

Domestic Violence A Health Emergency?



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Foreword

Domestic Violence is one of the most serious areas of crime in our society. Within the Foyle area deaths have resulted from domestic violence murder. It accounts for at least 25% of all violent crime reported to the PSNI. In recent years, the Derry City Council area, has recorded the highest reported incidents of domestic violence in Northern Ireland. Foyle Women's Aid over 26 years have provided support and developed services for women and children who survive domestic abuse, committing to the principle that survivors of domestic violence are best placed to inform others to respond to their needs. They seek also to challenge the cultural attitudes and disparate lack of knowledge and resources that enables domestic violence to continue. Domestic violence is a crime that impacts on the physical, emotional and psychological health of many women and their children and has been identified as such by the WHO and BMA.

The A&E research that follows illustrates the consequences for the physical and mental health and emotional well-being of domestic violence survivors who responded including significant physical harm, depression and anxiety. The potential implications of this and other research findings if replicated across the entire Foyle area can only be speculated but indicators are that it would be highly significant given the potential number of hidden victims. Recent research carried out by Derry Well Women found that 713 women identified violence in the home as the issue that was perceived as most important within behaviour and lifestyle health determinants.

We are very grateful to the Investing For Health initiative (WH&SSB), for providing the opportunity to carry out this crucial research.

Foyle Women's Aid has identified healthcare settings as crucial in responding to the needs of those affected by domestic violence. This research, carried out with the general public and staff members in the Accident and Emergency Department of Altnagelvin Hospital provides a clear response in terms of perpetrators and survivors of domestic violence that is capable of transference across all healthcare settings.

Thanks are due especially to Mr Alan McKinney, Consultant, Accident & Emergency Altnagelvin Hospital Trust who provided access and immense support during this research.

Foyle Women's Aid would wish to express their thanks and appreciation also to the research team from Consultancy Mentoring Works who carried out their work within a value base and working principles that are ethical and equitable.

They have produced a quality research document that reiterates the importance of strategic response and resource allocation though out the Foyle Trust and WH&SSB area. With the other members of the Foyle Domestic Violence Inter-Agency Partnership Foyle Women's Aid looks forward to developing a robust strategy and appropriate mechanisms to address domestic violence both for those who survive and those who perpetrate it. We look forward to hearing responses and feedback from all social partners to this document.

Marie Brown
Management Co-ordinator
Foyle Women's Aid

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The Project Steering Group who provided the research team with their experience and expertise. Phil Mahon [Foyle HPSS Trust], Margaret Gallagher [Foyle Women's Aid], Joanna O'Boyce [NIHE] and Caroline Shields [Waterside Health Centre].

The staff and patients in Altnagelvin Hospital Trust A&E Department who participated in the research, particularly the Consultant Mr Alan Mc Kinney and Kathleen Canney of the nursing service. CMWorks wishes to acknowledge the courage and resilience of the domestic violence survivors who completed the profiling questionnaire.

The paid staff and volunteers of Foyle Women's Aid including all those in the refuge and Pathways. Particular thanks are expressed to Marie Brown, Margaret Gallagher, Shauna Houston and Ann Mc Donald who helped to make it all happen.

Brendan Bonner of the Investing for Health programme for his support and the health care managers across all sectors who participated in individual interviews.

The respondents from the advice and information research who agreed to share their views on aspects of the research relating to Accident and Emergency.

Finally, to the women survivors who came forward to participate in focus groups or through the questionnaires to articulate the extent, context and impact of the domestic violence that is perpetrated against them.

Executive Summary

1. Background

The stated role of the WH&SSB is “to improve the health status and social well-being of our population with the resources allocated to us.” [ref WH&SSB website]

The Western Board area serves a population of 282,000 over a geographical area of almost 5000 sq kms. Working in partnership with its partners in primary care and the three local Trusts. One of those Trusts, Altnagelvin Hospital provides acute hospital services to the local community and also on an area and sub-regional basis.

Investing for Health is a government initiative that contains “a framework for action to improve health and well-being and reduce health inequalities which is based on partnership working” [Ref Investing for Health 2002]

The foreword in the Investing for Health government policy document states that:

“Investing for Health has the potential to improve all our health and, in particular that of those groups at greatest risk”
[ref pg 3]

Two primary Investing for Health objectives are:

To promote mental health and well being at individual and community level.

To offer everyone the opportunity to live and work in a healthy environment.

These two objectives provide the cornerstones for the commissioning, conclusions and recommendations of the research that follows.

Women’s Aid, as the lead agency responding to domestic violence in the Foyle area, proposed that within the context of domestic violence these objectives are inexorably linked to an improvement in health care services for domestic violence survivors based in a clearer picture of the nature and extent of domestic violence for all social partners, including statutory Care providers.

The Consultant in Accident and Emergency [A&E] in Altnagelvin Hospital is also committed to the continuous development of services for domestic violence survivors within A&E.

Foyle Women's Aid had also identified that an increasing number of professional women, including those employed by statutory health employers were seeking support for the domestic violence that they were experiencing.

Consequently, Foyle Women's Aid submitted a proposal to the Investing For Health Action Research Grants programme.

The primary purpose of the research proposed and commissioned by Foyle Women's Aid and funded by the Investing For Health Programme **was to investigate the context of domestic violence within the accident and emergency department of the Altnagelvin Hospital.**

The aims of this research were:-

- Investigate the extent of the experience of domestic violence presented in A&E amongst patients, staff and their family members.
- Carry out a Skills and Knowledge Audit of A&E staff responding to domestic violence.
- Identify the health information and referral needs of victims and the professional support needs of staff in relation to domestic violence.
- Make recommendations to support Health Trust employers, multi-disciplinary and inter-agency working.

2. Methodology

A Research Steering Group was established comprising staff from Foyle Women's Aid, a number of their social partners with specialist knowledge in health care and accident and emergency work and the research team leader.

Agreed terms of reference were drawn up based on the primary aims of the research proposal outlined in the previous section. Given the nature of the research focus, the healthcare setting and the safety needs of domestic violence survivors, a number of ethical considerations were discussed and resulting protocols and practice put in place.

A Multi-strategy research framework was designed in consultation with the project steering group within the areas of research respondents, instruments and process.

Research Respondents were as follows:

- Patients or those who accompanied them presenting at A&E for a period of one week.
- Staff who worked in the A&E Dept. Opportunities were provided for administrative, ancillary, medical, nursing and other healthcare and social services staff to respond.
- Women's Aid staff individually, and groups of refuge team staff and volunteers.
- 14 healthcare managers from the statutory, voluntary and community sectors.
- Advice and information staff and public population respondents from parallel research commissioned by Foyle Women's Aid.

A range of research instruments were designed and implemented to enhance validity and reliability as well as data collection purposes

Self-completion questionnaires were designed to gather quantitative and qualitative data from staff and patients.

A schedule of focus groups was carried out based on the need to include inter-agency and uni-disciplinary work and to access women survivors at different stages of their journey in relation to domestic violence.

Secondary data was searched for comparative purposes and to source models of best practice.

3. Findings

- 104 people [80 women and 24 men] completed the self-reporting domestic violence profiling questionnaire in the Altnagelvin Hospital A&E department. Their demographic profile showed them to be diverse in age, geographical location, religion and employment status. Minority communities of interest in terms of disability, sexual orientation and ethnicity were under represented.
- 27 women and no men among the respondents had experienced at least one form of domestic violence. This is a ratio of approximately 1:4. A further 25% of respondents knew of at least one person who had experienced some type of domestic violence.
- Although only five staff members returned the domestic violence-profiling questionnaire four of the women staff members are domestic violence survivors.
- One health manager [outside of A&E] was aware of a domestic violence perpetrator among the staff.
- Despite the extent of the violence recorded only 13 women considered identifying themselves as domestic violence survivors.
- A total of 408 separate forms of domestic violence were identified with a ratio of four incidents per respondent and a resulting range of physical injuries.
- The impact of domestic violence upon mental health and emotional well-being was significant with high levels of depression and anxiety experienced. A third of the women had had to take time away from work as a result of their injuries.
- Within the total domestic violence survivor respondents within the A&E and the general population research 12 women had made a suicide attempt as a result of domestic violence.
- Some women commented on their concern about the lack of understanding among some mental health professionals in regard to domestic violence, particularly to the prescribing of tranquillisers and anti-depressants.

- A consensus driven quality assessment tool was used as a framework to monitor and review the response to domestic violence within A&E in the Altnagelvin Hospital. The categories for review were:

Policies and Procedures
Physical Environment
Cultural environment
Training
Screening and Safety Assessment
Documentation
Intervention Services
Evaluation Activities
Collaboration

- Given the prevalence of domestic violence the findings, conclusions and recommendations need to be inclusive to healthcare settings beyond the A&E Department.
- There was inconsistency among the perceptions of staff as to the existence of the domestic violence policy in the hospital and therefore also in the levels of self assessed confidence in implementing it.
- There is no domestic violence policy currently operating in any healthcare setting among those researched including Board level with the exception of Foyle Women's Aid, which is currently under review.
- There was universal agreement among all respondents on the need to display posters and/or brochures related to domestic violence in the A&E area.
- It was suggested that domestic violence information should be included in general health information booklets being produced on issues such as smoking and healthy living. In this way a survivor or perpetrator could access support information without identifying themselves as such to other people in a shared environment.
- The nature of the emergency environment of the A&E Department has implications for staff and patients and for both survivors of domestic violence and those who support them within that environment.
- Staff self-assessed levels of confidence and competence in relation to domestic violence illustrated a disparity between identifying the signs of domestic violence, and a knowledge and understanding of the subject. A&E staff were less confident in identifying physical, emotional and mental signs than they were in their appreciation of the knowledge and understanding around the issue of domestic violence in general.
- Attitudes about domestic violence were more clearly defined. A total of 11 staff [78.57%] selected that they believed that a patient should be asked about domestic violence 'when you or others have a suspicion'. A further 2 staff [14.28%] preferred that the question be 'asked each time in a range of settings'. Only one staff member believed that it should be left to the patient to disclose.
- Among the A&E staff that responded to the staff audit questionnaire, only 6 out of the 14 said that they had received training on domestic violence. When then asked about the amount of time that had been given on the subject, 3 responded by saying that they had attended a half-day course, 1 had received training over two days, whilst the remainder had either voluntary counselling service training or 'less than ½ day' training.
- A wide range of differing opinions were voiced in regard to the issues of a mandatory universal screening policy on domestic violence with a consensus majority among the total population that the adult should only be asked when an A&E member is suspicious of domestic violence. However the A&E consultant and Women's Aid staff were in agreement that universal screening is the only way to determine the extent of domestic violence in A&E and to provide an opportunity for women to disclose. Women survivors more concerned with how and when the question was asked and reassurance about what would be done with the information if they did disclose following screening questions.
- Research by others showed that universal screening significantly raised the detection rate of domestic violence but needed to be maintained to continue to be effective.
- The prevalence and use of an instrument to record known or suspected domestic violence cases was also explored. Within the context of the A&E Department in Altnagelvin Hospital the particular issues addressed in focus groups or interviews were the use of cameras and body maps in particular with some reference as well to coding or recording domestic violence. Comments were made that any body mapping or photographs taken had to be presented within in an informed context for victims and those who assist them. Ethical and equality concerns with

- confidentiality and data protection were also explored.
- There are a number of reasons why intervention needs to be understood within the context of domestic violence. Domestic violence is recurrent and tends to become more frequent and severe over time. Early intervention can help prevent traumatic injuries, and potentially suicide and murder. Secondary data analysis suggests that intervention needs also be placed within an ethical and equality frameworks that enables a consistent standardised approach to be adopted. A need was identified for a sensitive yet robust risk assessment tool needed to be designed for local use accompanied with staff training in safety planning.
 - The Delphi programme resourced provides a quality assessment tool that addresses the strategy and the specifics of a response to domestic violence. The A&E Consultant felt it would prove an effective template for future working. It would transferable as a quality assessment tool in a number of settings.
 - Regardless of the proactive response of the A&E Department of Altnagelvin Hospital led by the Consultant Mr Alan Mc Kinney, there a need for a collaborative integrated response to domestic violence to be planned and implemented at all levels and healthcare settings throughout the WH&SSB area.
 - Opportunities to live and work in a healthy environment are eroded. For many victims of domestic violence whether this means having to leave their home to ensure their safety or to be absent, leave, or be unable to take up employment to meet their social and economic needs.
 - Five members of A&E staff [all women] returned a response to the domestic violence profiling questionnaire, 80% [four out of the five] were domestic violence survivors. This represents approximately 11-14% of the average number of the A&E staff. If this prevalence subset was to be replicated among all staff in the WH&SSB area based on current staff numbers of approximately 8,000, the potential transformation analysis would be a highly significant number of staff members who are victims of domestic violence. The number of perpetrators is more difficult to estimate.
 - 12 out of 14 health service managers across sectors and disciplines in the Western Health and Social Services Board (WH&SSB), who took part in the structured interviews, indicated that they were aware of staff or colleagues who had experienced domestic violence. One manager was aware of a staff member who had experienced domestic violence.
 - The woman staff survivors had experienced many of the forms of violence experienced by other respondents. They have also experienced a considerable impact upon their mental health and emotional well-being.
 - Interviews with a range of health managers across all sectors showed that while individually they were committed to responding to domestic violence and the welfare of their staff, many had never considered one in relation to the other.
 - The social and economic costs of domestic violence to individuals, to the public purse and within the workplace have yet to be fully realised but there is clear evidence that it affects productivity and may result in employee absenteeism and stress. However, a response to this will be affected by the awareness of domestic violence among employers and the presence (or absence) of a domestic violence policy that is inclusive of employees.
 - Perpetrators of domestic violence in the workplace may also mean a misuse of organisational resources or the employer being brought into disrepute and/or there may be increased risk to workplace safety that threatens the safety of all.
 - Women experiencing domestic violence are especially vulnerable when they are at work because once a woman attempts to leave an abusive partner; the workplace often becomes the only place she can be located and harmed.
 - There is a need for training around dealing with a broad range of issues for staff, particularly for managers. This should include input about identifying and supporting victims and indeed perpetrators of domestic violence.
 - The research has direct implications for the strategic planning and policy response of the WH&SSB.

4. Conclusions

The primary role and responsibilities of the WH&SSB are:

“to improve the health status and social well-being of our population with the resources allocated to it” and to:

- Identify health and social care needs.
- Buy services from a range of providers.
- Monitor the provision of services.
- Undertake important statutory responsibilities relating to, for example, public health and the care of children.

This research has significant implications for the WH&SSB and for the Investing in Health programme.

The research also has significant implications in regard to primary Investing for Health objectives including:

To promote mental health and well being at individual and community level.

To offer everyone the opportunity to live and work in a healthy environment.

These two objectives provided the cornerstones for the commissioning, conclusions and recommendations of the research that follows.

The research placed a response to domestic violence firmly within the statutory requirements of Section 75 of the Northern Ireland Act 1998 [and the Human Rights Act [N.I. 2000].

Issues such as User involvement, Promoting Social Inclusion, New TSN and NAPs should be outward facing to address and integrate the issue of domestic violence.

Other public and private law emphasises the need for domestic violence to be recognised fully as a statutory obligation by public and statutory bodies.

Unless domestic violence is placed within the context of Equality and Human Rights across all sectors, the correlation with statutory responsibilities and moral obligations will be at best minimised, at worse ignored.

There is confusion and lack of clarity about the presence of a domestic violence policy across most health care settings. Any policy needs to be placed within a strategy plan. There was no evidence of a domestic violence strategic plan at any level of health planners and providers within the Western Board area to respond to the physical and mental health needs of adults and children who are vulnerable and at risk as a result of domestic violence. Some individual managers are aware of the issue and are working towards a domestic violence policy, within their own setting.

A domestic violence strategy and policy that can be adapted for different healthcare settings is essential to inform decision-making and service development. The resource and expertise of the Foyle Domestic Violence Inter-agency Partnership could be utilised to support the strategic plan and policy development in all settings.

The issue of dedicated staff within A&E or the wider hospital setting responding to domestic violence has to be made within the context of its local setting. This has been demonstrated in other A&E Departments that have initiated pilot similar schemes.

Other discussion needs to be concerned with deciding if a dedicated person is needed to co-ordinate domestic violence policies and procedures etc throughout the hospital and to represent the Altnagelvin Hospital Trust at the Domestic Violence Inter-agency Partnership or to target resources first at front line intervention, particularly in A&E.

Protocols for staff to follow when they suspect or identify domestic violence or when a perpetrator is present are essential for staff training. The use of posters and charts made visible for use by all staff would ensure consistency of approach and enhance the support for the survivor.

Foyle Women's Aid either independently or in partnership with others have a wealth of resources for domestic violence survivors. These include leaflets on domestic violence for minority ethnic groups. Other agencies also offer support services for male victims, including accommodation and intervention programmes with perpetrators. It might be useful for the Foyle Domestic Violence Inter-agency Partnership to collate and review these materials from all social partners and to share the resources with the A&E Department.

The Investing for Health initiative may also wish to consider a review of the health materials provided within its own programmes and those of other health related events within the Western Board area. A domestic violence promotional campaign linked into other aspects of health information might be considered in the future, in partnership with local domestic violence fora in the WH&SSB area.

Foyle Women's Aid and other agencies need to provide referral information that is regularly updated.

Issues concerned with the cultural competence of staff were not addressed specifically in this research. However they provide a central theme of the advice and information research commissioned by Foyle Women's Aid. [Ref Whitehorn and Stubbings 2003].

Privacy, confidentiality and a space to recover, albeit temporarily, are determinants that may encourage domestic violence survivors to either disclose or seek support. The physical and environmental constraints of the A&E department in Altnagelvin Hospital are recognised. Any change can only happen within the parameters of what is considered feasible and achievable by those who work there and manage that environment.

It is difficult given that only 40%-47% of available staff responded to the audit questionnaire to accurately assess the skills and capabilities in A&E in Altnagelvin Hospital in relation to domestic violence. Non-completion of questionnaires may indicate a lack of individual awareness of the importance of the issue for A&E staff, a hectic working environment where questionnaire completion is a luxury or for a range of other reasons. This research can only be based on fact and not assumption and the conclusions in this section reflect that.

Attitude plays a significant role in the perception and understanding of domestic violence issues. Results from the questionnaires highlights that in addition to evaluating confidence and competence levels within a professional role, there is also the need to address the cultural competency of the individual which is an intrinsic contributor to thoughts and opinion formation,

A study by Bokunewicz and Copel showed that emergency nurses had changed their attitudes after a 60-minute presentation on the cycle of violence theory [Ref Bokunewicz and Copel 1992] there is an inevitable link between attitude, beliefs and behaviours. Any attempt to influence a proactive response and to dispel myths about domestic violence is more likely to occur either in formal training or discussion. Opportunities for both needs to be created. Foyle Women's Aid should consider designing and implementing attitudinal questionnaires prior to and post domestic violence training. The 'attitudinal statements' in the questionnaire could also be used to inform training structure and design.

Previous research has suggested that access to domestic violence training has a significant impact on both patients and healthcare staff.

There is, as in all health and social care settings a clear need to identify training needs and to develop a training plan within each setting or disciplinary area that will enhance the skills, knowledge and understanding of those who assist those affected by domestic violence.

Models of best practice and competence-based training are available to inform any future strategic training intervention that extends beyond the needs of A&E staff only. Foyle Women's Aid should consider using the opportunity provided by their Interagency Domestic Violence Partnership to develop competence based training and to pilot this with a range of staff across all sectors.

The issue of universal screening is one that results in much discussion. The implications when screening and safety assessment is left to individual choice, experience, expertise [or lack of it], is immense. However if it is to be introduced it needs to do so within a framework of adequate support for staff including training, recording systems, peer review, monitoring and the commitment of management to the issue.

The amount and type of information recorded and the mechanisms to do so need to be carefully considered in terms of ethics and equality. However, staff and ultimately domestic violence survivors need to be informed of the benefits of recording injuries. Any systems devised have to be realistic and achievable within the A&E Department to be effective.

Given the context of domestic violence and the impact upon the physical and emotional well being and mental health of victims the consequences of non-intervention need to be clearly understood by staff in other health and social care settings as well as A&E.

Collaborative partnerships with Women's Aid and the range of social partners within the Western Board area would greatly enhance the effectiveness of the support available for those affected by domestic violence.

The development of a robust assessment tool for support planning purposes could also be undertaken within a domestic violence task force in the Western area and disseminated to best benefit staff and service users alike.

Collaborative partnerships, the use of the User Involvement Forum, mapping exercises and the auditing of strategic objectives in relation to domestic violence would ensure that the overall service for those affected by domestic violence is effective, efficient and equitable. This needs to be extended beyond A&E.

The research found anecdotal and research evidence of the presence of perpetrators of domestic violence in healthcare settings. 4 women [approx1:10] of the A&E staff numbers identified themselves as domestic violence survivors.

There is an urgent need for employers and managers in the WH&SSB to consider the prevalence of domestic violence among their staff. For the true extent of the issue to be realised further research is required among staff in all HPSS Trusts, programmes such as Investing for Health and Health Action Zones and other identified health and social care initiatives.

Recommendations follow for all primary stakeholders. Suggestions for further action and activities are included in detail in the main research document.

5. Recommendations

- WH&SSB Board (supported by the Foyle Domestic Violence Interagency Partnership and the Sperrin and Lakeland Interagency Forum) produce and promote a cohesive domestic violence strategy to improve services for all those, including staff, who are at risk or vulnerable as a result of domestic violence in the Western area.
- The integration of domestic violence into all aspects of statutory duties and moral obligation be addressed in action with regard to healthcare planning, public policy, decision making and service development in the WH&SSB Board area. Review impact assessment tools need to be devised and implemented as for other equality and human rights issues.
- More opportunities need to be created by primary stakeholders, including all those involved with health prevention and promotion programmes, to enable perpetrators, survivors and the wider community to understand what domestic violence is.
- The A&E department of Altnagelvin hospital should consider using these findings to plan the next stage of their response to domestic violence.
- Foyle Women's Aid and the Foyle Domestic Violence Interagency Partnership review existing resources and promote models of best practice
- Disseminate findings of the childcare social audit and its' potential use to measure social capital and outcomes of social objectives.
- Seek funding for further research to assess and respond to the physical and mental health and emotional well being needs of children and young people affected by domestic violence.

- The Investing for Health programme should consider the implications of this research in terms of their key objectives to promote mental health and a safe and healthy environment in which to live and work

The Investing for Health programme needs to urgently respond to the findings of this research in regard to the impact of domestic violence on the mental health of survivors, mainly women.

The Report

1. Background

The stated role of the WH&SSB is “to improve the health status and social well-being of our population with the resources allocated to us.” [ref WH&SSB website]

The Western Board area serves a population of 282,000 over a geographical area of almost 5000 sq kms. Working in partnership with its partners in primary care and the three local Trusts. One of those Trusts, Altnagelvin Hospital provides acute hospital services to the local community and also on an area and sub-regional basis.

The foreword in the Investing for Health government policy document states that:

“Investing for Health has the potential to improve all our health and, in particular that of those groups at greatest risk”
[ref pg 3]

Two primary Investing for Health objectives are:

To promote mental health and well being at individual and community level

To offer everyone the opportunity to live and work in a healthy environment.

These two objectives provide the cornerstones for the commissioning, conclusions and recommendations of the research that follows.

Women’s Aid, as the lead agency responding to domestic violence in the Foyle area, proposed that within the context of domestic violence the promotion of mental health and well being meant implementing specific actions that relate to the improvement of services for domestic violence survivors and the building of a clearer picture of the nature and extent of domestic violence as a health and social care issue.

- In the United Kingdom 1 in 4 women will experience domestic violence from a male partner in their lifetime. [ref Dominy N. and Radford L, 1996]
- On average 1 woman is killed every 3 days in England by their current or former male partner. [Ref Stanko Prof .E.[2000]
- Between April 2001 and March 2002 the police in Northern Ireland attended 14,788 domestic violence incidents.
- Women’s Aid groups throughout Northern Ireland supported 1,174 women and 1,412 children and young people over the same period.
- The Women’s Aid Regional 24 hour help line in Northern Ireland responded to 15,640 calls relating to domestic violence.

The Consultant in Accident and Emergency [A&E] in Altnagelvin Hospital is also committed to the continuous development of services for domestic violence survivors within A&E. It is recognised that service development is best based on baseline indicators that enable an understanding of the extent and context of the identified need. (Whitehorn and Stubbings 2003).

A need was identified therefore to establish indicators related specifically to domestic violence among patients and their families who present at the A&E Department of the Altnagelvin Hospital.

Preliminary investigation, their experience and anecdotal evidence gathered by Foyle Women’s Aid had indicated that there was also a clear need to investigate the context of domestic violence not only among those who are the service users of personal health and social services but among staff themselves in order to assess their health and safety needs.

Recent guidelines produced by Women’s Aid [WAFE] and Opportunity Now [an initiative of Business in the Community and Employers Committed to Women] clearly articulated the relationship between the workplace and domestic violence.

“ The role of the WH&SSB is to improve the health status and social well-being of our population with the resources allocated to us”

(WH&SSB Annual Report 2001-2002)

“Investing for health contains a framework for action to improve the health and well-being and reduce health inequalities which is based on partnership working.”

(Investing for Health 2002)

While the guidelines refer to business and productivity, the need to address the issue of domestic violence is even more crucial in a sector that is concerned with the health and well-being of individuals and groups within the wider community.

Consequently, Foyle Women's Aid submitted a proposal to the Investing For Health Action Research Grants programme.

The primary purpose of the research proposed and commissioned by Foyle Women's Aid and funded by the Investing For Health Programme **was to investigate the context of domestic violence within the accident and emergency department of the Altnagelvin Hospital.**

1.1 Research Aims

The aims of this research were to:-

- Investigate the extent of the experience of domestic violence presented in A&E in Altnagelvin Hospital amongst patients, those who accompanied them and staff.
- Carry out a Skills and Knowledge Audit of A&E staff responding to domestic violence.
- Identify the health information and referral needs of victims and the professional support needs of staff in relation to domestic violence.
- Make recommendations to support Health Trust employers, multi-disciplinary and inter-agency working.

These aims provide the framework for the research design.

“For those experiencing domestic violence, it may affect their productivity, emotional and physical health and well being and they may also face increased risk of workplace violence.

However, the workplace is also one of the many places in which abused women can access help and support. If there are perpetrators of domestic violence in the workplace, this may also affect the business costs and productivity and workplace safety.

It is therefore crucial that domestic violence is seen as serious, recognisable and preventable and an important issue for business that cannot be ignored.”

[Ref pg 21]

2. Methodology

A Research Steering Group was established comprising staff from Foyle Women's Aid, a number of their social partners with specialist knowledge in health care and accident and emergency work and the research team leader.

The Steering Group key purposes were:

- To establish and agree the terms of reference.
- To provide ongoing support and a point of reference for the research team.
- To negotiate access and ethics.
- To comment on research design.
- To provide feedback for the draft report.

Agreed terms of reference were based on the primary aims of the research proposal outlined in section one.

A series of key questions were postulated that related directly to the research aims and identified concerns. These were used as the framework for the research findings and conclusions.

- What is the experience of domestic violence among patients and staff in the A&E Department Altnagelvin Hospital?
- What are the physical and emotional health and information needs during and immediately after presentation at A&E?
- What are the skills and knowledge capabilities of staff responding to domestic violence?
- What are the protocols, screening and training requirements of A&E staff responding to domestic violence?
- What is the impact of domestic violence on the emotional health and safety of staff and the implications of the findings for employers in the Health Service?
- What are the implications of the research findings and recommendations for all communities of interest including service users, the A&E Department, Inter-agency and uni-disciplinary agencies and all those concerned with the health and well being of those affected by domestic violence.

A series of key questions were postulated . . . these were used as the framework for the research and conclusions.

2.1 Design and Implementation

A number of other aspects had to be considered in designing and implementing the research methodology.

A considerable amount of research has already been carried out in terms of health and domestic violence in general, and specifically in relation to A&E. While a definitive account of the state of that research has not been produced here it has been used to inform methodological design and data analysis for comparative purposes. A catalogue of secondary data reviewed for research purposes is contained in the appendices. The research team would wish to acknowledge and thank the interagency and information staff in Women's Aid locally in Foyle and regionally in Northern Ireland Women's Aid Federation [NIWAF] as well as the NIWAF Help Line Co-ordinator. They all contributed to the collection of domestic violence research and documentation that has informed research design, conclusions and recommendations.

A key aspect of any research is the recommendations made to inform future policy and practice. In this research it is with the intent to secure a quality response for all those excluded and disadvantaged by domestic violence. The research team considered that in order to maximise the effectiveness and efficiency that a search would be undertaken regionally, nationally and internationally to find models of best practice. These would be used to provide specific samples or signposting for others to inform their future work. This involved a search and analysis of existing health care interventions in books, protocol manuals and guidelines. Extensive use was also made of Internet resources to access international material. In order to share the 'best' of what was found a separate section has been included to signpost access for individuals and organisations wishing to respond proactively to the recommendations.

Given the nature of the research focus, the healthcare setting and the safety needs of domestic violence survivors, a number of ethical considerations were discussed and resulting protocols and practice put in place.

- Discussion was held with the A&E Consultant and nursing staff to obtain agreement in principle, to address the issue with the hospital ethics committee and to ensure that the research did not disrupt working life in the Department. The Director of Health Care on the Foyle Health and Social Services Trust also agreed to keep the Foyle Trust ethics committee informed. The Foyle Inter agency Partnership was also informed prior to the research starting and in a focus group of the purpose and procedures of the research.
- All participants were informed that the information they gave would be used for research purposes in the public domain but that as individuals their confidentiality and identity would be safeguarded.
- Protocols to access women survivors who use the services of Foyle Women's Aid were agreed and focus groups carried out in a safe environment of their choice. For other non-survivor respondents arrangements were made to take account of other equality considerations e.g. a range of diverse community settings, one in Disability Action premises and were necessary in the respondents own work setting e.g. A&E Department and Community Health projects.
- Foyle Women's Aid also agreed to be available in the A&E department during office working hours in the event that the questionnaire completion meant that any of the respondents required emotional support.
- An ethics statement was provided to inform all participants. A complaints procedure was put in place and included in the information to participants. This was not used by any respondents.
- The research team leader was aware of her previous working experience and knowledge of domestic violence and the need therefore to be aware of any 'bias' in recording or interpreting information. Therefore a series of questions was agreed with the Steering Group for use in individual interviews and focus groups and responses were recorded on tape and paper versions. A draft version of the research report was presented to the Steering Group and two external readers for comment before final presentation.
- Participatory research methods based upon feminist values are embedded within the practice and process of the research team and its' commissioning client Foyle Women's Aid. Consequently a principal concern of the research team was to seek to secure the perspective of all those participating in the research to ensure their voices were heard and to develop a high degree of rapport between individuals and groups and the research team.

Feminist values are embedded within the practice and process of the research team and its' commissioning client, Foyle Women's Aid.

2.2 Research Design

A Multi-strategy research framework was designed in consultation with the project steering group within the areas of research respondents, instruments and process.

Research Respondents identified initially were as follows:

- Patients or those who accompanied them presenting at A&E for a period of one week.
- Staff who worked in the A&E Dept. Opportunities were provided for administrative, ancillary, medical, nursing and other healthcare and social services staff to respond.
- Women's Aid staff individually, and groups of refuge team staff and volunteers.

The number of research respondents was expanded as the research progressed.

Early on in the process, the research team leader expressed concerns to the Steering Group about:

1. The extent to which staff in A&E would respond to the domestic violence profiling questionnaire. The A& E Dept is a busy place with little spare time for completion. Any domestic violence survivors in the staff might be reluctant to complete the form in their own work setting.
2. Given the context of domestic violence in the workplace it might be necessary to identify the context of domestic violence among staff with health care managers across all sectors in the Foyle area.
3. While the primary focus of the research was A&E, there was a need to try and place this within a cohesive healthcare context. There was an identified need to look at 'pathways' to health care following attendance at A&E.

As a result individual interviews were added to the schedule with healthcare managers from the statutory, voluntary and community sectors.

Foyle Women's Aid was also carrying out another piece of research in the wider community concerned with advice and information requirements relating to domestic violence. It was decided therefore that an opportunity was available for the questionnaires used in the wider community research to also include questions to gauge wider public opinions on universal screening and ideas for support mechanisms in A&E. These have been included, where relevant in this research.

2.3 Research Tools

A range of research instruments were designed and implemented to enhance validity and reliability as well as data collection purposes.

Self –completion questionnaires were designed to gather quantitative and qualitative data from staff and patients. These had two primary purposes:

- To examine the context of domestic violence among all those attending A&E or working there. This is referred to throughout as the domestic violence profiling questionnaire.
- To examine the competence and confidence of staff responding to domestic violence and to explore their attitudinal responses to different aspects of domestic violence. This had been designed primarily for advice and information staff but was considered to have validity also for A&E staff. This is referred to throughout as the staff audit questionnaire.

[Copies of both questionnaires may be obtained from Foyle Women's Aid and it is requested that if they are used in future research that an acknowledgment is made of their source.]

The list of social partners was compiled with the local knowledge of the Steering Group. The research team are aware that some social partners may have been inadvertently left out and for this express their apologies. A comprehensive list of all the social partners who participated in the research in the Foyle area is included in the appendices.

Specific reference must be made to the sections concerned with identifying the type of domestic violence experienced and its' impact upon the individual. It has been well documented that victims and others who support them may not recognise that they are experiencing domestic violence for a whole series of reasons including individual and cultural attitudes and knowledge. It was decided therefore that rather than ask respondents a closed question of whether they considered themselves to be a victim of domestic violence, a list of forms and consequences of domestic violence would be presented. The respondents would then be asked if they [or someone they knew] had experienced any of them. [This was based on a Probation Board of Northern Ireland questionnaire designed for assessment purposes within their 'Men Overcoming Domestic Violence' programmes. The research team were guided in this by the Steering Group and the expertise of Foyle Women's Aid.]

Both questionnaires were designed taking into account previous research models for comparative purposes, previously unknown areas relating to staff competence and confidence in responding to domestic violence, and the need to gauge individual attitudinal responses and local context.

Particular acknowledgement must be made to the research carried out by Monica Mc Williams and Joan Mc Kiernan [1993]. Some of their questions have been replicated for comparative purposes to assist in this and future research in Northern Ireland.

A schedule of focus groups was drawn up based on the need to include inter-agency and uni-disciplinary work or to access women survivors at different stages of their journey in relation to domestic violence.

The schedule included:

- Foyle Inter-agency Partnership Members.
- Women's Aid refuge staff team and volunteers.
- 4 Multi-agency groups in diverse settings.
- Focus Group A&E department.
- Domestic violence survivors living in refuge.
- Domestic violence survivors living in their own homes in the Derry, Strabane and Limavady Council areas.
- Domestic violence survivors using aftercare support of Foyle Women's Aid.

The attitudinal section of the staff questionnaire was designed based on the exercise in the No Fear pack produced by Northern Ireland Women's Aid Federation [NIWAF] and the research carried out by Cann et al [ref 2001]

Structured individual interviews were also carried out with

- Foyle Women's Aid staff [Area Management Co-ordinator, Inter-agency Co-ordinator and Advice and Information staff].
- Statutory Healthcare directors and managers [Healthcare and Social Care, Mental Health, A&E Consultant, 2 voluntary and 2 community based health organisations, NIWAF Help Line Manager].

Due to scheduling arrangements, two individual managers were not available and their responses were gathered through a telephone interview or written response.

For individual interviews and all focus groups, a series of structured questions was designed and agreed with the Steering Group to ensure reliability and validity of the information. Copies of these questions are also available from Foyle Women's Aid.

2.4 Research Process

The research process was concerned not only with the scheduled stages but the way in which these stages would be carried out.

Collectively and individually the research team are committed to a value base and working practices that are feminist in their perspective and result in a concern with understanding people as conscious and social beings to be respected and valued. Therefore issues of ongoing consultation, equality monitoring, awareness of safety and confidentiality for participants and a commitment to genuineness, unconditional positive regard and empathetic understandings are key aspects of their working practice and process. The research team has sought to ensure that these issues have been regarded throughout the research process.

3. Domestic Violence and Social Inclusion

Working for a Healthier People is one of the Northern Ireland Government Executive’s five overarching priorities and an underpinning principle of Investing for Health.

Ill health, social exclusion, poverty, fear and disability can also be viewed as a part of the potential impact of domestic violence.

Domestic violence may be experienced regardless of age, racial group, political opinion, sexual orientation, religious belief, marital status, mental or physical ability, and for people with or without dependents.

Domestic violence can be experienced in same sex and trans-gender relationships and male victims from women. However women are the primary targets of domestic violence.

“We want people to live longer, but in doing so, we also want to improve the quality of that life in terms of the relief from ill health, social exclusion, poverty, fear and disability”

(Investing in Health Policy)

3.1 Research Respondents, Demographics and Profile

The actual number of patients presenting to A&E during the period of the research survey was 649. Of this number, 99 people [15% of those presented in A&E during a one-week period] completed the domestic violence profiling questionnaire.

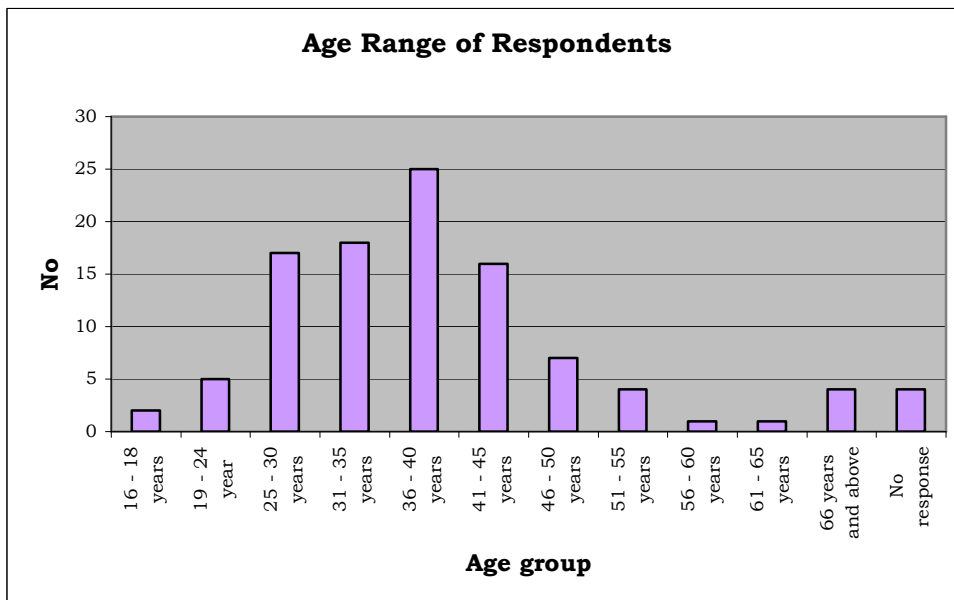
Over a one-week period, the average number of staff in Altnagelvin A&E Dept was between 30 and 35. A total of 5 staff members [17%-14%] completed the domestic violence-profiling questionnaire and 14 staff members [47%-40%] completed the domestic violence staff audit.

From a total of 104 individuals completing the domestic violence-profiling questionnaire. 80 were women and 23 were men [with one non response to this question]. Geographically, the highest concentration of responses was centred on L’derry [57.7%], followed by Strabane with 12.5%. The remaining 23.1% of respondents were spread between counties L’derry and Tyrone. 6.7% had not indicated where they resided.

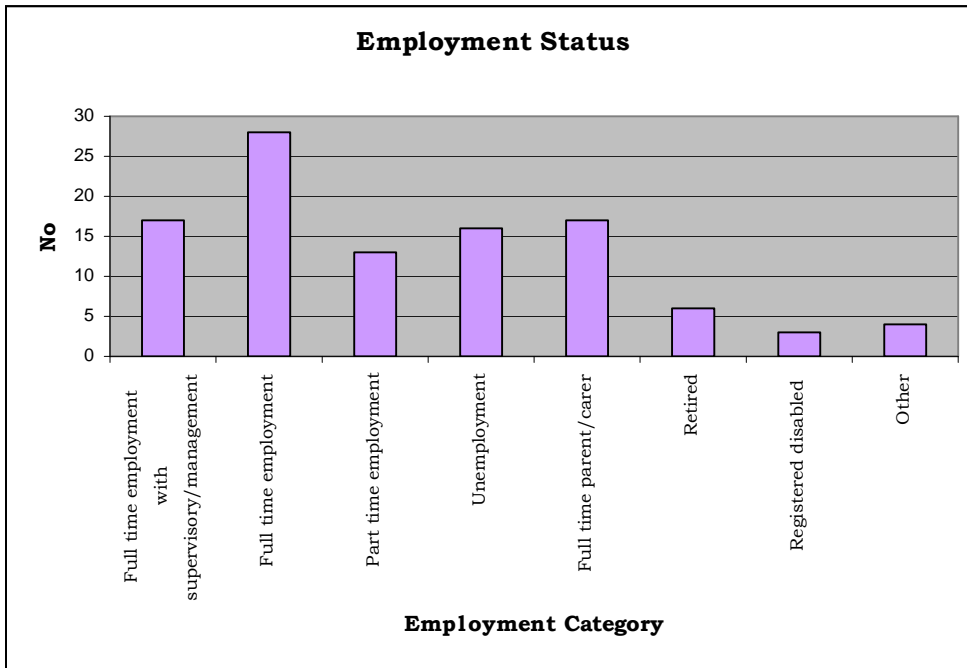
Respondents were asked to indicate which age group they belonged to and how they would describe their employment status – selecting from a defined list of options. From the bar charts illustrated below, the modal age group was the 35-40 years [equating to 25 of the 104 respondents].

“Crime statistics and research both show that domestic violence is gender specific. Usually the perpetrators of a pattern of repeated abuse is male and 81% of those who experience domestic violence are women”

(Opportunities Now 2003)



Employment status reflected 26.9% [28] respondents as being in full time employment. Full time employment with supervisory/management responsibility, and full time parent/carer were in joint second place with 17 respondents each.



12 women and 2 men responded to the staff audit questionnaire The breakdown of their area professional expertise [indicated from a defined list of options were as follows:-

Area of Professional Expertise	No of Respondents
Health and Personal Social Services	1
Health Clerical/Administrative	1
Health Emergency Services	1
Medical Staff	2
Nursing Staff	9

For both questionnaires, other generic information was gathered including: -

Marital Status	No of Respondents
Singe	27
Married	61
Separated	6
Divorced	5
Widowed	1
Co-habiting	4

Racial Group	No of Respondents
White	98
No response	6

[The above table only shows those racial groups that were completed by the respondents]

Religion	No of Respondents
Catholic	69
Protestant	26
Other	7
No Response	2

The question relating to sexual orientation asked the respondents if they considered themselves as heterosexual, homosexual, lesbian, or other. This was poorly completed, with the majority of respondents either opting to select 'other' or not to respond at all. The research team considered that the wording of this question may have led to confusion and therefore while the findings were recorded, no weight was placed on the outcome.

27 individuals identified themselves as survivors of domestic violence within the A&E setting. 100% of these were women - this was inclusive of staff and patients.

3.2 Conclusions

The low response to the questionnaires among staff and patients may be due to the specific context of the healthcare setting. One Women's Aid support worker who was administering the questionnaires in the waiting room commented to the research team leader that she was very aware that the primary concern of the majority of people in the waiting room was their health or the health of a loved one.

Foyle Women's Aid agreed to be available in the A&E department during office working hours (Section 2.1). However, it was impossible to staff this overnight for a week and at the weekend. Both times are arguably the busiest for A&E staff and may have effected the return rate.

Other issues concerned with confidentiality, reluctance to disclose, non-prioritising of issue among individuals or the crisis nature of the setting may all have contributed to the level of response both among staff and patients.

Staff were asked to complete both the audit and the domestic violence profiling questionnaires. A sealed container was left in the staff room for returns and the A&E Consultant and senior nursing staff encouraged staff to participate in the research.

The involvement of internally designated staff to aid procedural issues of questionnaire distribution and return e.g. internal mail may result in higher returns among staff in any future research.

The involvement of other senior managers, outside A&E, is essential to increase the validity and reliability of such research within a whole hospital approach.

The quote from an A&E nurse recorded below illustrates in a very practical way her opinion on how issues of equality and promoting social inclusion affect the context of domestic violence.

New TSN and in particular Promoting Social Inclusion "is about helping people who cannot enjoy the full range of opportunities in life which most people take for granted" [Ref New TSN 2001].

"I was very aware when I was there, giving out the questionnaires, that people there were worried about their health or the health of the people they were with"

(Women's Aid)

“Nothing can prepare you better than experience – If I am 18, 20 or 22 and have had an affluent background, would I be even thinking about that. The vast majority of doctors here would be privileged and they wouldn’t have a clue what domestic violence is about and take it at face value” [A&E Nurse]

Statutory duties arising from Section 75 of the Northern Ireland Act [1998] and the Human Rights Act [N.I. 2000] are central to public policy responsibilities.

In relation to domestic violence, healthcare planning, inclusive policies and service development would recognise that victims experience the social and economic impact of domestic violence regardless of their social, economic or employment status and include all communities of interest recognised within Section 75 and The Human Rights Act.

“We had a case recently where a lady had been badly beaten, not the worst I had ever seen, but bad enough. The doctor was horrified, had never seen anything like it. It highlighted to me how little she knew about it”

(A&E Nurse)

4. The experience of domestic violence among patients and staff in the A&E dept, Altnagelvin Hospital

4.1 Context

During the period April 2001 to March 2002, police in the Western Board area of Northern Ireland responded to the following number of domestic violence incidents.

Location	Total No of DV Incidents Attended	Total No where physical violence was present	Murder	Rape	Grievous Bodily Harm
Limavady	303	158	0	0	2
Strabane	370	117	0	0	1
Foyle	1021	569	1	0	1

Foyle Women's Aid accommodated 328 women and 358 children and supported over 1,120 women victims and survivors of domestic violence during the same period.

Previous research carried out by Women's Aid in the Derry City area showed that 75 people [approx 50% of respondents] had experienced some form of domestic violence. [Whitehorn and Stubbings 2003]

In the same research 64 [42.95%] of respondents reported knowing at least one other person who had experienced domestic violence. [Whitehorn and Stubbings 2003]

In a recent cross border research consultation carried out by Derry Well Women and the University of Ulster 76% of 713 respondents perceived violence within the home as the most important within the health determinant of behaviour and lifestyle.

4.2 Altnagelvin Findings – Prevalence of Domestic Violence

23 [23%] of those who attended A&E and completed the questionnaires, had experienced one or more of the identified forms of domestic violence.

An additional 25% responded that they knew someone else who had experienced domestic violence.

Although only five members of A&E staff returned a response to the domestic violence profiling questionnaire, 80% [four out of the five] were domestic violence survivors.

12 out of 14 health service managers across sectors and disciplines in the Western Health and Social Services Board (WH&SSB), who took part in the structured interviews, indicated that they were aware of staff or colleagues who had experienced domestic violence.

One was aware of staff who were perpetrators of domestic violence.

Research elsewhere has recorded or estimated the prevalence of domestic violence in A&E departments.

- 24-35% prevalence was found in anonymously self-reported questionnaires distributed within A&E departments in the U.K. [Ref Victim Support 1992]
- Random sampling of women seeking treatment at four A&E departments in Denver, USA found that more than half [54.2%] had been threatened or physically injured by a husband or boyfriend at some time in their lives. [Ref Abbot et al 1995]
- In a questionnaire carried out by Belfast and Lisburn Women's Aid on hospital attendance, including A&E 14 out of 17 women had attended A&E or another hospital department after a domestic violence assault. (Ref Belfast and Lisburn Women's Aid]

“ Whereas non battered adults make one injury visit to an emergency service in their lifetime, battered women average more than one such visit a year”

(Ref Stark and Flitcraft 1996)

The research team were unable to resource any research findings regionally or internationally that addressed the prevalence of domestic violence among health care professionals in general or specifically among staff in Accident and Emergency.

4.3 Conclusions

There is clear evidence that domestic violence is present within the Accident and Emergency Department of Altnagelvin Hospital among staff as well as patients.

Some form of domestic violence had been experienced by approximately 1 in four of those presenting at A&E who completed the questionnaires. No information was available from the others who presented to A&E during the same period. It is impossible to speculate either after the reason for not completing the questionnaires or the potential levels of domestic violence among that population. The research findings are therefore primarily concerned with the respondents, patients, those who accompanied them and staff who participated in the research. The prevalence rating of 23 % is within the tolerance rating of other research that used anonymous self-reporting questionnaires.

Until routine screening or assessment is introduced or until domestic violence victims, whether staff or patients, are encouraged or feel safe to do so, it is impossible to determine exact baseline indicators for domestic violence in the A&E dept in Altnagelvin Hospital. This will be addressed further in later sections.

The low return from staff does not allow a valid or reliable finding to be made in terms of the prevalence among staff. Nevertheless the four individuals who responded represent approx 11-14% of the average number of the A&E staff. If this prevalence subset was to be replicated among all staff in the WH&SSB area based on current staff numbers, the potential transformation analysis would be approximately 880 – 1,120 staff members who had experienced domestic violence (From total of 8,000 staff across the three Trust areas).

There is an urgent need for employers and managers in the WH&SSB to consider the prevalence of domestic violence among their staff. For the true extent of the issue to be realised further research is required among staff in all HPSS Trusts, programmes such as Investing for Health and Health Action Zones and other identified health and social care initiatives.

A commitment from senior staff to such research would be required to encourage response and to ensure safety and privacy among staff disclosing their experience as victims or perpetrators.

The need to integrate a response to domestic violence within statutory obligations in regard to human rights, equality and child protection is essential. Obligations in regard to health and safety in the workplace will be addressed later.

Knowledge of the extent of domestic violence among service users and staff should provide an overall direction within Health and Social Care Improvement Planning and inform practice response to public health policies and programmes such as Promoting Social Inclusion and Investing for Health.

“If they say they have a specialised service they should be able to stand over it”

(Woman Survivor)

“There needs to be much more consistency in policy and provision- particularly in a NHS which places values on a modernization agenda, partnership, collaboration, quality, equality and clinical effectiveness. The NI Dept. of Health’s strategy for Reducing Alcohol Related Harm (2001), the Promoting Health Strategy and Action Plan (2003-2008) make only a cursory mention of domestic violence. The failure to make the connection between these public health issues is a serious concern at a time when we should be developing partnerships with Health Trusts and Health Action Zones.”

(Ref Monica McWilliams Conference Speech 2003)

5. The Nature of Domestic Violence

An understanding of the parameters that define domestic violence is crucial in identifying and responding to the issue.

The definitions of domestic violence within the Northern Ireland policy document Tackling Domestic Violence and by Women's Aid groups throughout Northern Ireland are outlined below:

Domestic Violence is the use of physical or emotional force or threat within close adult relationships in a way that causes harm or distress to the victims. In addition to actual or threatened physical or sexual assault and damage to property, Domestic Violence includes non-physical intimidation, such as persistent verbal abuse, emotional blackmail and enforced social or financial deprivation. Having abused once perpetrators usually persist: intensifying and escalating the maltreatment.

[Tackling Domestic Violence Northern Ireland policy 1995]

“The intentional and persistent physical or emotional abuse of a woman, or of a woman and her child in a way that causes pain, distress or injury”

(Women's Aid)

This, along with the Women's Aid definition [illustrated right] recognises that domestic violence is more than physical assault. However, the experience of Women's Aid and anecdotal evidence suggested that the same understanding of domestic violence may not be prevalent among actual victims and survivors of domestic violence. The research sought therefore to find a way to enable assessment both of the context and impact of domestic violence.

Women's Aid works in partnership with the Probation Board of Northern Ireland and Social Services staff to facilitate the programme for male perpetrators Men Overcoming Domestic Violence [MODV] in the Foyle Trust area. This includes an assessment of the domestic violence perpetrated and experienced by individuals. It was an adapted version of this PBNI assessment checklist that was used to inform the research questionnaire.

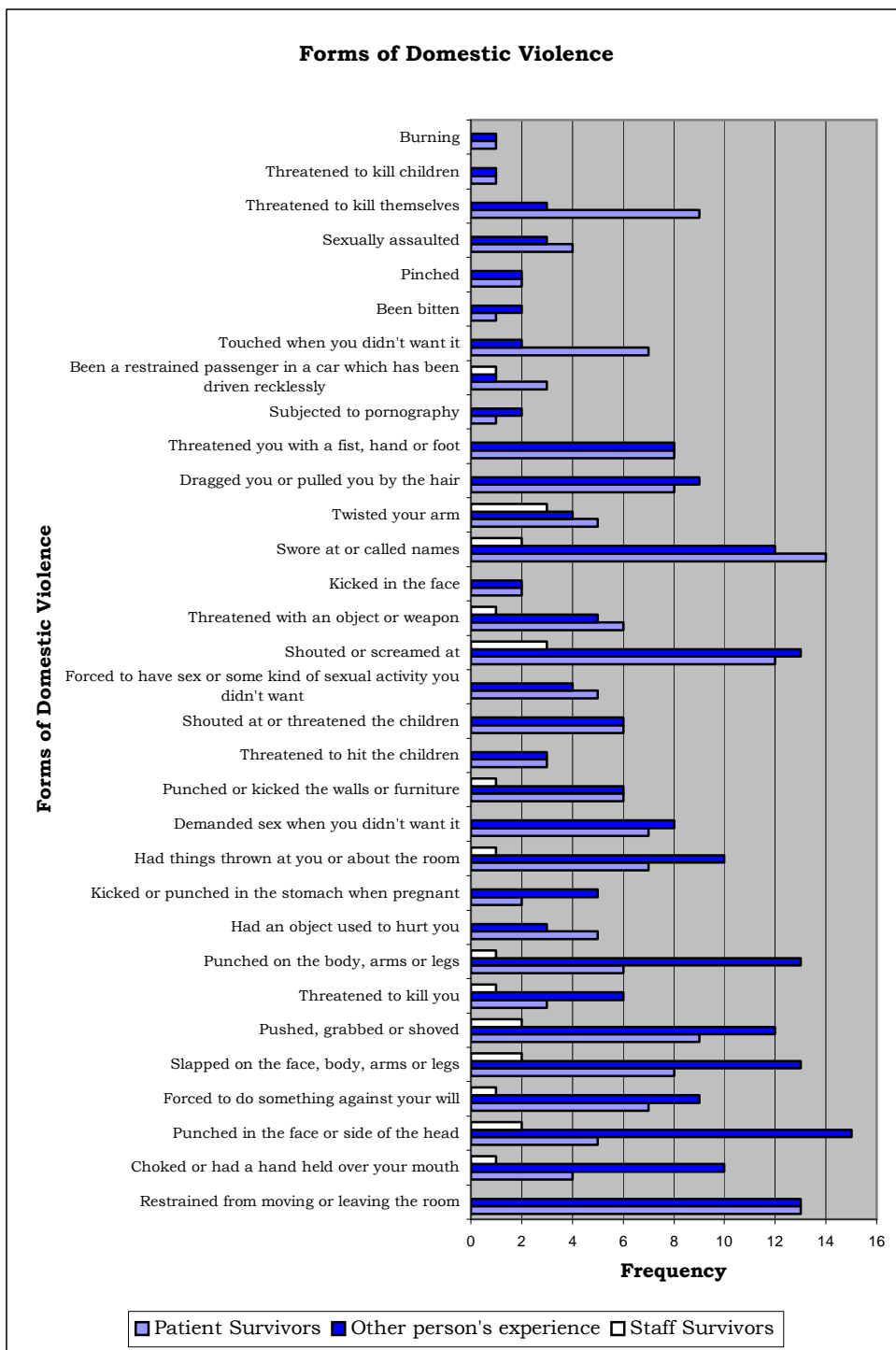
5.1 Altnagelvin Findings – The Types of Domestic Violence

All forms of domestic violence had been experienced by at least one woman survivor. The most common forms of violence recorded by patient survivors and those who recorded indirectly the experience of others are ranked below, along with staff survivors that had also experienced similar forms of abuse.

A total of 408 separate incidents of forms of domestic violence were identified within this question, a ratio of four incidents per respondent. The bar chart below seeks to graphically represent the finding, broken down into the three sub groups, i.e. patient survivors, other person's experience and staff survivors.

For patient survivors, verbal abuse was the most prevalent form of abuse with a record frequency of 14, followed closely by being restrained from moving or leaving the room [13]. For other person's experience, the highest recorded report was for being punched in the face or side of the head [15], with being slapped on the face, body, arms or legs, and restrained from moving or leaving the room, shouted or screamed at, each recording a frequency of 13. For staff survivors, [although these returns were significantly less in volume], they did however provide evidence a range of forms of domestic violence being perpetrated on or to them. The frequency distribution of the forms of domestic violence illustrated on the bar chart below, revealed that a high proportion of respondents [three out of the four] had been shouted or screamed at, as well as having their arm-twisted.

The frequency and intensity of the violence experienced was not asked for or recorded. Without this information it may be difficult for others not working directly with or informed by survivors to recognise the correlation between the abusive incidents, whether physical or psychological and the subsequent result in physical injuries and impact on emotional health and well-being (short, medium and long-term).



Whilst a total of 23% of A&E public respondents assessed themselves as having experienced a range of forms of domestic violence, only 9% considered and identified themselves as 'victims of domestic violence'. Conversely, within the staff survivor population, all four considered and identified themselves as 'victims of domestic violence'

5.2 Conclusions

All forms of domestic violence included in the pre-set assessment criteria were experienced by at least one of the domestic violence survivor respondents, whether staff or patients.

Not recognising or minimising that what is being experienced **is** domestic violence may be a coping mechanism for some survivors or a denial mechanism by perpetrators.

For others it may result from a lack of knowledge as well as understanding that what they are experiencing or perpetrating is domestic violence.

More opportunities need to be created by all stakeholders including those involved with health promotion programmes to enable and encourage perpetrators, victims and the wider community to understand what domestic violence is.

Understanding what domestic violence is, its frequency and intensity, and the range of types has implications for the competence of staff in identifying domestic violence or facilitating disclosure. [Whitehorn and Stubbings 2003]

An understanding of the range of violence and abuse perpetrated and experienced by individuals is an essential element of domestic violence training. The voices of survivors and perpetrators need to be 'heard' within this training. Utilising the experience of Women's Aid, probation staff and social services personnel domestic violence expertise within staff training is a safe and effective way for healthcare professionals to achieve this.

Any domestic violence staff training needs to consider that domestic violence training events may be emotive issues for victims, survivors and perpetrators attending the event. Managerial response and resulting support systems need to be clearly outlined within the WH&SSB training policy, staff welfare and health and safety policies. This will be referred to in later sections.

Domestic violence is rarely a one-off event. However, the frequency of that violence and the degree of physical harm inflicted or emotional health damaged may be not always be correlated in the minds of survivors or those who respond to them with its' accumulated impact over a period of time.

The sections that follow place the potential impact and effects of domestic violence within sub-categories, physical injury, emotional harm and mental health.

6. Physical, Emotional, and Mental Impact of the Abuse

There is clear evidence of the impact of domestic violence upon the health and well being of individuals.

- Domestic violence is more likely to result in injury than any other violent crime. 69% results in broken bones compared with 4% as a result of muggings. [Ref Mayhew et al in Stark and Flitcraft 1996]
- One in four incidents result in substantial physical injuries. [Ref Stanko et al 1997]
- Over half of the women in previous Northern Ireland research said that they needed medical treatment for their injuries while 39% required hospital treatment at least once. One third were hit while they were pregnant and two women suffered miscarriages. [Ref Mc Williams and Mc Kiernan 1993]

“The physical problem is the most immediate one.”

(Interagency Member)

6.1 Altnagelvin Findings – Physical Impact of the Abuse

Without wishing to minimise or trivialise the violence experienced by any individual nonetheless an attempt has been made to rank the prevalence of the physical injuries that resulted from the assault.

Given the potential importance of such information to healthcare providers and planners, the response from other research in the Derry City area is also included. [Ref Whitehorn and Stubbings 2003]

Each respondent was offered the opportunity to record the physical impacts of domestic violence not only experienced by themselves, but also for others they knew that had experienced abuse.

The findings were collated based on the frequency of a particular physical abuse recorded by individual respondent under four categories:

- Percentage experienced by A&E survivors [public and staff].
- Percentage experienced by A&E ‘other person’s experience’.
- Percentage experienced by others in local research (as explained above).
- Percentage experienced by ‘other person’s experience’ in other local research.

“ It needs a comprehensive assessment that looks at medical and mental health history and that asks not only what the problems are but also where they’re coming from”

(Interagency Member)

Calculations were measured as a percentage of total returns for each specific physical impact, e.g. split lip, loss of hair, etc. This allowed for comparable frequency distribution in the findings, recognising however, that this is a casual relationship depiction of the four categories.

[Please refer to the illustrated results below on the following page].

Suggestions were made by expert staff that would enable more effective identification of domestic violence as a source of the injury and to record the nature and extent of the physical injuries.

“First thing would be to have a clearer view in our own minds of the sorts of patterns of injury that people present so that we are more aware – so we can recognise even where the person is not prepared to confront the problem at this stage, at least we have in our minds have made the connection - and so I think that there is an educational thing there”

[A&E Consultant]

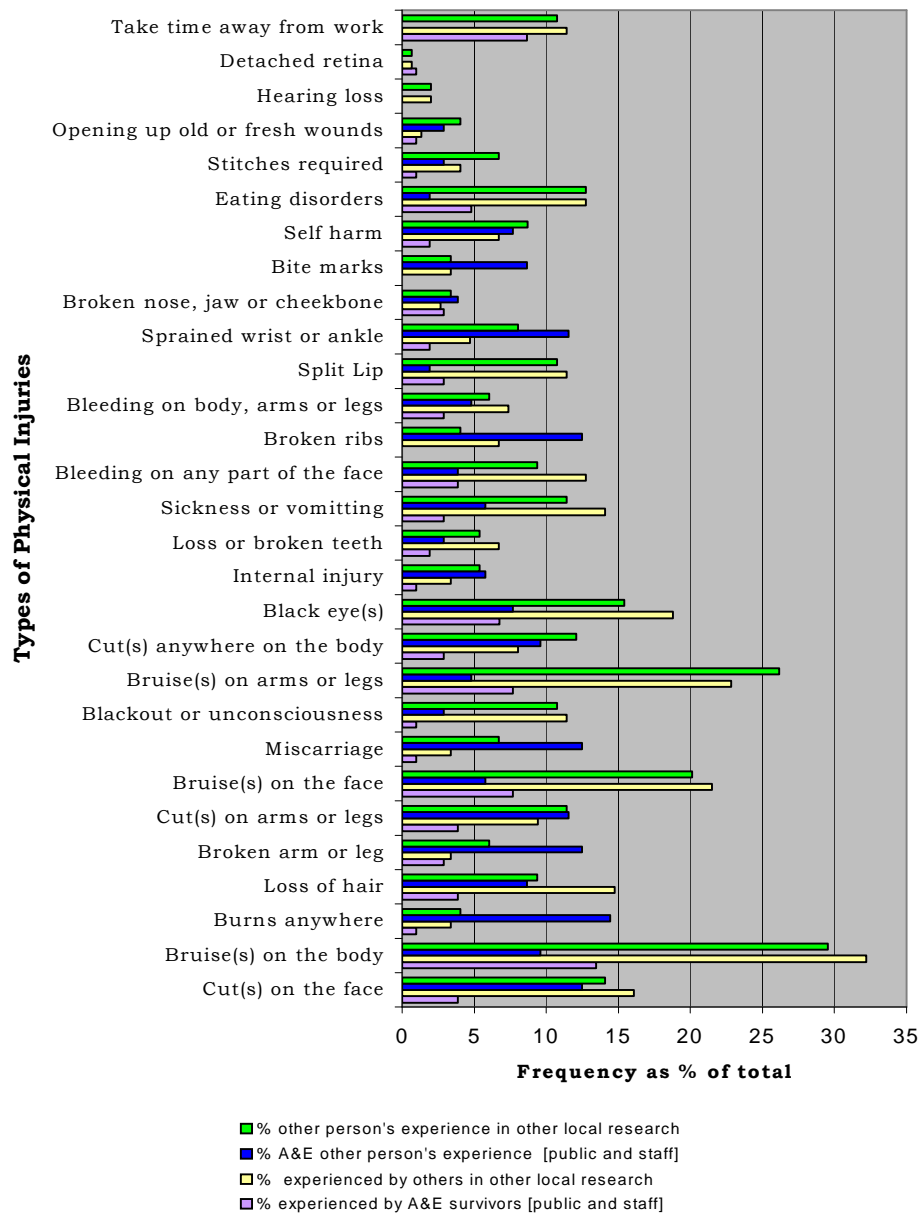
“ I had a broken wrist and bruising all over my head –mostly on the head he would just keep thumping me”

(Woman Survivor)

The A&E Consultant also agreed that the use of body charts that referred to the likelihood of accidental and non-accidental injury site such as those used in child protection training could be customised and used for medical and nursing staff training in all healthcare settings.

Throughout the research both survivors and staff participating in focus groups or individual interviews made comment that reflected the need for awareness to be raised and protocols put in place for adult as well as child victims of abuse.

Physical Injuries Experienced



“There was a male doctor examining me and he was wanting to note down every scar. It felt like an echo of all the abuse I had suffered all my life. They should make sure that they ask you if you want a women doctor. There must be one on call somewhere in a hospital It was the same when they put me in a mixed ward. They don’t think.”

[Woman Survivor the research team wish to note that this survivor was not referring to a previous experience in Altnagelvin Hospital]

“It’s like how children who have been abused need to be treated with respect and TLC [tender loving care] so to women that are vulnerable”

(Woman Survivor)

6.2 Emotional and Mental Health Impact of the Abuse

Central to the focus of this research are the objectives of the Investing for Health objectives which include:

To promote mental health and emotional well-being at individual and community level
[Ref Investing for Health 2002]

The emotional impact of domestic violence and its' impact upon the mental health and well-being upon victims and survivors has been noted previously in other research.

The prevalence and nature of the psychological abuse is difficult to gauge for a number of reasons.

Within the assessment tools provided for the research there was no opportunity to assess the nature of the psychological abuse experienced by the women victims, by male perpetrators.

Previous models have been provided by others to develop some understanding of the nature of psychological abuse and domestic violence. The use of Biderman's Coercion Chart, Walker's Cycle of Violence and the Wheel of Violence by Pense, and others have all contributed significantly to articulating the nature of physiological abuse within domestic violence, the strategies of the perpetrator and the impact upon survivors. [See appendices for reference]

However the research team leader considered that these are neither appropriate nor safe for abuse survivors as a self-reporting assessment research tools. For safety and support reasons experienced staff and appropriate response mechanisms are require to be in place for their administration on a one to one basis.

Other research has indicated that without administration by a 'knowledgeable person' that some risk assessment tools could cause the survivor to panic when confronted with the result. [For a full discussion on the issue see Schornstein S.L.1997]

Nonetheless, the domestic violence profiling self-reporting questionnaires and the written and verbal recorded comments from respondents provide a graphic illustration of the impact of domestic violence upon survivors.

“Eight women took overdoses as a result of the violence.”

[Mc Williams and Mc Kiernan 1993]

“Abused women are three times more likely to be diagnosed as depressed and 5 times more likely to attempt suicide”

[Ref Stark and Flitcraft 1996]

6.3 Altnagelvin Findings – Emotional and Mental Health Impact

Survivors both in the A&E and the general population research had experienced a considerable impact upon their mental health and emotional well-being as a result of domestic violence.

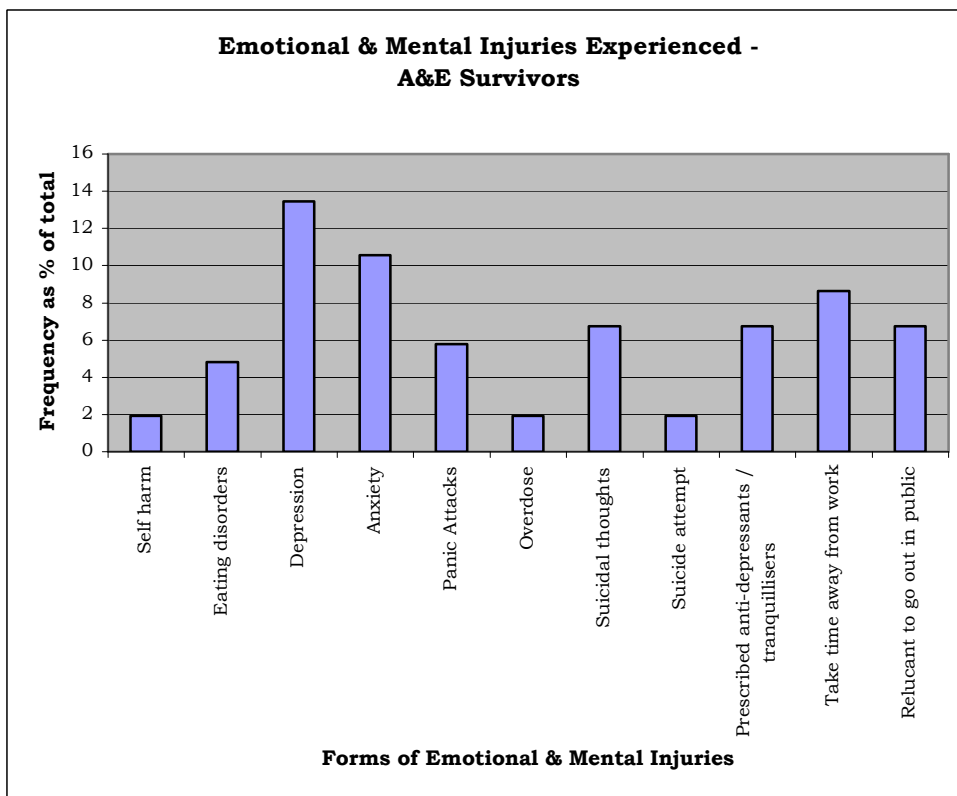
One woman survivor described how her mental health was itself used as a 'weapon' against her.

The quantitative response (illustrated below) to the consequences of the violence provided stark factual information. For patients and staff within the A&E setting, the women survivors involved had experienced at least one form of emotional and mental abuse.

Two out of the four A&E staff survivors of domestic violence recorded that they had experienced depression, one had experienced anxiety and one had had suicidal thoughts. Another had been prescribed anti-depressants or tranquillisers as a consequence of the abuse they had experienced. Notably, two out of the four staff respondents indicated that time had to be taken away from work as a result of domestic violence.

“When I went into (Named Mental Health Hospital) I felt like everyone else was taking over my health. He used to control me and they didn't listen. I would have a whole litany of what (named husband) says and they didn't really know him”

[Woman Survivor]



“It’s not the beating that’s the worst, it’s the emotional stuff, it’s not the scars, it’s the inside stuff”

(Woman Survivor)

The impact of domestic violence upon the lives of women survivors and the consequences for their mental health and well-being was also graphically illustrated by women within survivor groups. Here are just some of the recorded comments:

“Sometimes they mix depression up with domestic violence”

(Women Survivor)

“When I presented with an overdose or self-harming [named hospitals – not Altnagelvin] they stick patches on it and present you back into the world. I was crying for help but nobody was listening.
[Woman Survivor]

It was all about psychological abuse for me –no-one will believe you I thought anyway as I have no physical injuries. I felt it wasn’t domestic violence –it took me so long to see the mental side of it –I was living hour to hour never mind day to day.
[Woman Survivor]

I went to a psychiatrist but he didn’t really probe or asked why . I just didn’t have the strengths .You need support
[Woman Survivor]

I did go to a counsellor but didn’t see anything moving . I was too hysterical jumpy-too hysterical inside .I wanted him to fix it .
[Woman Survivor]

“We need to be giving women the message “It’s your husband’s who’s sick but you have the symptoms. You have the right to be how you are and that’s the way anyone would feel in those circumstances”

A number of women commented on their concern that there was a tendency for them to be prescribed anti-depressants. The extract from a speech given by Monica McWilliams at a Multidisciplinary Family Law Conference, March 2003 gives below echoes to the women’s experiences.

[Mental Health Social Services representative]

“Ten years ago, a frequent complaint from those abused in a violent relationship was that despite the medical practitioners being aware of the cause of the abuse, the only assistance offered was the treatment of injuries or the provision of tranquilisers. As Dobash and Dobash (1979) noted: “The doctor will almost automatically be predisposed to simply treat the injury, accept superficial explanations and stifle or ignore all others and send the woman back to the man who inflicts the injury.”
[Mc Williams 2003]

The response of mental health personnel is, as for any healthcare professionals, based on their individual competence and confidence to address the issues.

Two of the specialist mental health staff interviewed displayed a clear understanding of the issues for survivors as well as for staff. Both individuals had either undergone domestic violence training from Women's Aid or been directly involved in the Foyle Inter-agency Domestic Partnership.

"We need to be able to clearly clarify who's the victim and who's the perpetrator

A number of the mental health staff have gone to Pathways (Foyle Women's Aid) for domestic violence training. It has heightened awareness of the issue in their own workloads. In some ways it's a more stigmatised problem than mental health"
[Mental Health Manager]

"The doctor was a good listener but gave me tablets. I had no option – either take these or be suicidal"

(Woman Survivor)

"There is a 'wile' mix-up by social workers between domestic violence and depression – especially mental health teams – you have to see to many people"

(Woman Survivor)

7. Domestic Violence – A Quality Response

When researching secondary material to identify best practice models to inform a quality response to domestic violence, the research team sourced a consensus driven quality assessment tool developed by the Agency for Healthcare Research and Quality [AHRQ] to “permit formal evaluation of hospital based domestic violence programmes”. [See appendices for full reference]

The eight categories and the subsections within the Delphi Assessment programme provide a standardised assessment tool that has been used to present the findings and conclusions of this and other research [ref Whitehorn and Stubbings 2003] in relation to a quality response for domestic violence.

The Delphi Instrument adopts a ‘whole hospital’ response to domestic violence. This section has been written by the authors specifically in relation to the A&E department of the hospital but including reference to the findings and conclusions in relation to the wider health and social care planning and provision in the Western Board area.

7.1 Findings – Policies and Procedures

7.1.1 Policies

The 14 A&E staff who returned the questionnaire were asked if they were aware of a domestic violence policy for clients within their workplace. Responses varied; 6 believed that there was a policy in place, 2 thought that there was none, and 5 did not know. [There was one no response].

“As such I am not aware that the WH&SSB has a domestic violence policy”

(Statutory Health Manager)

For the 6 that responded to the first question, when asked how confident they would feel about implementing the policy only 2 self assessed themselves as confident. A further respondent identified them self as not very confident.

Whilst it should be acknowledged that self assessment questions are purely subjective in their response with the individual relating their level of competence/confidence based on their own experiences, it should be recognised that if a domestic violence policy exists and the research team are not certain given the responses above, the resultant ratio of 2:1 shows that for every two policies implemented, there is only one member of A&E staff that is at the very least not very confident in implementing it.

None of the voluntary or community health groups interviewed, with the exception of Foyle Women’s Aid, had a domestic violence policy in place. The Foyle Women’s Aid policy is currently under review.

“We have nothing specifically to address domestic violence”

(Voluntary Health Manager)

The response from statutory health managers in Foyle Trust and the Western Board indicated similar findings as to the presence or absence of domestic violence policies in the workplace.

“There is very little dedicated to domestic violence in terms of staff and resources. There are competing demands to meet the best configuration to meet needs”
[Statutory Health Manager]

“I’ve been involved in developing a policy for the Foyle Trust but at the moment there isn’t one. I would hope that some of this research would be part and parcel of that”
[Statutory Health Manager]

The presence or more significantly the absence of a domestic violence policy is a crucial factor in creating a framework from which to address domestic violence in any setting. This is extensively discussed in other research commissioned by Foyle Women’s Aid where clear explanation was given of the consequences of their absence or presence.

“If it’s not down on a piece of paper as a priority then there’s no money or action attached to it.”
[Interagency Member]

“Policies are crucial. Everyone from the Chief Executive down has to do it to get a cultural shift. Otherwise we’re continually having to re-explain ourselves.”
[Women’s Aid Worker – Ref Whitehorn and Stubbings 2003]

7.1.2 Procedures

The discussion on the role and responsibilities of personnel responding to domestic violence was discussed in focus groups and individual interviews.

A variety of options were discussed. These included: -

- Volunteer support work at A&E, particularly where an individual has been identified and the person has the skills to work with the individual.
- Paid position in the hospital.
- Designated staff member at each shift in A&E.

Women survivors in the refuge focus group highlighted the need to “have a face there in a crisis” but were clear that it needed not to be one person, as “she would be run off her feet with trying to work through all the hospital.” This was echoed by the Foyle Women's Aid Area Management Co-ordinator who commented that she thought that it should not be a specific nurse in A&E “cos it’s the busiest place in the hospital”. She also commented that she felt it was important that the hospital managers themselves decide how to resource the response. She suggested that a special support pilot could be facilitated with Women’s Aid volunteers for week-end cover for a time limited period and then to review the effectiveness of the project for all stakeholders. A statutory health manager commenting on the same type of scheme, although he did not specify if it was full time or part-time, suggested that this would put ‘additional resources’ on the volunteering and support agencies and he would “query their capacity to deliver on this”.

“You need somebody on standby who is trained . . . not a nurse, someone focused on domestic violence . . . solely their job”

(Woman Survivor)

Women in the refuge and focus groups suggested that a more multi-stranded approach be adopted: -

- Female doctor on call in hospital if requested by domestic violence survivor with specialist training.
- A dedicated nurse on each shift with specialist training.

The latter option found the most support with the A&E staff interviewed.

“Within our hierarchy – perhaps the font of information for staff should be the senior nurse on shift, which would be either an F or G grade nurse, which breaks it down into half a dozen nurses in total who could provide their colleagues with support and could be the source of all information and experience rather than trying to educate the entire workforce.”

[A&E Consultant]

“Someone with a better rapport with patients. Also we have a big male staff, we have four or five and people are not as willing to disclose to males. We have three males today, whereas if we had a dedicated person they could go to one on every shift.”

[A&E Nurse]

The Delphi instrument also identifies within the policies and procedures category other quality indicators:

- Evidence of a hospital based domestic violence task force.
- The provision of direct financial support for the domestic violence programme.
- Procedures for security measures to be taken when domestic violence is identified.

No evidence was available of these within the hospital setting. No research was instigated by the research team to ascertain their presence with the WH&SSB as a whole.

The issue of the abuser accompanying the victim to A&E and the subsequent impact on patients, staff and protocols was considered.

Attendance to A&E Dept	No of Respondents 'Yes'	No of respondents 'No'
Where you able to attend alone?	2	9
Did your abuser accompany you?	14	7

“I’ve been to A&E a few times. I was hoping they would cop on – but he was there and listening. Last time I went on my own and they said why don’t you leave that relationship?”

[Woman Survivor]

“Sometimes you would never get to see them alone, there are times where the husband comes in and they are hardly able to speak for themselves. You get the non-verbal. You would love to be asking the questions “how did you get this?” and your not allowed. They don’t give eye contact and he does the talking”.
[A&E Nurse]

7.2 Findings – Physical Environment

The context of the A&E Dept of any hospital and its primary purpose is to deal with crisis and medical emergencies.

The effectiveness of the response of an A&E Dept to domestic violence victims may be affected by a number of factors and have been documented in a number of research studies. [See appendices]

- An increase in the number of patients attending A&E.
- Increasing throughput.
- Staff shortages.
- Pressures on resources and time.
- The attitudes of individual staff.

This section attempts therefore not only to examine the findings based on the Delphi assessment criteria but other factors from the A&E environment that may impact on response to domestic violence.

There was universal agreement among all respondents on the need to display posters and/or brochures related to domestic violence in the A&E area. The A&E staff that responded to the questionnaire indicated particularly the need for domestic violence support material including credit card sized information cards, posters, general information leaflets and an Interagency Directory [to provide telephone points of contact for victims].

Suggestions were made about the design and content of this resource material and the A&E consultant recognised the potential availability of promotional material provided by others.

“We probably need to improve our range of advice leaflets, posters and things – update telephone numbers. Maybe try to tap into an outside source for these rather than try to make it in-house, which might not necessarily attract people’s attention.”
[A&E Consultant]

“The provision of information cards and leaflets is a very constructive idea and one that I would recommend particularly where a member of the staff is talking in confidence they can slip a small card to someone they feel is a victim –they can give them a help support line.”
[Statutory Health Manager]

“There is an opportunity for the provision of posters on display throughout A&E and also throughout the greater hospital premises, and indeed any premises that are used by members of the public”

(Statutory Health Manager)

“I think that they (posters & leaflets) are marvellous – out there in the waiting room. That’s the thing, you never get feedback on how useful they are”

(A&E Nurse)

A male support group worker suggested that domestic violence information should be included in general health information booklets being produced on issues such as smoking and healthy living. In this way a survivor or perpetrator could access support information without identifying themselves as such to other people in a shared environment.

The Delphi instrument suggests, as one of its indicators, that a hospital provides temporary shelter for domestic violence victims who cannot go home or cannot be placed in a community based refuge.

Within the local context of Altnagelvin Hospital the reality is that many accommodation providers have a Supporting People service for those who are homeless and Foyle Women's Aid provide a 24-hour specialist refuge service for women victims of domestic violence and their families.

“It’s only on Casualty, on TV, that they have the time to take your life history and sort it all out”

(Woman Survivor)

However, the provision of temporary accommodation within the hospital setting was raised primarily within the context of giving the woman time and space to recover from her injuries before getting support to address her other needs.

“It would be good if they had a built-in allocated room to hold women over and then they can make appointments the next day to see people”
[Women’s Aid Worker]

“The client has to dictate the terms. Maybe she could just be kept in overnight until a more concerted effort is made to open up questions.”
[Interagency staff]

The emergency nature of the A&E Dept was recognised by a number of respondents with the implications that can have for privacy and confidentiality.

“Need a private room /space to talk to and that is hard in A&E which is a busy, hectic place.”
[Women’s Aid Help Line]

“You may not always get honest answers because of the way the areas is laid out – confidentiality is not great because of curtained areas. So whilst you may ask the question, you may not get the honest answer. So I don’t think that it would work due to the way that A&E is laid out.”
[A&E Nurse]

“We have a relatives room that is really nice and very private but would be needed for relatives. But we do have that facility. So it is something that should be mentioned to [named Chief Executive]”
[A&E Nurse]

“People need to be interviewed in a safe environment and that isn’t a bed with the curtain around it”
[Interagency Member]

“Didn’t have no one to watch the kids, had to take them to A&S with me. I couldn’t tell the truth about what happened”

(Woman Survivor)

“You may not always get honest answers because of the way the areas is laid out – confidentiality is not great because of curtained areas. So whilst you may ask the question, you may not get the honest answer.”
[A&E Nurse]

The issue of childcare facilities is not included in the Delphi assessment but was addressed in this research.

“I had no provision for childcare so had to wait until a suitable time before seeking medical attention”

(Woman Survivor)

Attendance to A&E Dept	No of Respondents ‘Yes’	No of respondents ‘No’
Did you have your children with you?	4	10

7.3 Findings – Cultural Environment

In this category, the Delphi instrument uses as one of its' indicators the presence of a formal written assessment of the staff's knowledge and attitude about domestic violence.

While this research did not provide a formal assessment, the staff audit questionnaire did ask staff to self assess their confidence, competence and attitude about domestic violence.

A sample of eight recognised signs of domestic violence was used as a guide for the A&E staff to self-assess their level of confidence. Whilst the figures in the table below illustrate a breadth of return of response, it is interesting to note that a high proportion of respondents only deemed themselves to be either 'quite confident' or 'not very confident'.

When these findings are then compared to the returns for the confidence of knowledge and understanding of domestic violence, A&E staff again recognise themselves as predominantly falling within the categories of 'quite confident' and 'not very confident'. [See second table below]

Attitudes about domestic violence were more clearly defined. A total of 11 staff [78.57%] stated that they believed that a patient should be asked about domestic violence 'when you or others have a suspicion'. A further 2 staff [14.28%] preferred that the question be 'asked each time in a range of settings'. Only one staff member believed that it should be left to the patient to disclose.

A&E Staff Confidence in Identifying Signs of Domestic Violence

	Extremely Confident	Very Confident	Confident	Quite Confident	Not Very Confident	Not Confident at all
Physical injury	1	2	3	3	5	
Emotional abuse		1	2	3	8	
Mental health concerns related to/as a consequence of violence		1	1	3	9	
Financial deprivation		1		6	6	1
Child protection in relation to domestic violence		2	2	3	6	1
Sexual violence against women		1	1	2	9	1
Verbal abuse	1		1	3	9	
Emotional impact of domestic violence on children	1	1		6	5	1

“It can be difficult to engage people in a short period of a professional interview and to gain sufficient confidence to allow the patient to confide”

(Male Health and Personal Social Services Professional)

A&E Staff Confidence in Knowledge and Understanding

	Very Confident	Confident	Quite Confident	Not Very Confident	Not Confident at all
Extent of domestic violence in the Foyle area	2	2	3	7	
Causes of domestic violence	3	3	5	3	
Cycle of violence - how domestic violence increases in frequency and intensity	2	2	6	4	
Why women stay	2	5	5	2	
The help-seeking process of survivors of domestic violence	2	1	4	7	
Profiling perpetrators			4	8	2
Other agencies support services for survivors of domestic violence	2	2	4	6	
Other agencies support services for the perpetrators of domestic violence			3	9	2

Attitudinal responses were explored further by offering the respondents the opportunity to state their opinion from a list of predefined statements. They were asked to identify their level of agreement from a six-point agreement scale.

When analysing the results, the majority of respondents had shown a deterministic response to the statements posed. In other words, either all or an extremely high proportion of individuals had answered a question identifying the same level of agreement which seemed to support a generalised attitudinal rule in the wider community. For example, the statement 'It's ok for a man to hit a woman' yielded a "strongly disagree" response of 96%.

However, there were five statements, within the questionnaire, that did not meet the terms of the deterministic approach. These statements were: -

- Domestic violence is about power and control.
- Domestic violence is a crime.
- No-one should interfere in the affairs of a man and wife.
- Abused women should leave their partner if they do not like being hit, whatever the circumstances.
- If I ask every woman (who is relevant to my practice) if she has been abused I will offend a lot of my clients/service users.

The attitudinal responses for these were less defined in terms of their agreement, with their relative frequency distribution offering up no real clear consensus of opinion. This lack of unified agreement is an important consideration when then evaluating an individual's self-assessment response to their confidence and competence in addressing issues around domestic violence.

The research team recognised that further research would be required specifically focused on attitudinal responses within the context of the cultural environment. The team suggests that a form of benchmark system be developed that could assist informing a better understanding of the issues of domestic violence in the context of cultural competency. [Whitehorn and Stubbings 2003]

7.4 Findings – Training of Providers

The U.K. Department of Health in their resource manual on domestic violence make a number of key assertions on education and training based on the premise that “a goal for the future must be to include domestic violence as a subject in the core training of all health and social work professionals”.

Previous research has suggested that access to domestic violence training has a significant impact on both patients and healthcare staff.

Key findings were: -

- 86% of staff respondents stated that they had inadequate knowledge about domestic violence.
- A further 89.3% had not had the issue addressed as part of their basic medical/health training and only 11.1% had done so in postgraduate training. [Ref Abbott and Williamson]
- Similar results were found in another study where 61% disclosed they had received no training on domestic violence at any stage of their medical training and only 8% reported that they had received good training. [Sugg and Inui 1992]
- A Victim Support working party recommended “domestic violence be specifically included for all A&E staff and for all members of the primary health care team including reception and administration”. [Ref Victim Support 1992]

Among the A&E staff that responded to the staff audit questionnaire, only 6 out of the 14 said that they had received training on domestic violence. When then asked about the amount of time that had been given on the subject, 3 responded by saying that they had attended a half-day course, 1 had received training over two days, whilst the remainder had either voluntary counselling service training or ‘less than ½ day’ training.

In assessing staff training and development requirements consideration needs to be given to a range of aspects that may impact upon individual staff competence and confidence in responding to domestic violence.

Other research commissioned by Foyle Women’s Aid into the training and development needs of advice and information workers would suggest those aspects to be: -

- Skills
- Knowledge
- Confidence
- Attitude

[Ref Whitehorn and Stubbings 2003]

The Delphi programme sets out a clear framework for training in a health setting. These are: -

1	Definitions of domestic violence	2	Dynamics of domestic violence
3	Epidemiology	4	Health consequences
5	Strategies for screening	6	Assessment
7	Documentation	8	Intervention
9	Safety planning	10	Community resources
11	Reporting requirements	12	Legal issues
13	Confidentiality	14	Cultural competency
15	Clinical signs/symptoms		

[Ref Delphi Instrument for Hospital Based domestic violence programme]

Any such training needs to be set within a formal training plan that includes the provision of regular ongoing education for both clinical and non-clinical staff.

This was recognised by a number of health managers

“Only recently [named Women’s Aid staff member] has come in for one session but we do hope to repeat that every six months with medical staff turnover. She was cut down to a half a day/couple of hours”

(A&E Nurse)

We have had training – but we need increased level of training. But our problem is timing. If they do training it has to be done in their own time, as it is not recognised as being necessary for their day-to-day work. So we need time and we need money to get the girls trained up”

[A&E Nurse]

“It would be better to have more formalised study days that people could be seconded to, paid for, but that would take forever”

(A&E Nurse)

“ I believe that the staff who work in A&E and indeed in the Ambulance Service should be trained to identify the traits of domestic violence, providing information for the screening in terms of injury and analysis and give support and information where they can help and advise individuals as to where they can get support from the statutory and community and voluntary sector.”
 [Statutory Health manager]

One mental health manager had recently been to domestic violence training with other staff

“ There should be more joint training with Women’s Aid. I’m making it compulsory although all our other staff want to go on it anyway. A number of the mental health staff have gone to Pathways [Women’s Aid resource centre] and came back with feedback. They were annoyed at the extent of domestic violence, how well it’s covered up and it has heightened awareness of the issues in our workloads.”
 [Mental Health Manager]

“As managers we have a responsibility to a policy and training. Training should be compulsory. If we mean what we say about things like Pathways to Healthcare we need to start with policy and training and . . . begin with ourselves”

(Voluntary Health Manager)

The table below illustrates the training needs identified by A&E staff respondent based on pre-determined list of options offered for multiple selection.

Focus for Training on Domestic Violence	% Interest
Identifying immediate risk where there is domestic violence	14.6
Advising the victim on their personal safety in relation to domestic violence	12.5
Range of support services and programmes available across all agencies	14.6
The law and domestic violence	13.4
Physical and emotional needs of adult victims of domestic violence	11.5
Physical and emotional needs of child victims of domestic violence	11.5
Specialist services and programmes offered by Women’s Aid	12.5
Welfare rights, housing, financial support etc.	9.4

The Department of Health has also set out some guidelines in relation to domestic violence training. A number of them most relevant to this research are given below:

- ALL health professionals should be given basic domestic violence information, steps to support disclosure and prevention of future violence.
- Training should be available at undergraduate /pre-registration level and in specialist training and continuing professional development
- There are distinctive training needs in different health care settings
- There is a need to develop educational opportunities at a higher level that allows health care professionals to specialise
- Local domestic violence training needs to be developed in response to local situations and requirements
- Such training should involve working alongside key voluntary sector organisations such as Women’s Aid

(Ref Domestic Violence - A Resource Manual for Healthcare Professionals March 2000 (The emphases are theirs))

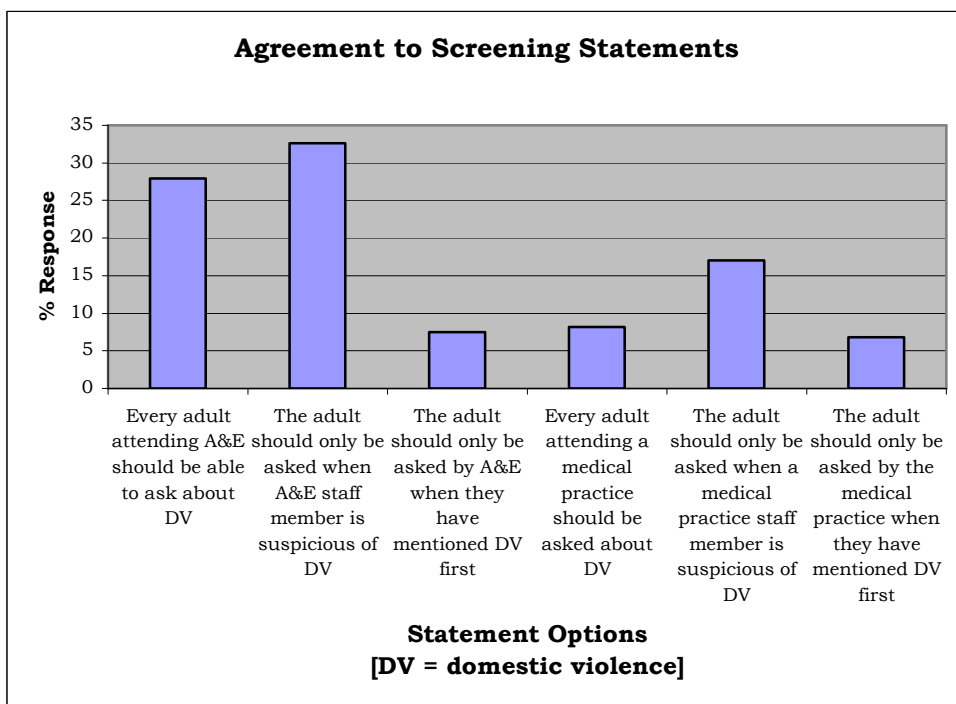
Foyle Women’s Aid in collaboration with the Foyle Domestic Violence Partnership has acquired funding from Government Executive funds for a domestic violence trainer in the Foyle area. The opportunity is there to create a sustainable domestic violence training presence in the Foyle area for the foreseeable future.

7.5 Findings – Screening and Safety Assessment

The issue of universal screening is one that has resulted in an extensive amount of research, discussion, with resulting tools and protocols. This research is no different but will attempt to summarise the issue, present findings and indicate sources to inform the process.

The assessment criteria used in the Delphi programme that is concerned with universal screening goes beyond considering whether individual staff members should address the question to enquire if there are administrative enforcement procedures to ensure domestic violence screening is being carried out. Other questions relate to evidence of a standardized instrument being used, the percentage incorporated in all clinical records throughout the hospital and responsibility for referral and reporting mechanisms.

The issue of a mandatory or voluntary screening policy is one that elicits a wide range of opinion and this research found no different.



“I’ve seen universal screening work in Boston and it works!”

(Interagency Member)

“Universal screening is probably the only way we are going to be able to identify the extent and I suppose the other thing is that if we ask everyone the question, if we don’t ask any questions then we won’t find anything so ideally that is the best way to do this. . . . The difficulty for us is that some people are not prepared to disclose domestic violence even if they are directly questioned about it and it has been disappointing in the past where we have had leaflets printed and have tried to encourage people to

Differing opinions were voiced in the questionnaire returns, focus groups and individual interviews. As these are opinion an extensive selection has been provided to illustrate the diversity of that opinion. Selected quotes from the 211 questionnaires distributed to advice and information workers in the Derry City Council area are included. Those from A&E staff or other primary stakeholders are also illustrated.

“Has to be universal. It’s a much better policy than leaving it up to individuals themselves. If she’s filling it in along with everyone else it doesn’t draw attention to her Relying on staff suspicions is ad hoc. Victims can come forward everybody knows they’re not being picked on Women might not answer the first time or even the fourth but it still provides an opportunity”
[Selection of staff from Women’s Aid]

“I am not sure whether universal screening would work as it is a very private individual thing and you are very concerned who you disclose to. So I don’t think that it would work due to the way that A&E is laid out”.
[A&E Nurse]

“If it’s universal it’s not discriminatory but people are at different stages. From what I understand victims reach a conclusion at different stages so universal screening may or may not help Individual staff are up to their eyes Are these staff the appropriate staff. Are they the best-placed people?”
[Statutory Health Manager]

“There are loads of time, loads of time that you would suspect, based on the injury. There are very few people that you would say – say that there was someone this morning and I thought that there was something there, they would be highly indignant, even her family if I were to broach the subject. I know that you can say that that women needs help, but I dared broach the subject I could come off worse”
[Selection from A&E Nurses]

Issues were also raised about the other aspects of universal screening that need to be considered whether universal or voluntary.

“Most of the nursing effort is focused on Triage and there is a real pressure on it..... Triage tends to be a sit down and ask people how they are . . . Actually it can be quite difficult keeping it up and I am anxious not to increase the Triage burden if we can avoid it”
[A&E Consultant]

“Importance of when it is asked You need a protocol of how, when and where it’s done and how it’s recorded”
[Interagency Member]

“It needs to be asked carefully rather than just a bold question. You have to build up some kind of relationship before you can ask”
[Interagency Member]

“If universal screening is happening and data is collected, it needs to be going somewhere and to be used specifically to affect change. Given the prevalence of domestic violence it justifies using it. If we want to provide a signpost for health therefore we have to ask the question.”
[NGO Health Manager]

“The problem is that sometimes people come up under pressure, they may have their husbands with them, they are under pressure not to disclose what has happened, they are afraid of the consequences, they are afraid that we will take them on and then let them down and drop them into something and it maybe that if we could empower them by at least giving them information in such a way that it isn’t obvious to their husband or boyfriend so at least we can plant a seed that there is help out there whenever they are ready for it, people are standing by. I think that the difficulty of screening people is that there is a danger that we could immediately put them on the defence and will deny, and that actually we are not going to achieve a lot despite the work that would be involved. But I am happy to take advice from anybody”
[A&E Consultant]

The views of women survivors were also sought.

“Need to know the consequences because you’re not ready to be forced into things. The children being taken away is always a fear”
[Women Survivor]

“Despite over a quarter of a century of activism and research, too many individuals and agencies are still hesitant about asking direct questions. It is now clear that the problem here is the professionals not wanting to know, rather than victims not wanting to tell. My earlier research and countless studies since have noted that what victims are looking for from health professionals is the permission to tell and to talk. We have to shift our perspectives from talking about silence to thinking about unwillingness to hear and/ or act”
[Monica McWilliams speaking at a recent conference commented on the need for a change of perspective]

A sample of other resources are referenced in relation to this issue follow:

- A pamphlet from the AMA suggests that doctors should routinely question female patients about violence in their lives and suggest first making an opening supportive statement such as “Because abuse and violence are so common in women’s lives, I’ve begun to ask about it routinely” [Ref AMA pamphlet 1992] The Women’s Aid Help Line Co-ordinator commented that she felt this was a gentle and

talk even where there has been strong evidence of domestic violence and physical injuries as a result. Sometimes quite significant injuries - fractures and so on. People are not prepared to make the move, they don’t feel empowered”

[A&E Consultant]

“If they have a disability and they’re injured and the carer takes them to the hospital if carer is the abuser then it makes it harder to present. The other side is it may be the only way to expose it”

(Interagency Worker)

“I would have liked to be asked”

(Woman Survivor)

safe introduction to universal screening for all patients.

- Research which has examined the effectiveness of such tools has found that women are three times more likely to report experiences of domestic violence when asked specific questions from abuse assessment devices than through routine interviews. The same research found that more women admitted having experienced abuse when questioned by a health provider compared to women who were asked to fill out an assessment form themselves. [Ref Norton et al 1995]
- Another research study showed that when patients were asked in the A&E department if it was acceptable to be asked about domestic violence 96% responded positively 3 % said no and 1% were unrecorded.
- McLeer et al found that that introduction of a screening protocol raised the detection rate of domestic violence from 5.6% to 30%. However, when they revisited the department eight years later the staff had become complacent about the protocol and the detection rate had dropped to 7.7%. [Ref Mc Leer et al 1989]

“If they had asked me at the time, I might have told them but it was like take two aspirin and go home”

(Woman Survivor)

The BMA [1998] points out a number of key factors that need to inform the issue: -

- While it may produce more statistics on prevalence of domestic violence there is the possibility that questions might be inappropriate or even induce greater reserve.
- Enquiries may damage the doctor patient relationship if raised in an insensitive manner.
- There is a need for discussion about confidentiality between the doctor/nurse and patient, and how this raises issues about time.
- There is a danger that routine questioning becomes purely procedural, without necessarily carrying the impression that the doctor has the time to cope with a full discussion following any disclosure.

The BMA concludes that further research is required to determine a practice that is acceptable to both doctors and to women and is sensitive to different areas and cultures. They go on to state that as in many areas of medicine

- Doctors should consider what is appropriate for each patient.
- There should be greater focus on training and educating doctors to enable them to detect the physical and mental symptoms, which may indicate domestic violence.

The A&E Consultant in Altnagelvin Hospital commented earlier on the need to empower survivors to speak. He also mentioned that what was also needed was to create an environment where there were clear messages about domestic violence and the safety for survivors to disclose.

“The other option might be – I don’t know. . . , we certainly need to highlight domestic violence much more clearly and more focusedly than we currently are, whether we put some of that with leaflets for patients in the waiting room or Triage area, posters around offering assistance, providing routes to professional counselling.
[A&E Consultant]

“I’m not sure about risk assessment, I think the best way to assess the extent of the risk is to ask the woman herself – she’s the best judge, e.g. ‘Do you believe your life is in danger?’

(Women’s Aid Help Line)

[Protocols and procedural tools concerned with screening are referenced in the appendices]

Previous research has also been carried out in the use of risk assessment tools. A standardised safety assessment means that all patients identified as in an active abusive relationship are asked a series of routine questions regarding their personal safety. These questions may be in the form of a standardised in the form of an assessment tool such as a formal risk assessment record or be verbally administered by those responsible for supporting all victims. It is suggested that whether written or verbal the safety assessment should be standardised.

A cautionary note is also sounded by practitioners that such tools are not meant to be self-administered by the domestic violence victim but by a specialist support worker be that Women’s Aid, a nurse, or social worker etc who will discuss the result of the assessment with the victim.

There was however clear understanding expressed by Women’s Aid staff that the emphasis should be on safety planning to be carried out with individuals. This is articulated in greater detail in the Advice and Information research [Whitehorn and Stubbings 2003]

7.6 Findings - Documentation

The prevalence and use of an instrument to record known or suspected domestic violence cases raises a number of key questions:

- Is information on the results of domestic violence screening recorded?
- Should the record describe current or past abuse and for what purpose?
- Does the document record the name of the alleged perpetrator and relationship to the victim?
- Are facilities such as body maps or photography used to document injuries and for what purpose?
- Is the information collected and documented with the informed consent of the patient and is this shown to the patient on request?

Within the context of the A&E Department in Altnagelvin Hospital the particular issues addressed in focus groups or interviews were the use of cameras and body maps in particular with some reference as well to coding or recording domestic violence.

Issues were raised concerning the possibility of coding of domestic violence on a record that was to go outside the domain of the A&E Department.

"We would give a letter to the GP or health centre. When they come in, and I might be the only person doing this, and I am aware of DV and they have disclosed that, I write it on their chart but I tell them that I am doing that"
[A&E Nurse]

"The problem is that once the letters go out we have no control over where they go to and if someone has been assaulted and is not yet ready to accept treatment or advice about where to go, we didn't want to go meddling sending information into practice where they could be exposed inadvertently and put at risk".
[A&E Consultant]

"We need to let women know the benefits of recording information, for example if she goes to court"

Comments were made that any body mapping or photographs taken had to be presented within in an informed context for victims and those who assist them.

"Body mapping of injuries and photographs are increasingly forming part of this training but too often, this is as a result of an individual social worker, nurse or consultant taking a special interest in the domestic violence. There are still no practical toolkits on identification to assist police prosecutions nor any mandatory training"
[Monica Mc Williams during recent conference]

(Women's Aid Help Line)

"Some women may not go if they're taking photographs but they may need to have the photos taken later for the like of the Criminal Injuries Compensation Agency There is vital evidence there that goes nowhere"
[Women's Aid]

A&E staff too had a mixed reaction to the use of cameras: -

"Photographs – we don't use photographs too much in terms of recording. There are three reasons for using photographs. The first would be for training purposes which would be quite an unusual thing, secondly if we had a complex orthopaedic injury or trauma where we need other people to see the injury but we don't want them to keep undressing the bandages because of the risk of infection. You take a photograph there and the experts see the photograph rather than see the injury. The other one would be the occasional recording of assaults and interpersonal violence where it is helpful to record"
[A&E Consultant]

"One lady asked for photographs to be taken and although we were unsure, the photographs were taken. They were used as evidence, but we feel that this is not the place, we are not here to be photographers. If they want photographs these should be done by their solicitors – we shouldn't have to do it"
[A&E Nurse]

The use of body maps was also discussed: -

“Well, I have no problem with any injuries being recorded on body charts or photographs and some of our new charts have body pictures drawn on them so that they can draw where injuries are sustained. I think as a general principle it helps to clarify in people’s minds exactly what they are talking about. As we start to describe an injury it is not always particularly clear to either outside agencies or legal agencies what it is that we have described, so it clarifies in peoples minds. So I think that pictures are useful”
[.A&E Consultant]

“Its more important that they record the discussion, never mind the body maps”

(Women’s Aid)

Ethical and equality considerations were also discussed:

“There are however the issues of the ethics of recording injuries and getting consent”
[Interagency member]

“Once I had a male doctor wanting to note down every scar it was like echoes of abuse” [Woman Survivor]

“If it was universal for a camera and for everybody’s injuries to be photographed there’d be no problem. But if they’re distressed how would they give permission”
[Interagency Member]

“The use of cameras to record injuries has to be at the approval of the victim. This is very important otherwise you are taking away an individual’s rights. I do appreciate that someone else may be taking away an individual’s rights by beating them up but that is not the issue –that individual still has the right and photographs should not be taken without an individual’s permission”
[Statutory Health Manager]

“Women might feel frightened but if they are reassured that they will keep control, of the situation, it gives her an option and that will be a support for the future”

(Women’s Aid)

“Women might feel frightened but if they are reassured that they will keep control; of the situation, it gives her an option and that will be a support for the future” [[Women's Aid]

The A&E Consultant stated his concerns about prioritising the purpose of any form of recording mechanism.

“I would be concerned not about the injuries that were actually identified, but the occasions where injuries were not identified – a bit like child abuse – if we identify it and someone admits to it then that’s easy, but it’s the one that we send home that we haven’t identified - so putting a code in will only identify on the database those confirmed rather than the backlog of those we are not aware of”

7.7 Findings – Intervention Services

There are a number of reasons why intervention needs to be understood within the context of domestic violence.

Domestic violence is recurrent and tends to become more frequent and severe over time. Early intervention can help prevent traumatic injuries, and potentially suicide and murder.

The reasons given by health professionals for not intervening are varied:

- Close identification with patients, especially by physicians with a history of abuse or by a physician with socio-economic status similar to that of patients
 - Fear of offending patients
 - Feelings of inadequacy and frustration in providing appropriate interventions and lack of training
 - Inability of physicians to control the situation and “cure the problem
 - Lack of time to deal appropriately with abuse
- [Ref Parsons et al 1995]

The ethical context of intervention or its' absence is explored in detail by Sherri .L. Schornstein in her work on Domestic Violence and Health Care where she comments on a doctor's ethical duty to diagnose and treat domestic violence. A reference to the AMA's Council on Ethical and Judicial Affairs states that physicians have an ethical duty to diagnose and treat domestic violence because of the principles of beneficence and malfeasance.

It is of interest to note that in the USA the lack of appropriate intervention may result in civil liability. The AMA has recognised that physicians may be held liable for failure to recognise abuse and respond to their patient's complaints [AMA]

A standard intervention checklist is a readily available reference for clinical staff to use that provides information on the required or suggested steps to take if a victim is identified.

The research team leader showed an example of one produced recently by the Sperrin and Lakeland Domestic Violence Inter-agency Forum to A&E staff.

"I like that type of thing because they are immediate. They are easier and act as a visual cue"
[A&E Consultant]

"The only other thing that we do is provide them with a card with numbers on it. But there is no pathway or plan. We advise them to call, we advise them to ring but whether they do that or not. And also how they feel when we talk to them is different from how they feel in an hours time"
[A&E Nurse]

A consistent standardised approach to domestic violence enables staff in every setting to know what is expected of them and enables the service user to experience a consistent quality of service regardless of the individual staff present on the day.

Lack of protocols results in much more decision making in regard to screening, recording, referral etc being left to individual staff choice.

The research team resourced best practice guidelines, suggested protocols, resource manuals locally, regionally and internationally in relation to healthcare and domestic violence .A catalogue describing some examples and their source is to be found in the appendices.

A notable challenge that was faced by the research team related to the sourcing of secondary data. In quite a number of cases (15 UK NHS Trusts) organisations that had promoted the work around domestic violence protocols etc, through such avenues as their website, and promotional material., could not subsequently find this relevant material to pass on to the research team. Feedback offered a variety of reasons for this including the relocation of the department, 'point of contact' no longer there, or more poignantly that they had never heard of the document/programme.

Other key interventions identified within the Delphi programme are:

- On site victim advocacy services either part-time or full time [This was discussed in detail in an earlier section]
- Mental health and psychological assessments performed within the context of the programme. [Given the earlier findings on the impact of domestic violence upon survivors such tools might be designed for use also in Gransha Hospital and in Community Health Teams.
- Follow –up contact and counselling
- On site legal options counselling for victims
- Domestic violence services for the children of victims
- Co-ordination between the hospital domestic violence programme and sexual assault, mental health and substance abuse screening and treatment

While the Delphi programme suggests that these interventions be available to hospital patients that are experiencing domestic violence there is no reference made to the fact that many of these services may in fact be readily available within a specialist provider for domestic violence such as Women's Aid.

Beneficence means doing good or doing the right thing for the patient. In the context of domestic violence this means intervening to treat the true cause of injuries and sequelae, not just the symptoms.

Nonmalfeasance means doing no harm. Failure to diagnose domestic violence can lead to ineffective and dangerous treatment. Examples include prescriptions and sedatives for abuse victims who may be at risk of suicide and substance abuse.

Jecker suggests that ethical duties should also address the principle of justice because failure to intervene can further disempower and revictimise a victim while simultaneously maintaining the batterer's privilege and dominance. [Ref Jecker 1993]

The A&E Consultant commented on this by saying: -

“The other thing I think is that we need to know more about the services that are available that are out there in the community that we are referring people to. At the moment we say ‘here are some telephone numbers’ but we don’t seem to know in most cases what these people are able to offer. If we are trying to make life changing interventions in peoples relationships then we need to be clear about what we are able to take on – rather than leaving them exposed to further danger because of us shambling into something that we don’t fully understand. So there is an educational thing.”

“It would be good to visit the refuge”

(A&E Nurse)

7.8 Findings – Evaluation Process

Patient Charters and accreditation for quality standards have become a regular feature of working life for many within Health and Personal Social Services.. Within the context of domestic violence this involves not only eliciting feedback from patients on service provision but regular monitoring of charts to audit for domestic violence.

The Delphi programme provides a quality assessment tool that addresses the strategy and the specifics of a response to domestic violence.

Commenting on the programme the A&E Consultant said;

“I think that it is important that we have a template that we can audit against, as it is much more effective and its all there. So, that would simplify the process enormously. The other nice thing is that it gives you implicit questions and answers – what we should be looking for. So it would be quite useful.”

The evidence of the findings for this category of evaluation is to be found throughout this research, which in itself is an evaluative tool. The research team would wish to formally express their thanks to the A&E Consultant in particular and the Department who opened their doors to evaluation and assessment..

7.9 Findings – Collaboration

Throughout this research comments were made about joined up working and cohesive strategies.

This is traditionally regarded as referral ‘out of’ and ‘into’ services. The A&E Consultant is aware of the need to examine this in terms of domestic violence.

However, within a healthcare system there is a need for “internal “ referral systems, among other departments in their own hospital , other hospitals, other disciplines within primary and social care and community health programmes locally and regionally. The final section of this research addresses this in more detail.

The one remaining issue to be addressed is the response to staff experiencing domestic violence. Given that this was a key objective of this research, a separate section has been included. The analysis that follows reflect many of the conclusions made throughout this research. The reality is that domestic violence requires a collaborative integrated response and the implications and recommendations of the research cannot be confined to one hospital department alone.

“We tend to use the established GP route. Well, this may be part of the whole education of what’s available, who are the best people because we tend to refer people back to their family doctors. Whether they are aware of the skills with various agencies are – sort of the ‘blind referring to the blind’ you know. So this is part of an education package we need to be thinking about for our staff is “so what is the best route what are the options so that we can pick the best ones for individual cases”

(A&E Consultant)

7.10 Conclusions

There is confusion and lack of clarity about the presence of a domestic violence policy across most health care settings. Any policy needs to be placed within a strategy plan. There was no evidence of a domestic violence strategic plan at any level of health planners and providers within the Western Board area to respond to the physical and mental health needs of adults and children who are vulnerable and at risk as a result of domestic violence. Some individual managers are aware of the issue and are working towards a domestic violence policy, within their own setting.

A domestic violence strategy and policy that can be adapted for different healthcare settings is essential to inform decision-making and service development. The resource and expertise of the Foyle Domestic Violence Inter-agency Partnership could be utilised to support the strategic plan and policy development in all settings.

The issue of dedicated staff within A&E or the wider hospital setting responding to domestic violence has to be made within the context of its local setting. This has been demonstrated in other A&E Departments that have initiated pilot similar schemes.

Other discussion needs to be concerned with deciding if a dedicated person is needed to co-ordinate domestic violence policies and procedures etc throughout the hospital and to represent the Altnagelvin Hospital Trust at the Domestic Violence Inter-agency Partnership or to target resources first at front line intervention, particularly in A&E.

Protocols for staff to follow when they suspect or identify domestic violence or when a perpetrator is present are essential for staff training. The use of posters and charts made visible for use by all staff would ensure consistency of approach and enhance the support for the survivor.

Foyle Women's Aid either independently or in partnership with others have a wealth of resources for domestic violence survivors. These include leaflets on domestic violence for minority ethnic groups. Other agencies also offer support services for male victims, including accommodation and intervention programmes with perpetrators. It might be useful for the Foyle Domestic Violence Inter-agency Partnership to collate and review these materials from all social partners and to share the resources with the A&E Department.

The Investing for Health initiative may also wish to consider a review of the health materials provided within its own programmes and those of other health related events within the Western Board area. A domestic violence promotional campaign linked into other aspects of health information might be considered in the future, in partnership with local domestic violence fora in the WH&SSB area.

Foyle Women's Aid and other agencies need to provide referral information that is regularly updated.

Issues concerned with the cultural competence of staff were not addressed specifically in this research. However they provide a central theme of the advice and information research commissioned by Foyle Women's Aid. [Ref Whitehorn and Stubbings 2003]

Privacy, confidentiality and a space to recover, albeit temporarily, are determinants that may encourage domestic violence survivors to either disclose or seek support. The physical and environmental constraints of the A&E department in Altnagelvin Hospital are recognised. Any change can only happen within the parameters of what is considered feasible and achievable by those who work there and manage that environment.

It is difficult given that only 40%-47% of available staff responded to the audit questionnaire to accurately assess the skills and capabilities in A&E in Altnagelvin Hospital in relation to domestic violence. Non-completion of questionnaires may indicate a lack of individual awareness of the importance of the issue for A&E staff, a hectic working environment where questionnaire completion is a luxury or for a range of other reasons. This research can only be based on fact and not assumption and the conclusions in this section reflect that.

Attitude plays a significant role in the perception and understanding of domestic violence issues. Results from the questionnaires highlights that in addition to evaluating confidence and competence levels within a professional role, there is also the need to address the cultural competency of the individual which is an intrinsic contributor to thoughts and opinion formation.

A study by Bokunewicz and Copel showed that emergency nurses had changed their attitudes after a 60 minute presentation on the cycle of violence theory [Ref Bokunewicz and Copel 1992] there is an inevitable link between attitude, beliefs and behaviours. Any attempt to influence a proactive response and to dispel myths about domestic violence is more likely to occur either in formal training or discussion. Opportunities for both needs to be created. Foyle Women's Aid should consider designing and implementing attitudinal questionnaires prior to and post domestic violence training. The 'attitudinal statements' in the questionnaire could also be used to inform training structure and design.

Previous research has suggested that access to domestic violence training has a significant impact on both patients and healthcare staff.

There is, as in all health and social care settings a clear need to identify training needs and to develop a training plan within each setting or disciplinary area that will enhance the skills, knowledge and understanding of those who assist those affected by domestic violence.

Models of best practice and competence-based training are available to inform any future strategic training intervention that extends beyond the needs of A&E staff only. Foyle Womens' Aid should consider using the opportunity provided by their Interagency Domestic Violence Partnership to develop competence based training and to pilot this with a range of staff across all sectors.

The issue of universal screening is one that results in much discussion. The implications when screening and safety assessment is left to individual choice, experience, expertise 'or lack of it is immense. However if it is to be introduced it needs to do so within a framework of adequate support for staff including training, recording systems, peer review, monitoring and the commitment of management to the issue.

The amount and type of information recorded and the mechanisms to do so need to be carefully considered in terms of ethics and equality. However, staff and ultimately domestic violence survivors need to be informed of the benefits of recording injuries. Any systems devised have to be realistic and achievable within the A&E Department to be effective.

Given the context of domestic violence and the impact upon the physical and emotional well being and mental health of victims the consequences of non-intervention need to be clearly understood by staff in other health and social care settings as well as A&E.

Collaborative partnerships with Women's Aid and the range of social partners within the Western Board area would greatly enhance the effectiveness of the support available for those affected by domestic violence.

The development of a robust assessment tool for support planning purposes could also be undertaken within a domestic violence task force in the Western area and disseminated to best benefit staff and service users alike.

Collaborative partnerships, the use of the User Involvement Forum, mapping exercises and the auditing of strategic objectives in relation to domestic violence would ensure that the overall service for those affected by domestic violence is effective, efficient and equitable. This needs to be extended beyond A&E to all care settings where survivors and perpetrators of domestic violence are to be found.

8. Violence in the Workplace

A primary objective of the Investing for Health programme is to offer everyone the opportunity to live and work in a healthy environment.

For many victims of domestic violence these opportunities are eroded whether this means having to leave their home to ensure their safety or to be absent, leave, or be unable to take up employment to meet their social and economic needs. [Ref Whitehorn and Stubbings 2003]

Given the prevalence of domestic violence, it is likely that “in any company employees will either be at risk or personally affected by domestic violence, either as a survivor or perpetrator.” [Ref Opportunity Now 2003]

Foyle Women’s Aid has experienced increasingly the need to assist professional women who come seeking help or who disclosed, following training events and informal discussion with others, that they were survivors of domestic violence. The Investing for Health Action research programme provided therefore the opportunity to investigate the context of domestic violence not only among those who are the service users of Health and Personal Social Services but among staff themselves in order to assess to assess their health and safety needs.

Research respondents for this aspect of the research were to be staff that worked in the A&E Department of Altnagelvin Hospital. Opportunities were provided for administrative, ancillary, medical, nursing and other healthcare and social services staff to respond.

However, as outlined previously, early on in the process, the research team leader expressed concerns to the Steering Group about the extent to which staff in A&E would respond to the domestic violence-profiling questionnaire. This was for a number of reasons:

- A& E is a busy place with little spare time for completion.
- Domestic violence survivors in the staff might be reluctant to complete the form in their own work setting.
- Given these potential research inhibitors it was necessary to expand the research on domestic violence in the workplace through interviews with health care managers across all sectors in the Foyle area.

Consequently, individual interviews were added to the schedule with healthcare managers from the statutory, voluntary and community sectors

“ . . . in any company employees will either be a risk or personally affected by domestic violence, either as a survivor or perpetrator”

(Opportunity Now 2003)

8.1 Findings

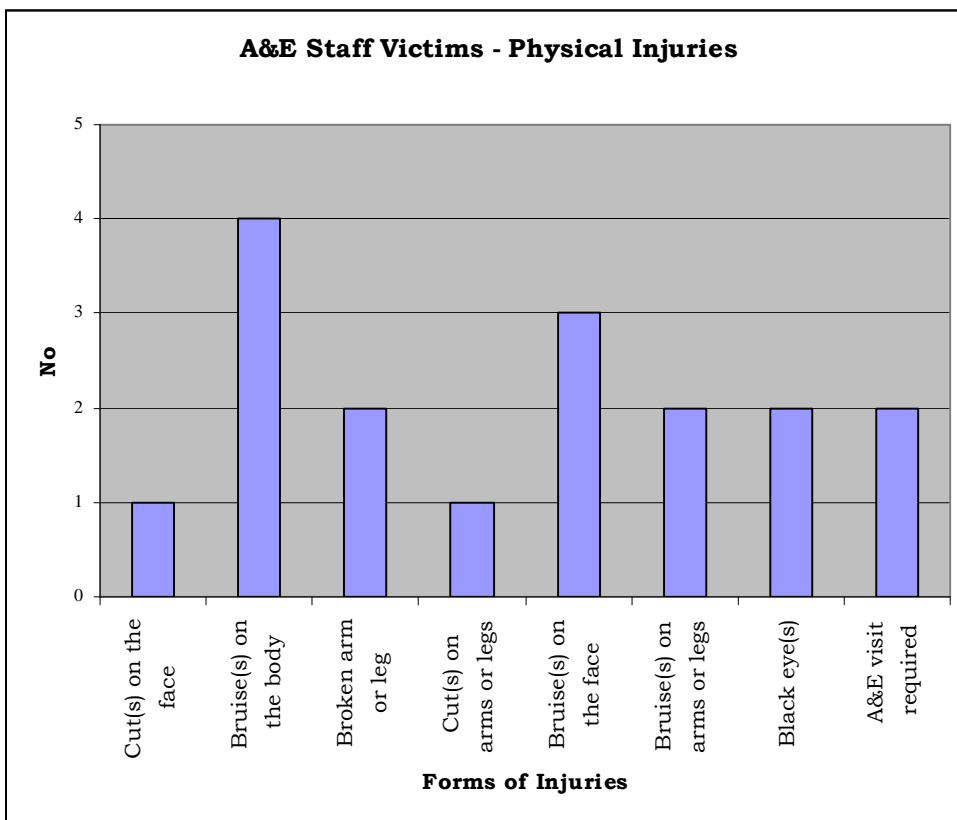
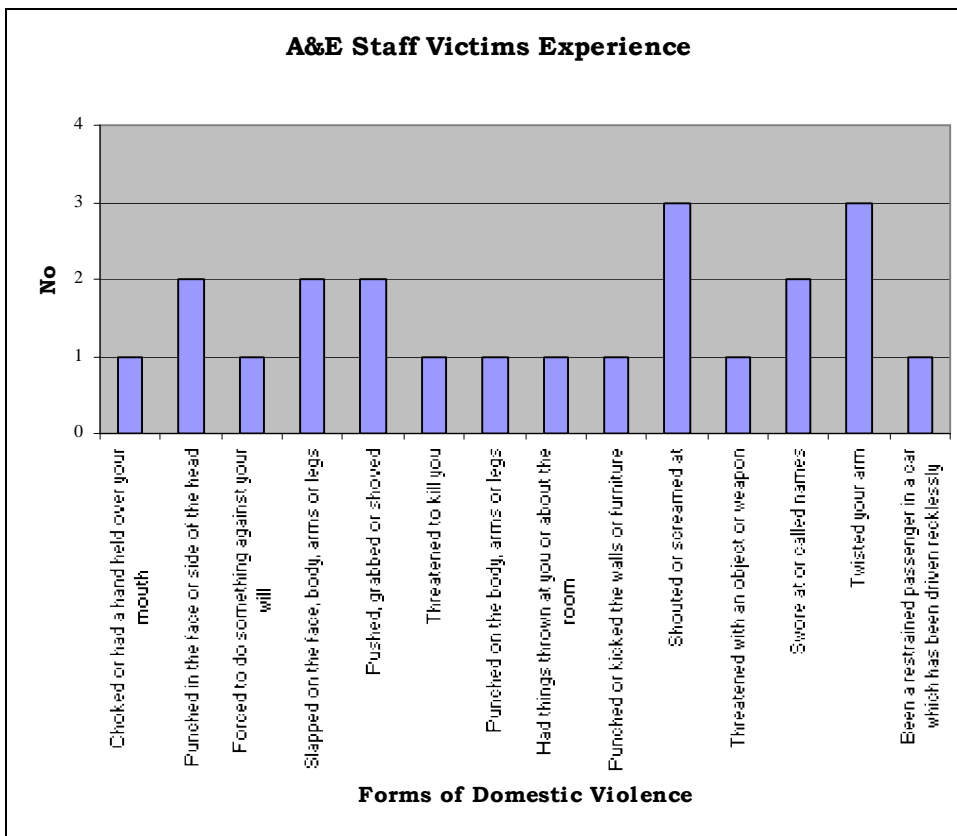
Only five members of A&E staff [all women] returned a response to the domestic violence profiling questionnaire, 80% [four out of the five] were domestic violence survivors.

The low return from staff does not allow a valid or reliable finding to be made in terms of the prevalence among staff. Nevertheless the four individuals who responded represent approx 11-14% of the average number of the A&E staff. If this prevalence subset was to be replicated among all staff in the WH&SSB area based on current staff numbers of approximately 8,000 (across three Trust areas), the potential transformation analysis would be a highly significant number of staff members who are victims of domestic violence. The number of perpetrators is more difficult to estimate.

12 out of 14 health service managers across sectors and disciplines in the Western Health and Social Services Board (WH&SSB), who took part in the structured interviews, indicated that they were aware of staff or colleagues who had experienced domestic violence. One manager was aware of a staff member who had experienced domestic violence.

Although the sample was small the research team wish to acknowledge the courage of the four women staff members who were prepared to take the risk of identifying themselves as domestic violence survivors.

The woman staff survivors had experienced many of the forms of violence experienced by other respondents.



“Domestic violence impacts greatly on a woman’s working life. Many abused women suffer physical injuries, sleep deprivation, low morale, poor self-esteem, heightened anxiety levels all of which may contribute to lateness, absenteeism, poor work performance and affect women’s ability to access career promotion opportunities or to even keep a job”

(Opportunity Now 2003)

Perhaps even more striking was the impact upon their mental health and emotional well-being

Interviews with a range of health managers across all sectors showed that while individually they were committed to responding to domestic violence and the welfare of their staff, many had never considered one in relation to the other.

The recently published document Domestic Violence and the Workplace [Ref Opportunity Now and WAFE 2003] articulates the context of domestic violence in the workplace for survivors' perpetrators and employers alike.

Some of the issues they identify have been used to provide a framework for the individual managers responses.

If a member of staff is identified as a perpetrator of domestic violence there is a responsibility for the Manager to ensure this does not impact immediately on his work and the working of his staff but also to ensure that member of staff gets the support they need to stop this particular behaviour trait.

[Health Manager]

- The social and economic costs of domestic violence to individuals, to the public purse and within the workplace have yet to be fully realised.
- Domestic violence affects productivity, may result in employee absenteeism and stress However, this will be affected by the awareness of domestic violence among employers and the presence (or absence) of a domestic violence policy that is inclusive of employees.

“As a manager I have responsibility for the health and well-being of staff and need to look at anything that interferes with that”

[Health Manager]

If it was drawn to my attention I would address it the same way as if it was any user of our service and try to have the same empathetic approach although I think I would find that easier with a victim than with a perpetrator”

[Health Manager]

“As such I am not aware that the WH&SSB has a domestic violence policy. However, we are currently doing a major review of the capacity of staff looking at both the physical environment and the work environment and under the Investing for Health agenda we have a clear commitment to ensure that we promote a healthy workplace.”

[Health Manager]

- Perpetrators of domestic violence in the workplace may also mean a misuse of organisational resources or the employer being brought into disrepute.
- There may be increased risk to workplace safety that threatens the safety of all.
- Regarding victims, it is the Manager's role to be vigilant and be aware of potential victims within the workplace. This is very much about building up relationships with the staff and very much ties into a Manager's responsibility to ensure there is a safe working environment.
- Women experiencing domestic violence are especially vulnerable when they are at work because once a woman attempts to leave an abusive partner; the workplace often becomes the only place she can be located and harmed.

Two out of the four A&E staff survivors of domestic violence recorded that they had experienced depression, one had experienced anxiety and one had had suicidal thoughts. Another had been prescribed anti-depressants or tranquillisers as a consequence of the abuse they had experienced. Notably, two out of the four staff respondents indicated that time had to be taken away from work as a result of domestic violence.

“Managers have a responsibility to get a policy and training in place, which should be compulsory along with an information pack for staff”

(NGO Health Manager)

There is a responsibility for Managers to ensure that if they identify a member of staff who is a victim of domestic violence they direct them to the sort of support that they need and allow the special leave that is available to be taken up for this.

- The legal liability in regard to health and safety in the workplace needs also to be considered in relation to domestic violence.
- Any staff policy in relation to domestic violence needs to clearly outline both support services for survivors and the consequences for victims, remembering that domestic violence is a crime and should be regarded as such by employers.

Within this there is a need for training around dealing with a broad range of issues for staff, particularly for managers. This should include input about identifying and supporting victims and indeed perpetrators of domestic violence.

“As a manager I've never thought of it before. If we had a policy clearly saying you don't have to put up with it . Make training available for managers”

[Health Manager]

"We could be much more prescriptive to managers in the form of a policy. We are a caring organisation but we need to engage the entire organisation in this. It is critical for managers."

[Health Manager]

"It has shocked me to realise that this could be going on with staff members and yet it is glaringly obvious"

[Health Manager]

"It has shocked me to realise that this could be going on with staff members and yet it is glaringly obvious"

[A&E Consultant]

There is an urgent need for employers and managers in the WH&SSB to consider the prevalence of domestic violence among their staff. For the true extent of the issue to be realised further research is required among staff in all HPSS Trusts, programmes such as Investing for Health and Health Action Zones and other identified health and social care initiatives.

"Sometimes as a team manager I see signs of stress but I wouldn't always think of domestic violence."

[Health Manager]

"A commitment from senior staff to such research would be required to encourage response and to ensure safety and privacy among staff disclosing their experience as victims or perpetrators."

[Health Manager]

"I would have a concern that the resources would not be there to back it up. If you're exposing a need, you need to have the resources there to feed it"

[Health Manager]

"By working to mitigate the risks related to domestic violence, a company will also create a safer workplace for women experiencing abuse and will send a powerful message to society that domestic violence is unacceptable, and that responding to it makes good business sense"

[Opportunity Now]

The Chairman of the WH&SSB writing in their annual report 2001-2002 stated:

"Previous generations would have found it unthinkable that staff who work in our emergency services or deliver care in the community and in hospitals could be subjected to physical violence"

He goes on to comment that public representatives, community leaders and public service must work together to tackle this growing problem. This research has shown that violence in the workplace is present for staff and patients but generated from a domestic setting.

9 Implications for Health and Social Care

The stated role of the WH&SSB is:

“to improve the health status and social well-being of our population with the resources allocated to it”

The main responsibilities of the Board are:

- Identify health and social care needs.
- Buy services from a range of providers.
- Monitor the provision of services.
- Undertake important statutory responsibilities relating to, for example, public health and the care of children.

These main responsibilities have been used as a framework to present the final section of the report on the implications for employers and managers and to inform the final recommendations.

9.1 To Identify Health and Social Care

The research has shown the significant impact of domestic violence upon the physical and mental health and emotional well being of 34.78% of the research respondents who are direct survivors of domestic violence. Indirect reporting of the domestic violence experience of others account for another 28.46% of the research population.

Although a very small sample is provided, when added to the anecdotal evidence of health managers across all sectors and the experience of Foyle Women's Aid there is evidence of health and social care needs for staff as well as service users who are affected by domestic violence.

For A&E staff and management there is evidence that domestic violence may affect a minimum of 1 in 7. Help of the patient population The main areas identified as need are the physical injuries and mental health. However there is evidence that domestic violence may either inhibit presentation of injury, resulting in later impact because of unattended wounds or increasing mental health difficulties.

The findings of this research have significant implications for The Investing for Health programme objectives in regard to promoting mental health and well being at individual and community level and to offer everyone the opportunity to live and work in a healthy environment.

Investing for Health may wish to consider taking the lead to establish a domestic violence task force at Board level to work collaboratively with the Domestic Violence Interagency Forum in Sperrin and Lakeland and the Foyle Domestic Violence Inter-agency Partnership in the Foyle Trust to develop strategies, policies and plans that improve care and services for all those affected by domestic violence.

9.2 To Buy Services from a Range of Providers

The experience and expertise of Foyle Women's Aid and their information on models of best practice would be essential to inform policy, decision-making and service development.

With a strategic plan in place and a commitment to following through in policy and practice there is an opportunity for the WH&SSB and the HPSS Trusts within it, including Altnagelvin Hospital to commission and contract expert services such as Foyle Women's Aid and other social partners in the community and voluntary sector to meet statutory and public sector need. These services could range from provision for service users to strategic planning and policy support in relation to domestic violence within the Board and Trusts itself.

The WH&SSB Board, in turn needs to be proactively lobbying Government for domestic violence to be included in Priorities for Action and consequently for Government Executive Funding to ensure that the resources allocated to them reflect the health and social care needs of the population in the WH&SSB area.

While the original focus of the research was to identify the context of domestic violence within the A&E Department of the Altnagelvin Hospital the need to create “pathways to health” into and out of A&E means that the issue is not one for A&E alone. There is a clear need for whole system working in relation to domestic violence.

9.3 Monitor the Provision of Services

One of the health managers interviewed for the research commented that there was a need to “demonstrate that what you’re doing is a health gain, you need to prove it. Domestic violence is bound to fracture social capital and social capital is bound to be a determinant of health”.

The social audit of the childcare services for the families of women using the services of Foyle Women's Aid may prove a pilot for future monitoring in other healthcare settings.

The Delphi programme referred to extensively in the section on service development provides an excellent template not only for A&E but for any organisation, agency or public body to monitor their services in respect to domestic violence.

“There needs to be a change from a reactive approach to a health management system. As community health, we need to check on health rather than illness. The way that health visitors get to do this for children to query injuries, and so on, . . . that’s what it needs”

(Interagency Member)

9.4 Undertake Important Statutory Responsibilities Relating to, for example, Public Health and the Care of Children

The first section of this research placed a response to domestic violence firmly within the statutory requirements of Section 75 of the Northern Ireland Act 1998 [and the Human Rights Act [N.I. 2000].

Issues such as User involvement, Promoting Social Inclusion, New TSN and NAPs should be outward facing to address and integrate the issue of domestic violence.

Other public and private law that should emphasise the need for domestic violence to be recognised fully as a statutory obligation by public and statutory bodies include:

- The Child Support (NI) Order 1991
 - The Children (NI) Order 1995
 - The Protection from Harassment (NI) Order 1997
 - The Family Homes and Domestic Violence (NI) Order 1998
 - The Criminal Evidence (NI) Order 1998
 - The Housing (NI) Order 2002
 - Separation, Divorce Etc (NI) Order 2003
 - Protection of Children and Vulnerable Adults (NI) Order 2003
 - Housing Support Services (NI) Order 2003
 - Children’s Commissioner (NI) Order 2003
- [Ref Mc Williams 2003]

9. Concluding Comments

The last words finally and perhaps appropriately are left with the A&E Consultant who permitted the research to take place to take place “in the workplace” and who showed throughout a commitment to identifying and responding to the issue of domestic violence within the A&E Department of Altnagelvin Hospital.

“Who has the ultimate responsibility of dealing with domestic violence? We need to have a more coherent strategy of who deals with what. Set out own house in order and then start tackling how to relate to outside agencies. There is quite a lot to be done”

“I don’t feel that we have any particular support structure in place for staff on either aspect [victim or perpetrator] .We, I suppose, fall into the trap of not having anything. There is no logic to that as it happens at all levels of society”.

“It is amazing the extent [domestic violence]. I don’t think it is worse here [A&E Altnagelvin Hospital] but that we are identifying it here. For other places, it has been brushed under the carpet”.

10. Recommendations

- WH&SSB Board (supported by the Foyle Domestic Violence Interagency Partnership and the Sperrin and Lakeland Interagency Forum) produce and promotes a cohesive domestic violence strategy to improve services for all those, including staff, who are at risk or vulnerable as a result of domestic violence in the Western area.
- The integration of domestic violence into all aspects of statutory duties and moral obligation be addressed in action with regard to healthcare planning, public policy, decision making and service development in the WH&SSB Board area. Review impact assessment tools need to be devised and implemented as for other equality and human rights issues.
- More opportunities need to be created by primary stakeholders, including all those involved with health prevention and promotion programmes, to enable perpetrators, survivors and the wider community to understand what domestic violence is. Opportunities to include:
 - Training and information needs.
 - Public health information resources.
 - Wider public campaign in collaboration with others.
 - Definitions in staff health and safety and training and development and personnel policies.
- The A&E department of Altnagelvin hospital should consider using these findings to plan the next stage of their response to domestic violence. Mechanisms for implementation should consider: -
 - A domestic violence policy that is to be clearly known and the implications understood for all staff in A&E and throughout the hospital setting.
 - A hospital based domestic violence task force and direct financial support for the domestic violence programme.
 - Use of the Delphi programme for planning, evaluation and monitoring.
 - A universal screening pilot for a time-limited period implemented with all staff trained and aware of protocols and procedures.
 - Use of body charts/photographs and recording information.
 - Development of specific protocols in relation to domestic violence with training and visible resources to support the service delivery.
 - Domestic violence specialist support within the department and/or the hospital as a whole.
 - Procedures for measures to be taken when domestic violence survivors or perpetrators are identified among patients and/or staff.
 - Increased range of domestic violence resource materials available throughout the department.
 - Ongoing review of other constraints such as privacy and childcare.
- Foyle Women's Aid and the Foyle Domestic Violence Interagency Partnership review existing resources and promote models of best practice including:
 - Training resources structure and content specific to the A&E setting.
 - Protocols for screening, recording, safety assessment and planning.

Referral mechanisms and information on the domestic violence provision of all social partners in the Foyle area.

Opportunities to address and assess cultural and attitudinal change in relation to domestic violence.

Programmes designed and implemented to identify and record training needs and best practice guidelines for training development.

Working with mental health professionals to design a sensitive but robust assessment tool.

- Disseminate findings of the childcare social audit and its' potential use to measure social capital and outcomes of social objectives.
- Seek funding for further research to assess and respond to the physical and mental health and emotional well being needs of children and young people affected by domestic violence.
- The Investing for Health programme should consider the implications of this research in terms of their key objectives to promote mental health and a safe and healthy environment in which to live and work. Activities within this should include:

A review within health programmes resource materials in the WH&SSB to 'proof' for domestic violence.

A domestic violence health campaign in collaboration with domestic violence fora in the WH&SSB area.

Take the lead in increasing the visibility of potential or actual domestic violence survivors and perpetrators among the staff of the WH&SSB and the three Trusts area. Lobby for and support the implementation of a review of staff safety and support policies to be cognisant of the presence of domestic violence victims and perpetrators within the workplace.

- The Investing for Health programme to urgently respond to the findings of this research in regard to the impact of domestic violence on the mental health of survivors, mainly women. Key tasks include:

Working with statutory, voluntary and community providers to initiate and effective response for adults and children vulnerable and at risk as a result of domestic violence.

Increasing awareness of the issue of mental health personnel.

Continuing to gather information to record and monitor the nature, extent and impact of domestic violence within the workplace environment of the WH&SSB and to disseminate this information locally and regionally.

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B. Identifying a 'Best of Breed'

Researcher	Short description	For further information
Allegheny General Hospital Pittsburgh PA, USA	Hospital based domestic violence programme (Delphi) The lead researcher is Dr Jeffery H Coben MD Agency for Health Research and Quality (AHRQ) Domestic Violence Senior Scholar in Residence This evaluation instrument is designed to permit formal assessment of a hospital's performance in implementing a domestic violence programme. It is designed to provide consistency of recording no matter the level of understanding or knowledge of domestic violence by the health professional.	http://www.ahcpr.gov/research/domesticviol/
Vancouver Hospital Canada	This prize winning hospital based development of a domestic violence programme acknowledges that Emergency Department staff "are responsible for ensuring that abused persons who come into the ER receive high quality and compassionate care while in the department" It also provides an understanding of the nature of the victim's experience and attending to emotional and physical symptoms. There is a handbook for hospital worker, which outlines areas including healthy and unhealthy boundaries, help for caregivers and availability of empowerment group meetings.	http://www.vanhosp.bc.ca/html/wellness_domestic_violence.html
Australian Medical Association	A study into the health impact of domestic violence, which led to the development of a domestic violence initiative to reduce the impact of domestic violence on women's health. A standardised method of identification was devised offering enhanced diagnosis and appropriate response to women survivors.	www.ama.com.au
Emergency Medicine Association of Pittsburgh Mercy Hospital, PA, USA	This is a medical advocacy project between Mercy Hospital and the Women's Centre and Shelter relating to the visitation of women survivors of domestic violence to emergency rooms. This project is designed to provide earlier intervention for domestic violence victims who present in a medical setting. Through this project, Mercy Hospital has mandated universal screen for all female patients.	http://www.mercyiowacity.org/
University College of Los Angeles	Domestic violence questionnaire developed (including the use of body maps) to be used by healthcare providers where there is a suspicion of domestic violence or assault.	http://womenshealth.med.ucla.edu/healthcareproviders/domesticquestion.htm
University of Iowa Hospitals and Clinics, USA	Domestic violence and primary care discussion paper that asks, in part, healthcare providers to examine how they can integrate assessment for domestic violence into routine history and follow-up care including knowledge of outside resources..	http://www.uihealthcare.com/uihospitalsandclinics/index.html

Researcher	Short description	For further information
University of Warwick	This is a mapping study of services working with families where there is domestic violence. It is called "From good intentions to good practice". It was developed involving collaborative research between the Centre for the Study of Safety and Well-being and the Domestic Violence Research Group.	www.domesticviolencedata.org/6_biblio/reports/gi2gp.htm
Applied Research Forum, Pennsylvania Coalition Against Domestic Violence, USA	The Forum has undertaken evaluating the outcomes of domestic violence service programmes, offering some practical considerations and strategies	www.vaw.umn.edu/documents/vawnet/evalout/evalout.pdf
Queensland Health Australia	Queensland Health, through its work on domestic violence has developed an assessment form for use by healthcare professional when speaking with survivors of domestic violence	www.health.qld.gov.au/
Hospital Soup.com	A web portal offering resource and direction for all things health related. One area relating to domestic violence issues offers suggestions questions and clinical guidelines when dealing with domestic violence issues.	www.hospitalsoup.com

The above list of information acts as a small representation of work that is being undertaken internationally around the issues of domestic violence within the context of the healthcare profession. The research team recognise that there are many more untapped resources available. However, in light of the focus of this particular research, it was not core requirement to take this secondary research study further than to identify and reference a sample representation of work that is actively being managed elsewhere.

The research team are also aware of the work carried out by the local Domestic Violence Interagency Fora in Northern Ireland. Examples of these include: -

- Foyle Women's Aid domestic violence policy work with Derry City Council, and their development of joint protocols with Police.
- Sperrin Lakeland Interagency Domestic Violence Forum - Multi agency guidelines for good practice 2003.
- The publication on pregnancy and domestic violence from Newry and Mourne Domestic Violence Interagency Forum.
- The GP flowchart produced by Homefirst Interagency Forum on Domestic Violence.

These and similar publications are available in all Interagency Fora in Trust areas throughout Northern Ireland.