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Tackling domestic violence: exploring the health service contribution

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The views expressed in this report are those of the authors, not necessarily those of the Home Office (nor do they reflect Government policy).

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Foreword

In 1998 the Home Office announced the Crime Reduction Programme (CRP), which aimed to develop and implement an integrated approach to reducing crime and making communities safer. As part of this programme the Violence Against Women Initiative (VAWI) was launched in July 2000, and specifically aimed to find out which approaches and practices were effective in supporting victims and tackling domestic violence, rape and sexual assault. Thirty-four multi-agency victim focused pilot projects were funded that aimed to develop and implement a range of interventions for various population groups in a number of different settings and contexts. The projects were originally funded until the end of March 2002; however, 24 of these projects had their funding, and in some cases their evaluations extended until the end of March 2003. A further 24 'Round 2' projects were funded in March 2001; however these were provided with money purely for services and were not evaluated by the Home Office.

For evaluation purposes the projects were divided into nine packages: projects with similar solutions or tactics, or those which were operating in the same contexts, were grouped together. Seven different independent evaluation teams were commissioned to assess the projects in terms of their development, impact, cost and cost effectiveness. The findings from all of the evaluations have been collated and a series of research reports and concise practitioner guides are planned for both the domestic violence and rape and sexual assault projects.

This report is one of a series of reports, which specifically reports on the findings from the evaluation of a number of domestic violence projects. The report aims to explore the health service contribution to tackling domestic violence, and draws upon the findings from four projects, which had developed and implemented interventions within a number of health settings. It places the findings from these projects in the context of the literature.

Previously published CRP: Violence Against Women reports

Domestic violence

Douglas, N., Lilley, S.J., Kooper, L. and Diamond, A. (2004). *Safety and Justice: sharing personal information in the context of domestic violence - an overview*. Home Office Development and Practice Report. No. 30. London: Home Office.

Mullender, A. (forthcoming) *Tackling Domestic Violence: providing support for children who have witnessed domestic violence*. Home Office Development and Practice Report. No. 33. London: Home Office.

Taket, A.R. (2004) *Tackling Domestic Violence: the role of health professionals*. Home Office Development and Practice Report. No. 32. London: Home Office.

Rape and sexual assault

Lovett, J., Regan L., and Kelly L. (2004) *Sexual assault referral centres: developing good practice and maximising potentials*. Home Office Research Study. No. 285. London: Home Office.

Regan, L., Lovett, J. and Kelly, L. (2004). *Forensic Nursing: An option for improving responses to reported rape and sexual assault*, Home Office Online Report. No. 28/04. London: Home Office.

Regan, L., Lovett, J. and Kelly, L. (2004). *Forensic Nursing: An option for improving responses to reported rape and sexual assault*, Home Office Development & Practice Report. No. 31. London: Home Office.

Skinner, T. and Taylor, H. (forthcoming) *Providing counselling, support and information to survivors of rape: an evaluation of the Surviving Trauma After Rape (STAR) Young Persons' Project*, Home Office Online Report. No. 51/04. London: Home Office.

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Abbreviations

A&E	Accident and Emergency Department
CRP	Crime Reduction Programme
CPS	Crown Prosecution Service
DETR	Department of Environment, Transport and the Regions
DV	Domestic violence
DVO	Domestic Violence Officer
DVU	Domestic Violence Unit
GP	General Practitioner
NSPCC	National Society for the Prevention of Cruelty to Children
PCG	Primary Care Group
PCT	Primary Care Trust
PSG	Policy and Strategy Group (Salford)
S&S	Support and Survival, Women's Aid-affiliated domestic violence support agency in Wakefield
SWA	Salford Women's Aid
VAWI	Violence Against Women Initiative
VSS	Victim Support Service
WA	Women's Aid

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Executive summary

This report draws on the process and outcome evaluations carried out on the four health projects (the health project package) funded under the CRP Violence Against Women Initiative.¹ It places the findings from these in the context of the literature, and also, where possible, the findings from other projects in the Violence Against Women Initiative that were evaluated by other teams.²

The health project package

There were four projects in the health project package, each of which implemented a different programme of work.

South West Birmingham Domestic Violence Programme:

- training and awareness-raising;
- protocol development;
- outreach service in a GP practice; and
- extension of telephone helpline hours.

North Devon and Torridge Early Intervention Programme:

- outreach service provision in A&E; and
- survivor resource pack.

Salford Enhanced Evidence Gathering Scheme:

- collection of enhanced evidence in GP practice setting, using Polaroid cameras;
- training and awareness-raising; and
- training and resource handbook.

Wakefield Support and Survival Health Initiative:

- routine enquiry in GP practices;
- training and awareness-raising; and
- training pack and 'screening' resource pack.

The common element in all four projects is the signposting³ of women into specialised support agencies, although the means of doing so differs. The lessons learnt from the evaluation can provide the route to earlier effective intervention for women experiencing domestic violence.⁴ In each case the agency/ies to whom the women are directed for further advice and support lie outside the health service. These agencies include organisations belonging to the Women's Aid Federation of England (all four projects) and Victim Support (North Devon and Torridge).

¹ The initiative did not aim to examine the needs of male victims of domestic violence.

² See the following website for further details:

<http://www.homeoffice.gov.uk/rds/violencewomen.html>

³ Giving contacts and advice about local agencies.

⁴ Domestic violence may include emotional, sexual and economic abuse as well as physical violence, and these may occur together or on their own within a relationship, although always in the context of coercive control by one partner over the other. Abuse may continue after the partners have separated. The terms domestic abuse or partner abuse are often used to reinforce the fact that domestic violence does not necessarily involve physical violence. In this report, both terms domestic violence and domestic abuse are used.

The evaluation study

The evaluation comprised a mixed method design, incorporating a combination of quantitative and qualitative methods to:

- undertake an interim (formative) evaluation of the projects after the first six months of the implementation phase of each project. This enabled early results to be fed back to aid development and refinement of each project where necessary (it was argued that this was particularly desirable given the developmental nature of the projects in the health package).

This evaluation included both process and outcome elements to:

- undertake a process evaluation of how each project has been implemented;
- undertake an outcome evaluation of the effects of each project;
- collect detailed cost information on the elements included in each project and provide data on project inputs, outputs and outcomes in a standardised format;
- provide an analysis of costs analysis for each project; and
- compare projects within the health project package to identify the overall effects of particular approaches in particular contexts.

Key findings

South West Birmingham Domestic Violence Programme

This project demonstrated that: provision of outreach support in the GP practice setting is a way of providing readily accessible support to women experiencing domestic violence. It showed that provision of expanded helpline hours is very important in enabling women to access services more readily. It also highlighted that training and raising awareness of health staff played an important part in facilitating women's access to domestic violence support services.

North Devon and Torridge Early Intervention Programme

The Early Intervention Project succeeded in providing support to survivors of domestic violence in an A&E department at relatively low cost to the agencies concerned by utilising Victim Support volunteers. While the numbers using the service were small, it is likely that there would have been higher uptake had the training for health staff been more comprehensive.

Salford Enhanced Evidence Gathering Scheme

The project has shown that the gathering of enhanced evidence through the use of cameras in the GP practice setting is possible. However, the extremely low uptake (only one person had photographs taken), and the reasons identified in this report for this, means that it cannot *currently* be regarded as a cost-effective use of resources.

Wakefield Support and Survival Health Initiative

This project demonstrated that routine enquiry about experience of domestic abuse in the GP practice setting was feasible. It indicated the value of short surveys into the prevalence of domestic abuse amongst women attending the practice as one way of confirming the importance of the issue in each practice. The project also showed the importance of introducing routine enquiry in GP practices and the need for appropriate training.

Two factors were particularly important in the success of this project. The first was the project team's expertise in the primary health care setting and the provision of support and other services to women experiencing domestic violence. The second was the creation of close partnership working at the operational level between the primary health care services and Support and Survival (the local Women's Aid-affiliated domestic violence support agency).

This study, together with findings from other recent studies not available at the time of the systematic review of research findings reported by Davidson *et al.*, (2000), demonstrate that there is sufficient evidence to suggest recommendations for action by the health service. The conclusions and recommendations are summarised below.

Conclusions

The health service *alone* cannot meet all the needs of women experiencing domestic violence. But it is uniquely placed to help change public and professional attitudes to domestic abuse, and to enable women experiencing domestic abuse to access specialist services, usually provided outside the health service.

Three types of action are needed within the health service:

1. Improving availability of information on domestic abuse and services for those who experience it.
2. Providing/acquiring appropriate training for health professionals.
3. Instituting systems of enquiry about domestic abuse.

These are expanded below.

- The provision of an outreach service by a specialised domestic violence agency in GP and A&E settings has the potential for allowing women to access specialised services more readily. These outreach services have particular value in rural or semi-rural areas, where women may find it difficult to travel to access support services in cities or town centres.
- The provision of cameras for evidence-gathering in the GP practice setting is not currently a cost-effective use of resources due to low uptake.
- Awareness-raising about domestic violence for both the public and health professionals is important.
- Good partnership working is important, in particular close working relationships of mutual respect between health organisations and the local specialised domestic abuse service agencies.
- Clear project management structures are important.
- Routine enquiry about domestic abuse is feasible in the GP practice and A&E settings and offers a number of potential advantages:
 - it uncovers significant numbers of hidden cases of domestic violence;
 - it is a form of prevention, by changing the perceived acceptability of violence in relationships, and by making it easier for women experiencing domestic violence to access multi-agency services earlier;
 - it changes health professionals' knowledge and attitudes towards domestic violence and helps to reduce social stigma;
 - it helps to maintain the safety of women experiencing domestic violence; abusive partners may be less likely to be suspicious and retaliate if they overhear: "We routinely ask every women about domestic violence..."; and
 - the majority of women find it acceptable to be asked about domestic violence by health professionals.
- This study, together with the findings from the published literature, has demonstrated the realisable benefits of routine enquiry in terms of improving access to specialised domestic abuse services and the impact this can have on the health and quality of life of women who have experienced domestic abuse and on their children. Specialised domestic abuse

services, in particular services provided by Women's Aid-affiliated organisations, are important in responding to the needs of women experiencing abuse and are key in achieving the benefits of routine enquiry. Funding needs to be assured for the provision of such specialised services.

- Training for routine enquiry needs to last at least one day, and to cover: the nature and extent of the health problem represented by domestic abuse; how to ask direct questions about experience of abuse; how to respond appropriately to those disclosing abuse; local availability of services for those experiencing abuse; safety planning; safe documentation of abuse. Training of this type should overcome professionals' concerns about asking women directly about domestic violence.
- Providing encouragement, advice and support to health professionals implementing routine enquiry is important, and not particularly resource-intensive.

Recommendations for practice

- In rural and semi-rural areas in particular, consider the provision of specialised outreach services in health service settings as a way of improving access to services for women experiencing domestic abuse.
- Improve information on domestic abuse services for both public and health professionals.
- In developing local training for health staff, make use of existing training and resource packs, including those produced for three of the projects evaluated in this study.
- Promote the implementation of systems for routine enquiry in the health service, emphasising the need for flexibility. This will require appropriate training and resourcing for local specialised domestic abuse services.

Recommendations for policy

- Ways should be explored of creating a national focus on domestic violence in public health terms. The prevalence of the problem justifies this, and since improving awareness is an important part of primary prevention, this represents part of the solution.
- Support the dissemination of guidelines, protocols, resource packs and training packs, for example through the support of suitable websites.
- Ensure training about domestic abuse is a part of the basic curriculum for every health professional. Such training should include:
 - the nature and extent of the public health problem represented by domestic abuse;
 - how to ask direct questions about experience of abuse;
 - responding appropriately to disclosure of abuse;
 - providing information on services for those experiencing abuse;
 - safety planning for those experiencing abuse; and
 - safe documentation of abuse.
- Ensure the continuing education/continuing professional development for all health professionals includes updates on domestic abuse, in particular on local systems for routine enquiry and local specialist services.
- The Home Office should explore ways of making the training and resource packs produced by the Birmingham, Salford and Wakefield projects available for widespread use.
- Policy mechanisms for ensuring implementation of systems of routine enquiry that reach all women need to be identified. Options to be considered include a specific national target on DV, introduction into contracts for GPs and a national service framework on domestic violence.

Recommendations for future research

- There are specific aspects of the different projects that have not yet been fully implemented that would benefit from further research as to their effectiveness. These include:
 - the computer protocol developed in Birmingham;
 - the midwifery link post being implemented in Birmingham;
 - the training video under production in Wakefield;
 - outcomes from the domestic abuse action plan being generated by nursing staff in one of the Wakefield PCTs; and
 - the provision of training in modules which together make up a full day, rather than a single day's training.
- Further research is needed into achieving appropriate documentation of domestic abuse while preserving confidentiality.
- A longer-term study of the implementation of routine enquiry in a variety of settings is recommended. This should include examination of long-term health outcomes for women and children as well as a more detailed exploration of the costs of specialised support provision.

1. Introduction

Domestic violence is a major public health problem. A review of over 50 surveys found that 10-50 per cent of women report having ever been hit or physically assaulted by an intimate partner at some time in their lives (Heise *et al.*, 1999). The most robust source of data on domestic violence for England and Wales is the national victim focused British Crime Survey (BCS). The 2001 BCS questionnaire included a self-completion component on domestic violence, and findings suggest that one in four (26%) of women and a sixth (17%) of men had experienced at least one incident of non-sexual domestic threat, force, financial or emotional abuse since the age of 16 (Walby and Allen, 2004). Younger women, pregnant women, and those separating from a relationship, report higher rates (Department of Health, 2000).

There is a considerable and growing body of research documenting the significant health impacts on both adults and children who have experienced abusive relationships. These include both short and longer-term effects on physical and mental health. Domestic violence can lead to acute and chronic physical injury, miscarriage, and loss of hearing and vision, physical disfigurement, and often depression, alcoholism and sometimes suicide (Abbott and Williamson, 1999). Physical health effects include injuries received as a direct consequence of any assault, and chronic physical health problems, for example, irritable bowel syndrome, backache and headaches (Campbell, 2002).

Increased rates of unintended pregnancies and terminations have been identified (Gazmararian *et al.*, 2000). Sexual health can also be affected, with studies reporting lower rates of contraceptive use and increased sexual coercion resulting in higher rates of sexually transmitted infections, including HIV (Garcia-Moreno and Watts, 2000). Finally, in terms of mental health, studies report higher rates of depression, anxiety, self-harm and suicide (Campbell, 2002), and a four-fold increased risk of post-traumatic stress disorder has been found in women experiencing domestic violence (Silva *et al.*, 1997).

Many children also develop post-traumatic stress disorder, and experience years of distress (RCN, 2000; Mullender, 2000). There are health consequences for children born to women experiencing domestic abuse. A meta-analysis of 14 studies found an increased risk of low birth weight in women who had experienced domestic violence during pregnancy (Murphy *et al.*, 2001). Children growing up in a family where domestic abuse is present are more likely to experience child abuse themselves, with estimates ranging between 30 and 66 per cent (Hester *et al.*, 2000; Edleson, 1999; Humphreys and Thiara, 2002). A UK study found a very high prevalence of psychological difficulties and health needs in a sample of children in refuges (Shankleman *et al.*, 2001). Children who witness and/or directly experience abuse may exhibit a range of behavioural symptoms including sleep disturbances, poor performance at school, emotional detachment, stammering, suicide attempts, aggression and disruptive behaviour (McWilliams and McKiernan, 1993; Stark and Flitcraft, 1988; Knapp, 1998; Shankleman *et al.*, 2001). They may learn to accept violence as an appropriate method of conflict resolution in adult relationships and go on to repeat these patterns in adulthood (Rosenberg and Rossman, 1990).

In this context, the importance of early intervention and prevention of domestic abuse is clear. One important question is: what is the role of the health service in tackling domestic abuse? This report presents the results of a Home Office study to evaluate four health projects (the health project package) funded under the Crime Reduction Programme (CRP) Violence Against Women Initiative. Each of these projects investigated a different programme of activities aimed at achieving earlier intervention.

Previous research on tackling DV in the health service: an overview

There is an extensive and rapidly growing literature on domestic violence, including a number of publications that provide overviews of initiatives to tackle the problem and guidance for public service professionals (for example Department of Health, 2000; Humphreys *et al.*, 2000; Royal College of Nursing, 2000; British Medical Association, 1998; Royal College of Midwives, 1998). However, there is still a lack of knowledge about the effectiveness of different strategies for tackling domestic violence. The report of a recent systematic review concluded that many of the evaluation studies that do exist are limited in scope and methodological rigour (Davidson *et al.*, 2000, 2001).

This section provides an overview of previous research that has examined the role of the health service in tackling domestic violence.⁵

Survivors often look to the health services to solve the health problems that are a consequence of domestic violence. Surveys indicate that women see the health service as an appropriate site for intervention, and that often they do not understand the failure of health professionals to ask in more depth about possible causes of their injuries or problems (Davidson *et al.*, 2000, 2001). The health service also provides a key route for identification, risk assessment and the provision of appropriate health and other support for survivors of domestic violence. It is almost always involved in providing services to pregnant women, and pregnancy is often a time when abuse begins or intensifies (Casey, 1989; Rodgers, 1994; Royal College of Midwives, 1998).

Davidson *et al.*, (2000, 2001) identified gaps in our knowledge of health service interventions. These include:

- the extent to which domestic violence impacts on health in the UK;
- the impact of intervention programmes in health care such as:
 - screening women to discover who is experiencing violence;
 - assessing with them their risk of serious violence;
 - what works to help them improve their lives; and
 - what services they need;
- links between health and other services;
- views of care givers and women;
- costs of care in the health sector for victims and their families;
- social and geographic variations within the UK; and
- the impact of violence prevention programmes.

The four health projects within the CRP Violence Against Women Initiative sought to improve the services that women received in response to their experience of domestic violence. Some of the projects also explicitly mentioned children. Their evaluation thus provides a good opportunity to fill some of the gaps outlined above.

It is not only in the health sector that knowledge about the costs of domestic violence is poor. As Crisp and Stanko (2000) point out, there is also a dearth of information about the immediate costs of domestic violence to the police and social services. This also applies to the longer-term costs associated with lost work time, re-housing, disruption to schooling of children, dependence on benefits and long-term psychological damage to survivors. While policies and practice targeted at women's needs are becoming better developed, those relating to children are particularly lacking (Mullender, 2000).

⁵ It is important to stress that this is not a review resulting from a systematic search strategy.

The context of this report

This report presents a synthesis of the key findings from all four evaluations; the data presented are the key findings in relation to how the health service can make a difference in the context of domestic violence.⁶

The report places the findings from the evaluations of the four projects in the context of the literature, and where possible, the findings from other projects in the Violence Against Women Initiative that were evaluated by other teams. The emphasis is on looking across the four projects, and pooling data to examine different aspects of the role of health services in tackling domestic violence and of the use of specialised services for those experiencing domestic abuse.

This report shows that a major role for the health service is in signposting women experiencing domestic abuse into specialised support services, often existing outside the health service. In this country, these services are often provided by voluntary organisations affiliated to the National Women's Aid Federation, and also by Victim Support. For this reason previous research into the effectiveness of the services offered by such agencies is relevant, and this is considered in appropriate places later in this report. In particular, research into the impact of such services on the health and quality of life of women and children is considered in Chapter 4. The report discusses findings from a number of studies, not available at the time of Davidson *et al.*'s (2000, 2001) review.

A number of limitations should be borne in mind when reading this evaluation report. These include the small sample sizes in some aspects of the studies and the lack of control over the data collected by the four projects being evaluated. In some areas, therefore, the demonstration of feasibility of interventions should be regarded as provisional. The results do, however, clearly illustrate the potential benefits of the interventions both to women who experience domestic abuse and to health professionals. Given the limitations of the study, no attempt has been made to derive population estimates of benefit at any point. The conclusions are those that arise from analytic generalisation rather than statistical generalisation, in sense of the terms described by Yin (1994).

The health project package

Table 1.1 presents some key characteristics of the areas where the projects were based. As the table shows, the projects took place in four contrasting areas: one rural and three urban, with varying levels of deprivation and population characteristics.

The programmes carried out by the four projects are outlined in Table 1.2. Diagrams depicting the operation of each of the projects are given in Appendices 1 to 4. The projects varied tremendously in size, as can be seen from the CRP grant figures and the total project costs shown in Table 1.2. Two of the projects dropped some elements of their programme of work during the period under evaluation. In North Devon, a second phase was planned in which outreach service provision would be implemented in other health care settings in the area. In Birmingham, outreach services were originally planned in two further health settings: an Accident and Emergency (A&E) Department and a Maternity Hospital.

⁶ For further details of the project evaluations, please contact the authors.

Table 1.1: Key characteristics of the project areas

	Birmingham	North Devon	Salford	Wakefield
Project area	Northfield, SW Birmingham	North Devon and Torridge	Inner city, Sure Start and New Deal areas	Entire district
Population (2001 census)	75,629	146,503	216,119 (all of Salford)	315,173
Minority ethnic population	13.9%	0.9%	3.9%	2.3%
Deprivation, rank of district in 354 districts, 1 =most deprived	43 (Birmingham)	127 (N Devon) 87 (Torridge)	28	62
Unemployment (% of population aged 16-74)	5.2%	3.5%	3.8%	3.5%
Type of area	Urban	Mainly rural	Urban	Urban and semi-urban

Sources:

Deprivation: DETR 2000

All other statistics from Census 2001, Crown copyright, <http://www.neighbourhood.statistics.gov.uk>, accessed March 2003

Table 1.2: The health projects – an overview

Project ¹	Programme elements
South West Birmingham Domestic Violence Programme Total project cost: £221,000 CRP grant: £192,000	(1) training and awareness-raising (2) protocol development (3) outreach service provision in a GP practice (4) helpline extension
North Devon and Torridge Early Intervention Programme Total project cost: £25,000 CRP grant: £7,000	(1) outreach service provision in A&E (2) survivor resource pack
Salford Enhanced Evidence Gathering Scheme Total project cost: £138,000 CRP grant: £102,000	(1) collection of enhanced evidence in GP practice setting, using Polaroid cameras (2) training and awareness-raising (3) training and resource handbook
Wakefield Support and Survival Health Initiative Total project cost: £211,000 CRP grant: £161,000	(1) routine enquiry in GP practices (2) training and awareness-raising (3) training pack and 'screening' resource pack
<p>Note:</p> <p>1. CRP grant and total project costs are given to nearest £1,000. The total project cost includes the cost of inputs to the projects provided by other agencies out of other sources of funds. These figures are used as a rough indication of the size of the projects.</p>	

The common element in all four projects was the signposting of women into specialised support agencies to provide earlier effective intervention for those experiencing domestic violence. The mechanisms for doing this varied considerably. In each case, the agency/ies to whom the women were directed for further advice and support were outside the health service. These agencies included organisations belonging to the Women's Aid Federation of England (all projects) and Victim Support (North Devon and Torridge). All four projects also included training and awareness-raising, although in one, the smallest project in North Devon, this was not a specific element in the programme of work.

Key dates in the timetables for the projects are shown in Table 1.3. Funding for all the projects was announced in July 2000. The start dates are those when work actually commenced on the project and exclude the time taken to recruit staff.

Table 1.3: Timetable of phases for health projects

	Birmingham	North Devon	Salford	Wakefield
Set-up ¹	June 2001 to September 2001 ²	June 2000 to March 2001	November 2000 to September 2001	October 2000 to March 2001
Implementation of project plans	October 2001 to March 2002	April 2001 to March 2002 Implementation in A&E	October 2001 to March 2002	Stage 1: practice 'audit' ³ March 2001 to December 2001 Stage 2: pilot of routine enquiry January and February 2002
CRP funded extension to project	April 2002 to March 2003	No extension given	No extension given	April 2002 to March 2003
End of CRP funding	March 2003	March 2002	March 2002	March 2003
Notes:				
1. Start of set-up is the point at which the first paid project worker took up post, except in North Devon where there were no paid workers.				
2. The start date for the Birmingham project given here is the start of the second set-up stage after the project was re-launched under a new lead agency. The Birmingham project experienced an unsuccessful first set up from October 2000 to May 2001.				
3. See footnote 9 for an explanation of 'audit'.				
Collection of cost and input data took place up until end of March 2002				

All projects were multi-agency partnerships; details of the different agencies involved are shown in Table 1.4. Each project had support from developers, appointed and paid for by the Home Office for the initial months of the project's life.

Table 1.4: Agency involvement in the health projects

Project	Lead agency ¹	Core agencies ²	Other involved agencies
Birmingham ³	Women's Aid	Health Authority Community Trust Women's Hospital	Victim Support, Housing, Probation Service
North Devon and Torridge	Police/Victim support	Women's Aid	Health Service ⁴
Salford ⁵	Social services	Health Authority	Police, education and welfare, Women's Aid, Victim Support, NSPCC, Probation Service, CPS, NHS Trusts
Wakefield	Support and Survival	Health Authority	Probation Service, CPS, Community Safety Partnership Office, Police
Notes:			
1. Lead agency: where the project is managed from.			
2. Core agencies: those closely involved in steering and/or delivering the project			
3. This relates to the current Birmingham set-up, the configuration in the abortive set-up phase was rather different.			
4. A&E staff were involved in project implementation, but were not represented in the management or steering of the project			
5. This relates to involvement in the project Implementation Group			

The structure of this report

Chapter 2 describes the evaluation methodology and design used for the evaluation of the four projects.

Chapters 3 and 4 describe findings that are central to the exploration of the role of the health service in tackling domestic violence. Chapter 3 focuses on the contribution that health service staff can make to tackling domestic abuse. It also covers women's experiences of the health service in relation to their experience of domestic abuse. Chapter 4 examines the impact of service use on the health and quality of life of women and children. It also examines the need for a multi-agency response.

Overall conclusions from the study are then discussed in Chapter 5, together with recommendations for practice, policy, and future research.

2. Evaluation methodology and design

The evaluation design

The evaluation of the four projects used a combination of quantitative and qualitative methods to:

- evaluate how each project was implemented;
- evaluate the effects of each project;
- collect detailed cost information on the elements of each project and provide data on project inputs, outputs and outcomes;
- provide an analysis of costs and effects; and
- identify the overall effects of the project and make recommendations.

The methodology was specifically designed to enable the evaluation to be responsive to features and timescales of the projects, and although a mixed methodological approach was adopted, the evaluation was largely qualitative in nature. A supportive and facilitative approach was adopted by the evaluation team. This was loosely based on an action research model (Winter and Munn-Giddings, 2001) and aimed to promote maximum learning from the projects. The lack of baseline and other existing data, the short implementation time available and ethical issues arising from the involvement of women who had used the project services had to be taken into consideration. Therefore, it was not appropriate to use an experimental approach involving control groups. The use of qualitative methods, backed up by assurances of confidentiality and flexible arrangements for information gathering, enabled data to be collected which otherwise would not have been accessible.

A combination of the following methods of data collection was used:

- *qualitative interviews* with project staff, stakeholders, and health service staff (124 interviews in total);
- *qualitative interviews* with women (44 in total, of whom 33 were survivors of domestic violence. Only three of the survivors had been in contact with a CRP-funded project);
- *questionnaires* to women survivors of domestic violence (20 in total);
- *observation* at a selection of project-related meetings;
- collation of *documentary and other information* from each project and secondary sources;
- collation of *input and cost data*;
- collection of *other data* by each project (details of the different samples involved are given in below); in summary they were:
 - short-term evaluation questionnaires on training received by 305 health service staff (Birmingham and Wakefield);
 - follow-up evaluation questionnaires on training administered one month after training and returned by 49 health service staff (Wakefield);
 - follow-up evaluation questionnaires on training administered three months after training and returned by 20 health service staff (Birmingham); and
 - data on 1,470 women (North Devon and Wakefield).⁷

The evaluation commenced in early 2001, and concentrated on the period up to the end of March 2002 in terms of input and cost data supplied by the projects and other data collated. Interviews and questionnaires were carried out over a longer period allowing for a lengthier examination of outcomes.

Ethics clearance for the study was obtained from London South Bank University's Research

⁷ These data are cross-sectional only. For the other two projects, Salford and Birmingham, only basic counts of users were collected.

Ethics Committee.

It is important to note that this evaluation has been affected by the constraints under which the projects operated, including the uncertainty over funding beyond 2002. The Home Office decision to fund projects for only a limited time, to seek proposals for a further year of funding, and then to notify projects about the extension of funding only in the last month of original funding have affected both project decisions and the evaluations. The most important effects were:

- Wakefield – the project experienced delays in getting necessary commitment from health professionals to participate. This resulted in a final pilot implementation of routine enquiry lasting only two months.
- Birmingham – at the point where the project was funded, no decisions had been made about what interventions were going to be implemented. These decisions were only made one year after funding was granted (after a failed initial set-up phase, and then a re-launch of the project). Decisions to implement were then put into effect immediately, thus closing off the possibility of obtaining any baseline data pre-implementation.

In addition, the overall budget of £81,650 available for evaluation constrained the amount of primary data collection that was possible, and in particular, ruled out the use of more sophisticated evaluation designs that would have incorporated more explicit comparative elements.

The intention of all four evaluations was to examine any criminal justice outcomes resulting from project interventions. In the event, it was not possible to gather data on this, and the short length of the evaluation period would have meant there was insufficient time for any cases to work through into the criminal justice system.

Interviews with health service staff, other service providers, project staff and key stakeholders

Interviews were conducted with health service staff, other service providers, project staff and key stakeholders. A summary of the numbers interviewed in each of the various categories is shown in Table 2.1. The number of interviews differed in each of the four projects, reflecting their different size and scope. The key stakeholder group included members of the project's steering group and key individuals from agencies involved with the project, but not in direct service provision. It is important to note that this definition of stakeholder does not restrict the group to supporters of the project, and indeed members voiced very diverse views. Other service providers refer to employees/volunteers associated with agencies outside the health service that were part of the project's intervention at health service settings; this category is only relevant for two of the projects (Birmingham and North Devon).

A total of 124 interviews were carried out. The overall interview guide⁸ was adapted to suit each project. It is important to note that the interviews were semi-structured and the informant rather than the interviewer led the order in which topics were covered.

⁸ The term guide is used deliberately, since this was not intended as a schedule that would be followed in the same way for each informant. Copies are available from the authors.

Table 2.1: Interviews with health service staff, project staff and key stakeholders

	Birmingham	North Devon	Salford	Wakefield	Total
Project staff	2	6 ¹	2	4	8
Key stakeholders	7		5	14	32
WA outreach workers	3				3
Victim Support volunteers		3			3
Health Service staff					
A&E staff		4			4
Counsellors	2				2
Midwives	8				8
GPs	5		1	11	17
Health visitors	1		5	7	13
Practice nurses	1		1	3	5
Other nursing in GP practices				2	2
Practice managers	3		2	8	13
Other admin staff	3			11	14
Total	35	13	16	60	124
<p>Note:</p> <p>1. In the North Devon project the two categories (of project staff and key stakeholders) are one and the same, since this was a very small project with no paid staff.</p>					

The overall strategy in selecting individuals for interview was to ensure that each of the different groups involved in the project were represented in the sample. The methods by which the samples were selected differed from project to project. Details are as follows:

Birmingham

Key stakeholders: seven interviews, all of those involved in project implementation group.

Project staff: the two members of staff.

Health service staff: project was operating in one practice and the women's hospital. Interviews were also carried out in two other practices that had outreach sessions on the premises (i.e. these two practices were offering the same service as the project practice, but the service was funded from different sources).

- Women's hospital – eight midwives, convenience sample, representing four per cent of midwife workforce in hospital.
- Practice where outreach service was CRP-funded, four out of four GPs, practice manager, one out of three practice nurses, two out of ten receptionists.
- First practice where outreach service was funded from other sources, one out of three GPs, practice manager, two out of two counsellors, one out of four health visitors, one out of six receptionists (all convenience samples).
- Second practice where outreach service was funded from other sources, practice manager.

Other service providers: the three Women's Aid outreach workers who did weekly sessions in the three GP practices.

North Devon

Key stakeholders and project staff: no paid project staff, six interviews, representing all agencies involved in management or steering of project.

Health service staff: project operated in a single A&E department, four staff members

interviewed, all non-medical, out of a pool of approximately 30. Note that effort was concentrated only on non-medical staff, since they were the staff group most involved in the project.

Other service providers: three Victim Support volunteers; these were the volunteers that had done most of the support work in relation to the A&E department.

Salford

Key stakeholders: five interviews, out of 12 individuals on implementation group.

Project staff: the two members of staff.

Health service staff: project was operating in six practices, samples yielding one out of 13 GPs, two out of six practice managers, five out of ten health visitors, one out of two practice nurses. Note that interviews with nursing staff were prioritised owing to their higher level of involvement with the project.

Other service providers: – none involved in this project.

Wakefield

Key stakeholders: interviews with stakeholders covered individuals involved in the project's steering group (nine interviews out of ten people), key individuals in agencies involved with the project (three interviews, all suggested by members of the steering group), and the chief executives of the two PCTs that cover the Wakefield area.

Project staff: the four members of staff.

Health service staff: project covered the entire district and all GP practices were invited to participate. The strategy for interviewing staff in GP practices was to interview a range of staff (medical, nursing, administrative) in practices that had participated in the project to varying degrees (those involved in 'audit'⁹ and pilot of routine enquiry, those involved in 'audit' only, those not involved in either 'audit' or routine enquiry pilot). Since the training sessions run by the project for those involved in the routine enquiry pilot were available to all practice staff in the area, interviews with practices not involved in the routine enquiry pilot were necessary in order to allow examination of the impact of the project in the area as a whole. Interviews were carried out in nine different practices. This included all of the three practices that participated in the routine enquiry pilot. The six other practices were selected randomly from two groups: (1) practices 'audited', but not participating in the routine enquiry pilot, three practices selected; (2) practices not participating in either 'audit' or pilot, three practices selected.¹⁰ In five of these practices, interviews were obtained from medical, nursing and administrative staff. The particular staff interviewed were those available and willing to be interviewed on the day(s) a member of the evaluation team was in the practice. Telephone interviews were used by arrangement if staff preferred. In the final practice (one of the practices that participated in neither 'audit' nor pilot) it only proved possible to interview one staff member, the practice manager.¹¹ A summary of interviews obtained by staff group and practice type is as follows:

- Three practices participating in both 'audit' and pilot: four GPs interviewed out of 13, three nurses interviewed out of 11, two receptionists interviewed out of 19, two practice managers interviewed out of three.
- Three practices in 'audit' but not pilot: four GPs interviewed out of 23, seven nurses interviewed out of 19, five receptionists interviewed out of 24, three practice managers interviewed out of three.

⁹ The terms 'audit' and 'auditing' appears in inverted commas in relation to this part of the Wakefield project to alert the reader that the project's use of the term 'audit' is rather different from the usual use of the term in medical circles and literature. The 'audit' in the project was a specially mounted prevalence survey (asking directly about experience of domestic violence) of all women attending the practice, carried out over the period of a week in each participating practice. During this survey, any woman who disclosed domestic abuse, either current or past, was offered information about specialised services available locally. The survey thus also served as a form of routine enquiry.

¹⁰ The procedure followed was to make a random selection of three from each of these two groups. If a refusal occurred on contacting the practice, a further random selection was made from the group concerned. Only one such further selection was necessary.

¹¹ It proved impossible to arrange a suitable date to visit the practice to carry out interviews in the time available, and by that point in time, it was not possible to pursue the selection of a substitute practice.

- Two practices in neither 'audit' nor pilot: three GPs interviewed out of ten, two nurses interviewed out of seven, four receptionists interviewed out of nine, two practice managers interviewed out of two.

Interviews were sought with as many as possible of the staff working on the days when the researcher visited the practice. There were no refusals.

Other service providers – none involved in this project.

Interviews with women and with women survivors of domestic violence

Interviews with women survivors of domestic violence were conducted in three projects: Birmingham, Salford and Wakefield. Interviews with women in the general population were also carried out in Wakefield. Table 2.2 summarises the number of interviews carried out. The age of interviewees ranged from 18 to 68.

The evaluation team did not interview survivors in the North Devon project. This was agreed with the Home Office in April 2002 as a variation from the original plan for a number of reasons. In view of limited evaluation resources and low level of uptake in this project, it was considered more useful to concentrate resources for interviewing women survivors in the other three health projects.

Because of the ways in which the women survivors were contacted for interview or questionnaire, most of them had not used the services of the projects. This was a deliberate feature of the design of the evaluation. It had originally been hoped that this might enable the evaluation to compare the experiences of women in contact with each project with those of other women who had not used the project's services. This was not possible owing to the very small numbers of women coming forward for interview or questionnaire who had actually been in contact with the projects; this, in turn, was related to the short implementation times.

Out of the 33 survivors interviewed, only three had used services provided by the projects (two in Birmingham, one in Wakefield). A further 12 had used a similar type of service but either at a different time or in a different place. Twenty-seven of the survivors interviewed had used some form of specialised service provision, located outside the health service, of the type that the projects were signposting women into.

The outcomes for these women, if any, of services used, enables the identification of the *potential* impact of the projects in the longer term; this is discussed in Chapter 3.

Interviews were semi-structured qualitative interviews. Although women were not specifically asked to relate the story of their abuse, all of them chose to do so to some extent. The women themselves led the pace and subject matter of the interview. In the majority of cases, no prompting was required to elicit their views on the nature of their contact with different service agencies, nor their views on how their lives and health had changed. The only specific prompts were to ask whether they had had any contact with a particular agency.

Table 2.2: Interviews with women and with women survivors of domestic violence

	Birmingham	Salford	Wakefield		Total
Women recruited from	Residents/ex-residents of refuges	Via SWA	Advert in local papers	Randomly selected GP practices	
Place of interview	Refuges	SWA	S&S	GP practice	
Total number of women interviewed of which:	9	7	14	14	44
• <i>Number of survivors of domestic abuse</i>	9	7	14	3	33
• <i>Numbers of Black and minority ethnic women</i>	5	2	0	0	7
Dates of interviewing	June-September 2002	June-July 2002	March-June 2002	October-November 2002	

As Table 2.2 shows, the method of recruitment differed from place to place. The reasons for this were the necessity of obtaining local agreement to the methods used and the need to arrange interviews in places where women's safety could be ensured, where childcare could be provided if required, and where women could be assured of easy access to any additional services they required. It cannot be claimed that the samples were representative. The approach was to maximise diversity in the sample.

The interviews with women in the general population were used to explore the acceptability of routine enquiry to women generally.

The quotations used in this report to illustrate the women's views are identified by the place of the interview and a pseudonym; "... " indicates that material has been omitted from quotes with the women and other interviewees.

Questionnaires to women survivors of domestic violence

In order to give more women a chance to contribute their views, in two of the project geographical areas¹², a short questionnaire was distributed via health professionals and support agency workers to any woman who wished to complete one.¹³ The questionnaires were piloted in areas outside those where the projects operated. There were 17 responses in Salford and three in Birmingham (Table 2.3).

The questionnaires were distributed to women with whom staff had contact during the course of their work, not only to women specifically in the practice areas. The low level of response may be partially or totally due to a low rate of distribution of questionnaires by staff rather than a low response by the women to whom they were given.

Out of the 20 survivors who completed a questionnaire, only three had used services provided by the projects (all in Birmingham). Seventeen had used some form of specialised service provision outside the health service.

¹² In the third project area where women's views were sought, all of the women chose a face-to-face interview.

¹³ Copies are available from the authors.

Table 2.3: Questionnaires to women survivors of domestic violence

	Birmingham	Salford
Numbers of questionnaires distributed to staff	80	60
Number of questionnaires given out to women	Unknown	Unknown
Staff	Women's Aid workers	Health Visitors and Women's Aid Workers
Number of completed questionnaires returned from women	3	17

Observation

In addition to visits for interviews, the project sites were visited for meetings, including those of the project steering or implementation groups. Field notes were completed following contact with the project using a specially designed template. Contact was also maintained via email and telephone communications and notes kept of such interactions. These were used for the process evaluation.

Documents

Documents relating to the project were collated by the evaluation team. These were produced by project and other implementation staff to provide a written record of how the project was progressing. These were also used for the process evaluation.

Data collected by projects

Two main types of data collected by projects were used in the evaluation. These related to:

- training provided by the projects for health service staff; and
- the women using the services provided by the project.

The evaluation team did not have control over the collection of this information, nor over the design of the instruments used.

As Table 2.4 shows, availability of both types of data varied by project, owing to: the different nature of the projects, differences in local priorities about collection of information, and stresses within some of the project teams. In no case did the data provided on women service users contain longitudinal data relating to outcomes. Although this had been a feature of project plans in North Devon, Salford and Wakefield, the short implementation times precluded this from happening.

Table 2.4: Data collected by projects on training and service users

	Training	Women Service Users
Birmingham	<ul style="list-style-type: none"> • Evaluation questionnaires completed by 135 members of staff immediately after training (representing 100% of staff trained in period October 2001 to March 2002) • Follow-up evaluation questionnaires completed 3 months after training by 20 members of staff (representing 42% of staff to whom questionnaires were sent), those trained between October 2001 and December 2001 	<p>Basic counts of users of:</p> <ul style="list-style-type: none"> • helpline • referrals to outreach workers <p>Not possible, however, to distinguish helpline users resulting from project-funded activities from those resulting from similar activities funded by other sources</p>
North Devon	Not collected, training carried out on only a very informal basis	Data on the nature of support sought by each survivor, descriptive information about the most recent injury, demographic information about the survivor and her family, previously reported incidents, and contributory factors full data 11 women, partial data for 12 women, i.e. a total of 23 women
Salford	Basic counts of those having training only	Basic count of users (1 woman only) ¹
Wakefield	<ul style="list-style-type: none"> • Evaluation questionnaires completed by 170 members of staff immediately after training (representing 90% of staff to whom questionnaires were distributed) • Follow-up evaluation questionnaires completed by 49 staff one month after training (representing 48% of staff to whom questionnaires were distributed) 	<p>'Audit'</p> <ul style="list-style-type: none"> • Basic data on 1207 women who were surveyed (exact response rate not known, it is however at least 40%, since the maximum number of contact letters that could have been given out was 3000) • Detailed data from 70 women survivors (out of a total of 214 women who disclosed abuse and were asked if they wanted to complete a questionnaire, a response rate of 33%) <p>Pilot of routine enquiry</p> <ul style="list-style-type: none"> • Limited data on the 170 women who were asked about their experience of domestic abuse during the pilot; 70 of these women completed a short questionnaire about the routine enquiry process, a response rate of 41%
<p>Note:</p> <p>1. The project staff had devised detailed monitoring forms for agencies to use to gather information about the women offered the scheme. A data-sharing agreement was drawn up that would have enabled women to be tracked, with consent, through subsequent contact with other agencies. However, the monitoring forms were an issue of dispute amongst the Implementation Group. The data-sharing agreement that had taken so long to negotiate lapsed before the forms had been used. One effect of this was that data were not collected about women who were offered the chance to have photographs taken by the practices but chose not to have this done.</p>		

Approach to analysis

The work of the projects was examined in relation to:

- barriers and facilitating factors to successful operation;
- service integration;
- multi-agency collaboration;
- organisational commitment;
- equity;
- effectiveness;
- decision-making; and
- other emergent themes.

The different types of analysis carried out are discussed below.

Process evaluation

The main aims of the process evaluation were:

- to provide an account of the development and implementation of each project; and
- to draw out, by comparing the four projects, general conclusions as to how effective different strategies were and why.

The process evaluation also addressed the following key questions:

- Were the tactics, strategies or approaches employed by the project associated with a change in the identified outcome?
- How much of this change can be attributed to the tactics, strategies or approaches employed?

In making these assessments, changes in the wider geographical area were also taken into account. This allowed the authors to assess whether the observed changes were merely part of a general trend in the area, or whether they distinguished the target area from others.

Interview data were analysed to identify informants' views of the work of the projects according to themes such as: access; acceptability; satisfaction; quality of service; plus any emergent themes. Survivors' views on services were coded independently by two researchers. Interview data were also used to build up a picture of the work of the projects using case studies of particular individuals and families. Wherever possible, findings from the different data sources (observation, documents, interviews, questionnaires, other quantitative data) were triangulated.

Outcome evaluation

In examining the outcomes of the projects (such as encouraging disclosure, facilitating referral and enabling help-seeking by women), it would have been preferable to use longitudinal outcome data gathered from large samples of women using the project services, and to compare these with women not accessing the project. This has not been possible in this study for a number of reasons. Firstly, the very short length of implementation (and evaluation) in each of the projects has meant that no longitudinal data were collected on women using their services. In North Devon and Salford, this was compounded by a correspondingly small number of women accessing the project.

The impact of services on women can, however, be explored using two of the sources of data collected in this study. In total, 20 women completed questionnaires (projects in Birmingham and Salford) and 44 women were interviewed. Of those interviewed:

- 33 said they had experienced or were experiencing domestic abuse; and

- three had had contact with the CRP projects.

In the interviews and, to a lesser extent the questionnaires, women talked about the services they had used¹⁴, how their lives, and the lives of their children had changed, and offered their understanding of the key elements in services that had been responsible for those changes.

Survivors' descriptions of changes, if any, in their health and quality of life were coded independently by two researchers. There were no discrepancies. These descriptions were unprompted and formed part of the women's narration of their experience. The approach to the analysis is best described as a grounded theory approach (Strauss and Corbin, 1998). Both interviews and questionnaires completed by women survivors were used in this process.

A limited amount of triangulation with respect to outcomes was possible using interviews with health staff and other service providers alongside the accounts of the women interviewed.

Interview and questionnaire data have also been analysed to identify informants' views of the work of the projects, according to measures such as acceptability, satisfaction, and quality of service.

¹⁴ It should be noted that because of the ways in which the women survivors were contacted for interview or questionnaire, not all of them had used the services provided by the projects (only three had been in contact with CRP VAWI projects).

3. Understanding the health service contribution

Owing to the frequency of contact between women and the health service, health professionals are in a unique position to provide women with clear messages about the unacceptability of domestic abuse and with information about specialised domestic abuse services. In addition to emergency care, the majority of women regularly access out-patient services such as contraception advice, cervical and breast-screening programmes, maternity care, and care for their children. Research evidence indicates that women experiencing domestic violence use medical care more frequently (Browne, 1992; Ratner, 1993), thus enhancing the opportunities for early intervention.

All four projects evaluated in this study signposted women to specialised support agencies. But first, women experiencing domestic violence had to be identified. The approach to doing this varied across the projects:

- In Wakefield, *all* women in the project setting (GP practices) were asked. Project staff referred to this as ‘routine enquiry’ rather than ‘screening’, since a flexible system was designed to meet the circumstances of each practice, rather than a common standardised protocol instituted across all practices.
- In Salford, all women presenting at the GP practice with a visible physical injury were asked.
- In North Devon, women in the A&E department were asked if they wanted support from a Victim Support volunteer, *if* they disclosed domestic violence during medical treatment *and/or* if any A&E staff member suspected domestic abuse (including emotional as well as physical abuse).
- In Birmingham, health service staff in the project settings (GP practice and maternity hospital) were trained with the aim that they would feel sufficiently confident to encourage disclosure. The training guidelines explicitly asked health service staff to consider both routine enquiry and selective enquiry (definitions are given in Figure 3.1).

Figure 3.1: Routine and selective enquiry, definitions from the Birmingham guidelines

1. **Routine enquiry.** *This refers to asking all women who are using the service direct questions about their experiences, if any, of domestic violence regardless of whether there are signs of abuse or whether abuse is suspected. Routine enquiry should not be treated as a one-off event but should be asked at specific times during her use of the service. Repeated questioning has been shown to increase the likelihood of disclosure.*
2. **Selective enquiry.** *This refers to asking women about their experiences, if any, of domestic violence where you have concerns or suspicions. Be alert to the possible signs and symptoms of domestic violence.*

The Department of Health resource manual on domestic violence (Department of Health, 2000) offers a definition of routine enquiry as:

“asking about the experience of domestic violence to all people within certain parameters, regardless of whether or not there are signs of abuse, or whether domestic violence is suspected” (Department of Health, 2000, page 23).

In routine enquiry, the question(s) and procedures are not necessarily standardised, giving individual health professionals a degree of flexibility. This definition is applicable to the practices investigated in each of the four projects, with the parameters applied varying between and within projects, as well as changing over time for the relevant staff.

All four projects also provided information to women about specialised support and other services, together in some cases (Birmingham, North Devon, Wakefield) with the possibility that the professional could contact the services concerned during the consultation and make an appointment for them. In Birmingham, health staff were explicitly encouraged *not* to make referrals on behalf of women, unless this was specifically requested, but rather to offer the information and allow women to decide what to do. This promoted the empowerment of women service users, a principle that the specialised services in all four projects actively supported.

Routine enquiry and signposting

This section reports the findings on routine enquiry, using data from all four projects wherever possible.

Acceptability of routine enquiry to health professionals

None of the health staff interviewed who had received at least a full day's training on domestic abuse expressed any hesitation about routine enquiry. Their training included how to ask direct questions about experience of domestic abuse and how to respond to disclosure. Staff who had actually carried out some form of routine or selective enquiry were the most emphatic about its value.

Interviews with health staff¹⁵ in all four projects established that, *for staff prior to training and for staff without training*, there was resistance to the adoption of routine enquiry, for the following inter-related reasons:

- the view that domestic violence is a 'social' issue;
- lack of confidence;
- misinformation about whether women want to be directly asked;
- time, conflict in priorities, demand for competing resources; and
- the view that research evidence demonstrated that routine enquiry was not useful.

These are discussed below. These sources of resistance are very similar to those identified in Waalen *et al.*'s (2000) review of studies focusing on provider-specific barriers to screening for intimate partner violence. Waalen *et al.* identify the three top provider-related barriers as: lack of provider education, lack of time, and lack of effective interventions. Patient-related factors (e.g. patient nondisclosure, fear of offending the patient) were also frequently mentioned. In this study, training successfully addressed each of these sources of resistance.

The view that domestic violence is a 'social' issue

Some health staff working in GP practices reported that the view that domestic violence is a 'social' issue led to resistance to routine enquiry in their surgery. The following quotes come from staff in Wakefield. Similar statements were heard in other project locations.

"Many colleagues think it is not their responsibility. They are medical people and not social workers. My colleagues and I are trained to look at disease and not the whole person." [GP, Wakefield]

"When I brought it up at the meeting, we didn't get past the first stage because I was told in no uncertain terms that DV is not a health problem, it is a social problem."

¹⁵ There were 78 interviews carried out with health staff across the four projects (detailed breakdown given in table 2.1). Of these, 42 had received no training and 36 had received project (or similar) training.

[Health visitor, Wakefield]

Lack of confidence

The interviews with health professionals who had not received training show that lack of confidence poses a barrier to routine enquiry. The majority spontaneously discussed either a lack of confidence or personal discomfort with the topic of domestic violence.

One doctor reported that she felt she did not have enough training to ask. She therefore fails to ask even when she suspects a patient is currently living with an abusive partner.

"I certainly don't feel as if I am trained enough in this line. I suppose, I am not actively looking. There are times, when I wonder if she is an abuse victim. I know somebody who I am positive is, but I actually have never said anything to her." [GP, Wakefield]

Other staff who had been trained reported a lack of confidence prior to training, and emphasised how implementing routine enquiry had raised their confidence.

"Initially, I found it difficult in asking the questions because I didn't feel that confident. You do feel like you are prying, in a way. I found I got all stumbly, and the words wouldn't come out." [Health visitor, Wakefield]

Misinformation about whether women want to be directly asked

The interviews show that health professionals who have not been through domestic violence training hold the misunderstanding that women do not want to be asked about domestic violence. Again, health staff were not directly asked whether they believe women want to be asked about domestic violence. Nonetheless, the majority of those who had not been trained spontaneously volunteered the opinion that women would not want to be asked.

"It's very difficult to know how to get to these people without alienating them, or getting up their guard, or feeling that you are accusing them or that you are prying." [Receptionist, Wakefield]

"You can't just go and ask a question like this. They might think you are intruding into their personal affairs. Especially someone who hasn't had violence and suddenly you ask this question. It needs some training, especially a lady, to go gently and find out if it is worth pursuing. If you just routinely ask, you'll get, 'Oh, hell. What the hell are you asking me this for?'" [GP, Wakefield]

The same health professionals generally feel that women will disclose domestic violence if they need help.

"Women have to want to tell you. They've got to want to come and tell you, you can't delve into them more." [Receptionist, Wakefield]

Time, competing priorities

The majority of the practice staff interviewed mentioned time¹⁶ or competing priorities as a major barrier to routinely enquiring about domestic violence.

"If you know them well enough and you have long enough time with them, you can probably get to the bottom of it. In an ordinary seven-minute appointment, you may not uncover that. That's the problem in general practice. You don't have enough time; you might need half an hour to get to the bottom of it." [GP, Wakefield]

¹⁶ This refers to staff perceptions about the time that would be involved in enquiry, a later section presents some data on the actual time taken.

One practice manager described how he saw it as in the interest of most surgeries to ignore the underlying causes of ill health, and argued that the lack of time means that doctors ignore signs of domestic violence unless a woman discloses that she is living with an abusive partner:

“So, I wouldn’t say it gets brushed under the carpet. If the patient presents with a DV issue at the doctor’s desk, it will get dealt with. But the doctors are not actively looking to identify patients who may have – it’s only when the patient asks for help do we make the time to offer it. It’s self-limiting, if you like, unless the patient actually wants to speak out, because of the time required to help the patient through that, they are not going to make the time for really complicated cases, which these tend to be.” [Practice manager, Wakefield]

The major reported reason for limits placed on time and resources are the number of competing health priorities. One doctor describes her day-to-day job, revealing that the complexity of the human body makes it difficult for doctors to screen for every possible source of ill health:

“You feel sometimes overwhelmed at all the things you have to try to remember to do. Unless something triggers that thought and gets it going... if someone walks in with a bad chest, you start thinking. How old are they? Did they get the flu jab? ... Blood pressure? Was that checked recently? ...Theoretically, you could have a checklist of 50 different things you could potentially bring into any one consultation. I know I am making excuses here but that is how it is.” [GP, Wakefield]

Many different health promotion projects contribute to the conflict in doctors’ priorities. Practice staff also reported how the restructuring of health authorities and other government initiatives interfered with their ability to meet the preventative health needs of their patients. The project staff in Wakefield reported that in this environment, it was very difficult to get practice managers to bring their requests for an ‘audit’ to surgery planning meetings. The conflict in priorities was felt by managers at the highest position in the Primary Care Trusts, and was explicitly linked by one of the Chief Executives interviewed to conflict in priorities at the national level, and the lack of priority given to domestic violence.

Misperception about what research evidence has demonstrated

Three of the GPs interviewed in Birmingham offered the view that the systematic review of screening for domestic violence published in the British Medical Journal (Ramsey *et al.*, 2002) proved that routine enquiry was not worth doing.¹⁷ The same GPs all also agreed that they would find it difficult to broach the subject with women.

Acceptability of routine enquiry to women

The interviews with women survivors indicate that a strategy of merely encouraging disclosure is less appropriate than one of routine enquiry to *all* women, using simple direct questions. This is in line with the findings of the systematic review of ‘screening’ for domestic violence carried out by Ramsey *et al.*, (2002), that found clear evidence of increased identification of domestic abuse when ‘screening’ was in place.

None of the 44 women interviewed in this study expressed any discomfort with the idea of routine enquiry. Notably, this included both women with personal experience of domestic abuse (33 women) and women who did not disclose such experience (11 women). This finding is in line with that reported in a wide range of studies that a majority of women are in

¹⁷ This is an interesting example of a serious misreading of the review’s conclusions, which were that, although there was insufficient evidence to recommend the implementation of screening programmes, health services should aim to identify and support women experiencing domestic violence. The authors of the review highlighted the importance of education and training of clinicians in promoting disclosure of abuse and appropriate responses to disclosure (Ramsey *et al.*, 2002).

favour of routine enquiry about domestic abuse (Friedman *et al.*, 1992; Bacchus *et al.*, 2002; Bradley *et al.*, 2002; Richardson *et al.*, 2002).

One practice manager in Wakefield reported that he gets complaints about every project implemented in his practice. He did not, however, receive even one complaint about the one-week domestic violence prevalence survey:

"I didn't get a single complaint about it from the patients, which is unusual. Most times when we are doing something like this the patients complain: 'Why are you doing this?' 'Why do you drag us in for this?' 'Why do it this way, do it that way, or the other way.' They're not formal complaints, just feedback from the patients, normally verbal... But we had no adverse feedback from that questionnaire at all. I think most people actually say it has been quite useful." [Practice manager, Wakefield]

One GP, who had been doing routine enquiry for about 11 months at the time of the interview, reported that there was:

"not a single woman who said 'what a daft thing to do'." [GP, Wakefield]

Women's reluctance to disclose without direct questioning was emphasised by both the health staff experienced in routine enquiry and the women themselves.

"Told him [her GP] I'd fell. ... He didn't quiz me about it. He didn't say anything more about it. I just said I fell and the look he gave was, 'well, I don't think you have, but...' I remember sitting there and thinking 'quiz me, quiz me, ask me', and he never did. And I think if he had done, because I had quite a good relationship with my doctor, he was very good, and I think if he'd have pushed it I probably would have told him. But because he didn't, I didn't tell. I could tell by the look on his face he knew I'd had a bang, but he never pushed it." [Kerry, Salford, her GP had not received training]

A reluctance to disclose without direct questioning can also be connected to women's sense of loyalty to their partners, compounded by the threats that they may have received about what will happen if they tell anyone. A direct question, particularly from a respected source, such as a health professional, someone who is perceived to have the right to ask personal questions and to merit an honest answer, enables the woman to disclose her abuse.

For some women, reluctance to disclose without direct questioning stemmed from a concern about what health professionals' views of them might be. As one woman reported, she was worried about what doctors would think of her:

"I don't know what to say to them actually. What they might think, this pathetic person, why do I put up with all this?" [Mary, Birmingham, her GP had not received training]

Direct questioning allows the health professional to tell the woman that the abuse is not her fault, and that she is not any less worthy for having experienced it.

One health visitor emphasised the need to ask repeatedly and to be direct:

"If you ask people – don't pussyfoot around – I don't like that – if you ask, I have found that people are very honest. I remember when I first plucked up the courage to ask on an antenatal visit. I had never seen this woman before. She wasn't in this particular relationship but she had been previously. She gave me the reasons to carry on because she said, 'You must ask everybody. Because I just wanted somebody to come out and ask me.' She lived in a nice house, partner, everything hunky dory, and she were really depressed, and her health visitor kept saying, 'I can't see why you're depressed.' She just wanted someone to ask her. That gave me the reason to carry on asking..." [Health visitor, Wakefield]

A nurse reported how her views had changed:

“I thought it was crap at first, to be honest: ‘Oh, what are they having us do now?’ But on reflection, I think that if we didn’t do routine enquiry you wouldn’t be able to get to where we are now. The people who disclosed would have done it before now if they were going to do it without being prompted. It’s got to be done. It’s a big shift.” [Nurse manager, Wakefield]

Findings here are similar to those in a number of studies that have shown women are reluctant to disclose domestic abuse to health professionals in the absence of direct questioning (for example, McLeer and Anwar, 1989; Hayden *et al.*, 1997).

Time required for routine enquiry

Some data on the time taken for routine enquiry were collected from health staff and women in Wakefield; these are summarised in Table 3.1. Differences in the two distributions are only to be expected, since each source of information relates to a different subset of the total number of women involved in the routine enquiry pilot, and since the figures are estimates.

Table 3.1: Time required for routine enquiry, estimates by women and staff

Time taken	% of total with time in range shown, estimated by women (note 1)	% of total with time in range shown, estimated by health staff (note 2)
1- 5 minutes	74%	83%
6-10 minutes	21%	15%
11-15 minutes	6%	0
16 and over minutes	0	3%
Number where time not specified	2	7
Average length of time (minutes)	5	4
Notes on sources:		
1. Project data: questionnaire to women in pilot of routine enquiry, Wakefield, N=68		
2. Project data: collected by health staff during pilot of routine enquiry, Wakefield, N=42		

Although based on small numbers, what is notable is the low average length of time required for routine enquiry, approximately four to five minutes per woman.¹⁸ This was also commented on by some of the staff practising routine enquiry who had not contributed to the estimates shown in the table:

“On the time issue, once you’ve gone through the support, built up to asking routinely, the actual asking and the continued involvement is quite small, actually, it’s quite staggeringly small because a lot of the answers I know. And the yeses, you go through basic awareness with them and ask them how to proceed. And for the majority of people, they don’t want to do anything about it. There and then, anyway... A disclosure is different than someone saying they need to get out of there quick. The response, ‘I need to get out of here quick’, are rare in comparison. I’ve come full circle and I realise it’s about raising people’s awareness, just reiterating to people that you don’t have to live like this, you don’t deserve this, no one deserves it.” [Health visitor, Wakefield]

Some GPs recognised that routine enquiry was possible within their severe time constraints. While this doctor still has concerns about time, she feels she could handle what she refers to as the ‘preliminaries’ that routine enquiry involves:

¹⁸ This represents the time required for the routine enquiry part of the consultation, not for any other matters dealt with in the consultation; it is also the average per woman, including both those who have and have not disclosed abuse.

“The (‘audit’ stage of the) project was interesting because you could dare to ask every lady because you could feed through to somebody else. I would love the time to do all that, and I am not saying that you necessarily need a Support and Survival worker on tap to do that with. I feel that I could handle at least the preliminaries and then refer on.” [GP, Wakefield]

The importance of asking all women

The importance of asking all women, i.e. routine rather than selective enquiry in the terms of Figure 3.1, was emphasised by many of the women interviewed, the health staff who had been trained, and by some of the staff who had not received training. This was considered important for two reasons: not stigmatising women, and protecting the woman’s safety. Some staff emphasised that, if the enquiry was somehow disclosed to the perpetrator (always a possibility even in the case of high quality risk management practice), a statement that this was an enquiry directed to *all* woman offered the best possibility of minimising risk to the woman concerned. Some staff also reported that the practice of asking all women made it easier for them to raise the issue with women directly.

A number of professionals also emphasised the importance of asking all women because they were unable to identify women without directly asking.

“It really surprised me ... I’ve known these ladies for a long time, they’d come for repeat prescriptions, things like that, and they’ve never mentioned it before, so I think it is a good idea, yes.” [Practice nurse, Wakefield]

“It was quite a shock to me that people don’t talk to me about it unless they are asked. Some patients where I was rather sniggering to myself and knowing the answer would be ‘no’, I heard, ‘Yes, I’ve dealt with it, I was abused...’ It has made me routinely ask about it if they have not been seen by anyone else.” [GP, Wakefield]

This is a finding also reported in other studies (Cant and Irvine, 2001).

Ensuring the safety of women in routine enquiry

It has been noted that staff who practise routine enquiry consider that asking all women is supportive of women’s safety. The training given to staff for routine enquiry, discussed later, as well as the various guidelines and protocols produced, emphasises procedures to be followed to ensure the safety of women, as well as that of the health professional making the enquiry.

During the course of the routine enquiry practised in the four projects evaluated in this study, *no* adverse incidents were reported where safety had been compromised by the enquiry.

During the time from the start of project implementation up to the end of March 2002, the exact number of women questioned is not known. These figures were not collected by the projects in Birmingham and Salford. For North Devon the figure is known to be at least 50 (the number of survivor resource packs distributed). For Wakefield the figure is at least 1,377 (the number of women questioned in the prevalence survey, plus the 170 questioned in the two-month pilot of routine enquiry in the three practices supported by the Wakefield project), out of which 249 disclosed abuse. The figure in Wakefield is a definite underestimate, as it does not include the women questioned by those members of staff who attended the training, but were not based in the three practices in the pilot. From these figures the success of the training and associated guidelines in not compromising women’s safety can be seen.

Remembering to ask

A number of health professionals reported that although they intended to implement routine enquiry, they often found it difficult to remember to raise the issue. They stressed the importance of easily visible reminders such as posters, leaflets, cards, coasters, and branded 'post-its'. Health professionals in Wakefield reported that pads of 'post-it' notes with the phone number of the local specialised domestic violence agency were particularly helpful.

In North Devon, as one A&E worker reported, staff members were more likely to identify domestic violence immediately following the introduction of the project, when it was on their minds:

"Obviously when it was new, we were all more on the look out perhaps and then we got a bit complacent." [Nurse, North Devon]

Ongoing support for routine enquiry was also specifically mentioned by a number of health professionals as helping to keep the issue high on their agenda. This is discussed further in this chapter.

Importance of flexibility of routine enquiry

Experience of working with the different practices in the second stage of the Wakefield project demonstrated the need for flexibility in implementing routine enquiry. Features of the practice premises, such as availability of suitably private space, whether non-medical health professionals were based on the practice premises or elsewhere, all needed to be taken into account.

Three practices participated in the routine enquiry pilot in Wakefield, and each of them decided to implement it in a different way. Project staff actively supported practice staff in working out how training and implementation could be carried out in their own setting, and also produced a resource pack that has been useful to other practices in the area.

One practice systematically adopted routine enquiry by finding a way to manage the time restraints. The GPs at this practice found routine enquiry unduly time-consuming within their general practice. They found, however, that routine enquiry in their Well Woman clinic resolved many of their problems. One doctor said:

"We found the Well Woman clinic was best... I think because our nurses did it as a tag end to the well women questionnaire where you ask about smoking and drinking and health questions anyway. It wasn't listed as an obvious question. We coded it on the form 'Practice name yes/no.' The evaluation showed that 99 per cent of the women thought it was no problem at all to be asked. She saw lots of people as most come along to get their smears. You get the odd one, but most come alone. It's a great opportunity, and I was always around as well as a health visitor to scoop up any woman who needed to speak with someone urgently. We did have one woman who burst into tears when we asked, but we sorted that out. We had a lot of backup in place." [GP, Wakefield]

The nurses running the Well Woman clinic explained that they had arranged for one of their number to always hold a paperwork session at the same time as the clinic. Then, if a woman disclosed domestic violence and considerable time was required for her during the clinic session, another nurse would be available to step in so that other clinic attendees would not be disadvantaged.

By using the Well Woman clinic to ask women about their experience of domestic abuse, this practice will ensure that they ask every woman registered at their surgery every three years.

At the second Wakefield practice, a GP and a practice nurse tried to screen every unaccompanied woman. In addition, two health visitors agreed to screen any woman they saw with a child under two years either at home or in the clinic setting. The practice recognised that women might well be asked on multiple occasions, and emphasised this to the women they saw. They reported that no woman had found being asked problematic, even on repeat occasions. This was confirmed in the interviews with women. Some added that their acceptance of routine enquiry was provisional upon all women being asked.

At the third Wakefield practice, one GP agreed to ask one woman during each surgery. She considered she was under too much time pressure to ask every woman attending an appointment.

In Salford and Birmingham, interviews with health staff, in particular health visitors, again emphasised the importance of flexibility. One stressed that the timing of questioning was important so as not to lose the trust of the woman. Others emphasised the importance of being able to decide themselves when it would be appropriate to ask. They all, however, emphasised the importance of asking *all* women.

Routine enquiry: conclusions

In response to a question about the future for routine enquiry, one GP said:

“It will go much more into education, GP practice, [as a] routine thing for registrars to do, for practice nurses in the Well Woman clinic, and in 30 years we will be astonished that we didn’t do it before.” [GP, Wakefield]

The conclusions offered by this study strongly support this view.

The first conclusion that can be drawn from the experience of the four projects is that routine enquiry is *feasible* within both the GP practice and A&E settings. As the interviews with staff implementing routine enquiry in Wakefield showed, it is also sustainable.¹⁹

The approach that can be adopted in the A&E setting will of necessity be more selective than is possible in general practice. One reason for this is the frequent presence of the abusing partner; all A&E staff interviewed in the North Devon project drew attention to this. In addition, some staff in the A&E department argued that it would be inappropriate to adopt anything other than a highly selective approach to enquiry given the level of trauma that the woman may be experiencing:

“I don’t think it’s a good time to deal with it, you could talk about acutely disturbed patients, all we do is make sure they are safe and pass them on, because now is not the time to sort out that sort of crisis... That Friday night may not be the best time to do anything about it.” [Nurse, North Devon]

For routine enquiry to be effective, in terms of allowing women to access specialised domestic abuse services, this study, has indicated the necessity of:

- a full day of appropriate training that includes practice in how to ask direct questions about experience of domestic abuse and how to respond appropriately to any disclosure;
- provision of information to health professionals on locally available specialised services; and
- the resourcing of local specialised services to respond to increased uptake.

The study has also demonstrated the value of ongoing training and support to routine enquiry.

¹⁹ Staff practising routine enquiry in Wakefield had been doing so for ten or more months by the time of our interviews with them.

The fifth report of the confidential enquiries into maternal deaths (CEMD, 2001) recommends that all women should be asked about domestic violence as part of their social history taken at antenatal booking, and have the opportunity to discuss their pregnancy with a midwife without their partner present at least once during the antenatal period. This study has not had the chance to examine any implementation of routine enquiry in the hospital setting aside from A&E, as data collection was completed prior to the implementation in the women's hospital in Birmingham. One of the necessary preconditions for successful routine enquiry, namely appropriate training, has been received by staff and has been effective.

Routine questioning has also been found to have a high level of acceptability, both amongst women who have experienced domestic violence and those who have not (Domestic Violence Initiative, 2001; Cant and Irvine, 2001; Richardson *et al.*, 2002; Watts, 2002). This study supports the same conclusion.

Research to date (Rodriguez *et al.*, 1996; Williamson, 2000; Laing, 2001; Bacchus *et al.*, 2002; Humphreys and Thiara, 2002; Taft, 2002) highlights the importance of asking about, and responding to disclosure of, domestic violence in a non-judgemental way, serving to validate the woman and her experience, advocating safety and building options. The present study reinforces these conclusions. Training of health professionals is therefore important. Availability of local information on referral options, support and advocacy agencies and raising general awareness about domestic abuse are both important and are considered later in this report. Provision of information and appropriate response by health professionals to disclosure are valued and useful outcomes for women who experience domestic violence. The question of the impact of routine enquiry on the health and quality of life of women is considered in Chapter 4. The value of asking all women and the willingness of women to disclose when asked directly (either at the time of first asking or on a later occasion) is also found in other studies, for example in the antenatal setting (Cant and Irvine, 2001; Bacchus *et al.*, 2002; DVI 2001, 2002).

This study has indicated that routine enquiry is not particularly time-consuming. For example, the GP who chose to implement routine enquiry by asking one woman each surgery session can expect to work through the women on her list within two to three years. As another example, the practice that has incorporated routine enquiry into the Well Woman clinic will ask every woman once every three years, the frequency with which women are called routinely to the clinic.

Finally the study has indicated the necessity of flexible approach. The results suggest that GPs are more likely to find selective enquiry (in the terms defined in Figure 3.1) more acceptable or feasible; however, all groups of staff recognise the beneficial effects of asking all women in terms of enhanced safety and reduced stigmatisation.

Availability of information

This section analyses the importance of readily-available information on local specialised services for women experiencing domestic violence.

Women's lack of knowledge of specialist services

All 33 of the survivors interviewed (across all areas) mentioned how hard it was to find out about specialist services for women experiencing domestic violence.²⁰ Many of them also reported that when they disclosed their experience to different agencies – health, police,

²⁰ It should be noted that because of the ways in which the women survivors were contacted for interview or questionnaire, most of them had not used the services provided by the projects (only three had been in contact with CRP VAWI projects). The experiences described by the women included both recent experiences and those further in the past.

social services, or solicitors – they were not given information on support services available. Some women who completed questionnaires also mentioned this.

“I felt very let down, on reflection, by GP services and medical staff in terms of offering me information as to where I could go for outside support. And again, I look back and think, well, is that because they saw a very close family and didn’t feel the necessity to give such information? And that’s the only answer I can sort of come up with.” [Sarah, Wakefield]

“I don’t think Support and Survival is advertised enough for women in my situation because I’ve had to do without any kind of support for over ten years. So, like I said, I did contact them, because the harassment was getting too much.” [Karen, Wakefield, who eventually received information about the existence of Support and Survival through the police domestic violence unit]

“Police officers often came to the house and I remember one police officer who came and he said to me that in his opinion my partner was violently possessive, those were the words he used, and I should try and get away – and that was it. No form of how to get away, no ‘I’ll take you to somewhere safe’ because in all the time I didn’t know anything about Women’s Aid. If I had have known I’d have gone.” [Beth, Salford]

As these quotations illustrate, for many women this meant a considerable delay before they could access the services they needed.

Women suggested that they would find a wide variety of means of presenting such information helpful (posters, leaflets, postcards, small cards with key contact numbers), both inside health service settings and elsewhere, in shopping centres, public service buildings and offices. They also mentioned the importance of radio and television programmes, as well as newspapers and magazines.

All four projects included the provision of a range of information for use in public places or to hand out to individual women. For example, in Salford, all GP practices (whether participating in the camera scheme or not) had posters and leaflets available in reception areas and toilets; health visitors also now routinely distribute the ‘Breaking the Chain’²¹ leaflet to all new clients. As emphasised earlier, the majority of the women interviewed had not been in contact with the project in their area, so could not comment on the specific provision of information by the projects.

Health service staff knowledge of local specialist domestic abuse services

Interviews with health service staff in all four project locations suggested that one of the major reasons for not raising the issue of domestic abuse with women during a consultation was lack of knowledge about local specialist services.

If health professionals do not know about service availability, combined with women’s lack of knowledge, it is not surprising that women have great difficulty accessing specialised services. This was illustrated by the experience of one woman who went to her GP, seeking services for her abusive husband, to help him change his behaviour. When asked by the interviewer whether she had requested any help for herself, she replied:

“I didn’t know they could help me, I didn’t ask.” [Mary, Birmingham]

An important part of training for health professionals was the chance to learn about the different services available locally, together with contact details. The training provided in all of

²¹ The ‘Breaking the Chain’ leaflet has now been updated and appears as the ‘Domestic Violence’ leaflet. Available at <http://www.homeoffice.gov.uk/docs/mag.html>

the four projects succeeded in providing health service staff with this knowledge (see following section).

Health service staff also emphasised the value of using various media to present the information, such as posters, leaflets, coasters, key rings and 'post-it' blocks, as well as in the information packs/guidelines with which they were provided. Highly visible information in the consultation setting provided much-needed prompts to implementing routine enquiry. In Wakefield, health professionals found post-it notes containing the phone number for Support and Survival particularly helpful.

These findings are similar to those reported elsewhere in the literature (Bewley *et al.*, 1997; Cosgrove and McCartney, 1999; Humphreys and Thiara, 2002; Croston and Wallace, 2003).

Awareness-raising and training for health service staff

Each of the four projects included some form of training for health service staff; a summary is given in Table 3.2. As this table clearly shows, the coverage of the training in North Devon was the most restricted and this was implicated in the low uptake of the outreach service provided in this project. Training delivered in Salford was the next most restricted; sessions lasted one to two hours at times to suit individual practices. The coverage shown in the table is based on the contents of the training handbook. No detailed information is available on how many staff received training on all the elements included, but interviews with staff indicated that most of the training focused on awareness-raising alone. The coverage of the training provided in Birmingham and Wakefield was the most comprehensive, and there are strong similarities.

Table 3.2: Features of training provided in the four projects

	Birmingham	North Devon	Salford	Wakefield
Length of training	1 day	1 day ¹	Variable ²	1 day ³
Coverage of training				
• Awareness-raising about domestic abuse	✓	✓	✓	✓
• How to ask women about abuse	✓	✗	✓ #	✓
• Handling disclosure	✓	✗	✓ #	✓
• Documentation of abuse	✓	✗	✓ #	✓*
• Safety planning	✓	✗	✓ #	✓*
• Inclusion of specific guidelines/protocols for practice	✓	✗	✓ #	✓*
• Locally available services for women experiencing abuse	✓	✗	✓ #	✓
Pack/handout included	✓	✗	✓	✓
Time/resources included to respond to trainees' own needs regarding any personal experience of abuse	✓	✗	✗	✓
Training evaluation questionnaire				
• distributed immediately after training	✓	✗	✗	✓
• distributed some time after training	✓	✗	✗	✓
Notes:				
1. Informal training sessions in the use of project documentation were also provided to A&E staff in the department.				
2. No detailed information is available on how many staff received training on all the elements indicated by #, the sessions given were not sufficiently long to include all the elements, and content varied from session to session.				
3. A second follow-up workshop, supported by a resource pack, aimed to provide attendees with opportunities to discuss their experience of conducting routine enquiry about domestic abuse, and to explore ways to implement routine enquiry in their own practice environment. The asterisks indicate those items that are covered in depth in this resource pack, along with assessing the needs of children, and whether child protection issues are involved				

The resistance of health staff to routine enquiry prior to training about domestic abuse has been explored, and later in this section, the effectiveness of training in overcoming such resistance is demonstrated. There is still the important issue of ensuring that all relevant staff in the settings where routine enquiry is being implemented receive training. Lack of training opportunities limited the implementation of routine enquiry in all of the projects. In North Devon, even though training was offered in the A&E setting, this was reported not to have reached all staff:

"I remember her [the trainer] dropping in one morning to talk to some of the staff. The trouble is doing it that way; you catch three people out of thirty people. It's not a very good way of formally teaching anyone anything. [Name of member of staff] has said that one of the nurses had said to her recently 'what do you do with these packs?'. So there is reason to doubt that everybody is totally sure what they are supposed to do."
[Nurse manager, North Devon]

The effectiveness of the training was examined using several different sources of data.

- Questionnaires administered to trainees immediately following training (Birmingham and Wakefield).
- Questionnaires administered to trainees three months after training (Birmingham) and one month after training (Wakefield).
- Interviews with health service staff, including both trainees and those who had not attended training, carried out at different intervals after training, from about one month to one year (all four projects)²².

Results from the analysis of these different sources of data are discussed below. It should, however, be borne in mind that they were gathered by varied means and in different contexts.

As part of their activities, three of the projects produced resources to support their training. These were:

- training pack for health staff (Birmingham);
- training and resource pack for GP practice staff (Salford);
- training pack to help deliver basic one-day training (Wakefield); and
- resource pack to help professionals consider the particular type of routine enquiry to be implemented; this also formed the basis for training sessions (Wakefield).

All the packs were produced with help from workers with a background in Women's Aid affiliated organisations. There is a considerable overlap in pack contents, as they each draw on the same body of previous good practice and accumulated knowledge and experience. These packs represent a valuable resource for widespread use in the future.

Views of training – immediate

Both Birmingham and Wakefield used questionnaires to evaluate trainees' views of the training, immediately following the session. The questionnaires were designed locally and were quite different.

In Wakefield, out of 170 completed training evaluation questionnaires²³, 68 (40%) health professionals who attended said they learned more about the local specialised support agency, 99 (58%) said they learned more about domestic violence, and 114 (67%) learned specific domestic violence identification and referral skills.

In Birmingham, participants were asked to rate the day overall.²⁴ All 135 gave the training day

²² There were 78 interviews carried out with health staff across the four projects (detailed breakdown given in Table 2.1). Of these, 42 had received no training and 36 had received project (or similar) training.

²³ This represents 90% of the staff to whom questionnaires were distributed.

²⁴ A total of 135 people were trained in all the sessions held in the period October 2001 to March 2002, all of them

an overall rating of either 4 ('Good') or 5 ('Excellent') on a scale of 1-5, indicating a high level of satisfaction. Participants were then asked a number of open questions:

- The most common response to the question: 'Has anything on the training helped you in relation to the issues you find difficult?', help in asking direct questions and addressing the issue of domestic abuse were mentioned by 43 participants.
- In response to the question: 'What will you be able to take back into your work practice?', the Information Pack was most frequently mentioned (by 58 participants), followed by increased awareness, knowledge and understanding (35 participants).
- In response to the question: 'Are there any related issues on which you would like further training?', more information was requested on legal issues (eight participants), child protection (seven participants), and minority ethnic groups (seven participants), as well as regular information updates (ten participants).

Effects of training – longer term

In Birmingham, a follow-up evaluation questionnaire was sent to trainees three months following the training session, and in Wakefield, a questionnaire was sent one month after training.

In Wakefield, the questionnaire was distributed to 103 health professionals who had attended the training day. Forty-nine were returned, a response rate of 48 per cent. A summary of results is shown in Table 3.3. Most notable among the findings are that 98 per cent considered that the training had some impact on their practice (with 49 per cent reporting a great deal of impact), 59 per cent had started to ask women about their experiences of abuse, and 100 per cent felt more confident in dealing with issues of domestic abuse.

Table 3.3: Responses to follow-up training evaluation questionnaire, Wakefield

	Number	%
What impact has the training had on your current practice?		
A great deal	24	49%
Some	24	49%
Very little	1	2%
Have you discussed issues raised during the training with colleagues?		
Yes	45	92%
No	4	8%
Have you been able to put any of your ideas into practice?		
Yes	24	49%
No	22	45%
Have you started to ask women about their experiences of abuse?		
Yes	29	59%
No	19	39%
Do you feel more confident in dealing with issues of domestic abuse?		
Yes	49	100%
No	0	0%
Have you made any referrals as a result of asking about domestic abuse?		
Yes	10	20%
No	38	76%
Leaflets given where no referral accepted	4	8%
Have you been able to access support for yourself when dealing with issues of domestic abuse?		
Yes	27	55%
No	10	20%

Source: Wakefield project data, N=49

In Birmingham, the questionnaire was sent to all 48 training day attendees. Their initial training took place in October to December 2001. Twenty participants returned forms, a

completed an evaluation form, i.e. a response rate of 100%.

response rate of 42 per cent. The follow-up evaluation indicated a number of positive and long-term effects of training. The majority (85% or 17 respondents) of those who replied said that the training had changed the way in which they responded to domestic violence in the workplace. The responses included:

- increased awareness and a change in attitude towards women experiencing abuse;
- confidence in handling domestic violence issues;
- the ability to utilise information given out during the day;
- a commitment to raise the profile of domestic violence in the workplace; and
- improved procedures for handling domestic violence cases.

The follow-up questionnaire also provided evidence that training led attendees to improve their systems of documentation and referrals to other organisations, and 65 per cent of respondents described how this had been achieved.

Interviews with health professionals in all four projects also showed the effects of training in the longer term. Interviews were carried out with health professionals who had not received training as well as those who had. *All* staff who had received training valued the sessions highly; this was consistently found across all four projects. Staff emphasised the importance of the training they received in raising their awareness about the prevalence of domestic abuse:

"It was something that up until us having these meetings I don't think any of us were aware of what a problem it was." [Practice manager, Salford]

Training prompted and helped staff to change their practice:

"We attended the basic 'Insight into Domestic Violence' and it [routine enquiry and participation in the camera scheme] just took off from there as they were so interested. Some of the staff have actually gone through domestic violence themselves so it was enlightening to them – in that it wasn't just about bruising and being battered." [Health visitor, Salford]

One health visitor described how the training gave her the confidence and knowledge she needed to conduct routine enquiry:

"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...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]

Another reported:

"At first, I positively squirmed at the thought of asking somebody if they were experiencing domestic abuse because it seems such a personal question. But when we talked about it on the study day, we said, well, we routinely ask women about the state of their perineum, family planning, and if so, why do we have to be squeamish about asking about DA?" [Health visitor, Wakefield]

In response to a question about specific exercises they had found beneficial, staff in Birmingham described how their knowledge about domestic abuse had increased:

"Barriers to women leaving abusive relationships – a subject quite alien to me and I had previously viewed it in quite a simplistic and quite judgemental way." [NHS staff]

member, Birmingham]

“Myths and stereotypes about DV because it eliminated any of my own stereotypes.”
[NHS staff member, Birmingham]

Staff in interview also reported:

“The training has alerted me to that kind of thing [controlling behaviour] so I’m a lot more aware that there might be problems.” [Midwife, Birmingham]

Interviews with health professionals who had been trained also emphasised the importance of understanding that survivors will usually not leave their partner immediately:

“I’ve had one leave and go back, but again that is part and parcel... and that is where the training comes in useful because you know that is part of the cycle that she goes through. You could put in 25 hours a day and that wouldn’t necessarily stop them from going back to that relationship.” [Health visitor, Wakefield]

This professional realisation leads to safer transitions for domestic violence survivors:

“I probably wasn’t aware of how much it went on, or that you can’t force someone to get help or to leave the relationship, you can only give support and make sure they know where to go when they do get to the point of leaving. In that sense, the training was really good... I suppose from that point of view, that is what the change is, the reason why they often stay and whether you can influence whether they stay or not. I think often you can’t, you can just make sure they are safe and when they do decide to leave, to point them in the right direction.” [Community nurse, Wakefield]

“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]

A comparison was made of responses from health staff who received general awareness-raising training in North Devon and Salford with those who received more comprehensive training in Birmingham and Wakefield. This clearly showed the importance of training in addressing how to frame direct questions about domestic abuse. It indicated that a full day’s training (although not necessarily delivered in a single session), is the minimum amount needed to impact on knowledge, confidence and practice. This training should also include those subjects covered by Birmingham and Wakefield (Table 3.2). Far more limited effects can be expected with the extent and type of training delivered in North Devon, i.e. restricted to general awareness-raising.

Further evidence on the length of training necessary comes from the interviews with health staff in Birmingham. The hour-long meeting at the practice where the outreach service was placed had had a detrimental effect on health staff’s perception of their ability to cope with DV. They felt it had highlighted that there was a problem (namely low referrals to the outreach service) but had left them feeling powerless to do anything – and possibly even less receptive to the issue. Only one member of staff at this practice had attended the full-day training, and she was the only one who felt confident in dealing with the issue of domestic abuse by asking direct questions and responding appropriately to disclosure.

The interviews with health professionals in Wakefield who had been trained were compared with those who had not been trained to see whether training had changed practice. They were asked whether they had attended the training provided by the project and whether they practised any form of routine enquiry. Twenty-three health professionals were interviewed across eight practices. Twelve had attended at least the first full-day training workshop, and they all practised some form of routine enquiry. They had started this after attending the training. This was true of both the three practices where the project had piloted routine enquiry and the practices where the project had only supported training²⁵. The remaining 11 health professionals had not attended the full-day of training and did not practise any form of routine enquiry. Seven were from practices where general awareness-raising training (of around two to three hours) had been provided to all practice staff, as part of a domestic abuse survey amongst women attending these practices. It could be concluded, from this case, that general awareness-raising training on its own is unlikely to lead to change in practice with regard to routine enquiry.

Comparing responses from those who had completed questionnaires on the training they had received in Wakefield, Birmingham and Salford with those who had not, those trained were:

- more aware of the prevalence of domestic abuse;
- more knowledgeable about domestic abuse, in particular in terms of not expecting domestic abuse to be confined to particular groups in the population, and the barriers women face to leaving an abusive relationship;
- more knowledgeable about local specialised services available for women experiencing domestic abuse;
- more confident in responding to disclosure of domestic abuse;
- in Birmingham and Wakefield, able to overcome barriers to raising issues of domestic abuse with women, including lack of confidence, misinformation about whether women want to be asked, fear of dealing with disclosure. Those who had received training in Salford reported this to a lesser extent; and
- where training had explicitly covered issues of how to ask direct questions about women's experience of domestic abuse (Birmingham, Wakefield), more likely to be putting this into practice through some form of routine or selective enquiry.

The value of ongoing training and support

Both the training evaluation questionnaires administered by project staff in Birmingham and Wakefield and the interviews with staff who had received training, emphasised the value of ongoing training. They also showed the value of support/facilitation/specialist expertise in achieving lasting change in practice and effective identification and signposting of women experiencing domestic abuse.

“And somebody with the dedication of someone like [the trainer]. I know I’m always singing her praises, but she’s been fantastic. She didn’t give up. ... Because she kept coming in when we were doing the screening, it didn’t slip. She didn’t come a lot, but it was there and it’s there now, nine, ten months down the line. It should be normal. It’s really helped me having it so much in the front there...(It’s) in the front of my mind now.” [GP, Wakefield]

This would suggest that the support required is not particularly time-consuming; it is just important that staff know it is there.

²⁵ In Wakefield, project staff were unaware that routine enquiry had been introduced in practices beyond the three practices supported in the routine enquiry pilot. This would suggest that: a) training alone, without additional support, can be sufficient to stimulate changes in practice; b) an ‘audit’ stage as a precursor to the introduction of routine enquiry may not be necessary; c) the fact that not all practitioners who had attended the training were surveyed may lead to an underestimation of the impact of the project.

In some instances, staff emphasised the importance of peer support and being able to discuss issues openly with colleagues:

“In another Health Authority where I worked I saw many cases of domestic violence not just from partners but from mother-in-laws. The women would come in with bouts of depression or they’d repeatedly want to be seen to check the baby. Through experience you could sift out the ones who were trying to get help. We’ve actually helped mothers to escape, through the clinic. ...It’s really quite disturbing. We tend to need to debrief each other afterwards.” [Community midwife, Birmingham]

Several members of staff noted parallels to the situation in respect of responding to child protection. Here there is a named specialist and a means for all staff to receive information, advice and support via various methods, such as clinical supervision, specialist advice/support posts. Staff suggested that a similar system of a named specialist for domestic violence would be useful.

Awareness-raising and training – conclusions

This study joins others (Cant and Irvine, 2001; Bacchus *et al.*, 2002) in showing that training of health professionals can alleviate their concerns about “opening a can of worms”, the fear of which can stop them asking about domestic abuse. Appropriate training equips health professionals with knowledge of local advocacy and support services, and the skills to ask direct questions about abuse, encourage women to disclose, and provide an appropriate response.

Training of health staff addresses some of the barriers to routine enquiry about domestic violence that have been identified in health studies, e.g. attitudes of staff, difficulties in framing questions or seeing the patient alone, recording information, legal implications, confidentiality, child protection concerns, lack of awareness of support services, frustration at survivors’ responses, raising expectations of the client, and safety. Similar findings are reported elsewhere (Cant and Irvine, 2001; Protheroe *et al.*, 2001; Watts, 2002; Bacchus *et al.*, 2002; MacVean *et al.*, 2003; Mezey *et al.*, in press).

In terms of affecting practice, specific training in asking direct questions about domestic abuse is required, as well as how to respond appropriately to disclosure, safety planning for the woman, documentation, and local service availability. The packs that have been produced by three of the projects evaluated in this study, Birmingham Salford and Wakefield form an extremely valuable resource for use elsewhere.

In Wakefield, extended project funding from the CRP (beyond the period covered by this evaluation) has been used to fund the production of a training video. This, together with the training packs, will provide a resource to be drawn upon.

One final point is the importance of getting general awareness and appropriate response training on domestic abuse into pre-registration curricula of every health professional. This is justified given the prevalence of the problem and the proportion of women that will be affected at some time in their lives, and the considerable health impacts on women themselves and their children. This was something that was explicitly suggested in a number of responses to training evaluation questionnaires and staff interviews in both Birmingham and Wakefield.

Documentation

Documentation of abuse in women’s health service records

An important element of the guidelines and training to health service staff in the Birmingham, Salford and Wakefield projects, is that of documentation of domestic abuse in health service records. It was outside the scope of this study to examine health service records themselves to evaluate how these guidelines had been put into practice. However, the issue of

documentation was something that was raised in interviews by women survivors as important to them, although for some women, this was an issue they found somewhat problematic owing to fears about possible breach of confidentiality. It was also discussed by some of the health professionals in their interviews.

Guidelines provided in the projects on documentation emphasised its importance in terms of:

- ensuring appropriate delivery of health services to the women and of monitoring any care given;
- validating the women's experience and demonstrating that she is being taken seriously; and
- its potential value to the woman if she chooses to pursue a prosecution, or in relation to any divorce proceedings, child contact cases, or applications for non-molestation orders.

Maintaining confidentiality of records is extremely important and is stressed in the projects' guidelines, as is allowing other appropriate health professionals to know that a woman is experiencing domestic abuse. In Wakefield, one practice that had implemented routine enquiry did this by a simple code of either 'yes' or 'no' entered into a field that was given the name of the practice itself. Some staff in other practices reported that the different software used by different levels of health practice staff for their computerised notes, including different coding systems, posed severe challenges to appropriate sharing of information.

Guidelines on documentation need to explicitly warn of the dangers of including the names of perpetrators in the records of the woman experiencing abuse, as this opens up the possibility of a request (under Data Protection legislation) by the perpetrator for disclosure of information held on them. It should be noted that legislation does contain safeguards here, in offering grounds whereby such a request can be refused, although the interpretation of whether these grounds apply in any particular case remains subject to local interpretation.²⁶

For some women survivors interviewed, the issue of documentation was clear-cut and they valued this being done:

"My doctor at the time asked me, 'would you like me to keep this on a permanent report, to go on the files and stuff?' he says, 'so in case like you change doctors, obviously you might change your doctor now in the circumstances', and I said 'yes, there's no problem, I'd rather it was there as background'." [Nicki, Birmingham]

Other women survivors reported the conflicting views they had about documentation. At the time of abuse, fear often made them reluctant about documentation, in some cases actually asking staff not to document. Later, however, when involved in court proceedings, they wanted records to be there to help their case. Figure 3.2 presents an extract from an interview that graphically illustrates the dilemmas that documentation can pose for women.

²⁶ For further information and advice, contact the Office of the Information Commissioner: www.informationcommissioner.gov.uk. Also see Douglas, N. *et al.*, (2004) *Safety and justice: sharing personal information in the context of domestic violence – an overview*. Home Office Development and Practice Report No. 30. London: Home Office. <http://www.homeoffice.gov.uk/rds/dprpubs1.html>

Figure 3.2: The dilemmas that documentation can pose for women

B [Beryl]:	So years on when I went to court and I was thinking 'where's this Health Visitor' – get all your notes out, but she didn't document it – I'd asked her not to because I was so scared.
A [Interviewer]:	Did your doctor write anything down in your notes?
B:	Well, they had access to my notes you see and there was nothing. Which I would have been happy about at the time – because it was 'I've not said anything to you – don't write anything down', and I'm wondering should they have done. Because if they're confidential records and he can never get hold of them, what would have been the harm.
A:	Maybe you didn't know the notes were confidential. Sounds like you were very scared?
B:	Well it were an irrational scare – if I'd have been rational I'd have thought well – confidential – I can say to her – make sure they're confidential – I don't want this getting out, but I didn't think I'd be in court in a year's time and I would need evidence. So, it's just so confusing.

[Beryl, Salford]

Photographs in the health service setting

In the Salford project, the central element was the collection of enhanced evidence in the GP practice setting through the provision of Polaroid cameras. The practice guidelines contained procedures to be followed when taking photographs. In the Wakefield project, a camera was provided for use at the premises of Support and Survival. Two resource packs produced by the projects include protocols for gathering photographic evidence (Salford, Wakefield).

The background to the Salford project was the experience gained during a photographic evidence scheme that was successfully piloted by the Salford Division of Greater Manchester Police from February to July 1999. The officers were trained to use the camera and received guidance on administering the scheme, which included the use of specially designed consent and DV incident report forms. During the six-month pilot period, a total of 68 photographs were taken. A number of successful high profile cases, where the photographs were used to obtain convictions, generated positive media coverage and encouraged officers to continue with the scheme. It is still in operation at the time of writing and was one of the main drivers for the application to the CRP for the GP-based scheme. It was hoped that the placing of cameras in primary health care settings would be equally successful and would make the service available to a wider range of women experiencing domestic violence. It was also suggested that this would enable earlier intervention. This, however, was not borne out in practice, as this section outlines.

By the end of the project in March 2002, the camera scheme had been introduced to five GP practices, with implementation periods of between three and six months. In total only one woman was photographed. Practices did not collect information on the numbers of women offered the scheme. In interviews, practice staff reported that women were being offered the scheme but declined for a variety of reasons. Reasons included:

- lack of sufficient time to prepare the practice staff adequately;
- the presentation of the intervention, its association with the police and the use of the term 'evidence'; and
- the placement of the camera in the practice.

Practice staff reported that they intended to explore different ways of presenting the opportunity for photographs to be taken and the use of cameras outside the practice. Future research could explore whether these changes have taken place and what effect, if any, they have had.

In Wakefield, no photographs were taken; again no data were collected about the number of women who were offered the opportunity to have photographs taken.

In Salford, women who had experienced domestic abuse were asked by interview (N=7) and questionnaire (N=17), whether they had heard of the camera scheme and whether they would use it if it were offered to them. The combined responses are shown in Table 3.4.

Table 3.4: Numbers of women hearing of and using the camera scheme

	Heard of scheme	Not heard of scheme	Total
Would use scheme	6	7	13
Would not use scheme	4	7	11
Total	10	14	24

Source: Service user interviews and questionnaires, Salford, N=24

From this table it can be seen that just over half the women said they would use the scheme. The main reason given was to obtain proof of injuries. All 13 women who said they would use the scheme mentioned this.

However, 11 women said they would not use the scheme. For these women fear was a major inhibitor:

“I’d love to say ‘yes I would have had them done so get on with it – because it’ll help’ but I can honestly say that I wouldn’t have had the photographs taken because I kept it secret and there’s no way I would have wanted anybody to have any evidence to say that I discussed that outside of our relationship because he was a controlling person and I was so terrified of him.” [Beryl, Salford]

Fear not just of the perpetrator, but of not being able to trust health professionals with information, was an issue, especially where the GP was also the doctor of other family members.

Many women described the dilemma of recognising evidence would be useful, but being to afraid to seek it:

“It’s hard really because later on, years later, I wish that I’d have had the photographs taken but I still know now that I wouldn’t have had them taken. Maybe someone could have reassured me at the time because if I’d had them photographs developed and they’d ended up in court... because that was the problem – I had no evidence. I had no evidence whatsoever and as far as the courts are concerned there’s no domestic violence if you have no evidence. So if I’d had the photographs I’d have been sorted.” [Beryl, Salford]

One interviewee was doubtful about the value of photographic evidence. She had previously used photographs that had been taken by the police in a court case, but had been put off using such evidence again by her experience. She recalls that:

“He got a really good barrister...the GP stood up in Court and said ‘they could have been bruises where she could have fallen or hurt herself’. The case was thrown out.” [Ravinda, Salford]

Another woman also questioned an underlying assumption of the camera scheme, and by association the criminal justice system, in asking why a woman should need photographic evidence at all:

“Why is the woman not believed, why humiliate her more by taking photos of her?” [Questionnaire, Salford]

The difficulty in looking at photographs was also given as an inhibiting factor. This was supported by the experience of those working with survivors. They explained that the photographs could be a very painful reminder of the abuse and would force some women to acknowledge it was really happening, something they might not be ready to do.

Another reason given for not wanting photographs, mentioned by many women during the evaluation interviews, was that they had no intention of pursuing the matter through court and so would have no need of photographs. They described how they had no interest in the criminal justice process, but just wanted to be free from the violent relationship and be rehoused in a safe place. In the words of one interviewee:

“How I feel now, 'cos I don't ever want to see them (the perpetrators) again, I don't ever want to look at them, so I don't even want to go to court. Do you know what I mean? I just want to be left alone and want to get on with my life now and you know, look after my kids. I think if it will help you getting out, getting somewhere, then yeah. I mean maybe then use them for Court. But I think the main thing is you just need to get away – just need a bit of help, somebody to take you seriously when you're sending in letters.” [Juliet, Salford]

Another bar to having photographs taken in a health service setting was the difficulty women reported in leaving the house at times when physical injuries were visible. They also made the point that photographs would not be of any use in cases of internal injuries or psychological harm.

The interviews showed that women did not associate the health service with the gathering of evidence; for them this was something that the police did. It was often not until they had sustained very severe injuries and/or were at the stage of leaving that they involved the police. Many already knew the police had cameras and could take photographs of injuries but they regarded this as something to be done at a time of crisis.

All the women interviewed during the evaluation in Salford had used health services during the time the abuse was happening. They had wanted health staff to recognise the abuse, to document it in case notes and to offer ongoing support, advice and referral to other sources of help. But they wanted health staff to understand that they might not be able to act on the advice or seek help at that time. For many this was because they were still living with the perpetrator and felt they were not in a safe position to act.

The decision to have photographs taken or not is a complex issue and is influenced by many factors, including the woman's readiness to seek help, the level of fear, her trust in the health staff and an intention to progress the matter through courts. The provision of the camera scheme also relies on confidence of staff in handling disclosure of abuse, of being able to provide what is needed in terms of support and advice and having time to take photographs and complete documentation.

These factors indicate the complexity and fragility of transplanting a scheme from one setting to another. Factors related to the health setting, the implementation process and the women themselves all interplay to affect the outcome. The Salford project has shown that success in one area is not a guarantee of success in another, and the lack of any recorded use of cameras in the Wakefield project gives further evidence supporting this conclusion.

Outreach in the health service setting

The hosting of specialised outreach workers in health settings was investigated in two of the projects: Birmingham and North Devon. In Birmingham, the outreach workers were Women's Aid salaried workers, and in North Devon, they were Victim Support volunteers.

The rationale behind the use of specialised outreach workers is that it will be easier and safer for women to access the services than if they have to travel to another location. In Devon, the outreach workers were placed in the A&E Department of a general hospital. In Birmingham, they were placed in a GP practice, and a maternity hospital.²⁷ In the maternity hospital delays caused by practical issues rather than a lack of will held up the start of the outreach service. This meant that this evaluation is not able to report on the experience of an outreach service in this setting; this remains a topic for future research.

During the evaluation period, uptake of the outreach service in the Birmingham GP practice was very low, with only three women using it. The evaluation team found two main reasons for this:

- staff at the practice had not received training in encouraging and handling disclosure at the time of the start of the outreach service; and
- not all staff in the practice were aware of the existence of the outreach service.

The evaluation identified two other practices in the same area of the city, where outreach workers held weekly sessions; this provision was not funded through the CRP project. The experience in these two practices, where staff had received training and were well informed about the outreach provision gives a different picture of the potential and value of this form of outreach provision.

Again, the uptake of the outreach service in the North Devon A&E department was low, the total number of survivors helped dropped sharply during the second and subsequent quarters of implementation.

The evaluation team found three reasons for this and the resulting limited success of the project:

- The project experienced limited success due to a lack of leadership. No single individual with responsibility for project management was identified.
- Deficiencies in the training provided for A&E staff. Training was limited to a single day that included six presentations on different aspects of domestic violence. Not all the staff were able to attend this. No formal training on the project protocol was provided for A&E staff. Most importantly A&E staff members did not receive any formal training on how to speak to survivors who were disclosing domestic violence, how to ask about domestic abuse, or how to proceed if the perpetrator was present.²⁸
- This project may have also been limited by its location in the A&E department: survivors' partners often attended with the injured women making it difficult for staff members to provide support and referral information.

The impact of routine enquiry and signposting: actual and potential

The value of routine enquiry to women, from the information they receive about services and the appropriate responses by health professionals to disclosure, has already been identified. The short implementation times for the projects under evaluation have meant that there is not a body of data available for a large sample of survivors detected through routine enquiry that traces their route through service use and assesses the impact on their health and quality of life and that of their children. This remains an area for further research. However, the potential value of routine enquiry in terms of impact on health and quality of life *can* still be adequately demonstrated by using interview data from women who had accessed *similar* services to those evaluated under the CRP VAWI. Many of the women interviewed discussed their

²⁷ The Birmingham project also originally aimed to investigate placement in an A&E department. However, difficulties engaging A&E staff and the limited time available for implementation were contributing factors in the decision not to place an Outreach Worker in this setting.

²⁸ The Victim Support volunteers reported feeling adequately trained for their role by virtue of the training provided from Victim Support; this was training provided outside the remit of the project. They also commented favourably on the back-up and support available to them if they needed it from their own organisation.

experience of domestic abuse, how they had left the abuse situation, and how their lives had changed over time. Chapter 4 considers the impact of service use on health and quality of life. In this section, these interviews are used to explore the potential value of routine enquiry in achieving earlier intervention. This operates through giving women experiencing abuse information about, and facilitating their access to, local specialised domestic abuse services.

Two case studies drawn from interviews with women in Birmingham (Figures 3.2 and 3.3), illustrate graphically the considerable potential that routine enquiry has to enable women to access services at an earlier point in their experience of domestic abuse.

Figure 3.3: Mary: a case study

Mary – her story in summary	Missed opportunities for enquiry
<ul style="list-style-type: none"> • In her early fifties • No children • Emotional abuse for over 20 years • Abuse intensified over time • Physical abuse started 3 years prior to interview • Enters refuge after contacting Samaritans, this is the first time she learns about the existence of any service for women experiencing domestic abuse 	<ul style="list-style-type: none"> • Abortion counselling • Visits GP with psychological distress, anti-depressants prescribed, and continued for 12 years • Period spent as psychiatric in-patient (after breakdown when stopping taking anti-depressants without support or supervision) • Calls police when threatened physically, unhelpful response • Throughout all of the above contacts she is never asked about abuse, or about her perspective on her relationship with her husband • Visits GP for help for husband, discloses abuse, not informed about any services for herself, not validated in her disclosure, lack of referral for husband

Mary had a history of over 20 years of abuse during which she had a considerable number of contacts with the health service – all generated by the abuse she experienced. In none of these contacts was she ever asked whether she had experienced domestic abuse, or about *her* perspective on her relationship with her husband. Instead, she reports how staff effectively colluded with her husband’s abuse of her, failing to ask about her side of the story, and instead taking her husband’s word, and encouraging her to remain with him. When the abuse she received became physical she sought help from the GP to assist her husband in changing his behaviour. On disclosing abuse to her GP, she was not asked about her own needs, or offered any information about services available for herself (she did not ask about these, as she did not envisage that there might be any). No services were arranged for her husband, and the abuse escalated further. She eventually called the Samaritans, and finally received information about Women’s Aid and refuges. The Samaritans arranged a room for her in a refuge.

Mary’s case was not an isolated example in the sample of 33 women survivors interviewed. Another six women (from Birmingham, Salford and Wakefield) each reported a similarly long list of contacts with the health service where opportunities to ask direct questions about abuse and home circumstances existed, and the circumstances of the consultation indicated that such an enquiry would have been highly relevant. These opportunities were not taken. In some instances women made explicit disclosures, as Mary eventually did to her GP, but this was not followed up with information about relevant services.

Cases like this indicate the enormous potential for enabling women to access services at an

earlier point in their experience of abuse. Given the prevalence of domestic abuse, such cases also suggest the potential for substantial savings in health service costs. For example, in Mary’s case, if she had been able to access appropriate services at an earlier point, potential savings may have included the costs of an extensive length of time on antidepressants, and of her period as a psychiatric in-patient.

In contrast, Nicki’s case study (Figure 3.4) was unique amongst the sample of survivors interviewed. This was due to the relatively swift and co-ordinated response she received from a number of agencies once she started to access specialised services. She presented at her GP with injuries and was given information about the specialist outreach service available in the practice. An appointment was arranged for the following day. The outreach worker discussed options available with Nicki and a few days later she moved into a refuge with her children. She was given help applying for housing, and relatively quickly was offered a suitable property by the council. She left the refuge after three months for her new home. Although it is impossible to state what her life would have been like if she had received an unhelpful response at the point of initial disclosure to the GP, it is also evident that the validating, co-ordinated and informed response of the surgery had a profound and health-improving impact on Nicki and her children.

Figure 3.4: Nicki: a case study

Nicki – her story in summary	Effective signposting through services
<ul style="list-style-type: none"> • As a child, had experienced physical abuse from father • In her early 30s, with two children • A relatively long history (years) of abuse from her partner, initially when they lived together and then also after he moved out and they lived separately • She stopped being isolated at home with small children when she started taking the children to school and making friends. She realised that “something was wrong”, and that she should not have to tolerate the abuse 	<ul style="list-style-type: none"> • Visits GP about injuries • GP tells her about specialist outreach worker who runs sessions at the practice • Saw outreach worker the next day • Enters refuge with children a few days later • Relatively quickly offered suitable property by the council • Leaves refuge for new home after three months

The potential impact of routine enquiry is also shown by the interviews with health professionals who practise it. They emphasised the importance of providing on-going support to women, thereby improving their health care, in particular through supporting them in maintaining their safety.

One health visitor discussed the importance of “being there” for survivors to talk to:

“It’s helped me approach women more easily and with a better understanding on how they feel and more empathy with how they sometimes don’t do anything about it. A lot of people who haven’t suffered it ask why do they stay, but now I know they stay for all these reasons; it’s got to be the right time or have a plan of escape. Some people think, well, if you aren’t going to help yourself why bother. But no, you have to never give up on these people. You can help them by being there for them to talk to.” [Health visitor, Wakefield]

Routine enquiry can allow for complete health documentation, leading to more accurate diagnosis and treatment of health conditions:

“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 was a good opportunity to go and find out. I've got this lady who is a victim of abuse. ...I think this has a big impact on her health. 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. ... 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]

Women's expectations of the health service

Women's experiences of using health services were explored during the interviews and via the questionnaires. The majority of the contacts the women discussed took place before the operation of the projects and thus were not with staff who were trained during the projects. They reported a wide variety of responses ranging from active support and referral, through a complete absence of recognition despite their presenting with physical injuries, and a failure to discuss any possible services/options after disclosure of domestic violence.

The women commented on what they would have found helpful from the health service. They wanted:

- to be asked directly about abuse;
- to learn and be reassured that their abuse was unacceptable;
- to receive information about services available; and
- in a smaller number of cases, to have some action taken by health service staff.

All women commented spontaneously on how difficult it was to discover information about their options, and many said that it would have been helpful to have had this information earlier.

As discussed earlier, many women reported that they wanted to be asked about domestic abuse and some commented how helpful it was to realise that abuse was unacceptable when this was explicitly acknowledged by their GP.

A number of women reported that they expected their experience of abuse to be carefully documented, although some held conflicting views about documentation. A much smaller number specifically expected health professionals to initiate action on their behalf:

"I went to the GP and, unknown to me, the GP had actually written a report out of my injuries. ... And I didn't find that out until five years later when I went to court. It was in my records and I was so annoyed because I felt that if the GP can actually write on that headed paper the extent of my injuries yet he did not let any people know – i.e. social services or anybody connected. He'd not let anybody know. He actually knew what had been going on." [Beth, Salford]

One of the four projects (Birmingham) included provision of an extended helpline service as a part of their programme activities. However, interviews and questionnaires from women in all areas commented on the importance of phone helplines, and the importance of phones being staffed for the maximum amount of time. Helplines can provide crisis advice on the phone without an appointment.

The experience in the Birmingham project demonstrated that when extended helpline hours were implemented, usage increased. The existence of the helpline was publicised to health staff during the training provided by the project. Prior to this training, in the year April 2000 to March 2001, 12 per cent of calls to the helpline resulted from information given by health staff to women. In the following year, that included the six-month project implementation period, 28

per cent of calls to the helpline resulted from information given by health staff to women. Whilst this does not allow the increase to be definitively attributed to the project, it indicates that some effect from the project is likely.

Interviews and questionnaires completed by women were systematically coded for women's self-reported contacts with different types of health service in relation to domestic abuse and also as to whether they perceived their experience as positive, neutral, mixed or negative in terms of meeting what they perceived as their service needs. The results are presented in Table 3.5.

The uneven response that women experienced from the health service, with the most positive response coming from health visitors, reflects findings of other studies such as Humphreys and Thiara (2002) and Bacchus *et al.* (2003).

Table 3.5: Women's experiences of health services in relation to domestic abuse

Type of service used	Number of women	Experience of service (% of those using service)			
		Positive	Neutral	Mixed	Negative
GP	25	7	1	5	12
A&E	7	0	2	0	5
Health visitor	11	8	0	0	3
Other health *	9	4	0	0	5

Source: Interviews and questionnaires from women survivors in Birmingham, Salford and Wakefield (N=53)
* Includes: midwife (2), hospital (2), counselling/therapy (2), nurse(1), inpatient psychiatry(1), ambulance service

It is important to emphasise that in this study the negative responses received do not represent a failure on the part of the training provided by the different projects. As demonstrated earlier, the training provided by projects did change health professionals' knowledge, attitudes and practice positively in relation to domestic abuse. The uneven response documented above may be a reflection of the generally low percentage of health professionals who have received training, which was not compulsory in any of the projects.

Women's views on specialised domestic abuse services

Interviews and questionnaires completed by women were also systematically coded for women's self-reported contacts with different types of specialised domestic abuse services and also as to whether they perceived their experience as positive, neutral, mixed or negative in terms of meeting what they perceived as their service needs. The results are presented in Table 3.6.

Although, the women reported much more mixed and negative experiences for refuges compared to the other specialist DV services, it should be noted that often the negative experiences related to aspects of refuge life that would be hard to change, for example restrictions on visitors (which are necessary to maintain safety of residents).

Table 3.6: Women's experiences of specialised domestic violence services

Type of service used	Number of women using service	Experience of service (% of those using service)			
		Positive	Neutral	Mixed	Negative
Specialised DV services					
Individual advice/support/advocacy	33	32	0	1	0
Support groups	17	16	0	0	1
Refuges	21	12	0	7	2

Source: Interviews and questionnaires from women survivors, Birmingham, Salford, Wakefield (N=53)

4. Impact of services

In examining the impact of the projects, it would be preferable to use longitudinal outcome data gathered on sufficiently large samples of women who had contact with the projects, alongside comparison groups of women who had not. This has not been possible in this study. The short implementation (and evaluation) period in each of the projects meant that it was not possible to collect longitudinal data on women using their services. In North Devon and Salford, this was compounded by a correspondingly small number of women using the projects' services.

The impact of services on women can, however, be explored using two of the sources of data collected in this study: the interviews carried out with women in Birmingham, Salford and Wakefield (N=44, 33 of whom identified themselves as having experienced or experiencing domestic abuse) and the questionnaires completed by women in Birmingham and Salford (N=20). In the interviews and, to a lesser extent the questionnaires, women talked about the services they had used, how their lives, and the lives of their children had changed, and offered their understanding of the key elements in services that had been responsible for those changes.²⁹ In this chapter, these data are used to examine the impact of services on health and quality of life of women and children. These findings are compared to those obtained from other studies.

Health and quality of life of women and children

Information was available on the change in health and quality of life of women and children from the qualitative interviews carried out with women survivors (N=33) and, to a more limited extent, from the questionnaires (N=20). The interviews in particular presented detailed information about the impacts of domestic abuse on the health and quality of life of women and their children, and how these had changed over time. Of particular interest here was how some women related changes in their health and quality of life specifically to their use of specialised domestic abuse services. The strongest impacts reported by women survivors were, for them, associated with support groups and support/advice/advocacy services provided on a one-to-one basis.

Out of the 53 women who completed either a questionnaire or interview and who had experienced or were experiencing domestic violence, 44 identified one or more ways in which their health and/or quality of life had improved. The types of improvements are discussed in the women's own words in the following sections.

Confidence and self-esteem

Almost every woman who had used specialised support services mentioned how important they were in enabling her to regain or gain confidence and self-esteem:

"If you'd seen me, four years since, I wouldn't have been coming in here, my confidence was, well I've never had any confidence." [Susan, Wakefield]

As one woman explains explicitly, use of services (in this case a support group), enabled her to regain the confidence she felt before her experience of domestic abuse:

"It brought me out of myself quite a lot. Don't get me wrong – before being in that situation [the abusive relationship] I was really a competent person. But after that, I

²⁹ Although only a few of these women had contact with the projects, the vast majority of them had used the same range of specialised services that the projects were signposting women into through routine enquiry. The outcomes for these women from this service use thus provide a measure of the realisable benefits to women in terms of health and quality of life that can be expected following successful routine enquiry and signposting.

wasn't half the person I am now. I'm confident now, I don't mind talking about it now...."
[Janet, Wakefield, discussing what she obtained from attending a group for women experiencing domestic abuse]

Mental health

For some women, the mental health effects of their domestic abuse had resulted in use of anti-depressants, and in at least one case, a period of time as a psychiatric in-patient. Use of specialised services were associated with improvements in mental health:

"In the end, I was in such a situation where I went through depression, I went through traumatic stress as well after a certain time... I eventually came off anti-depressants [after accessing support services]. I was on anti-depressants for over a year. ... I was always on edge, I couldn't relax, I couldn't sleep...." [Karen, Wakefield]

For some women, the effects included an increase in their resiliency, or ability to cope with challenges in life, for example:

"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." [Jean, Wakefield, summarising what she gained from use of specialised services]

Isolation, social support and supportive relationships

Women talked about the importance of reducing their sense of isolation and of building social networks, new friendships and supportive relationships.

Being able to discuss their situation with health professionals reduced their isolation:

"It [talking to her health visitor] made me understand that I was not alone and not in the wrong, also helped me to unload the burden." [Birmingham, questionnaire 2]

Contact with specialised domestic abuse agencies was also important. Women valued individual advocacy and support services highly, for a number of reasons. Firstly, for their reinforcement to survivors that the abuse was not their fault, and that they did not deserve it. Women also learned that they were not alone, and their contact with support services helped reduce the stigmatisation and sense of isolation they often felt. They valued the non-judgemental approach of the support provided and the understanding for themselves and their situation. Contact with other women survivors was also important, especially in providing women with social support and supportive relationships.

Quality of life

For many women, use of services was associated with improvements in their quality of life:

"They gave me the support, help and advice I needed ... I had my first night's sleep without nightmares ... I felt better about myself, not so afraid and worried about things ... My own experience with the workers at Women's Aid has made my life so wonderful and peaceful. I will never forget them; they have made my life worth living. I have my own flat and peace of mind, ... best of all I feel safe and happy." [Birmingham, questionnaire]

Women's relationships with their children and their children's health

Another positive impact reported by a number of women were improvements in their relationships with their children:

“As for the kids, they started noticing a difference in my behaviour. ... When you become a victim you can become so het up with anger. And you can’t, you’ve never got anyone to mash out, get angry with, and argue, because that partner is no longer there. So you’ve still got all these feelings inside of you. And S&S [Support and Survival] could reach these feelings, and the children noticed a difference in my behaviour towards them, and the way I was. ... I started joining in more, taking more of an interest in them. Whereas before I used to be so distant.”
[Karen, Wakefield]

Similar findings are reported in Anderson’s study (2002) of 15 women who had used specialised services (counselling, advice, support, on both an individual and group basis) provided in Redbridge and Waltham Forest. She found that almost all of the women who had children described themselves as being better parents as a result of the services used.

Women also reported improvements in the health and quality of life of their children, again similar to the findings of Anderson (2002). Some of this resulted from women accessing specific services for their children.

Accessing education and employment

Another area where women reported a significant impact on their lives was in commencing or re-commencing education or employment. The women identified two crucial points here: information on the opportunities available to them; and support to enable them to access education and employment, either individual and/or from groups.

“But by the time I did finally get it [separation from abuser] finished it was the November. I was strong then. I’d started college, doing a college course. Support and Survival turned my life round.” [Jean, Wakefield]

Similar findings are about the importance of support in accessing education and employment opportunities are reported in Anderson (2002).

Some women identified the potential for much earlier intervention by providing information about opportunities for education:

“It’s amazing you don’t get to know any of this information unless you’re in circumstances like this. It’s unbelievable isn’t it? I mean a lot of it could be prevented, a lot of people, I mean a lot of domestic violence women who are at home with kids, totally bored out of their brain, who are intelligent women, need releases like this and you can’t get into it unless you’re in a situation, when it’s too late.” [Nicki, Birmingham]

Explaining the impacts of service use

The interviews and questionnaires completed by women who had experienced or were experiencing domestic abuse were explicit in explaining their views on what had helped improve their situation:

“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]

The women’s experience of specialised domestic abuse services was overwhelmingly one of satisfaction³⁰, and in most cases, the women linked these services most to improvements in their health and quality of life. While women did report receiving help and support from other

³⁰ The exception to this was the experience of living in refuges, which for some women, particularly those with older children, caused considerable constraints in their life. However, women also appreciated that, to a great extent, this was unavoidable, given the need to maintain the safety of all women resident in the refuge.

services, this was by no means the case for all women, as is discussed in Chapter 3. The interviews and questionnaires also identified women who had used specialised DV services, and those who used other services in relation to domestic abuse, referred to as non-specialised services. Table 4.1 summarises the results.

Table 4.1: Women’s reports of service use and changes in their health or quality of life

	Number of women	Positive change reported	No change reported
Used specialised services	45	40	5
Not used specialised services	8	4	4
Total	53	44	9
Used non-specialised services	43	38	5
Not used non-specialised services	10	6	4
Total	53	44	9

Source: Interviews and questionnaires from women survivors, Birmingham, Salford, Wakefield, N=53

Outside the health sector, there are some good examples of evaluations of the effectiveness of support from specialised domestic abuse support agencies: (Hague, 1997; McFarlane *et al.*, 1997; Hague and Malos, 1998 a and b; Home Office, 2000; Humphreys *et al.*, 2000; Sullivan, 2000; Humphreys and Thiara, 2002, 2003; Anderson, 2002; Wathen and MacMillan, 2003). These studies find that provision of information about referral options, and signposting to advice, support, advocacy and other services (usually outside the health service) result in a variety of positive outcomes for women (and their children).

One study evaluated a community-based advocacy intervention in the United States for women entering a shelter to escape from domestic violence using a randomised design. Women were interviewed six times over two years. After two years, one in four of the intervention group did not experience further violence compared to one in ten of the control group. Women who received the intervention reported higher quality of life, and social support, were more able to access community resources, and depression was also less frequent (Sullivan, 2000).

A study of 200 women who had used domestic violence specialised services³¹ provided for women not resident in refuges (Humphreys and Thiara, 2002) found that, out of the 46 per cent who were living in situations of domestic violence when they first contacted the service, all said that the services had helped them to leave the abusive relationship, a valued positive outcome.³² Humphreys and Thiara (2002) also report a range of positive impacts on the life of the women and their children.

Putting together the results of this study with these others from the literature allows the conclusion to be drawn that there are realisable benefits from routine enquiry. These benefits are in terms of achieving earlier access to specialised domestic abuse services, leading to positive impacts on health and quality of life for the majority of women who access those services and also for any children.

³¹ Humphreys and Thiara (2002) refer to services for women not resident in refuges as ‘outreach services’, this is a different from the use of the term outreach service in this report to denote a specialised service provided in a health service setting by workers from a specialised agency.

³² It is possible that there may be overlap between the sample of women survivors interviewed in this study in Wakefield and Humphreys and Thiara’s work. The women for the Humphreys and Thiara study were drawn from the users of 12 organisations affiliated to the Women’s Aid Federation of England, one of the organisations was Wakefield Support and Survival. It should be noted, however, that none of the interviewees for this study mentioned completion of prior interviews/questionnaires, and given that the way samples were recruited in the two studies was very different, the likelihood of overlap is assessed as very small. The size of this overlap can be assessed as six women at the very maximum.

The need for a multi-agency response

The research evidence available suggests that multi-agency responses to domestic violence are more effective than each agency acting alone (Mullender and Hague, 2000; Hague, 2000). This study supports the same conclusion. Each of the four projects was explicitly set up with some form of multi-agency steering or advisory group, and for each of the projects the development of improved partnership working was an important objective.

The interviews with women survivors carried out in this study all emphasised the multi-agency nature of the services required to help them move out of abusive relationships. This often necessitated change in housing, contact with schools where children were involved, and dealing with the legal system over financial and child contact arrangements and if divorce or criminal prosecution was involved.

Interviews and questionnaires completed by women were systematically coded for women's self-reported contacts with different types of service in relation to domestic abuse and also as to whether they perceived their experience as positive, neutral, mixed or negative in terms of meeting what they perceived as their service needs. The results are presented in Table 4.2.

An important theme to emerge from the questionnaires and during the interviews was the lack of consistency that these women had experienced in the response of the non-specialised statutory agencies. The response a woman received was often dependent upon the individual staff member they came into contact with and that individual's attitude to domestic violence. Similar findings are reported in Humphreys and Thiara (2002).

Table 4.2: Women's experiences of services

Type of service used	Number of women	Experience of service (% of those using service)			
		Positive	Neutral	Mixed	Negative
Police	31	11	0	7	13
Courts	5	0	0	4	1
Housing	10	2	0	1	7
Education	5	0	1	3	1
Social services	3	0	1	1	1
Other #	6	2	0	0	4

Source: Interviews and questionnaires from women survivors, Birmingham, Salford, Wakefield (N=53)
Includes: solicitor (4), abortion agency, counselling (outside health service)

A number of women identified schools as important settings for education and awareness-raising around domestic abuse:

"If we start off teaching our children when they're very very young that it's wrong to hit anybody regardless of age, sex, gender whatever, ethnicity. That might be a great help as well but what you're taught in school, it can be undermined by what they're taught and what they see in the household, and Daddy's a big bad bully and that's what it's like to be a man. And you've got a little boy and he's going to think that's what he's got to be to be a man. How do you educate people, to stop that kind of thing, so it's not perpetuating it through the generations? Because that's what a lot of it is, I think – it's learned behaviour." [Margaret, Birmingham]

In relation to their own and their children's experience, women commented on what a difference appropriate action by schools could make. One woman related her own experience of difficulties caused by the nature of the response at her daughter's school, and contrasted this with her experience in relation to her son's school:

“No, the school weren’t very helpful – they didn’t pick up on [daughter’s name] being very quiet after the divorce. I noticed it. I had a quiet word with the teacher who said, ‘oh yes she’s fine’, but I thought ‘no she’s not’. ... If school had said ‘well [daughter] is very quiet – can you explain why’, I might have said ‘there’s a problem at home’, but they didn’t. And the problem I’m having at the moment with the High School is getting a copy of the school report. And parents’ evening – I can’t go because he’ll be there. And they said, ‘well it’s either that or nothing’. And yet [son’s name]’s primary school, his parents’ evening is on Monday and they made his [the father] appointment early and mine at the end. Not a problem, they’ve been lovely.” [Kerry, Salford]

Obtaining suitable housing was a major issue of concern, raised by all but one of the women interviewed in Birmingham. One woman contrasted her experience with housing once she had had to move into a refuge as less favourable than when she had previously sought re-housing. Her view was that the housing department tended to regard women living in refuges as less important.

Two of women in Wakefield reported that their positive experience of seeking new housing helped them leave their partner. For two further women, negative experiences with temporary accommodation (in local authority-run hostels) led to them leaving the hostels and returning temporarily to their partners.

Outside domestic violence specialist units, the women’s experience of the police was extremely varied. Many explicitly commented that it depended on the particular officer(s) involved; this was linked by some to the need for comprehensive education and awareness for all police officers.

5. Conclusions and recommendations

Conclusions

As explained earlier, this evaluation report has a number of limitations. These include the small sample sizes in some aspects of the studies and the lack of control over the data collected by the four projects being evaluated. In some areas therefore, the demonstration of feasibility of interventions should be regarded as provisional. The results, however, do clearly illustrate the potential benefits of the interventions to both women who experience domestic abuse and health professionals.

This study, together with findings from other recent studies not available at the time of the systematic review of research reported by Davidson *et al.* (2000, 2001), provide evidence to suggest recommendations for specific action by the health service. There are substantial opportunities for health professionals to contribute to tackling domestic abuse, improving the health and quality of life of women and children and realising savings in health service expenditure. The conclusions and recommendations are presented below. It should be emphasised that these recognise that:

- the needs of women experiencing domestic violence can be met by various organisations, not just the health service alone; and
- the health service is uniquely placed to contribute to changing public attitudes to domestic abuse and to enabling women experiencing domestic abuse to access services to help them change their situation.

The feasibility and advantages of routine enquiry

This study has demonstrated that routine enquiry is feasible within both the GP practice and A&E settings. Routine enquiry is acceptable to women and to trained staff. The approach adopted in the A&E setting will of necessity be more selective than in general practice, owing to the frequent presence of the abusing partner. Routine enquiry needs to be implemented flexibly to take account of the particular context of each setting, including the availability of space, the staff, any specialised clinics run there and so on.

Training is required in order to implement routine enquiry. This should explicitly cover how to ask directly about experience of domestic abuse and how to deal appropriately with any disclosure, and plan for the safety of the woman and any children. Routine enquiry does not take a long time in the vast majority of cases.

Routine enquiry has a number of clear advantages. Firstly, it provides a good opportunity to inform *all* women about the unacceptability of domestic abuse. This helps to reduce both the stigma associated with abuse and the hidden/taboo nature of abuse. It changes the perceived acceptability of violence in relationships and makes it easier for women to access multi-agency services earlier. In this sense, routine enquiry can be regarded as an important form of primary prevention. Secondly, routine enquiry provides women experiencing domestic abuse with clear messages 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.

It appears that routine enquiry in the sense of asking all women, has several distinct advantages over selective enquiry (in which women are only asked if the health professional has concerns or suspicions, or if certain signs or symptoms are present):

- It contributes to changing health professionals' attitudes to domestic abuse.

- It is less likely to make women experiencing abuse feel stigmatised.
- It is less likely to compromise the safety of women experiencing abuse.
- Health professionals reported that their perceptions about which women were free from abuse were often incorrect.

Importance of specialised domestic abuse services and realisable benefits of routine enquiry

This study has also demonstrated that there can be realisable benefits of routine enquiry in terms of improving access to specialised domestic abuse services and the resulting impact on the health and quality of life of women who have experienced domestic abuse and their children. The responses of these women survivors in interviews and questionnaires indicate that they have found the advocacy and support function of specialised agencies crucial in enabling them to change their lives. Very positive effects of support groups were identified.

To realise these benefits, local specialised domestic abuse agencies require sufficient funding to offer support and advocacy services to women. This study has highlighted the importance of phone helplines as a component in this support, and the importance of extended opening hours. Specialised domestic abuse agencies in the voluntary sector, in particular Women's Aid and its affiliated organisations, experience particular difficulty in securing long-term funding. This needs to be addressed, given the value of these services to the women who access them. One quotation, typical of many from the survivors in this study, summarises this succinctly:

"I left after 48 years of marriage of which I suffered 33 years of verbal abuse. WA gave me a new life at 71. [After] about a month of contact with WA I was in my own flat and at peace for the first time in many years. Three and a half years on they are still there when I need them, no praise is high enough for the women who run this service..."
[Questionnaire respondent, Salford]

The nature of adequate training for routine enquiry

This study suggests that effective training for routine enquiry should be at least one day in length (possibly spread over a number of sessions) and cover:

- the nature and extent of the health problem represented by domestic abuse;
- how to ask direct questions about experience of abuse;
- how to respond appropriately to those disclosing abuse;
- information on the local availability of services for those experiencing abuse;
- safety planning for those experiencing abuse;
- safe documentation of abuse; and
- explicit recognition of trainees' personal experience of domestic abuse, with time/resources set aside to respond to trainees' own needs.

The evaluation team also notes the particularly effective training delivered in the Wakefield and Birmingham projects was provided by local Women's Aid-affiliated organisations.

Benefits were also identified from:

- follow-up workshops where participants had the opportunity to discuss their experience of conducting routine enquiry about domestic abuse, and to explore ways to implement routine enquiry in their own environment; and
- delivery of training by a team with experience of both specialised domestic abuse services and health services.

Importance of reinforcement, advice/support to practitioners

The importance of reinforcement, and the provision of advice/support to practitioners,

emerged in the projects in different ways. In North Devon, it was notable that the distribution of packs in the A&E department dropped when someone from the project had less time to spend there. In Wakefield, the support the project offered during the routine enquiry pilot was highly valued by health professionals. In Birmingham, the provision of advice and support to health professionals by helpline and outreach workers, as a part of their planned programme of work, was very valuable. Reminders to ask women about their experiences of domestic violence, for example in the form of 'post-it' notes, also proved useful.

The study also suggests, however, that the requirements for support were not intensive. Many of those involved in the projects suggested that a system of identifying a lead practitioner with responsibility for domestic abuse in each setting was a useful one. Unfortunately, owing to the time limits on this evaluation, it has not been possible to examine the impact of the implementation of such a post in Birmingham.

Value of outreach provision in health service settings

This study has demonstrated that the provision of an outreach service from a specialised domestic violence agency in the GP setting and the A&E setting has the potential for allowing women to access specialised services more readily. These outreach services have particular value in rural or semi-rural areas, where women may find it difficult to travel to access support services in cities or town centres.

Lack of value of cameras for evidence-gathering in GP practice setting

The study of the Salford project demonstrates that the gathering of enhanced evidence through the use of cameras in the GP practice setting is feasible. However, the extremely low uptake rate in Salford (only one person had photographs taken), together with the lack of any reported use of a camera provided in Wakefield, mean that it cannot *currently* be regarded as a cost-effective use of resources.

Importance of awareness-raising about domestic violence

All projects have already identified (in different ways) the importance of work to raise the profile of domestic violence as a precursor to successful project implementation in health service settings. Provision of basic information about the nature and incidence of domestic violence remains important. Given the early stage of many of the projects, it is difficult to make any definitive comparisons between different health professional groups, although there are indications that GPs in particular need to be convinced that domestic violence is an issue for them. Health professionals and the public need to have readily available information on local specialised services for women experiencing domestic violence, and this needs to be presented in a wide variety of formats and locations.

Importance of good partnership working

Good partnership working was influential in the progress made in the four projects. Close working relationships, based on mutual respect, between health organisations and the local specialised domestic abuse services were particularly important, as was a central position for the local specialised domestic abuse agencies in the multi-agency groups steering the projects. The role of these agencies was important for two reasons:

- their approach to empowering women who have experienced domestic violence to take control over their lives; and
- their success in enabling women to improve their health and quality of life, and that of their children.

These findings are close to those of Hague *et al.*'s (2001) analysis of the Canadian experience.

Lack of evidence on criminal justice outcomes

The timescale available for both the projects and their evaluations meant that it was extremely

unlikely that this study would detect criminal justice outcomes. Interviews with women survivors have also indicated that for many women criminal prosecution is not a favoured option.

Lack of robust estimates of cost analysis

The analysis of costs (see Appendix 6) that has been possible in this study cannot be regarded as providing robust estimates. It is likely that the figures present the different interventions in a less favourable light than those that would have been obtained from a longer evaluation period. Because costs per unit are always higher in the period where staff are being trained and new systems introduced, output takes time to build up. Details of cost analysis have been included in Appendix 6 as they may contain some useful information about costs incurred by the projects.

Importance of clear project management structures

The importance of clear project management structures is apparent in each of the projects. For example:

- In Wakefield, the strength of their project management allowed the project to respond flexibly to problems and setbacks as they arose, and to adapt plans to keep the project on schedule.
- In Birmingham, the lack of clear project management structures was one factor contributing to an abortive first set-up stage; a new lead agency in the re-launched project implemented a clear management structure and succeeded in moving to implementation after a relatively short set-up period.
- In North Devon, the lack of project management input was one factor that resulted in the lack of implementation of the originally planned phase II of the project.
- In Salford, clear lines of management accountability allowed re-direction of project staff when initial plans for the sharing of training proved to be unworkable.

Recommendations for practice

- Promote the implementation of systems for routine enquiry in the health service. This will require provision of:
 - adequate training for *all* health staff; and
 - adequate resourcing for local specialised domestic abuse support services. In most cases this can be effected by ensuring resourcing for local Women's Aid-affiliated organisations and, in some situations, Victim Support.
- In view of the advantages of asking *all* women compared to more selective forms of enquiry, efforts need to be made to ensure that in each locality there is a mechanism and setting whereby all women can be reached. These are likely to differ from place to place. Primary health care, and in particular general practice, may provide the best settings for reaching all women.
- In rural and semi-rural areas in particular, consider options for provision of specialised outreach services in health service settings as a way of improving access to specialised services for women experiencing domestic abuse.
- Improve provision of information on specialised domestic abuse services for both public and health professionals, making use of multiple forms of information provision.
- In developing local training for health staff, use should be made of training and resource packs already in existence, including those produced for three of the projects evaluated in this study.

Recommendations for policy

- Ways should be explored of creating a national focus on domestic violence in public

health terms. The prevalence of domestic abuse justifies this, and since improving awareness is an important part of primary prevention, this represents part of the solution.

- Ensure training about domestic abuse is a part of the basic curriculum for every health professional. Such training should include:
 - the nature and extent of the public health problem represented by domestic abuse;
 - how to ask direct questions about experience of abuse;
 - how to respond to disclosure of abuse;
 - providing information on the availability of services for those experiencing abuse;
 - safety planning for those experiencing abuse; and
 - safe documentation of abuse.
- Support the dissemination of guidelines, protocols, resource packs, and training packs, for example via suitable websites. The Home Office should explore ways of making the training and resource packs produced by the Birmingham, Salford and Wakefield projects available for widespread use. Doing so via a suitably publicised website would be particularly cost-effective.
- Ensure the continuing education/professional development for all health professionals includes updates on domestic abuse, in particular on local systems for routine enquiry and local specialist service availability.
- Policy mechanisms need to be identified for ensuring implementation of systems of routine enquiry that reach all women. Options to be considered include a specific national target on DV, introduction into contracts for GPs, and a national service framework on domestic violence.

Recommendations for future research

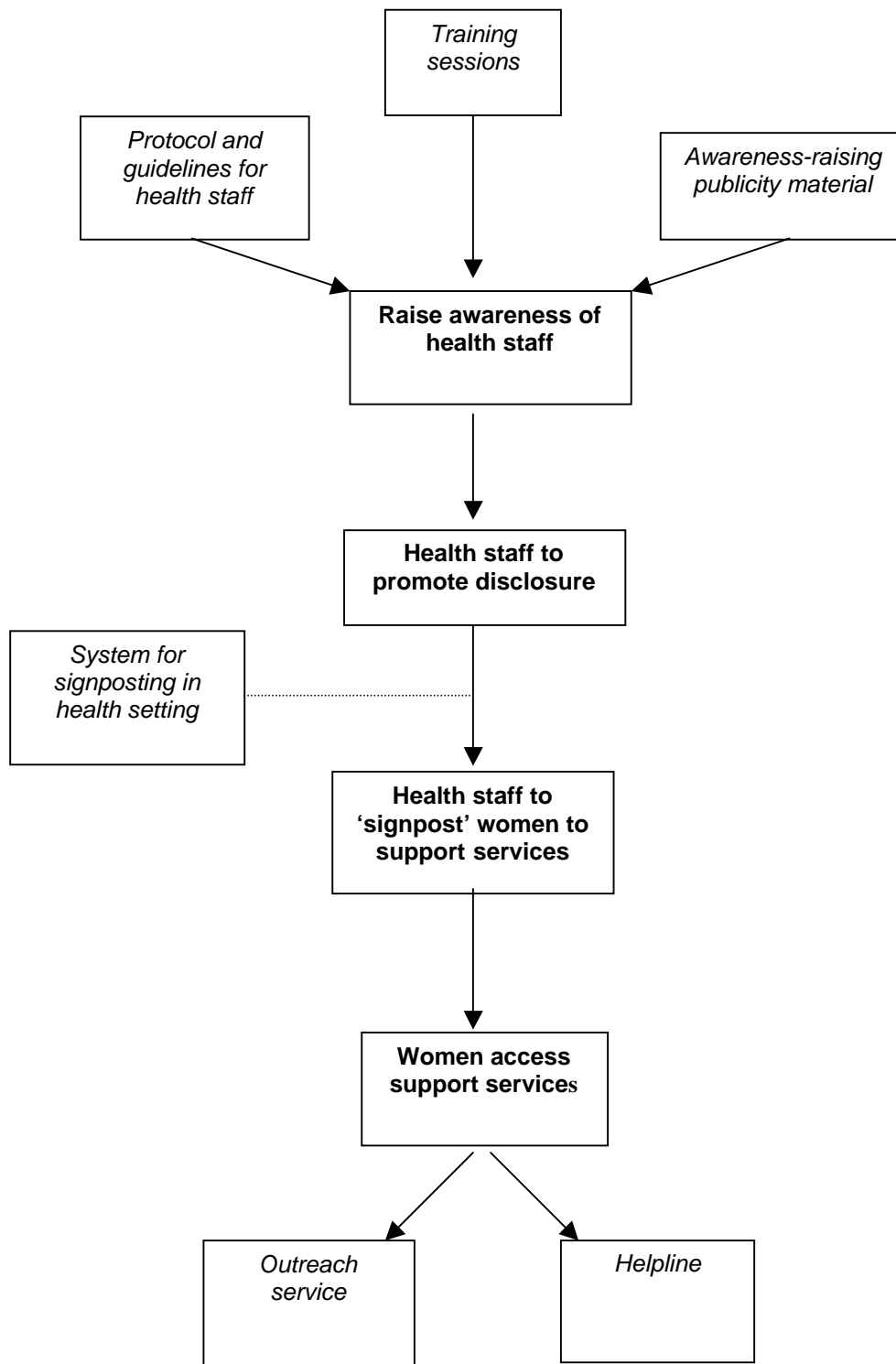
- While this report has concluded that routine enquiry in a variety of health service settings is both feasible and provides the opportunity for women who are being abused to be identified and referred to appropriate support services, there are further questions that remain unanswered about how best to implement this. There is also an absence of robust cost estimates for its provision. That this study could not provide these is largely due to the constraints imposed on the projects and this evaluation, as discussed above. A longer-term study of the implementation of routine enquiry in a variety of settings is recommended. This would include examination of long-term health outcomes for women and children as well as enable a more detailed exploration of the costs of specialised support provision.
- Further research into achieving appropriate documentation of domestic abuse while preserving confidentiality would be valuable given the difficulties in this area identified in the projects.
- There are specific aspects of the different projects that have not yet been fully implemented that would benefit from further research as to their effectiveness; these include:
 - the computer protocol developed in Birmingham;
 - the midwifery link post being implemented in Birmingham;
 - the training video under production in Wakefield;
 - outcomes from the domestic abuse action plan being generated by nursing staff in one of the Wakefield PCTs; and
 - the provision of training in modules which together make up a full day, rather than during a single day.

Appendix A1: The South West Birmingham Domestic Violence Programme

The project was situated in the south west of the city (wards of Longbridge, Northfield and Weoley). These areas are less deprived than other parts of Birmingham. However, uncertainty about the future of local car manufacturing and food production industries and the potential for mass unemployment has added to existing life stresses in this highly urban setting.

Although a Birmingham-wide Interagency Domestic Violence Forum existed, there was no history of the involvement of the health service in domestic violence initiatives in Birmingham. The project, therefore, provided an opportunity for this to be developed.

Figure A1.1: Flow chart illustrating project interventions and project outcomes in the South West Birmingham Domestic Violence Programme



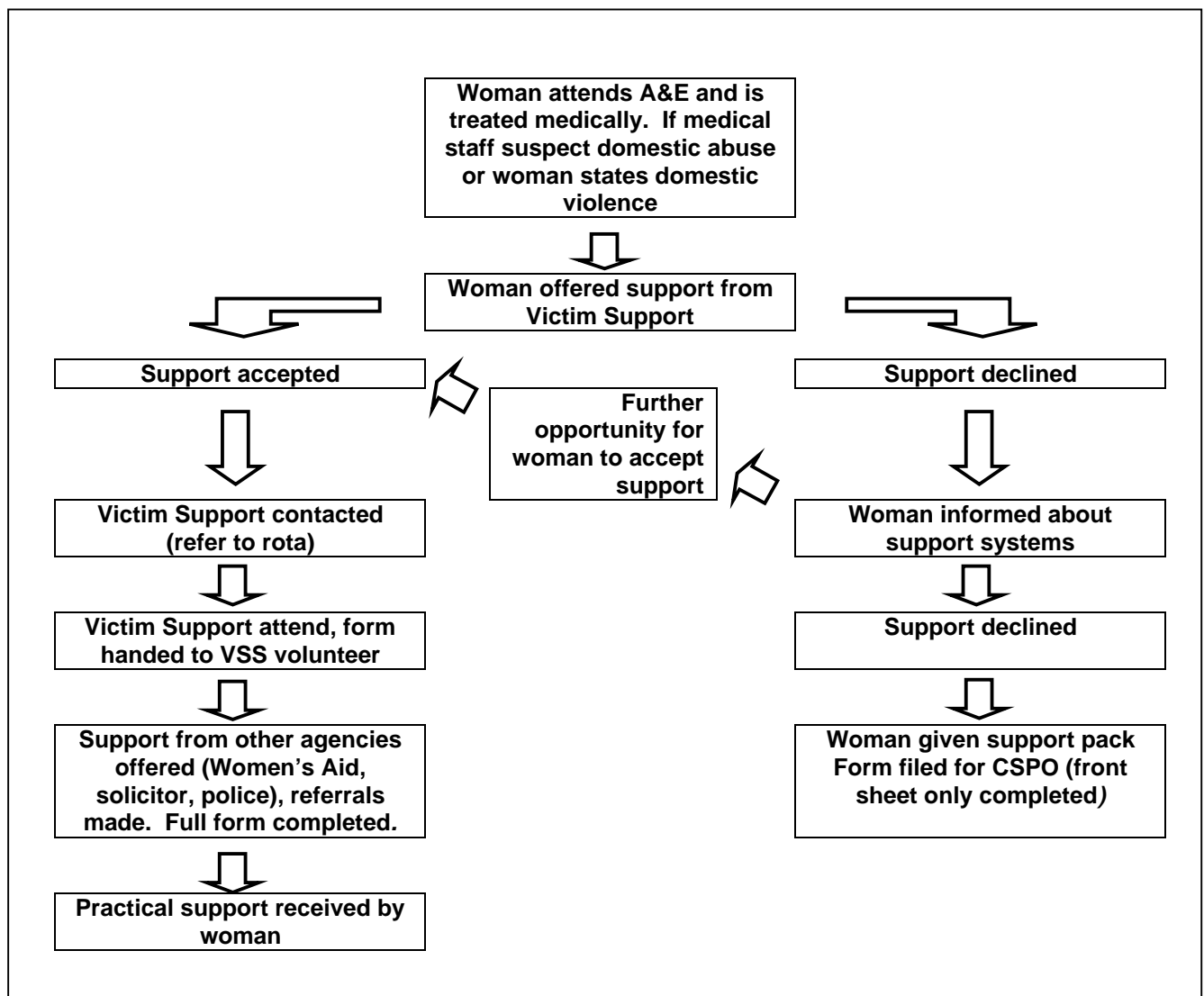
KEY: Project Interventions are shown in *italics*, Project Outcomes are shown in **bold**.

Appendix A2: North Devon and Torrridge Early Intervention Project

This project covered the communities of North Devon and Torrridge. Three of the North Devon wards (Barnstaple Trinity, Ilfracombe Central, and Barnstaple St. Mary's) are amongst the 1,000 most economically deprived wards in England. Gross weekly earnings in Devon have been below the English national average for 25 years (Tearle and Martin, 2001) and a number of rural wards experience low average birth rates, high average long-term illness rates, and high mortality rates (Tearle and Martin, 2001).

Prior to the project, North Devon had an operating refuge, Women's Aid support workers, domestic violence officers, and Victim Support volunteers. However, there was no co-ordination between agencies. Various agencies then organised a Domestic Violence Forum to develop co-ordinated domestic violence strategies, the Early Intervention Project in North Devon being the first cross-agency domestic violence intervention in the area.

Figure A2.1: Flow chart illustrating project interventions and project outcomes in the Early Intervention Project in North Devon and Torrridge



There are two things to note about the protocol:

- It did not include specific guidelines on what to do if the perpetrator was present.
- It does not amount to a comprehensive system of screening for women presenting in A&E. It is important to note that the project did not set out to systematically screen for domestic violence; however, those involved with the project tended to refer to the first part of the protocol as screening.

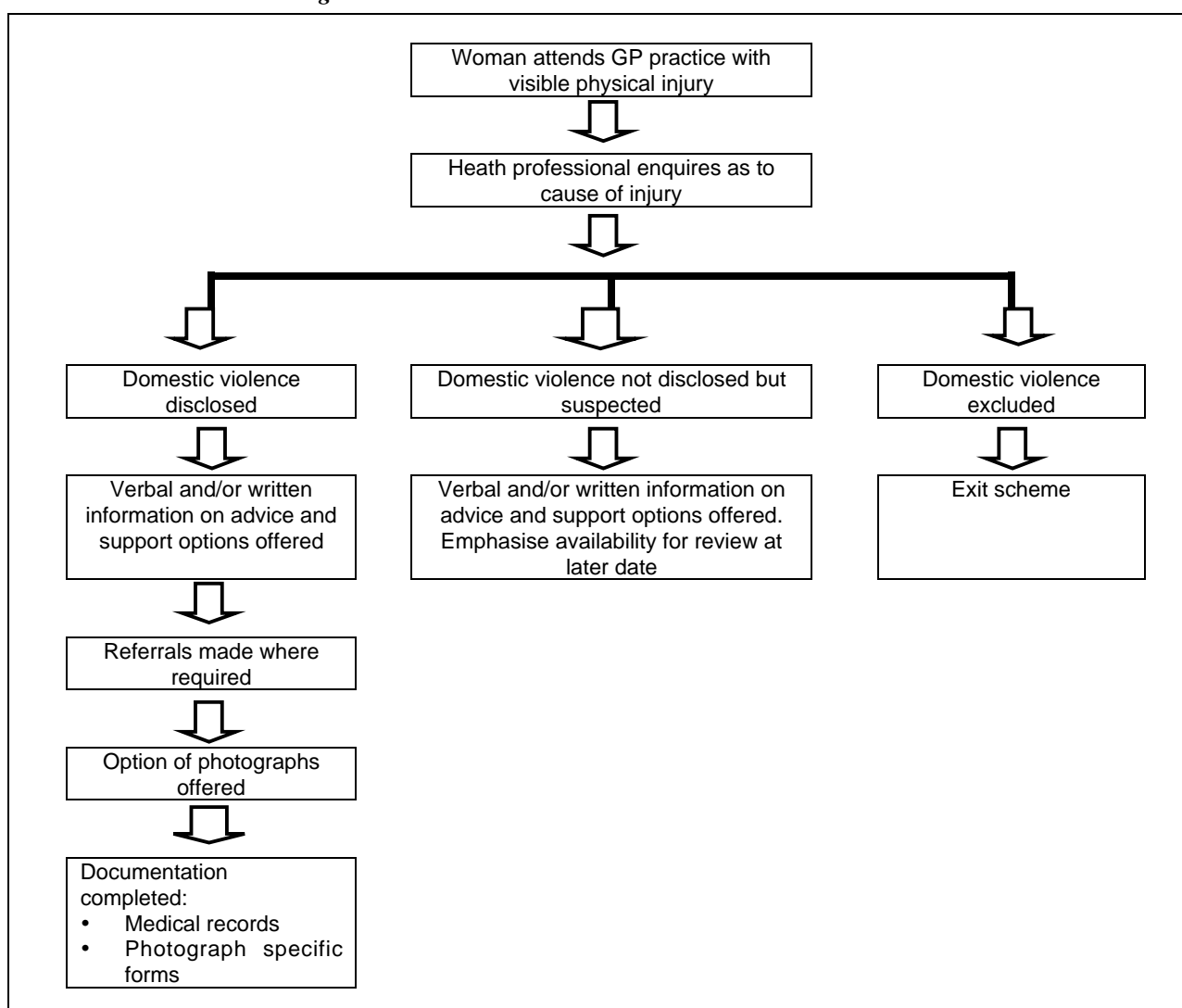
The protocol relies on either staff suspicion of domestic abuse (including emotional as well as physical abuse) and/or a statement by the patient that domestic violence is involved, to trigger support. It does not apply a series of specific screening questions, and can thus only be regarded as a form of selective screening.

Appendix A3: Salford Enhanced Evidence Gathering Scheme

The Salford project was set in an area of high urban deprivation. Long-term unemployment rates ranged from 9.1 per cent to 25.8 per cent (reported in the Salford Reducing Violence Against Women Project Bid, 2000). The area was undergoing widespread urban renewal but social conditions remained a challenge for those living in the city, with Salford being ranked ninth in the scale of most deprived districts by the School for Advanced Urban Studies (1999). Reported figures for personal and property crime, which include violence against women, compared unfavourably with the national average. In Salford the number of reported incidents of domestic violence rose from 5,228 in 1998, to 6,128 in 1999, an increase of 17 per cent (Source: Greater Manchester Police data).

Salford has a relatively short history of inter-agency working on domestic violence issues compared to some of the other sites involved in the Violence Against Women initiative. A Policy Group and a Steering Group, responsible for influencing policy and informing practitioners, were first set up in 1993. Two multi-agency groups were involved in managing the project, the Policy & Strategy Group (PSG) and the Implementation Group (IG).

Figure A3.1: Flow chart illustrating project interventions and project outcomes in the Salford Enhanced Evidence Gathering Scheme

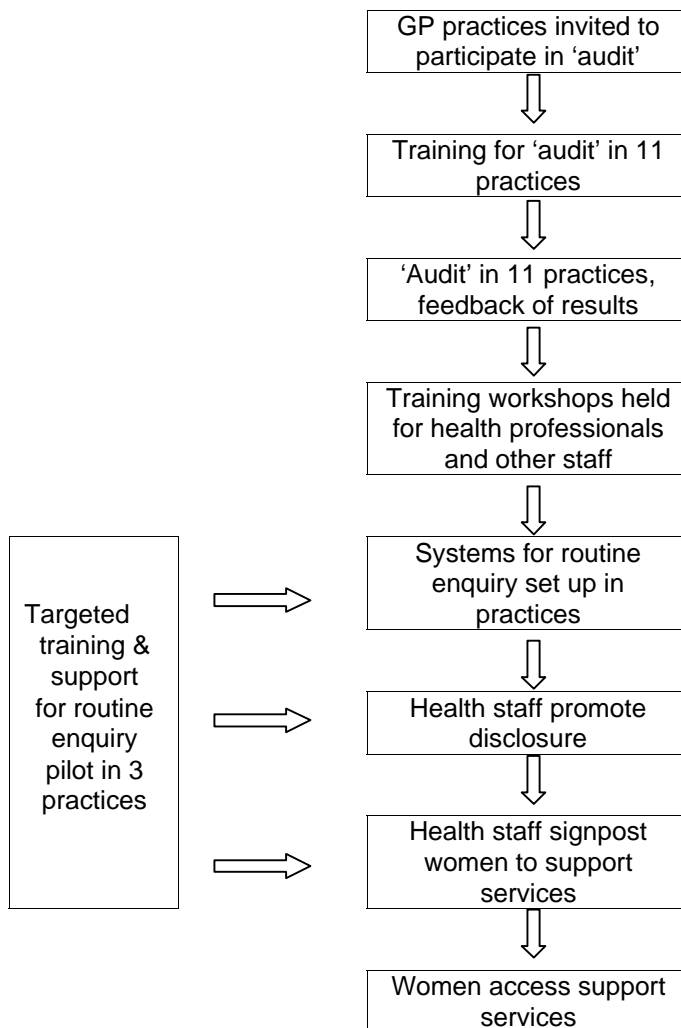


Appendix A4: Wakefield Support and Survival Health Initiative

Parts of Wakefield experience high levels of economic deprivation. Twenty-five per cent of the district's population live in the most deprived ten per cent of wards nationally (Harris, 2002). The Wakefield Community Safety Partnership Crime and Disorder Audit showed that between April 1999 and March 2001, there were 7,170 recorded domestic abuse cases, an average of 3,585 per year (Harris, 2002).

The first Wakefield voluntary sector domestic violence support service, Support and Survival, began in 1995 as a self-help support group for women seeking legal advice through a local solicitor. It is now affiliated with Women's Aid and provides a range of support services to survivors of domestic abuse and the provision of information and advice to agencies. The project staff reported to the manager of Support and Survival. There is also a multi-agency steering group.

Figure A4.1: Flow chart illustrating project interventions and project outcomes in the Wakefield Support and Survival Health Initiative



Appendix A5: The development of the work of the different projects

The background to the health projects was described in Chapter 1. Details of the development work of the different projects are given here.

Birmingham

The management of the project changed and developed during different phases of the work. The initial proposal was submitted by a team including a consultant in public health, the director of Birmingham Women's Aid and a public health practitioner. A programme manager was appointed and an advisory group established. This structure continued for the first eight months, referred to as Set-up, Phase I. The project experienced significant difficulties during this phase. These included:

- the aims of the initial proposal were too ambitious;
- accommodation was a problem from the outset, with no office space having been prepared in the host PCG premises; and
- the lack of progress on the project, compounded by the programme manager's unfamiliarity with Birmingham and with the structure of health services in the city.

The project was re-launched during June 2001 with changes to the management structure to improve the clarity of lines of responsibility and accountability of those involved. One of the outcomes of this restructuring was the emergence of Birmingham Women's Aid as the lead agency in the project.

The first phase of the set-up period ran for eight months, almost half the total funded project time. The second phase of the set-up period ran for four months. Half of this time was spent in re-negotiating the proposal and appointing new project staff. Even given the speed at which this second set-up phase took place, only six months were left for implementing the project.

North Devon

Originally this pilot programme was split into two phases. For Phase I, the project planned to train A&E staff and Victim Support volunteers on the project while raising general awareness of domestic violence. After training, the A&E staff would begin implementing the project protocol.

In the end, Phase I of the Early Intervention Project experienced limited success and the project failed to implement Phase II. This lack of success can be attributed to:

- poor central management;
- poor communication between partner agencies;
- limited training of A&E staff members; and
- an over-reliance on the A&E setting as the only site for early intervention.

There was also a sharp drop in project referrals. Most staff members attributed this to variation in interest in the project, coupled with lack of clear leadership.

Salford

Support and advice on establishing the project was offered by a Home Office-sponsored project developer and this was highly valued by the project staff. Of particular benefit was the wide experience of multi-agency domestic violence work that the developer brought. This was useful at both the policy and strategy level, where the initial development effort was directed, and at the implementation level where the project staff received ongoing support and encouragement in setting up the scheme. The developer's contribution helped project staff feel less isolated in that they had a sense of being part of a wider group of domestic violence initiatives.

However, the project encountered a number of setbacks:

- not all the practices were running the camera scheme for the full six months of implementation time. This was due to a number of factors, including the loss of a key member of staff in the initial GP practice;
- tensions between those introducing the scheme to practices caused further delays;
- time taken to supply the practices with the IT hardware to support the scheme was given as another reason for delay;
- the project plan, which had been to introduce the scheme initially to two practices and then roll out to four, was not followed;
- plans to include a helpline could not be realised due to lack of funding; and
- partnership working proved a huge challenge, with tensions developing amongst the Implementation Group.

The resolution of these tensions and difficulties was achieved by dividing the project into components according to the different objectives and realigning staff responsibilities accordingly. In practice this meant splitting off the camera scheme from the inter-agency work objectives.

Wakefield

The implementation of the project took place in two stages: the 'audit' stage and the routine enquiry pilot. Support and Survival successfully completed both stages. They did, however, face a number of obstacles through the course of implementation:

- difficulty in gaining ethics clearance for the project;
- resistance by health professionals to the project; some saw domestic violence as a 'social issue', displayed a lack of confidence in asking women about it and cited a lack of time and resources; and
- uncertainty over funding continuation.

A key factor in the success of the project was a team that brought together expertise in support work for women experiencing domestic violence with expertise in health service structures and functioning at the practice level, i.e. partnership working at the most operational of levels. The multi-agency steering group brought together agencies that had a considerable history of partnership working in the area. This group was important in helping the project surmount the barriers it encountered, particularly in the early stages.

Common issues

There were a number of issues common to all four projects during the implementation:

- The projects took place during a time of significant structural re-organisation in the health service.

- Despite the fact that domestic violence is a priority for the police, health staff reported their perception that DV is currently a low priority with the police.
- The projects relied on there being a local 'champion' with appropriate authority in each setting. Different rates of progress and achievement both between and within projects are directly related to the existence, or not, of such champions in the health service.
- The nature of inter-agency relationships varied considerably between the four projects, as did the range of partners involved.
- All of the four projects highlighted the importance of achieving close working relationships between health agencies and the specialised domestic abuse agencies for project outcomes to be achieved.
- The lateness of notification of extended funding caused considerable disruption to the projects, as did their short-term nature.

Appendix A6: Cost analysis

The limitations of the analysis of costs

There are particular problems in conducting an analysis of costs on the four projects owing to their developmental nature. This is particularly so for Birmingham, where project interventions were not identified at the start of project funding. In all four projects, considerable start-up times were necessary. This has a number of consequences:

- there are particular problems with obtaining sufficient data on effects for these projects;
- any analysis requires a considerable number of assumptions, a firm basis for which is not available from the data;
- at the end of the evaluation, with the possible exception of the North Devon and Torridge project, the interventions have not had sufficient time to 'bed in' properly, thus making it too early in their life to yield a stable analysis;
- the planned size of some of the projects is also very small (a total target of 20 women using the Salford project for example, with only one achieved), thus again affecting the stability of any analysis; and
- the short set-up period was likely to lead to higher costs per unit of effect than had the projects been implemented over a longer time.

The analysis performed is *not* a full cost-effectiveness analysis. Instead costs are examined in relation to the measures of effects that are available. This includes measurement of the direct costs associated with the projects borne by the different agencies involved. Measurement of indirect costs has been possible to only a limited extent, thus restricting the scope of the analysis of costs and effects. In most cases it has been possible only to use measures of output, rather than outcome; this is again a consequence of short implementation times.

The results of any analysis of costs are thus open to considerable challenge and must be treated with great caution.

Input and cost data

Data were collected by the project staff for the set-up period and then for each subsequent three-month period (quarterly) during the life of the project up to March 2002.

As Table A6.1 shows, with the exception of the North Devon project, the periods for which input and cost data were collected were shorter than those usually expected for a comprehensive evaluation. With any new intervention or service, problems may occur during the initial implementation and take-up is less than it would be in the longer term. This makes the project appear less cost-effective than it would be if data were collected over a longer period.

Table A6.1: Input and cost data collected by projects

	Set-up	Implementation
Birmingham	June – September 2001 ¹	2 quarters
North Devon	June 2000 to March 2001	4 quarters
Salford	November 2000 to September 2001 ² (note 2)	2 quarters ³
Wakefield	October 2000 to March 2001 (note 2)	3 quarters 'audit' 1 quarter routine enquiry
Notes: 1. This refers to the second set-up period for Birmingham. The first, unsuccessful, set-up lasted until May 2001 and is omitted here. 2. Start of the set-up period is taken to be when project staff started in post. 3. The Salford project was implemented in five practices. Only one of these was active for the full six months, the others were active for three to four months.		

Inputs were collected in the following categories:

- staff time;
- training;
- transport;
- equipment;
- publicity;
- overheads; and
- premises.

For each project, the proportion of input attributable to each of the different local interventions was entered as a percentage on the input sheets. From these percentages the cost attributable to each intervention was calculated.

Specific project costs

Provision of Polaroid cameras in GP practices – Salford

The placing of Polaroid cameras in five GP practices in Salford cost £60,000 and resulted in one set of photographs over a six-month implementation period. This cannot be regarded as cost-effective.

Outreach service provision in different settings: GP practices (Birmingham) and A&E (North Devon)

In two of the projects, outreach provision in different settings formed part of the programme of work. In Birmingham, the setting was a GP practice, and the service was provided by a Women's Aid salaried worker, supported by a crèche worker. In North Devon, the setting was the A&E department, and the service was provided by Victim Support volunteers. For the purpose of the calculations of unit cost, the volunteers' time has been costed and included in the calculations. Unit costs, per hour of support delivered are presented in Table A6.2.

Table A6.2: Unit costs for outreach service provision, Birmingham and North Devon

Output measure – hours of support delivered	Number	Cost (rounded to nearest £100)	Cost per unit output
Birmingham ¹	156	£ 7,500	£ 48
North Devon ²	444	£12,900	£ 29
<p><i>Note:</i> Assumptions on which above output cost calculations are based:</p> <p>1. Based on salary of Outreach Worker, Crèche Worker, Management support input of 1hr/week and overheads for 6 sessions per week over 26 weeks</p> <p>2. Includes cost estimates for volunteer time, and uses estimate of number of hours of support derived from interviews with volunteers providing that support over the course of 52 weeks</p>			

The lower unit cost in North Devon is unsurprising given the absence of crèche provision and a lower level of organisational costs such as premises, due to the use of volunteers. It would therefore be realistic to regard the two unit costs as broadly comparable once these different features are taken into account.

Helpline provision (Birmingham)

Provision of a telephone helpline was part of the programme of services provided in only one project, Birmingham; unit cost for this provision was a relatively low £11 per call. It should be noted however, that a helpline is not sufficient by itself to achieve positive long-term outcomes.

Provision of advice, support and information to women (North Devon, Wakefield)

In two of the projects, the component for which costs could be separately identified related to the provision of basic advice and information to women:

- In North Devon, survivor resource packs distributed in A&E to those women that wanted them.
- In Wakefield, basic advice and information given to all women in the course of the survey carried out in 11 practices, and to the women in the routine enquiry pilot.

In North Devon the Survivor Resource Packs cost £117.90 per woman, while in Wakefield, the cost per woman was £89.³³ These figures must be acknowledged to have a high level of uncertainty associated with them. It is also necessary to emphasise that the Wakefield figure should *not* be taken to represent the cost of implementing routine enquiry.³⁴

Training and awareness-raising (Birmingham, Salford, Wakefield)

Training and awareness-raising formed a specific part of the programmes of work in Birmingham, Salford, and Wakefield. Tables A6.3 and A6.4 present unit costs in relation to training sessions, and training packs and other resources respectively.

³³ It should be noted that this figure has been calculated using all the women surveyed during the 'audit' and those in the screening pilot and is not restricted to those that identified themselves as having experienced/experiencing domestic abuse. It was considered more appropriate to calculate a cost per woman rather than a cost per survivor.

³⁴ It is worth noting that the cost of providing a pack to each woman is expected to reduce over time during implementation. This is because the cost of producing the pack remains constant. However, the cost-per-woman reduces as more women are given the pack over time and staff become more experienced with distribution. Our assessment was made after only a short running period for the screening pilot and we would expect costs-per-woman to reduce over longer implementation periods.

Table A6.3: Unit cost for training sessions, Birmingham, Salford, Wakefield

Output measure: number of staff trained	Number	Cost	Cost per unit output
Birmingham training ¹	135	£91,900	£680
Salford training ²	57	£36,000	£632
Wakefield training ³	260	£54,561	£210
Salford fora ⁴	140	£8,000	£57

Note: Assumptions on which above output cost calculations are based:
 Costs include the time for development of the training sessions
 1 & 3. Day-long training sessions, covering general awareness and asking women about domestic abuse (routine enquiry)
 2 & 4. General awareness-raising only, 2-3 hours

The costs shown include the resources (staff time) required to develop the training sessions. It is thus hardly surprising that the project that trained the greatest number of staff experienced the lowest unit cost, as the fixed cost element (development of training) was spread over a larger number of individuals. On average, the Wakefield project provided training for £210 per person. This cost is low in comparison to training courses on offer elsewhere, where fees of £250 and upwards per person per day are common.³⁵

Table A6.4: Unit cost for training packs and other resources, Birmingham, Salford, Wakefield

Output measure	Number	Cost*	Cost per unit output
Birmingham: written guidelines files ¹	344	£47,700	£138
Salford handbook	2,000	£36,000	£18
Wakefield training pack	200	£12,032	£60
Wakefield routine enquiry pack	200	£4,924	£25
Wakefield project reports	500	£14,719	£29
Birmingham: laminated guideline sheets ²	160	£270	£1.70

Note: Assumptions on which above output cost calculations are based:
 1. Based on usage by 315 health staff in GP practices plus 29 files already distributed
 2. It was not possible to identify development cost for this item in isolation, hence unit cost based on reproduction only

Costs for training packs and other resources include the cost required for development.³⁶ It is thus not surprising that unit cost is lowest where volume of production is highest (Salford), as the fixed cost of development is spread over a larger number of units. The scope of the material covered in the Birmingham and Salford packs is roughly the same, and corresponds to that given in the two Wakefield packs taken together.

Routine enquiry

Direct calculation of the cost of implementing routine enquiry in health service settings cannot be carried out from the data collected from the four projects considered here. The main reason for this is that the short length of implementation of routine enquiry in the projects means that information was not gathered on the complete service use history of women survivors following any disclosure at routine enquiry. Further research is needed to address this issue.

³⁵ Examining the inserts on training courses in the Health Service Journal during the month of December 2002 revealed that the *cheapest* fee for a one-day training course was £225 per person per day. This was for a course with a single trainer. The Support and Survival courses always used two trainers.

³⁶ The exception to this is the laminated guidance sheets. It was not possible to obtain a development cost for this item separate from the guideline files, and so unit cost relates to reproduction only.

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