don't leave, because I think your initial reaction when somebody tells you is 'Leave' and if they don't leave then it is their fault. But things aren't that simple. It's taught me a little how to support people if they decide to stay in that situation because you can't just wash your hands of them. You need to provide on-going support and advise them how to stay safe while in that situation.” [Health visitor, Wakefield]

“If we can support a woman through HIV screening, we can ask domestic violence questions” [Midwife, Birmingham]

On routine enquiry - I

“I started asking early last year, after the first study day, but I probably do it more now, after the second study day. It was more practical; we covered the aspects of asking and what to do after you've asked and how to handle different responses. They showed us how to do an escape route and a risk assessment, so if a woman wanted to leave we could help her to escape. It was like, before, we could ask, but we didn't know what to do after that. Now we know what to do, we are much more equipped to deal with anything that comes up, all the practical things, like wearing two sets of clothes to go out and leaving one with a friend, not to tell the children, things like that.” [Health visitor, Wakefield]

On routine enquiry - II

“It's like taking care of someone's bad knee and not taking any notice of the fact that they weigh 25 stone and don't do any exercise. If you ignore it, you can't manage your patient effectively. I felt (domestic violence) was a huge undiagnosed problem. I felt uncomfortable about what to do, so it [the training] was a good opportunity to go and find out. I've got this lady who is a victim of abuse, but it is emotional and financial; it used to be physical, but not anymore. ... And because we both know, we can talk about it; we don't pretend that I can make her better. She has been offered help, and she's refused, she copes the way she can. It makes it a lot more effective, and I don't beat myself up that I can't get her better. At least I know I have been able to offer the help. ... we can keep talking about it until she decides to deal with it in a more formal way. That is going to take time.” [GP, Wakefield]

In women's own words

"I really hope Women's Aid get the credit they deserve from everybody. Because I give them credit for everything they've done. I couldn't have done anything without them. I think I probably still would have been there." [Beth, Salford]

"And sometimes you still get down, but I know when I'm down without a shadow of a doubt, I'm going to come back I'm happier now. In one of my things I wrote at college - I say this to a lot of women I talk to - I had to write, you know you used to write about what you'd learned that week and what have you, and I thought 'I was somebody's wife, I was somebody's mother and then I was somebody's possession and **now I'm me**' [emphasised]. That you should put down because that I feel is relevant." [Jean, Wakefield]

Flexible routine enquiry - I

- A GP systematically works his/her way through all the women on their list by asking one woman each surgery session.
- A practice runs a well-woman clinic to which every woman registered with the practice is invited once every 3 years. Questions on domestic abuse are included in the list of areas to be covered. Each woman is seen on her own, in a private room.
- A large general practice has practice nurse cover at all times surgeries are running. Women are invited for a short health promotion consultation before or after a GP appointment. This is used to take BP, weight (if not taken recently), to discuss smear and breast screening and to enquire about domestic abuse.

Flexible routine enquiry - II

- Women are asked about domestic abuse in the course of routine home visits following childbirth
- At antenatal booking, midwives have instituted the practice of always setting aside some private time with the woman on her own, in order to enable her to raise any issues she likes. This private time is also used to enquire about domestic abuse.
- At A&E/Minor injuries units/Walk in centre, every unaccompanied woman is asked about domestic abuse. This is done in a private space with the woman on her own for confidentiality.

Advantages of routine enquiry

- Gives all women basic information about the unacceptability of domestic abuse, and that abuse is not just about physical violence
- Gives all women information that will be relevant to their friends, relations, neighbours, even if it is not personally relevant to them
- Helps reduce both the stigma associated with abuse and the hidden/taboo nature of abuse
- Gives a clear message to women experiencing domestic abuse that they are not alone in their experience, that the abuse they experience is unacceptable, and that there are services available for them to seek help in changing their situation

Importance of specialised services

- Knowledge about services and how to access
- Importance of advocacy/support across range of issues
- Importance of extended opening hours
- Importance of support from other survivors

Conclusions

- scope for tackling domestic violence through health service is enormous
- many missed opportunities for routine enquiry
- importance of training
- importance of expert non-statutory agencies like Women's Aid