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The Health Visitor Response to Domestic Abuse

Clare Winifred McFeely

MPH, BSc, RM

Submitted in fulfilment of the requirements for the degree of Doctor of Philosophy

School of Medicine, Dentistry and Nursing

College of Medical, Veterinary and Life Sciences University of Glasgow

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Dedication

For Graeme, whose strength inspires me still.

Acknowledgements

Abstract

Background: Domestic abuse is a global public health issue which results in wide ranging health consequences. There is an increased risk of domestic abuse in pregnancy and the post-natal period. In the UK, health visitors provide a public health nursing service to all families with young children, through regular contact from birth until the child starts school. Health visitors therefore, appear well placed to identify, support and protect women experiencing domestic abuse.

Study Aim: This study sought to describe the health visitor response to women experiencing domestic abuse in Scotland and to investigate the experience of the recipients of this response, in particular, women involved in domestic incidents reported to the police.

Methods: A mixed research methods approach was employed. Data were collected in three NHS Board areas in Scotland. Data collection included; focus groups with practicing health visitors (n=20); semi-structured interviews with health visitor service users involved in police reported domestic incidents (n=17) and a secondary analysis of routinely collected police data (n=100).

Results: Health visitors stated that women rarely disclosed experience of domestic abuse or requested support. Further, health visitors stated that women involved in police incidents were rarely experiencing ongoing domestic abuse. In contrast, the secondary analysis of the police data found that women involved in domestic incidents reported to the police had often been involved in more than one incident (79%); been injured during the incident (40%) and that children were often aware of the abuse (41%). Similarly, the majority of health visitor service users involved in police-reported incidents described experience of ongoing domestic abuse, which children were frequently exposed to, and a health visitor response which did not address their experience of abuse or support needs. Integration of research findings identified challenges to responding to survivors which included lack of a trusting relationship between health visitor and service user, health visitor practice, influenced by organisational issues, such as a child-focused approach and service constraints, and the consequences of domestic abuse for service users including fear of violent repercussions and fear of loss of their children.

Conclusion: This study provides new evidence that domestic abuse is often not identified by health visitors and that when abuse is identified, the service response rarely meets the needs of service users. The findings support existing research which indicates a lack of trust between health visitors and service users and provide new insight to the interaction between them. Recommendations from this study are that service responses aim to address the consequences of abuse to effectively engage with survivors of abuse.

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Author's Declaration

I declare that, except where explicit reference is made to the contribution of others, that this thesis is the result of my own work and has not been submitted for any other degree at the University of Glasgow or any other institution.

Signature:

Printed Name: Clare Winifred McFeely

Abbreviations

BMA	British Medical Association
BME	Black & Minority Ethic
CSA	Child Sexual Abuse
CTS	Conflict Tactics Scale
DA	Domestic Abuse
DoH	Department of Health
FGM	Female Genital Mutilation
FRA	European Union Agency for Fundamental Rights
GBV	Gender-Based Violence
GP	General Practitioner
HV	Health Visitor
NHS	National Health Service
NICE	National Institute for Health and Care Excellence
NMC	Nursing & Midwifery Council
PTSD	Post Traumatic Stress Disorder
SCJS	Scottish Crime & Justice Survey
UKNSC	United Kingdom National Screening Committee
UN	United Nations
VAW	Violence Against Women
WMA	World Medical Association
WHO	World Health Organisation

1 Introduction

1.1 Introduction to the Research Presented in this Thesis

Domestic abuse is a global phenomenon and a major public health issue (WHO 2014). Domestic abuse is a term used to describe a range of behaviours, perpetrated by current or former intimate partners, which include physical, sexual, mental and emotional abuse (Scottish Government 2008a). The far reaching consequences of domestic abuse have long been recognised as adversely affecting the individuals who experience it, their families and the wider society in which they live (United Nations 1993). It is estimated that a quarter of women in the United Kingdom (UK) will experience domestic abuse at some point in their lifetime (FRA 2014).

The dynamics of domestic abuse are complex, incorporating a range of personal and societal factors which present barriers to exiting an abusive relationship (Cluss et al 2006). Abuse may continue after the relationship has ended (Cluss et al 2006) and the health and social consequences can persist after the abuse has ceased (Department of Health 2005).

Health professionals regularly encounter individuals and families exposed to domestic abuse (Feder et al 2009) and have a specific duty to recognise this and respond appropriately (Scottish Government 2008b). Whilst there are evidence based recommendations regarding the identification of domestic abuse (Feder et al 2009) and providing an immediate response through provision of information and assessing risk (NICE 2014), there is little evidence of an effective health professional response to families living with abuse over a longer period of time.

In Scotland, policy directs efforts to the support and protection of young people to maximise health and social outcomes, with particular attention to protection from violence, abuse and neglect (Scottish Government 2008a). In the UK health visitors provide a universal public health service to all families with children from 10 days after birth until the child enters education at around 5 years old.

Health visitors have a professional duty to identify and respond to families at risk of harm from domestic abuse (Hall & Elliman 2004). Domestic abuse presents specific risks to health visitor service users for whom abuse has commenced or escalated in pregnancy or following childbirth (DoH 2005). Domestic abuse in pregnancy is associated with poor pregnancy outcomes such as preterm delivery and low birth weight babies who may require additional support in the early years (DoH 2005). Children who are exposed to domestic abuse may experience behavioural and mental health problems and present with physical health needs (Radford & Hester 2006). Further, women experiencing domestic abuse can face specific challenges in mothering and may require support with parenting in addition to protection (Radford & Hester 2006). Therefore, women experiencing domestic abuse may face specific challenges in mothering, relating to their own wellbeing or that of their child, and may require health visitor support with parenting and protection (Humphreys et al 2008a, Radford & Hester 2006)

Despite their pivotal role in responding to domestic abuse, little is known about the way in which health visitors assess or address domestic abuse during the five year period of their involvement with families. The implementation of increased identification and protection of families at risk of harm sits within the health visitor purview, however, the service has experienced re-structuring and lack of resources in recent years (Scottish Executive 2001, Scottish Government 2013) and therefore, the way in which the service meets these expectations and the extent to which this has been achieved is unknown. The research reported in this thesis aims to explore this.

1.2 Aim of Research

The primary aim of this study was to describe the health visitor response to domestic abuse, and gather the views of service users who experience domestic abuse on this response.

The secondary aims of this research were to describe the nature and extent of domestic abuse experienced by women involved in police reported domestic incidents and to provide recommendations for practice and further research.

1.3 Investigations Central to this Thesis

This thesis reports a mixed methods study, underpinned by a pragmatist, feminist theoretical approach. The research was conducted in three phases. The first phase was a qualitative, exploratory study which aimed to describe the health visitor response to women experiencing domestic abuse and the challenges, if any, to delivering this. Focus groups were conducted with a convenience sample of practising health visitors in 2010/11. This study provided descriptive data on routine responses to domestic abuse when women disclosed or, more commonly, when police shared information regarding domestic incidents with health visitors. Phase one produced interesting findings regarding health visitor views on the nature and extent of abuse experienced by service users and ongoing risk of harm, specifically those involved in a domestic incident reported to the police. This generated further research questions regarding identification of domestic abuse by health visitors and focussed the following phases of the research on police reported domestic incidents.

In phase two a secondary analysis of routinely collected police data was conducted to explore the nature and extent of domestic abuse which occurred during police reported domestic incidents. A sample of 100 female health visitor service users involved in a police reported incident in the calendar year 2012 was analysed.

In the third phase of this study health visitor service users who had been involved in police reported domestic incidents participated in semi structured interviews. The interviews sought to describe the nature and extent of their experiences of abuse, health consequences of this and their views on the health visitor response to domestic abuse. Interviews were conducted in 2013/14.

1.4 Research Questions

Phase One – Exploratory Study.
- How do health visitors currently respond to disclosure of domestic abuse?
- What, if anything, limits this response?
- How does the current response address safety and protection of women who experience domestic abuse?

- What support do health visitors require to improve their response to abused women?

Phase Two – Secondary Analysis of Police Data

- What is the extent of abuse experienced by women with children aged less than five years involved in police reported domestic abuse incidents?
- What is the nature of these incidents?
- Did women require medical treatment as a result of the domestic incident?

Phase Three – Service User Interviews

- What is the nature and extent of domestic abuse experienced by health visitor service users involved in police reported domestic incidents?
- What are the views of health visitor service users on the current health visitor response to women involved in police reported domestic incidents?
- What are the barriers and enablers for women to engage with health visitor support in response to police reported domestic abuse incidents?
- What are the support requirements, if any, of health visitor service users involved in police reported domestic abuse incidents?

1.5 The Doctor of Philosophy Degree (PhD)

This research was conducted in part fulfilment of a PhD. I embarked on the PhD journey after fourteen years working for the NHS initially as a clinical midwife and latterly working on research, evaluation and development. I hoped that on completion of this process I would have enhanced my research skills, increased my knowledge of research practice and ultimately be more confident in my abilities as a professional researcher. On reflection, I have moved towards each of these goals to some extent but, in doing so, have increased my awareness of the scope of research theory and practice in my own and other disciplines. Thus my original hopes now appear to be the first step in a longer journey.

PhD research is required to make an original contribution to knowledge. Adoption of a mixed methods design provides new insight to the dynamic between health visitors and women who experience domestic abuse, and in doing so, challenges assumptions about the therapeutic value of that relationship. Importantly, for research conducted within feminist

research principles, this research highlights the experiences and conditions of women as workers and as survivors of domestic abuse identifying challenges for both workers and service users which were previously unreported. This research informs the current debate on responding to those who experience abuse by highlighting the limitations of the service response, the factors which create the limitations and the way that women negotiate services which do not meet their needs. In addition, the research describes the nature and extent of abuse experienced by women involved in police reported domestic incidents, concluding that these incidents are indicative of ongoing domestic abuse. Secondary analysis is an underused method. This research demonstrates the potential for data routinely collected by partner agencies to increase awareness of health care providers of the needs of their service users.

1.6 Structure of the thesis

The findings of this research are relevant to researchers and practitioners from a range of disciplines and careful consideration was given to the presentation of this thesis. It is anticipated that the majority of readers will be nurses or health professionals in clinical practice, policy development or academic roles and so the thesis is presented in the style of this discipline.

The following two chapters present the context for this study. In Chapter 2 domestic abuse is defined, the impact of domestic abuse is explored and policy responses are described. Chapter 3 explores the health consequences of domestic abuse and a structured review of literature pertaining to health visitor responses is presented.

A discussion of the methodological considerations and study design are presented in Chapter 4, alongside the rationale for selection of research methods deployed.

Each of the three study phases are then reported in separate chapters (Chapters 5 to 7). These chapters will re-state the research questions, present the process of data collection and analysis. The study findings will be presented in full and discussed in relation to the literature. The strengths and limitations of research methods are also discussed to enable the reader to fully consider the findings.

Chapter 5 presents the first phase of the study and describes the impact of domestic abuse on health visitor workload, the health visitor response to women who experience domestic abuse and challenges to delivering this response. The subsequent two chapters describe the nature and extent of domestic abuse experienced by health visitor service users. Chapter 6 presents the second phase of the research, a secondary analysis of routinely recorded police data, and Chapter 7 presents the final research phase, qualitative research with service users.

Chapter 8 integrates the findings from all three research phases and discusses this in the context of the literature.

Conclusions and recommendations from the current research are presented in Chapter 9. The unique contribution of the current research is detailed in this chapter with a reflection on the strengths and limitations of the overall study design and a reflection on my PhD experience.

2 Domestic Abuse

2.1 Chapter Introduction

Domestic abuse has a profound effect on the health, dignity, autonomy and security of those who directly experience it, their children, families and wider communities (United Nations 1993). It is estimated that a quarter of women living in the UK will experience abuse from a partner at some point in their lives (FRA 2014) resulting in considerable personal and social cost.

The complex dynamics of an abusive relationship occur within an equally complex context influenced by individual, family and societal factors (Stark 2010). Thus there is much debate and some division on the issue of domestic abuse and appropriate responses. Issues such as the need for gender specific services, the appropriateness of routinely asking about domestic abuse and how best to respond to child protection concerns in families affected by domestic abuse are contested areas. In order to respond effectively to those affected by domestic abuse it is important to understand this context and the consequences of domestic abuse.

After defining the terms used in this thesis, this chapter establishes domestic abuse as an important issue and, drawing on literature and policy, discusses the context in which research questions in the current study emerged. In view of the adverse health impact of domestic abuse, health services have a key role to respond to survivors of abuse. As part of this response health visitors have a key role to identify and support young families exposed to domestic abuse. For that reason, Chapter 3 discusses the health impact of domestic abuse, states the central role of health visitors in addressing the consequences of domestic abuse and presents findings of a structured review of the literature pertaining to health visitor responses to domestic abuse.

2.2 Understanding Domestic Abuse

2.2.1 Terminology

Domestic abuse is

> "perpetrated by partners or ex-partners and can include physical abuse (assault and physical attack involving a range of behaviours), sexual abuse (acts which degrade and humiliate women and are perpetrated against their will, including rape) and mental and emotional abuse (such as threats, verbal abuse, racial abuse, withholding money and other types of controlling behaviour such as isolation from family and friends)" (Scottish Government 2008a).

Women may experience one or all forms of domestic abuse. The terminology used to describe domestic abuse has evolved over the past 40 years alongside a deepening understanding of the dynamics of this abuse. Historically, research focused on physical violence with terms such as "wife battering" and "domestic violence". These terms were superseded by "spouse abuse" and "domestic abuse" which encompass emotional, psychological and sexual abuse. "Intimate partner violence / abuse" was later adopted to highlight the importance of the specific nature of the relationship in which abuse occurs and to encompass relationships where couples cohabit, are dating or are in same sex relationships (Dutton 1992).

Subsequent work by Stark (2010) emphasized that abusive behaviour is used to control women, framing this as an attempt to reassert patriarchal power in the home, in response to increasing freedoms for women in social life. As such, physical abuse may be relatively minor but is supplemented by continual efforts to frighten, undermine and humiliate women, the impact of which is restricted freedom, diminished sense of self-worth and ill health (p171). Stark suggests a further change in terminology, arguing that "abuse" indicates an assumption of male power which is abused. As an alternative he created the term "coercive control".

Johnson (2008), a contemporary of Stark, further developed the terminology in this field. Amid debates on a gendered analysis of domestic abuse (section 2.2.2), Johnson (2008) introduced a Typology of Domestic Violence. He created terms to identify characteristics

of abusive relationships; intimate terrorism, situational couple violence, violent resistance and mutual violent control. Intimate terrorism describes the controlling pattern of behaviour described by Stark (2010) as coercive control, where one partner consistently attempts to control the other. Situational couple violence describes couples who both use violence, most likely due to an inability to effectively communicate in other ways. Violent resistance (also described by Stark (2010)), describes the violent retaliation of women who are the primary victim of abuse and have been exposed to their partner's controlling behaviour. Violent resistant usually occurs after a prolonged period of abuse at a point when women fear for their lives. To complete the model Johnson describes mutual violent control where both partners use a pattern of abusive behaviour in an attempt to control each other, however, he states that there is no evidence to support this dynamic.

Domestic abuse is part of a wider continuum of abusive behaviours known as Violence Against Women (VAW) (Kelly 1988) or Gender-Based Violence (GBV) (Heise et al 2002). The United Nations Declaration on the Elimination of Violence Against Women (1993) defines VAW as 'Any act of gender-based violence that results in, or is likely to result in, physical, sexual or mental harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life'. These terms encompass a range of abuse predominantly experienced by women and perpetrated by men. They include, but are not limited to, child sexual abuse, domestic abuse, rape / sexual assault, stalking, sexual harassment, commercial sexual exploitation, and harmful traditional practices such as Female Genital Mutilation (FGM) and forced marriage (Heise et al 2002). Women may experience more than one form of GBV in their lifetimes (Davies et al 2015). Terms such as GBV and VAW recognise that this range of abuses reflect and reinforce gender inequality, highlight the characteristics of perpetrators of abuse as well as victims and the need for responses to GBV to consider the implications for both men and women.

The term domestic abuse has been adopted throughout this thesis in keeping with the Scottish context in which the study was conducted. In reference to those who experience domestic abuse the term "victim" is often replaced with "survivor" as survivor acknowledges the strengths, rather than the vulnerabilities, of those exposed to abuse (Bewley & Welch 2014). In this thesis both terms will be used as "victim" is appropriate in the context of reported crime discussed in Chapter 6.

2.2.2 Gender and Domestic Abuse

Internationally, domestic abuse is considered to be both cause and consequence of gender inequality. That is, men use violence to assert their greater status and power in society. The resulting fear of further violence limits women's participation in some areas of society and so perpetuates the inequality (Stark 2010).   Gender, and inequality between genders, influences the power dynamic within interpersonal relationships, as well as the wider society. This gendered analysis of domestic abuse has been consistently challenged and this section will explore the current evidence.

 Men, women, boys and girls can be subjected to GBV however, evidence suggests that this type of abuse is predominantly perpetrated by men and disproportionately experienced by women and girls (Heise et al 2002).   For example, both male and female children experience sexual abuse but there is a greater prevalence of victimization in female children (Radford et al 2011, Krug et al 2002). Men perpetrate the vast majority of child sex abuse, regardless of the victim's gender (Gannon & Cortoni 2010). Similarly, men predominantly use women and men involved in prostitution (Jeffreys 2008). In relation to domestic abuse, the vast majority (around 80%) of incidents reported to the police are female victims of male perpetrated domestic abuse (Scottish Government 2013).

Dobash & Dobash (1979) and others such as Stark (2010) state that abusive behaviours are rooted in traditional beliefs that women are subordinate to men, men have ownership of women and this entitles them to control women's behaviour. This is illustrated in a list of events that were said to trigger domestic abuse in a multi country study; when women express their own opinions, do not follow their husband's instruction or do not fulfill their duties in the way their husband demands (WHO 2005). In this same study an Indian husband is quoted as saying, "If it is a great mistake then the husband is justified in beating his wife. Why not? A cow will not be obedient without beatings," equating women with property (WHO 2005). These beliefs are supported by societal norms of women's roles as subservient and expectations that women will tolerate abuse for family cohesion (WHO 2012).

Similar beliefs and expectations are repeated around the world. Nevertheless attempts have been made to reopen the debate on the gendered nature of domestic abuse with suggestions that men and women experience and perpetrate domestic abuse to an equal

extent, also known as gender symmetry (Johnson 2008). Much of the evidence presented to support equal perpetration of abuse uses quantitative measures which do not capture the severity of impact of abusive behaviours (Dobash & Dobash 2004). Indeed, a single incident of violence perpetrated by a man against his female partner is sufficient to alter the power balance in the relationship (Joyner & Mash 2012). Whereas men are less likely to report fear following violence (Rowland & Robinson 2000).

Graham-Kevan & Archer (2009) conducted quantitative research comparing use of controlling behaviours, including use of violence, economic control, intimidation and isolation in intimate relationships and concluded that men and women perpetrate these behaviours to a similar extent. Their work is underpinned by a theory of biological imperative that all behaviours relate to procreation. Therefore, the foundation of this work differs considerably from the gendered analysis of cause and consequence of domestic abuse adopted in this thesis. Graham-Kevan & Archer (2009) conclude that men and women both use controlling behaviours, women in order to secure a partner with resources and men to ensure that offspring in the relationship have been fathered by them. This theoretical stance excluded current social context in the interaction, such as a pre-existing power imbalance in heterosexual relationships and considered biological sex roles rather than the expectations and experiences associated with gender. Further the data collection tools did not measure use of sexual abuse, a form of physical violence and means of degrading and humiliating women, thus removing an important gendered aspect from their analysis.

To investigate the gendered nature of abuse Hester (2009) examined police reported domestic abuse incidents with female only, male only and both male and female (dual) perpetrators with a total sample of 126 perpetrators. Hester's findings support the gendered analysis of domestic abuse and describe the different ways that men and women use violence. Men were more likely to use fear and control tactics than women; a greater number of abusive incidents were attributed to men and violence used by men against women was more severe. In contrast, women were more likely to use weapons than men, often to defend themselves. The strength of this study was that it tracked relationships over a period of time which enabled the researchers to consider abuse as an ongoing pattern of behaviour rather than isolated incidents.

Johnson's typology of domestic abuse (introduced in section 2.2.1) developed from attempts to understand apparently conflicting research findings regarding gender symmetry in abuse perpetration. In common with Hester (2009), Johnson analysed routinely collected police data and found when male and female partners in the relationship both used violence, men used violence more often and women were more likely to be seriously injured (Johnson 2008). Application of Johnson's typology to police and survey data provides an important insight. Johnson (2008) states that use of intimate terrorism (domestic abuse) is far greater with male perpetrators than female perpetrators, and that cases of gender symmetry are likely to relate to the use of situational couple violence. This was recently supported by research in the UK conducted by Myhill (2015). Analysis of data gathered from the general population in the Crime Survey England & Wales in 2009 found that situational couple violence featured both male and female perpetrators, however, use of intimate terrorism or coercive control was "highly gendered" with the vast majority of perpetrators being male with female victims (Myhill 2015). Therefore, a gendered analysis locates domestic abuse within wider social inequalities and a wider scope of violence against women. Women can and do perpetrate violence against male partners but the evidence suggests that this occurs less frequently and the experience of male and female victims will differ because of the wider inequalities that women experience such as financial disadvantage (Scottish Government 2014a).

The experience and consequences of abuse differ for men and women. Women who experience abuse from male partners are more likely to describe a range of abuse (psychological, sexual or physical) than men and are more likely to report being afraid of their partner than men who experience abuse from female partners (Johnson 2008). Men are less likely to experience severe injury or repeated incidents of violence and are less likely to report feeling afraid or isolated (Robinson & Rowland 2006). This suggests that men require a different response to their experiences, for example, men are less likely to use refuge accommodation (Robinson & Rowland 2006).

Domestic abuse also occurs in same sex relationships and again, individual and social factors impact on the nature of abuse (Scottish Government 2008a). Some differences have been noted in the nature of domestic abuse perpetrated and experienced by lesbians and gay men. Donovan et al (2006) conducted research with people in same sex relationships in the UK using questionnaires (746 respondents), focus groups (21 respondents) and semi structured interviews (67 respondents). They found that men were

more likely to have their spending controlled, to be forced into sexual activity and more likely to be physically threatened by a male partner. Women were more likely to experience threats to "out" (expose their sexual orientation), be blamed for their partners self-harm and have their children used against them by a female partner.

Sexuality can be used as part of the abuse in both lesbian and gay relationships. For example perpetrators may undermine their partner's homosexual identity by stating they are not a "real" lesbian or gay man if they have a preference or dislike of some sexual acts (Donovan et al 2006). Experiences of homophobia and discrimination can present additional barriers to seeking help (Hester et al 2012).

The extent to which women and men experience domestic abuse is widely debated. In 2012/13, 17% of domestic abuse incidents reported to Police in Scotland were made by men who experienced abuse from a female partner and 80% of reports were incidents with a female victim of a male perpetrator (Scottish Government 2013). Groups which offer support exclusively to men who experience domestic abuse state that this is due to greater under-reporting of abuse by men than women as a result of greater stigma for male victims (Dempsey 2013). Whilst theories of gender support the concept of masculinities as a barrier to disclosure of experience of abuse, there is no research evidence to support this or to suggest that masculinities present a greater barrier than the shame and stigma experienced by female victims of abuse.

In contrast to reported crime where the majority of incidents involve a female victim, greater parity was found in the Scottish Crime & Justice Survey (SCJS), a large scale population survey in Scotland. In 2012/13, 3% of men and 4% of women who participated reported experience of domestic abuse in the preceding 12 months (Scottish Government 2014b). Lifetime experience of domestic abuse suggested some difference between men and women, with 17% of women and 10% of men disclosing domestic abuse at some point in adulthood, but still presents greater parity than reported crime. Gadd et al (2004) explored this further by interviewing men who stated they had experienced domestic abuse in the SCJS and concluded that men's experience of domestic abuse had been over-reported. Half of the men who disclosed domestic abuse completed interviews (44 participants). Some men had not understood the question and had answered positively if they had been burgled or for other incidents relating to the home environment. In addition, some men reported their female partners' violence in response to their own initial act of aggression or violent resistance as described by Stark (2010) and Johnson (2008). Only a

third of the sample considered themselves to be victims of abuse. A criticism of this work is that only half of the men who disclosed domestic abuse in the SCJS participated in the follow up research. Even assuming that all of the men who declined to participate were victims of domestic abuse the work of Gadd et al would suggest that prevalence is substantially lower amongst men than women.

To date evidence in this area strongly supports a gendered analysis of domestic abuse. There is little evidence to support the assertion that men and women experience and perpetrate domestic abuse at similar rates. A gendered analysis is important in understanding the nature of domestic abuse, in considering the service response to survivors of abuse and ultimately to end domestic abuse.

This thesis will focus on women who have experienced abuse from male partners or ex-partners.

2.2.3 Dynamics of Domestic Abuse

Worldwide it is estimated that between 10% and 50% of women will experience domestic abuse in their lifetimes (WHO 2005). Before describing the impact of domestic abuse and considering effective responses to this, the dynamics of abusive relationships will be explored.

Since the 1960s a sophisticated understanding of domestic abuse has developed which highlights internal (individual experiences of, and responses to, living with domestic abuse) and external (wider cultural and social) factors associated with domestic abuse. This understanding was informed by the work of specialist domestic abuse agencies and subsequently by academics such as Stark (2010), Johnson (2008), Stark & Flitcraft (1996) and Kelly (1988).

Historically, domestic abuse was considered a problem for individual relationships. Feminist activists first challenged this perception, defined domestic abuse as a social problem and raised awareness of domestic abuse as a means for men to control women (Dutton 1992). It is now recognised as an international concern (WHO 2013). In addition, the feminist analysis of domestic abuse challenged traditional victim blaming approaches which viewed stereotypical feminine characteristics, such as dependency, lack of

assertiveness and poor problem solving, as causes of abuse by identifying these behaviours as consequences of abuse, refocusing responsibility for abuse on the perpetrator. Despite decades of campaigning and research, stigma and shame associated with abuse continues to present a barrier for abused women to seek help (Garcia & Lila 2015). A recent meta-analysis of survey and study data in the European Union found that victim blaming attitudes persist. Even in countries with a history of activism and support services for survivors of domestic abuse a substantial proportion of the population hold women fully or in part responsible for the abuse that they experience (Garcia & Lila 2015).

The ecological model of domestic abuse developed by Heise (1998) provides a concise illustration of the multiple factors which enable perpetration of domestic abuse and present barriers to women exiting abusive relationships (Figure 2.1). These barriers include individual factors (relating to the perpetrator), the relationship, social structures and cultural values. Social and cultural aspects compound women's experience of living with domestic abuse, such as fear of the perpetrator, expectations of women in relationships, fear of victim blaming from people outside of the relationship and shame (Pain 2012).
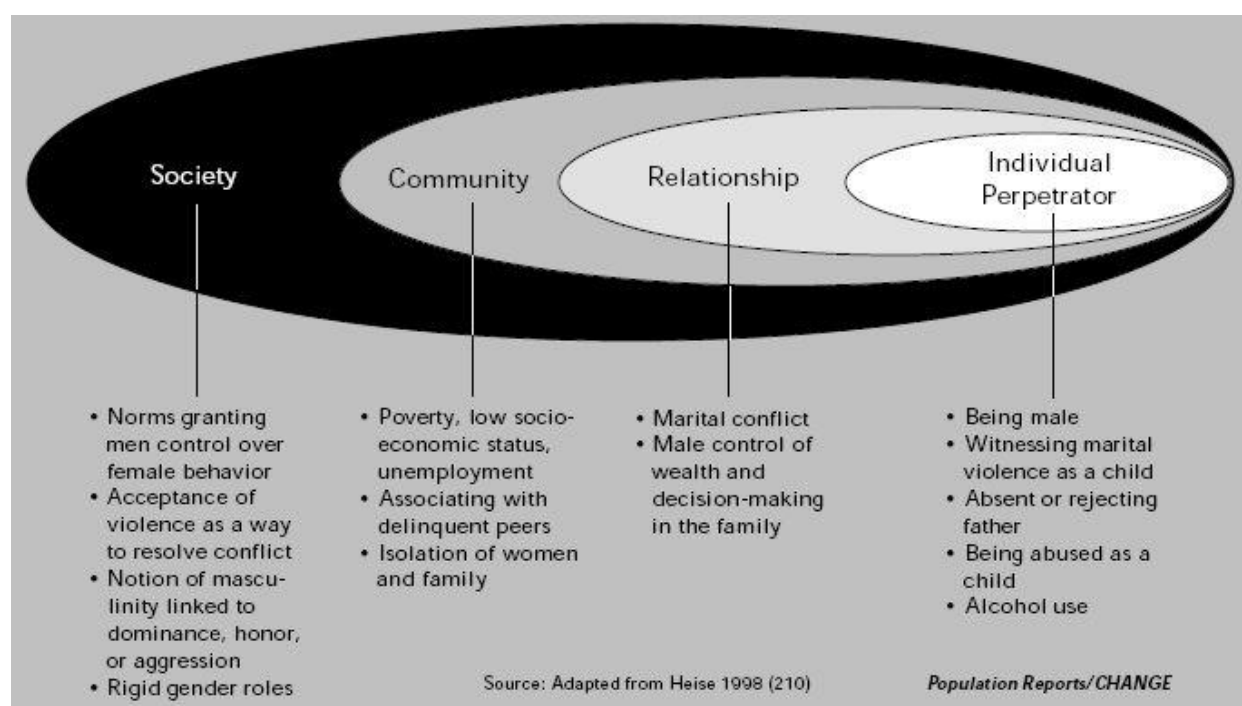
Figure 2-1 Ecological model of domestic abuse (Heise 1998)

Within the relationship, domestic abuse manifests as deliberate and ongoing use of violence, threats, intimidation and undermining the victim's feeling of self-worth intended

to control, harm or punish (predominantly female) partners (Home Office 2013, Stark 2010, Johnson 2008).   In 1979 Lenore Walker described domestic abuse as a "Cycle of Violence" (represented in Figure 2.2). The model was designed to support women to reflect on their relationships and see abuse as characteristic of their relationship rather than an exceptional or isolated incident. This model is still used today as many survivors can associate their own experiences with the cycle.

The cycle consists of three phases; honeymoon, tension building and serious incident. The honeymoon period first occurs at the beginning of a relationship. The abusive partner is attentive and attempts to please the woman. In the second phase tension begins to build. The abuser may be discontent and criticise their partner's appearance or begin to undermine, intimidate or threaten them. In response, the abused partner may attempt to please or pacify the abuser and Walker described this experience as "walking on eggshells". Tension continues to build and in the third phase reaches a climax of physical or sexual violence. Following this incident the abuser will appear repentant and return to the behaviour demonstrated in the honeymoon phase. During this time abusers may try to rationalise their behaviour using stress, alcohol or the behaviours of the woman as a justification. They will also demonstrate regret, guilt and love for the woman (Walker 1979).
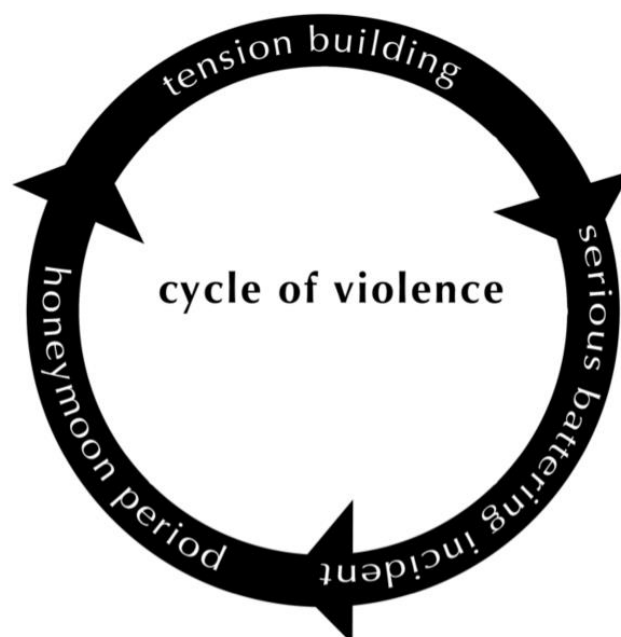
Figure 2-2 Cycle of violence (Walker 1979)

Many women love the abuser and want him to change and the partner's remorseful behaviour in the honeymoon phase suggests that change is possible but it is a further attempt to exert control and keep the woman in the relationship (WHO 2012). Walker's cycle predicts that the tension will build again and ultimately result in violence again. The length of time between phases is not regular or predictable. Walker (1979) states that this will vary by relationship but generally the cycle period will shorten over time.

Despite many women reporting the cycle represents their experiences, it has been criticised for oversimplifying a complex dynamic and for exclusion of women who experience constant, rather than cyclical, abuse. Taft & Shakespeare (2006) present two alternative patterns of abuse. In the first the perpetrator uses predominantly psychological and emotional abuse to control women with minimal, if any, use of violence. In the second the perpetrator is frequently violent both in and out of the home, lacks any empathy and shows no regret or guilt for their actions.

2.2.4 Women's Experience of Domestic Abuse

Kelly et al (1999) developed a model which represents women's experience of living with and leaving an abusive relationship. The model aims to provide an understanding of women's perspectives and responses to living with abuse in order to indicate how workers can best provide support. The model was developed during the evaluation of a multi-agency crisis intervention for women following the arrest of an abusive partner. The intervention was originally provided by civilian support workers to over 1200 women in London. Kelly et al (1999) identified 6 stages of living in and exiting an abusive relationship (Table 2.1). This is not a linear process and not all women will move through every stage. Indeed, women describe a range of experiences but with some commonalities. Stages were identified from work with women who had experienced a first physical assault but can be applied to the experiences of women who have experienced other forms of abuse from their partner or repeated physical abuse. Strengths of the model include the recognition of internal and external factors which impact on the perpetration of abuse and the women's ability to leave and the distinction between exiting a relationship and ending abuse.

While every woman's experience of abuse will be individual, commonalities are present in their accounts. Stage one of Kelly et al's model echoes the honeymoon phase of Walker's

Cycle of Abuse when abusive partners attempt to excuse the abuse and transfer responsibility to the abused woman. Similarly in stage two, distortion of perspective, tension is building and women alter their behaviour to avoid escalation of abuse. This is also consistent with more recent research conducted by Pain (2015) where survivors of abuse described feeling responsible for the abuse and tried to fix their relationships by adapting their behaviour. The work of Williamson (2010) further supports this concept by describing women's feelings of becoming implicit in the abuse by concealing the abuse and their attempts to manage increasingly unpredictable and bizarre demands made by their partners. Women may also experience feelings of responsibility for the abuse and to look after the abuser or may still have an emotional attachment to him which present emotional barriers to exiting the relationship (Scottish Government 2011a, Cluss et al 2006, Kelly et al 1999).

1.	Managing the situation	Women find an explanation for the violence and develop a coping strategy.
2.	Distortion of perspective	Women take responsibility for the abuse and spend increasing amounts of time trying to do, or not do, things to avoid violence.
3.	Defining Abuse	Women understand that the abuse is the perpetrator's responsibility, although they may not use the term "abuse" at this time.
4.	Re-evaluating the Relationship	Women review their relationship in a new context after defining abuse. They may consider leaving temporarily or permanently.
5.	Ending the Relationship	Women leave the relationship. Many will return to their partner once or many times for a variety of reasons including financial / practical barriers or pressure from others
6.	Ending the Violence	Leaving the partner does not end the violence. Only the partner can stop this.

2-1 Stages of exiting an abusive relationship (Kelly et al 1999)

Ongoing experience of abuse and attempts to pre-empt and minimize abuse can ultimately result in loss of sense of self, self-worth, potential development of alter egos to function in other areas of life (e.g. work) and significant mental and emotional health issues (Pain 2015, Williamson 2010).

Returning to Kelly et al's model, the final two phases of the model highlight an important distinction between leaving a relationship and being free from abuse. The act of separation can increase risk to women and their children as abuse frequently persists following separation and can increase in severity and frequency, therefore separating from an abusive partner does not end the abuse (WHO 2012). Moreover, fear of violent reprisal for exiting the relationship may lead women to remain with abusive partners in an attempt to manage risk (WHO 2012, Krug et al 2002). In addition to safety, physical and psychological health challenges, women must also consider the practical implications of exiting a relationship. These include financial dependency on the abuser and concerns about housing (Cluss et al 2006, Kelly et al 1999).

Practical and emotional considerations notwithstanding, professionals often assume that exiting a relationship is the only reasonable course of action for abused women (Virkki 2015, Stanley 2011, Kelly 1999). This creates discord between the aims of the health professional and those of women who have not defined their experiences as abuse and are trying to improve their relationship. Kelly and colleagues recommend that professionals identify which stage women are at in living with and exiting an abusive relationship and tailor their response to effectively support women to recognise abuse and consider their risk of further harm.

This section has explored the nature of domestic abuse. The consequences of abuse for individuals who experience it, and public perceptions of those affected by domestic abuse, present challenges for professionals who hold a responsibility to protect and support women exposed to domestic abuse. The next section will describe the impact of this abuse on individuals and society.

2.3 Impact of Domestic Abuse

As stated, the consequences of domestic abuse are wide ranging and impact upon individuals, families and wider society. Experience of domestic abuse can result in physical, sexual or psychological harm and loss of freedom which prevents women from fully engaging in society (Johnson 2008, United Nations 1993). Domestic abuse constitutes a violation of the human rights of women as it thwarts fulfillment of their right to life, to integrity and security and to the highest attainable standard of health (WHO 2013).

In addition to physical and mental health consequences, described fully in Chapter 3, humiliation, degradation and consistent undermining, characteristic of domestic abuse, have a profound impact on individuals which diminishes self-worth, self-esteem and self-confidence of individual. These in turn impair decision making, coping ability and self-efficacy (Stark 2010). Perpetrators may blame women for abuse and supported by wider societal views can instill feelings of shame and stigma in women who experience abuse (Stark 2010). Consequently it can be difficult for women to view their experiences objectively, to perceive themselves as living with an abusive partner, in order to name and attempt to free themselves from harm.

The additional support needs of women and children exposed to abuse place a social and financial burden on society. In 2009, the cost of domestic abuse, including costs incurred for health care, legal support and economic cost to the individual of lost working days was approximately £15.7 Billion per annum (Walby 2009). This estimate is based on domestic incidents reported to the police and as such is likely to be an underestimate as only a proportion of all abuse will come to the attention of police.

The cost of wider consequences of exposure to domestic abuse such as the lifelong and intergenerational impact of domestic abuse, are difficult to quantify. In recent years, a strong evidence base has emerged which demonstrates the negative impact of domestic abuse on children living in the household (Stanley 2011). Children can be affected by witnessing abuse of their mother, attempting to intervene to stop abuse or through feelings of guilt for not intervening (Humphreys et al 2008a). Children living in homes where domestic abuse is perpetrated will also experience an insidious impact which extends beyond individual incidents (McGee 2000a). Children may experience negative

consequences from being subjected to a controlling regime at home or by the effect of the abuse on their mother's well-being (Humphreys et al 2008a, Mullender et al 2008). If abuse leads to parental separation children can be disadvantaged through reduced family income or standard of housing (Berman et al 2011). Furthermore, exposure to domestic abuse can impair social adjustment and academic achievement. This in turn can negatively impact health and social status throughout the life course (Wilkinson & Marmot 2003). An association has been made to childhood exposure to domestic abuse and homelessness, unemployment and premature death in adulthood (Taylor & Lazenbatt 2014).

Children living with domestic abuse are exposed to the view that women are subordinate to men (Berman et al 2011). This may shape the views and behaviours of the children as adults. An increased incidence of both perpetration (boys) and of personal experience of domestic abuse (girls) in adulthood has been observed in those exposed to domestic abuse in childhood. However, Berman and colleagues stress that this does not automatically follow and many survivors of exposure to domestic abuse will neither experience nor perpetrate abuse. They describe a number of mediating factors, most importantly the relationship with the non-abusing parent, yet this relationship is often eroded in the presence of domestic abuse.

Women may have a limited ability to parent and care for their children as a result of the abuse. This can be compounded by behaviours such as alcohol or substance misuse, adopted by women to cope with ongoing abuse (Humphreys et al 2005). Furthermore, the perpetrator may actively undermine a woman's authority through erosion of her parenting role and relationship with her children (Humphreys et al 2008b, Mullender et al 2008, Radford & Hester 2006). A particularly harrowing example of this is found in studies where women reported they had been raped in front of their children (Humphreys et al 2008a). One such study demonstrates the extent of children's exposure to domestic abuse. McGee (2000a) conducted qualitative research with a sample of 54 children aged between five and 17 years old and 48 mothers in England and Wales. Women and children were recruited through a variety of methods including adverts on local media, mailing information and through workers in health, social care and specialist domestic abuse agencies. McGee et al's approach successfully recruited participants who were living with an abusive partner at the time of interview (40% of participants) as well as those for whom the abuse had ceased. Although a relatively small sample, the representativeness of this sample is a strength of this study.

The findings clearly identified the extent of children's exposure to domestic abuse. McGee et al report that 34 children (71%) had seen their mother physically assaulted, in three families men had threatened to kill their partners in front of the children, five men threatened their partners with weapons in front of the children and in five families the men had raped their partners in front of children, some on many occasions.

There is a strong association between domestic abuse and direct abuse of children in families where domestic abuse occurs. It is estimated that in 30% to 60% of cases of domestic abuse, children are also directly abused by the perpetrator (Berman et al 2011; Edleson 1999) and so for a considerable proportion of children exposure to abuse of their mothers will be compounded by their own experience of victimisation. Domestic abuse presents a significant child protection issue and Scottish National policy directs health and social care professionals to address it as such.

> "it must be recognised that children are witness to and subjected to much of this abuse and there is a significant correlation between domestic abuse and the mental, physical and sexual abuse of children" (Scottish Government 2008a)

Therefore domestic abuse is an infringement of human rights, restricting the freedom of those who experience it. The impact of domestic abuse is far reaching and carries an immense financial and social cost for families and societies in which it occurs. Domestic abuse also creates a significant health burden and this is explored in Chapter 3.

2.4 Extent of Domestic Abuse

2.4.1 Reported Crime

A range of methodological, definitional and practical issues limit the accuracy of prevalence estimates of domestic abuse. Police reported domestic incidents are frequently used to indicate the extent of this issue but it is estimated that as little 20% of domestic abuse incidents come to the attention of the police (Scottish Government 2014b). Women's decision to involve the police is based on consideration of a range of factors including fear of repercussion from the perpetrator, stigma or lack of confidence in support

services (Novisky & Peralta 2015). The Scottish Crime & Justice Survey (SCJS) 2012/13 found that around a third of women (36%) anticipated a poor response from the police service which acted as a deterrent to reporting incidents of abuse (Scottish Government 2014b). It is often stated that women will be assaulted on average 35 times before contacting the police citing a study conducted in the USA in 1984 (Jaffe 1984). In the 30 years since this research was conducted, Scotland has adopted regular national domestic abuse awareness campaigns to challenge public attitudes and has invested in the police force to improve the response to families affected by domestic abuse. Therefore, it is possible that women now contact the police sooner but there is no available evidence to support this.

Further analysis of SCJS data found that abusive incidents were most likely to come to the attention of police if children were directly involved or if the victim sustained a physical injury from the assault but sexual and psychological abuse were less likely to be reported (MacQueen 2013). As discussed, cultural attitudes can inhibit disclosure of physical, psychological and emotional abuse (Hester 2004). Greater stigma is associated with sexual crimes which, overall, are less likely to be reported to police than other crimes (Scottish Government 2014b). Reports of sexual violence by partners are relatively low but research suggests that experience of sexual abuse frequently occurs alongside other abusive behaviours perpetrated by partners, with two thirds of women who disclosed physical abuse also reporting sexual abuse (FRA 2014, WHO 2005).

A further limitation of using reported crime as an indicator of the extent of domestic abuse is that women experience domestic abuse as ongoing conduct of their partner and this cannot be accurately reflected in an incident based police recording system (Myhill 2015, Walby 2004). In addition, police can record that both the male and female partners are perpetrators of abuse, known as "dual perpetrator" or "counter allegations". Recent research in Scotland estimated that 5.4% of all reported domestic incidents have dual perpetrators (Brooks & Kyle 2015). Counter allegations may result from situational couple violence; violent resistance or male partners making counter claims to discredit women and discourage help seeking in the future. Police officers are advised that counter allegations should only be recorded if there is sufficient evidence of a crime independent of witnesses, for example an injury, or if they judge that "in the balance of probability an offence took place" (Richards et al 2008, p105). It is not known how this is implemented in practice.

Whilst it is widely acknowledged that police data is not representative of all those affected by domestic abuse (Walby 2004), Wykes and Welsh (2009) suggest that police statistics underestimate the number of domestic incidents which are reported. Opportunities arise throughout the reporting and investigation of domestic abuse to obscure the nature of the incident and prevent accurate recording as a domestic incident (Wykes and Welsh 2009). For example, behaviours perpetrated as part of domestic abuse, such as physical abuse, sexual abuse, threats, intimidation and some aspects of coercion can be prosecuted through a range of legislation within the UK. A call handler may not recognise that the perpetrator and victim are intimate partners or accurately record this. Later in the process attending officers may not consider the relationship to be an important factor or recognise this incident as part of ongoing abuse. These recording processes can result in under-recording of domestic abuse.

There is no single crime of domestic abuse. A consultation is currently underway in Scotland regarding the creation of an offence of domestic abuse. Whilst current legislation already identifies much abusive behaviour as a criminal act, a single crime could enable prosecutors to consider abusive behaviour which occurred throughout the relationship rather than single incidents and facilitate prosecution of coercive control (Scottish Government 2015a).

Finally in relation to police data, variation in recording practices reduces data quality. When attending a domestic abuse incident police officers are directed to ensure the safety of the victim, control the situation and gather evidence (Police Scotland 2013 Toolkit). As part of their assessment officers will observe the reactions of the victims and perpetrators (Police Scotland 2013). Women who have experienced abuse may attempt to conceal this if their partner or other witnesses are present for fear of violent reprisals (Wykes and Welsh 2009) or may be distressed and find it difficult to answer questions limiting accuracy of the assessment (Richards et al 2008). When it is not possible to speak with those involved in the incident officers will record their own observations for example if perpetrator or victim were under the influence of alcohol or injured (personal communication 2013). Therefore differences will occur in recording practices and responder bias (victim or perpetrator) and researcher bias (police officer or data collector) may influence data quality. In 1999 Kelly et al observed that police recording of domestic abuse was neither "consistent nor systematic".

There is currently no consistent approach to enquiring about and recording experience of domestic abuse in mainstream services such as health or social work (Walby 2004) and despite limitations described here, police reported data is often used to describe the extent of domestic abuse in the UK.

2.4.2 Research Data

Research has been conducted worldwide to assess the extent of domestic abuse, however challenges of recruitment and methodological differences mean that caution is required in interpreting results.

Difficulties in recruitment to research on sensitive topics are well documented, with difficulty increasing with the sensitivity of the topic (Lee 1993). Domestic abuse is a sensitive topic because it occurs in the private sphere, can involve humiliation and shaming of women and requires secrecy (Renzetti & Lee 1993). As stated (section 2.2.3), women may not recognise abuse as such and therefore may not disclose in general population research or volunteer to participate in domestic abuse specific research. Consequently, researchers frequently approach specialist domestic abuse services to support recruitment, however this is not representative of abused women who are unable or unwilling to contact specialist supports. Further, women living in refuge (safe accommodation for women fleeing an abusive partner) are likely to be experiencing a time of crisis and therefore data gathered on consequences of abuse or support needs may be exaggerated, limiting the transferability or generalisability of findings (Feder et al 2009).

Methodologically, the definition of domestic abuse can differ between studies with some considering only physical abuse and others physical, emotional and sexual abuse (Walby 2004). Differences occur in timescale of experiences of abuse such as lifetime, the preceding 12 months or during pregnancy (for example Bacchus et al 2004; Bateman & Whitehead 2004 used both measures). The method of assessing domestic abuse also varies. A range of tools have been developed to measure domestic abuse with varying validity and sensitivity (Rabin et al 2009). For example, the validity of the frequently used Conflict Tactics Scale (CTS) and subsequent revisions have been criticised for focusing on specific acts of violence, in particular for the omission of sexual assault and the impact of violence (Walby 2005).

Sampling bias can disproportionately exclude women who have experienced domestic abuse in population wide surveys (Walby & Myhill 2001). The sampling strategy for large scale population surveys are based on households but excludes those living in temporary accommodation such as refuge, with relatives or in accommodation for people experiencing homelessness. In 2001, Walby & Myhill also argued that telephone surveys exclude greater numbers of women who have experienced abuse as lower income households were less likely to have telephones. In 2016 the vast majority of people on lower incomes have access to mobile telephones but these can be changed frequently and are not listed on a universal directory. This limitation may persist to some extent or have been superseded by use of digital recruitment or research which also excludes those with a lower income or in some rural areas.

Finally, the method of enquiry can influence the response of the participant. When a computer assisted self-completion module was introduced to the British Crime Survey to enquire about domestic abuse, disclosure from participants increased 5 fold from the previous face to face interview method (Walby 2005). It is therefore, difficult to synthesize these extensive, but varied data sets.

2.4.3 Prevalence

The World Health Organisation (WHO) conducted a large scale study to assess the prevalence and impact of domestic abuse experienced by women across 10 countries (Bangladesh, Brazil, Ethiopia, Japan, Namibia, Peru, Samoa, Serbia & Montenegro, Thailand, United Republic of Tanzania). In total 24,000 women participated in interviews. Considerable efforts were made to ensure privacy and confidentiality to increase disclosure and limit risk associated with participation. The ethical considerations in this study were adapted to form a framework for conducting research on violence against women (discussed in Chapter 4).

Reported prevalence varied considerably between countries which the authors suggest is the result of cultural variation in attitudes towards VAW (WHO 2005).

WHO (2005) reported that of women who had ever had a partner:
- 13% to 61% had experienced physical abuse

- 6% to 59% had experienced sexual abuse from their partner

- 20% to 75% reported emotional abuse in past 12 months

- 21% to 90% of women experienced controlling behaviour from partners.

A more recent survey of VAW gathered data from 42,000 women living in the 28 European Union member states (FRA 2014). Data was collected in face to face structured interviews during which interviewers read questions from, and entered data into, a computer. This study found an average of 22% of women had experienced abuse from a partner ranging from 12% to 31% between countries. In the UK sample 29% of women stated they had experienced abuse from a partner. The researchers note that disclosure of abuse was higher in countries with greater gender equality (FRA 2014). Whilst this appears contrary to the theory of domestic abuse as a consequence of gender inequality it is likely that views which challenge gender stereotypes are more common and therefore VAW is less socially acceptable and more readily identified.

As anticipated, reports of experience of sexual violence were lower than reports of other physical violence. In the European Union study conducted in 2014 an average of 9% of women stated they had experienced sexual violence from a partner or ex-partner (FRA 2014).

The Scottish Crime and Justice Survey (SCJS) is a large scale population based survey which aims to provide a deeper understanding of experience of crime to supplement reported crime data (Scottish Government 2014b). The survey includes a computer assisted self-completion module on experience of partner abuse. In 2013/14, 17% of women completing the survey stated that, since the age of 16, they had experienced abuse from a partner. This is a considerably lower rate of disclosure than that in the European research and is surprising as both studies used an address based randomisation to identify participants and higher disclosure is associated with self-completion surveys (Walby & Myhill 2001).

The greatest risk factor for experiencing domestic abuse is to be female (Feder & Howarth 2014) however, some groups are at greater risk than others such as women from Black and Minority Ethnic (BME) groups (House of Commons Affairs Committee 2008), women with disabilities (Hague et al 2008), women with low socioeconomic status or lower

educational attainment (Humphreys 2007). Women are also at greater risk in youth, during childbearing years and in older age.

Age can affect the nature of abuse and the consequences for those who experience it. Young women and childbearing women are believed to be at greater risk of abuse (Barter et al 2010, DoH 2005). In a sample of 680 girls in the UK, aged between 13 and 16 years old, 25% reported physical abuse from a partner, 11% reported severe physical abuse and 31% reported sexual abuse (Barter et al 2010). Pregnancy is a risk factor for domestic abuse and it is estimated that 30% of abuse begins in pregnancy (DoH 2005). A Norwegian study of abused women found that motherhood was associated with longer duration of psychological, physical and sexual abuse (Vatnar & Bjorkly 2010).

Little research has been conducted on the experiences of older women but a number of factors associated with older age (low socioeconomic status, greater perception of stigma of domestic abuse, caring responsibilities) present additional challenges to exiting the relationship and indicate that older women will continue to live with abusive partners (Scott 2008).

Women with physical or learning disabilities have an increased vulnerability to all forms of GBV and their impairments often present a barrier to seeking help or accessing services (Olofsson et al 2015, Sequeria et al 2003, Voice, Respond & Mencap 2001). There is also a high prevalence of domestic abuse and other forms of GBV amongst women with long term mental illness and substance misuse disorders (Lothian & Read 2002).

Women from BME communities are at risk of domestic abuse and other forms of GBV such as FGM and forced marriage and may experience abuse from other family members as well as partners (Scottish Government 2009b). Language and cultural perceptions of abuse also act as barriers to disclosure and help seeking. This may include fear of being ostracised from the community or of violent consequences of actions perceived to dishonor a family or community such as disclosure of abuse (Scottish Government 2009a, Hester 2004).

2.5 Policy

2.5.1 Global Responses to Domestic Abuse

The United Nations Declaration on the Elimination of Violence Against Women (1993) gives clear direction to all national governments to develop policies which address this issue:

> "States should condemn violence against women and should not invoke any custom, tradition or religious consideration to avoid their obligations with respect to its elimination. States should pursue by all appropriate means and without delay a policy of eliminating violence against women." (United Nations 1993)

Despite high level international support for this work, the development and implementation of policies differs across the globe. Within Europe there is considerable variation with regard to ownership and accountability for implementation, progress of implementation and the type of abuse addressed in the plan (e.g. domestic abuse, rape or sexual assault) (Kelly et al 2011). For example, in countries where plans had been developed, there was little evidence that these had been formally adopted or supported by government.

More recently, the Global Status Report on Violence Prevention (WHO, UNOCC & UNDP 2014) reviewed responses across 133 countries (covering 88% of the world population) and also found variation in the extent of the response and the nature of the response delivered. Again the authors state that this reflects cultural factors which must be addressed by individual countries. For example, some countries prioritise forced marriage or FGM and may have greater attitudinal barriers to address (Hester 2004). They conclude that gaps remain in service provision for victims in all countries. This may, in part, be attributable to the use of unreliable prevalence data (discussed in section 2.4.) in service and policy development (Butchart et al 2014).

2.5.2 Scottish Policy Response to Domestic Abuse

Equally Safe is a national policy document which states the Scottish approach to tackling domestic abuse and other forms of VAW (Scottish Government 2014a). This policy locates VAW in an equalities and human rights framework in concurrence with the UN

Declaration on Elimination of Violence Against Women (1993). This differs from the stance adopted in England & Wales which retains a gender neutral definition, despite the UN guidance and a public consultation which urged adoption of a gendered analysis of domestic abuse (WNC 2009).

Domestic abuse is a long standing national priority in Scotland, driven by an active feminist movement. Feminists campaigned for representation of women in all fields of policy and planning. In 1999 devolution and formation of a Scottish Parliament presented further opportunities to inform national priorities and discuss VAW in the context of inequalities (Burman & Johnstone 2015). The National Strategy to Address Domestic Abuse was introduced in 2000 to develop services for survivors of abuse and strengthen legislation. In 2001, the themes of prevention, protection and provision were identified in the Preventing Violence Against Women action plan (Scottish Executive 2001). This was followed in 2003 by the National Prevention Strategy which aimed to raise public awareness, provide education and training, support services for women and develop services for perpetrators of abuse. In 2009, the Scottish Government launched the cornerstone of the national policy framework, 'Safer Lives, Changed Lives: A Shared Approach to Tackling Violence Against Women' (Scottish Government 2009). This document (re)states that the protection of women and children from all forms of violence is a national priority and provides guiding principles for agency responses with a focus for multi-agency activities.

To improve the health service response to survivors of abuse, all NHS Boards (regions) in Scotland were instructed to develop and implement a Gender Based Violence Action Plan (Scottish Government 2008b). Four key actions were identified: introduction of routine enquiry of domestic abuse in six priority healthcare settings; dissemination of guidance for health professionals; production of a domestic abuse policy for employees and multi-agency working to improve responses to those affected by domestic abuse. The current research commenced as part of this programme.

The first action, routine enquiry, involves asking every patient attending priority health settings about domestic abuse, whether abuse is indicated or not (Scottish Government 2008a). Priority health areas were selected as those areas that survivors of domestic abuse were most likely to present and included maternity, mental health, substance misuse,

sexual health, community nursing (specifically health visitors) and emergency medicine (Scottish Government 2008b). This is discussed further in section 3.3.2.

2.5.3 Scottish Policy Responses to Children Exposed to Domestic Abuse

The National Domestic Abuse Delivery Plan for Children and Young People (DADPCYP) (Scottish Government 2008a) applies the principles of protection, service provision and primary prevention to children and young people. Thirteen priorities were identified including the NHS Gender Based Violence Action plans. Other priorities included improvements to legal processes, enhancing support services and ensuring safety of children exposed to domestic abuse.

Alongside the DADPCYP, Getting It Right For Every Child (GIRFEC) is a policy approach that aims to improve outcomes for all children and young people by prioritising their needs and building support around the child (Scottish Government 2010a). Importantly GIRFEC directs professionals, through guidance on assessment, to consider positive factors which can mediate the impact of domestic abuse for young people, such as a positive relationship with the non-abusing parent (section 2.3). GIRFEC is the foundation for work with all children and young people, including adult services delivering support to parents. In 2007, GIRFEC launched pathfinder projects in four NHS Boards in Scotland. The pathfinders aimed to demonstrate the implementation of the GIRFEC approach in response to the single trigger of police reported domestic abuse. The projects implemented a multi-agency response with information sharing and risk assessment at the core (Scottish Government 2010b). Learning points from pathfinders highlighted the importance of communication and the vital role of universal services, such as health visitors, in responding to domestic abuse. The evaluation focussed on process as, study time constraints resulted in insufficient time to measure health and safety outcomes or other indicators of wellbeing in women and children.

2.6 Chapter Summary

This chapter defined domestic abuse, discussed domestic abuse as a form of gender based violence and described the personal and social consequences for those who experience this abuse and the wider society in which it occurs. The following chapter will describe the

health consequences of domestic abuse, health responses and associated challenges and focus on the role of the health visitor.

3   Domestic Abuse and Health

3.1 Introduction to Chapter 3

Domestic abuse, whether physical, sexual, emotional or psychological, can have a negative impact on physical and mental health with greater detriment to health the longer the duration of abuse (Porcerelli et al 2005, WHO 2005). Ill health can persist long after the abuse has stopped and some conditions may only become apparent after separation from the abuser (Pain 2012, WHO 2005). Consequently, women who have experienced domestic abuse are more likely to require healthcare and more likely to access health services than women who have never been abused (Feder et al 2009). Studies in the USA and UK estimate substantially higher health care costs for women who have experienced domestic abuse (Walby 2009, Jones et al 2006). In 2009 the health costs of domestic violence in England and Wales were estimated at £1.7 billion (Walby 2009). Therefore the health impact of domestic abuse has consequences for individuals and for the wider society.

This chapter first presents an overview of the literature on health consequences of exposure to domestic abuse, then considers health service responses to this with discussion on identification of abuse and risk assessment. The pivotal role of health visiting services is then presented with a structured review of the literature relevant to health visitor responses to women affected by domestic abuse.

3.2 Health Consequences of Domestic Abuse

3.2.1 A Public Health Issue

The health consequences of domestic abuse are wide ranging. In terms of physical health, women may experience traumatic injury resulting from assault but they are also more likely to report problems which affect day to day functioning, such as limited mobility, pain, memory loss and dizziness, than women who have never experienced abuse (WHO 2005). In the Scottish Crime & Justice Survey in 2012/13, two thirds of women who disclosed experience of domestic abuse stated this resulted in negative psychological

consequences and almost half (48%) reported a negative impact on physical health (Scottish Government 2014b). Table 3.1 provides an overview of the most common health consequences of abuse. Hence health professionals working in a range of clinical settings are likely to encounter women who have some experience of domestic abuse and carry a professional duty to identify current risk and address health related consequences of this abuse.

The consequences of domestic abuse can be fatal. Globally around two fifths of all women who are murdered are murdered by a partner or ex-partner (WHO 2014). In the UK half of all women who are murdered are killed by a partner or ex-partner with an average of two women killed every week (NICE 2014). Experience of domestic abuse is also associated with self-harm and suicide (Krug et al 2002). In 2011 Scottish Women's Aid (SWA), a third sector provider of refuge and support for women experiencing domestic abuse, conducted an outcome evaluation with service users. All women who contacted the service in a single day were invited to participate in a self-completion questionnaire and 340 women participated, 12% of whom stated that, without access to refuge accommodation they would be dead. Of these over half (56%) stated they would have taken their own lives, 7% feared their partner would have killed them and 37% stated either their partner would have killed them or they would have committed suicide (SWA 2011).

The social impact of domestic abuse can also adversely affect the health of women. Access to employment and social support has a positive impact on health (Wilkinson & Marmot 2003) but women who experience domestic abuse may be unable to sustain employment or social relationships due to attempts to hide physical abuse or because their movement and freedom is controlled by a partner.

Physical:	Psychological and behavioural:	Sexual and reproductive:	Fatal health consequences:
Abdominal / thoracic injuries Bruises and welts Chronic pain symptoms Disability Fibromyalgia Fractures Gastrointestinal disorders Irritable bowel syndrome Lacerations and abrasions Ocular damage Reduced physical functioning.	Alcohol and drug abuse Depression and anxiety Eating and sleep disorders Feelings of shame and guilt Phobias and panic disorder Physical inactivity Poor self esteem Post traumatic stress disorder Psychosomatic disorders Unsafe sexual behaviour Smoking Suicidal behaviour and self harm	Gynaecological disorders Infertility Pelvic inflammatory disease Pregnancy complications / miscarriage Sexual dysfunction Sexually transmitted diseases, including HIV / AIDs Unsafe abortion Unwanted pregnancy	AIDS related mortality Maternal mortality Homicide Suicide

3-1 Health consequences of experience of domestic abuse. (From Krug et al 2002 p101)

3.2.2 Behavioral and Psychological Health Consequences

There is a greater prevalence of experience of GBV among mental health service users than in the general population with up to two thirds of mental health service users disclosing some form of abuse (Feder et al 2009, WHO 2005, Krug et al 2002, Lothian &

Read 2002, Golding 1999). Research in the mental health field often conflates experiences of GBV and neglect in childhood in the single term "abuse" as survivors report similar mental health consequences following these experiences (such as Post Traumatic Stress Disorder (PTSD), depression and anxiety). Oram et al (2013) conducted a systematic review focused exclusively on domestic abuse and concluded that approximately one third of female psychiatric in patients (30%) and out patients (33%) had experienced domestic abuse.

Beck et al (2014) found that female survivors of domestic abuse who accessed mental health services had a high prevalence of social isolation, low self-esteem, greater difficulty with problem solving and greater propensity to be overwhelmed by problems. A limitation of this study is lack of a control or comparison group who had not experienced abuse. This precludes conclusions on whether these symptoms result from domestic abuse, poor mental health or a combination of both. However the study is useful in increasing our understanding of the impact of living with domestic abuse.

People who access mental health services (Lothian & Read 2002) and members of the general public (Cavanagh et al 2004) believe that experiences of abuse can cause mental illness. In contrast some mental health practitioners subscribe to a biomedical model of health believing only biological factors affect mental well-being (Cavanagh et al 2004). This in turn influences practice and practitioners who hold these beliefs are less likely to ask about abuse during assessment or attempt to address the experience of abuse in the care they provide (Young et al 2001). As a consequence service users who associate abuse with their mental health can perceive the bio-medically focused assessment as a barrier to disclosure, believe that they have been misdiagnosed and be dissatisfied with their care (Rose et al 2011, Lothian & Read 2002, Rodriguez 1996).

Experience of domestic abuse is associated with alcohol and substance misuse (Humphreys et al 2005, Galvani 2005). Humphreys et al (2005) found that between 22% and 44% of women accessing services for alcohol misuse and between 10% and 25% of women accessing services for drug addiction disclosed experience of domestic abuse. Further, experiences of domestic abuse, whether current or historic, can adversely affect the success of interventions which aim to support women to reduce or stop alcohol and substance misuse (Sun 2008, Covington 2008, Galvani 2006).

Substance or alcohol misuse is often understood as a consequence of domestic abuse where women use alcohol and other substances to manage the physical and psychological pain which results from abuse (Dolev & Associates 2008). While this argument is well supported in women's accounts (Humphreys et al 2005) some research suggests that pre-existing addiction issues can increase vulnerability to domestic abuse (Dolev & Associates 2008). For example, abusive partners may use access to, or supply of, alcohol or drugs as a means to control women's behaviour (Stella Project 2007) but findings to date are equivocal (Humphreys et al 2005, Galvani 2005).

In addition to the health impact, any use of alcohol or other substances can alter the response of others to women's victimisation. Perpetrators of abuse may use their partner's consumption of alcohol to excuse their own use of violence and, if required to respond, statutory agencies place greater responsibility for abuse with a victim who has consumed alcohol (Leonard 2001). This service response was observed in the USA where health professionals placed more responsibility for the abuse on women who had consumed alcohol and diminished the responsibility of the perpetrator (Harrison & Willis Esqueda 2000). Therefore alcohol use can obscure professionals' perceptions of the relationship, minimise the incident and obfuscate the risk to women.

A strong association has been identified between alcohol consumption and perpetration of domestic violence (Foster 2014, Foran & O'Leary 2008). In a meta-analysis of 47 studies Foran & O'Learly (2008) found a small to moderate effect of alcohol on the use of physical violence by men against female partners. There is no evidence regarding an increase in the use of abusive and controlling behaviours other than physical violence (Foster 2014). Further, women who report their partners' use of violence when under the influence of alcohol report that they are also abusive when they had not consumed alcohol; therefore alcohol is not a consistent factor in their perpetration of abuse (Galvani 2004). Theories which aim to explain the relationship between alcohol and abuse perpetration present a complex picture which incorporates pharmacological, individual, relationship and social factors mediating or exacerbating the effect (Foster 2014, Galvani 2004, Foran & O'Leary 2008).

Despite the co-occurrence of alcohol use and domestic abuse there is some resistance to exploration of the relationship between these two behaviours. This is attributed to concerns of feminist theorists that if alcohol is perceived to be a cause of abuse then

perpetrators will be absolved of the responsibility for their actions and the underlying inequalities will be masked (Foster 2014, Galvani 2004, Foran & O'Leary 2008). Galvani (2004) addresses these concerns in her theory of "responsible disinhibition", which emerged from qualitative research with 20 female survivors of domestic abuse. Galvani's theory brings together a recognition of the pharmacological effects of alcohol, men's ability to tolerate alcohol, their individual character traits and mood at the time of alcohol consumption. Crucially, Galvani identifies that men have responsibility for their behaviours. If men have a history of abusive actions when under the influence of alcohol, they must take responsibility for choosing to consume alcohol, knowing the potential effect of this on others (Galvani 2004). This feminist analysis presents a foundation for further research and exploration of this relationship.

Therefore the relationship between alcohol and domestic abuse is complex. There is a strong association between alcohol (and substance) misuse and domestic abuse with high prevalence of domestic abuse victimisation in female addictions and mental health services. When women consume alcohol, socially or as a coping mechanism, their experience of abuse is diminished by service providers and women can be held responsible for the abuse they experienced. Therefore, health professionals working with women who have addiction or mental health issues should consider their experiences of current or historic abuse. Whilst there is a clear association between alcohol use and perpetration of domestic abuse there is no evidence to suggest alcohol is a causal factor.

3.2.3 Sexual and Reproductive Health

Good sexual health encompasses the freedom and ability to engage in positive, satisfying sexual relationships (Coker 2007, Kalmuss 2004). Coercion and control, characteristic of domestic abuse, prevent women from enjoying this aspect of health. Abused women report diminished enjoyment of sex (Pikarinen et al 2007) and frequently experience rape, birth control sabotage (de Bocanegera et al 2010, Decker et al 2009, Raj et al 2007) and restricted access to sexual and reproductive health services (Wilson et al 2007).

Keeling & Birch (2004) reported that 35% of women attending a UK family planning clinic reported experiencing domestic abuse at some time in their lives. High levels of condom refusal are reported by perpetrators of abuse, often with women other than their partners, increasing exposure to infection (Decker et al 2009, Raj et al 2007). Behaviours

which place sexual health at risk such as having multiple partners and sex after alcohol and or drug consumption can be higher in abused women (Littleton et al 2007).

It is perhaps unsurprising then that almost half (47%) of women presenting to a genito-urinary clinic reported some experience of domestic abuse (Loke et al 2008). Women who have experienced abuse at any point in their lives are twice as likely to have a sexually transmitted disease (STD) as women who have never been abused (Coker 2007). Women who report current abuse are three times as likely to have an STD such as Chlamydia, Gonorrhea, Bacterial Vaginosis, Trichomoniasis, Genital Warts, HIV / AIDS (Coker 2007, Johnson & Hellerstadt 2002). In addition, an association has been observed between domestic abuse and poor attendance for cervical screening (Loxton et al 2009) and an increased incidence of cervical cancer (Coker et al 2009 & 2000).

Further consequences of condom refusal and rape are unplanned pregnancies. Domestic abuse is associated with large families (Krug et al 2002), rapid repeat pregnancies in adolescent women, (Jacoby et al 1999), unplanned (Miller et al 2014) or unwanted pregnancies (Gazmararian et al 1995) and termination of pregnancy (Hedin & Jansen 2000). Wokoma et al (2015) found that women in the UK seeking a termination of pregnancy were six times more likely to have experienced domestic abuse than those who planned to continue their pregnancy. Bourassa and Berube (2007) found that 41% of women seeking termination had experienced domestic abuse. For some women the abusive relationship is the primary reason for ending the pregnancy (Williams & Brackley 2009, Glander et al 1998). For others, partners force termination of pregnancy as part of the abuse (de Bocanegra et al 2010, Raj et al 2007). Abused women often choose not to disclose pregnancies, their decision to terminate (Glander et al 1998) or diagnosis of STD (Loke et al 2008) to abusive partners for fear of a violent response.

Pregnancy is a time of increased risk of domestic abuse although for some women abuse may decrease or cease during pregnancy and escalate following delivery. It is estimated that 30% of domestic abuse starts in pregnancy and for those already living with domestic abuse this can escalate in pregnancy (Department of Health 2005). The Centre for Maternal and Child Enquiries (CMACE 2011) in the UK reported that 12% of women who died from any cause during pregnancy or the post-natal period had experienced domestic abuse. In a two year period, eight women were murdered by partners and a further three were murdered by other family members. Research in the USA found that women who

experience domestic abuse during a pregnancy are three times more likely to be murdered by their partners (McFarlane et al 2002).

There are specific consequences of domestic abuse related to pregnancy which place both mother and fetus at increased risk of harm. These include: delayed ante natal care; placental abruption; spontaneous abortion and stillbirth; preterm delivery; low birth weight babies and post natal depression (Krug et al 2002). Factors associated with poor pregnancy outcomes such as smoking, alcohol consumption and non-prescribed drug use can be higher in women who experience domestic abuse (Bailey & Daugherty 2007) so domestic abuse can directly or indirectly affect the health of the woman and fetus. Figure 3.1 summarises the reproductive health consequences of domestic abuse.

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                    ┌─────────────────┐
                    │     Rape /      │
                    │  Condom Refusal │
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  │ Sexually Transmitted│          │     Conception     │
  │     Infections      │          │     Unwanted /     │
  │                     │          │ Unplanned Pregnancy│
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                 │  Termination of│          │ Continuation of│
                 │    Pregnancy   │          │    Pregnancy   │
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                           │ Maternal and fetal│    │ Abuse escalates after│
                           │ health compromised│    │    birth of child    │
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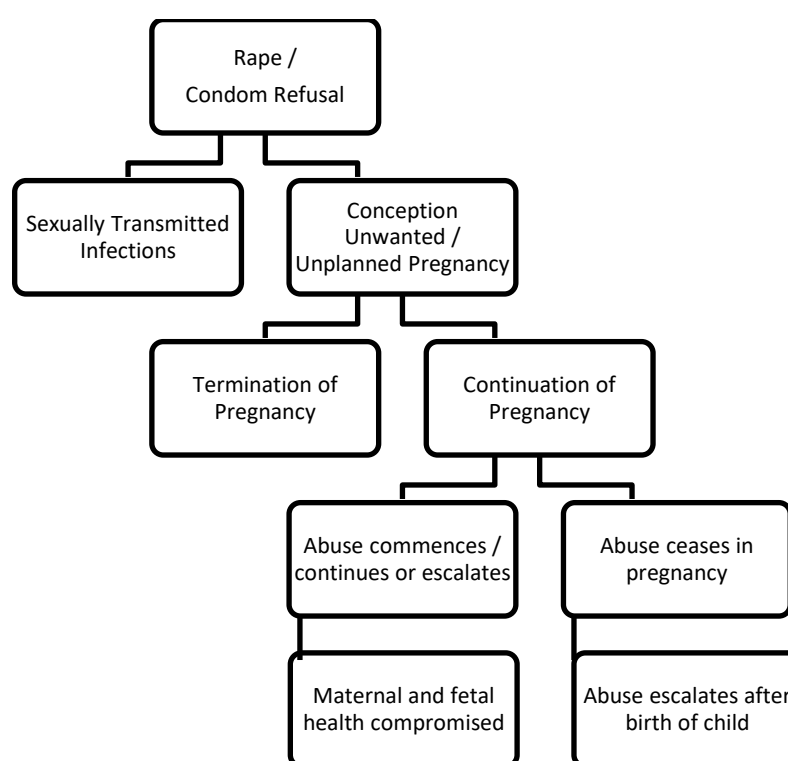
Figure 3-1 Potential reproductive health consequences of domestic abuse

Two UK studies measured the prevalence of domestic abuse amongst maternity service users (Bacchus et al 2004; Johnson et al 2003). Both studies defined domestic abuse as physical, emotional or sexual abuse from a partner or ex-partner. Bacchus et al (2004) conducted structured interviews using the Abuse Assessment Scale to identify women who had experienced abuse. They found that 23.5% of the 200 women in the sample disclosed experience of domestic abuse in their lifetime and 3% during their current pregnancy. In the second study Johnson et al (2003) distributed self completion questionnaires which

initially asked women if they were afraid of their partners and then progressed to more detailed questions about the abuse than the tool used by Bacchus et al (2004). This study achieved a 95% response rate and a sample of 475 women. They found a lower disclosure rate of 17% of women reporting experiencing domestic abuse at some point in their lifetime but a similar rate of those reporting abuse during the current pregnancy at 3.4% (Johnson et al 2003).

The potential for abuse to start in pregnancy and specific health risks to both woman and fetus places a responsibility on maternity services and community nurses caring for young children, such as health visitors, to engage with women about this issue.

3.2.4 Health Consequences for Children Affected by Domestic Abuse

There is substantial evidence on the impact of exposure to domestic abuse on children's health and wellbeing (Stanley 2009, Humphreys et al 2008a). As stated, domestic abuse can be detrimental to health from conception and the consequences of exposure to abuse in childhood can persist throughout the life course (Felitti et al 2009, Krug et al 2002). For example, violence may result in placental abruption which in turn can lead to fetal hypoxia, preterm delivery of a compromised infant and potential physical or mental disability.

Children who witness abuse can experience the same mental and physical health consequences as those who are directly abused (Berman et al 2011, Mullender 2004). Consequences include anxiety, depression, attempted suicide, enuresis and behavioural problems (Holt et al 2008, Humphreys et al 2008a). Conditions such as asthma can be more prevalent and more severe in children exposed to abuse (Bair Merrit et al 2013). Delayed immunisations, increased use of health services and increased use of medication are also associated with exposure to domestic abuse (Berman et al 2011). Children may experience traumatic stress disorder from the sense of endangerment related to exposure to domestic abuse. The term Post Traumatic Stress Disorder (PTSD) is more appropriately applied to responses to exceptional circumstances rather than the regular exposure to fear experienced by children living with domestic abuse. The term "complex trauma" is used to describe these symptoms in children following exposure to domestic abuse (Berman 2011, Herman 1996).

Domestic abuse can affect all aspects of children's development demonstrated by a higher prevalence of limited interpretative functioning, learning disability and poor emotional health in children who have been exposed (Bair Merrit et al 2013). Some children will present with complex and co-occuring consequences of living with abuse while others may not display any obvious symptoms both of which present a challenge for health professionals to identify the presence of risk to children (Peckover & Trotter 2015, McGee 2000b). Mullender (2004) cautions that children living with their mothers in refuge accommodation may display temporarily elevated symptoms of stress and distress, exacerbated by the crisis and flux of leaving the family home, loss of possessions and familiar surroundings and moving into new, potentially shared, accommodation. Further, mothers may over-report children's symptoms if they themselves are in crisis which presents an inaccurate picture of the impact of abuse (Mullender 2004).

The adverse health effects of childhood exposure to domestic abuse can persist into adulthood. Felliti and colleagues (2009) identified a causal link between substance misuse, poor mental health and cardiac conditions in adults who had experienced domestic abuse as children. That said there is an emerging body of research which considers resilience factors which mediate the negative impacts of abuse on physical and psychological health such as a positive relationship with the non-abusive parent (Taylor & Lazenbatt 2014, Humphreys et al 2008b). Therefore recognition and enhanced support to sustain and establish factors which support resilience in children should be included in assessment and care planning in any health response (Stanley 2009, Mullender 2004).

The evidence clearly identifies a role for health services in responding to the substantial health burden of domestic abuse and for health professionals, particularly those working with families such as health visitors, to recognise, identify and respond to the wider support and protection needs of those affected by domestic abuse. The following section will discuss the literature on responding to domestic abuse.

3.3 Health Service Responses to Abused Women and Children

3.3.1 Health Service Responses

Due to the range of health consequences of domestic abuse (section 3.2) women who experience abuse present to a variety of health settings (Feder et al 2009, Rivara et al 2007, Bair Merrit et al 2008). For many of these women, health professionals will be the only professional with whom they have contact and indeed may be their only contact outwith the home (Bacchus et al 2012, DoH 2005). This section will describe the key issues in health service responses to domestic abuse.

As stated, domestic abuse is a global issue and international responses vary. Bacchus et al (2012) mapped the health service responses to domestic abuse in community and maternity services in Europe. The researchers suggest that variation between countries is the result of differences in the funding and structure of health services; the presence and influence of survivor groups and the availability of specialist resources such as refuge and perpetrator programmes. The mapping exercise identified challenges for health providers across Europe, specifically lack of funding for evaluation and research; lack of funds for initial and ongoing training and difficulties in releasing staff to attend training when it was available. Case studies used in the review focus on the identification of abuse and onward referral from health services to specialist services; however, Bacchus et al state that case studies were selected due to the authors' familiarity with the programmes rather than representativeness of approach.

Following a review of available evidence WHO (2013) created best practice guidance for health professionals and policy makers on responding to domestic abuse. The guidance highlights an overall dearth of reliable evidence on effective health service responses to domestic abuse.   The importance of an individually tailored response to disclosure of domestic abuse is stressed throughout the guidance as survivors who report similar experiences of abuse can have differing health and support needs (WHO 2013).

There is little evidence that health service responses to women who experience domestic abuse can improve health status. In common with many public health interventions, time constraints prevent the longer term follow up required to demonstrate change in health

status (Millward et al 2003). Proxy measures for health benefits are often used and can include:

- Disclosure of experience of domestic abuse (e.g. McNutt et al 2002)
- Women's perception of safety (e.g.Hathaway et al 2008)
- Use of safety behaviours (e.g. McFarlane et al 2006 and 2002)
- Quality of life (e.g. Tiwari et al 2005, Sullivan & Bybee 1999)
- Social support (e.g. Sullivan & Bybee 1999)
- Referral to, or use of, community resources (e.g. Hathaway et al 2008, Sullivan & Bybee 1999)
- Ongoing experience of abuse (e.g. Curry et al 2006, McFarlane et al 2006)

Despite common use, ongoing experience of abuse is not a useful indicator of effectiveness as interventions delivered to abused women have a limited (if any) impact on the abuser's behaviour (Campbell et al 2009). Similarly, exiting a relationship does not mean an end to experience of abuse or the impact of abuse (Pain 2013, Ford Gilboe et al 2011, Humphreys 2009) and abuse may continue or escalate following separation (Krug et al 2002). Therefore, although frequently presented as such, exiting a relationship is not indicative of increased safety or short term improved health status. Indeed, measurement of physical and mental health over a short timescale may be misleading (McCloskey et al 2006).

McCloskey et al (2006) conducted a retrospective study, interviewing 132 women, twelve months after disclosure or police report of domestic abuse. They compared outcomes of women who had and had not disclosed domestic abuse to a health care provider. The validated 12 item short form health survey was used to assess changes in health and interviews enquired about experience of abuse in the preceding 12 months and exiting the abusive relationship. There was no evidence of improvement in mental health following the intervention or after exiting the relationship. The authors state that this does not indicate the effectiveness of the intervention but rather should be expected to some extent in women who have recently exited a relationship, particularly those in refuge. Exiting a relationship can create a crisis and exacerbate the negative health impact of abuse in the short term. As with Mullender's (2004) observation regarding exacerbation or over-reporting of health issues in children, the relationship between cessation of abuse and health improvement is not linear (Pain 2013). Women may experience a period of poorer health immediately after separation but will potentially go on to experience improved

health in the longer term (Pain 2013, McCloskey et al 2006). Therefore, few studies report on mental and physical health outcomes. More commonly used health outcomes include survivors' perception of healthy and unhealthy behaviours such as smoking and diet (Hathaway et al 2008); health care utilisation (Constantino et al 2005); self-reported health related quality of life measure and the Edinburgh Post Natal Depression Scale (Tiwari et al 2005).

In view of the limited evidence on the impact of domestic abuse interventions on health recommendations for best practice are limited and have changed little in the past 20 years. In 1996, Orloff comprehensively described the role of nurses and midwives to identify women experiencing domestic abuse, ask about abuse, understand the woman's experience, provide emotional support, maintain confidentiality, provide information, discuss safety planning and make referrals to legal and social support agencies. Drawing on the evidence base almost 20 years later, WHO (2013) produced guidance for health workers which, other than stressing the requirement for an individualized approach, adds little to Orloff's earlier work. WHO (2013) recommend identification of domestic abuse, risk assessment and onward referral to specialist services. However, there are no recommendations for health professionals who have ongoing contact with women and children exposed to domestic abuse in their routine work.

More recently, the UK National Institute for Health and Care Excellence (NICE) (2014) created guidance for health care providers on responding to domestic abuse. Again the recommendations relate to identification and onward referral and provide guidance on an appropriate, immediate response which involves listening to the woman, being non-judgmental and assessing risk. This response is appropriate for health professionals who identify domestic abuse in the acute setting and engage with women over a short period of time (McGarry et al 2015) but again provides little detailed guidance for workers engaging with families over time in the community. The emphasis on onward referral presents three challenges firstly, this could be perceived as placing responsibility to respond to domestic abuse on specialist workers and removing responsibility from health professionals; secondly, availability and accessibility of local specialist services and thirdly women's ability to access additional services (Peckover & Trotter 2015).

3.3.2 Asking About Domestic Abuse

The health professionals' responsibility to identify abuse is consistent throughout the literature, yet health professionals rarely identify survivors of domestic abuse (Feder et al 2006). Women living with domestic abuse seldom spontaneously disclose to health professionals. In the 2012/13 SCJS, a minority of women experiencing domestic abuse had disclosed to a doctor (10%) and even less had disclosed to a health visitor or nurse (3%) (Scottish Government 2014b). Therefore, the need to enquire sensitively and appropriately about domestic abuse is reiterated throughout guidance for health professionals (WHO 2013, NICE 2014).

Health professionals may have concerns that asking about abuse will adversely affect the professional-patient relationship. Health professionals with experience of asking about abuse state that they rarely encounter negative responses from service users and women who have experienced abuse want health professionals to ask (Feder et al 2009). A study of family doctors in the USA reported an improvement in the doctor-patient relationship in the majority of cases and doctors who asked about abuse perceived that positive outcomes of disclosure for women outweighed any negative experiences (Glowa et al 2003).

Routinely asking about domestic abuse has been shown to be acceptable to women who use health services and effective in increasing disclosures of abuse (Feder 2009, Seng 2008, Trabold 2007, Renker 2007, Renker & Tonkin 2007, Bacchus et al 2004, Lothian & Read 2002). Women who have experienced abuse support the introduction of routine enquiry in clinical encounters and request that health professionals ask clear and direct questions about domestic abuse (Feder et al 2009, Lutenbacher 2003). In addition, women who have experienced abuse report that the experience of being asked, whether they disclose or not, is beneficial (Leibschultz 2009, Rodriguez 1996).

Despite support, the practice of routinely asking about domestic abuse has been a contested area since the publication of a high profile report produced for the Canadian Prevention Task Force (Wathen & MacMillan 2003). Following a review of the literature, the findings of which confirmed the lack of evidence demonstrating health improvement, Wathen & MacMillan (2003) concluded that there is "insufficient evidence to recommend for or against screening" for domestic abuse. This was widely challenged by survivors of domestic abuse, academics and specialist domestic abuse practitioners (Klevens &

Saltzman 2009). They argued that routinely asking about domestic abuse increases disclosure which creates opportunities to offer support and protection. In addition, they argued that when disclosure does not occur the act of asking helps women to identify abuse in their lives (Campbell et al 2003) and can increase awareness that health professionals are available to support victims of abuse (Stenson et al 2005). However, these outcomes are more difficult to measure.

McCloskey et al (2006) present an alternative argument for routine enquiry. They state that enquiry increases disclosure, disclosure increases opportunities to access supports, supports increase likelihood of exiting an abusive relationship and exiting an abusive relationship will eventually improve health. The assumptions of causality in this argument would fail to satisfy a biomedical-oriented practitioner or the research community that the initial intervention of asking about abuse improves health. The conclusions appear plausible but the evidence is insufficient in terms of study design, consistency of evidence and reversibility.

Klevens & Salzman (2009) suggest that much of the debate around asking about abuse is a "question of semantics". The term "screening" is used to describe routinely investigating non symptomatic individuals to identify those in the latent phase of a disease, who could benefit from diagnostic investigation or treatment, for example three year cervical screening for women. The same screening method is used for all those at risk of the disease. Routine enquiry has been defined as asking people "within certain parameters" questions about domestic abuse whether the health professional suspects they are experiencing abuse or not (Feder et al 2009). In 2009, Feder et al conducted a systematic review to assess if the evidence on asking about abuse fulfilled the UK National Screening Committee (UKNSC) Criteria for introducing screening programmes (Public Health England 2015).

A limitation of this study design is that the screening criteria are disease focussed. As domestic abuse is not a disease, the authors removed criteria they considered inappropriate such as the requirement that the "disease" had "detectable risk factors, disease markers and a latent or early symptomatic phase" and a pathway to progress to diagnostic testing if screening is positive. These criteria are specifically disease focussed but removal of criteria indicates that this approach is essentially flawed. The authors describe a systematic approach to searching and critique of literature. The review concluded that the evidence

on asking about domestic abuse does not fulfil the UKNSC criteria and therefore, state that screening for domestic abuse is not recommended. However, the authors state that routine enquiry about domestic abuse need not fulfil the screening criteria and indeed, the findings of the review support asking questions about abuse in specific health settings, confirmed that domestic abuse is a significant public health problem and restated service user support for enquiry.

Selective enquiry about abuse involves asking questions about abuse if the health professional suspects that women are living with domestic abuse. There is greater support for this practice (Feder et al 2009) however, a significant drawback of this approach is that health professionals often do not recognise the indicators of abuse.
Failure to respond to indicators of abuse can suggest to women that they are not important or do not deserve to be helped and can increase women's sense of isolation and disappointment with their care (Leibshutz et al 2008, Lothian & Read 2002, Rodriguez 1996, Warshaw 1996). In their most recent guidance WHO (2013) recommend enquiry about domestic abuse if health conditions associated with domestic abuse are present. Given the wide ranging health sequelae of domestic abuse (section 3.2) the list of associated conditions is extensive and in practice may result in more frequent enquiry across a range of settings than the introduction of routine enquiry.

A limitation of the literature, identified by Feder et al (2009), is the lack of evidence on harm resulting from asking about domestic abuse. There was no evidence that harm resulted from asking but equally, within the literature selected by Feder et al, there was no evidence that enquiry is not harmful as very few researchers measured or reported this. However, there is evidence in the wider domestic abuse literature (beyond the scope of studies of both Feder et al (2009) and Wathen & MacMillan (2003)) that not asking about abuse can also be harmful. This is a considerable omission from the enquiry / screening debate. From a health perspective failure to identify abuse can result in misdiagnosis and inappropriate treatment (NICE 2014). Therefore, omission of questions about abuse can also present a potential harm to service users (Keeling & Fisher 2015).

Despite support for this practice from survivors of domestic abuse, the debate on asking about abuse continues. Systematic reviews conclude that the evidence on routine enquiry / screening is insufficient; not that the evidence demonstrates it is inappropriate or causes harm (Wathen & MacMillan 2003).

3.3.3 Risk Assessment

Health professionals have a responsibility to assess, monitor and respond to risk of harm to those in their care, such as women and children living with domestic abuse (Nursing & Midwifery Council (NMC) 2010). Indicators in domestic abuse risk assessment tools include recent separation, pregnancy, children not fathered by the abusive partners, disputes regarding child contact, sexual violence, perpetrators with previous conviction for domestic abuse and victims' perception of their safety and that of their children (Robinson & Howarth 2012).

Risk assessment tools specific to domestic abuse (for example, the Co-ordinated Action Against Domestic Abuse (CAADA)) are widely used in social work and third sector domestic abuse services. In the UK risk assessment practice varies across the health setting and use of risk assessment tools remains in the pilot or planning phase. The risk assessment tools also vary in relation to content, methodology and validity of the tools (Hoyle 2008). Joyner & Mash (2012) state that risk assessments must take account of cultural context and in their research in South Africa incorporated suicide and matricide in routine risk assessment.

With any assessment tool, bias can be introduced by either the professional completing the assessment (recorder bias) or by the potential victim of abuse who provides information on their experiences (responder bias) (Hoyle 2008). This also applies to risk assessment, the accuracy of which is a contested area (Debbonaire 2011, Hoyle 2008). Risk assessment is not an exact science and, as in other disciplines, health professionals are advised to balance experience, professional judgment and women's perception of risk in their assessment (Scottish Government 2009a). Most often professional judgement increases the risk rating but assessment based on individual domestic incidents, rather than the ongoing experience of abuse, discounts factors associated with re-victimisation and underestimates the potential for further harm (Robinson & Howarth 2012). Debbonaire (2011) and Hoyle (2008) observed that a false positive, where high risk is identified but women are not at risk, can unnecessarily infringe the freedom of women and their partners. Further, as limited service resources are directed at those at greatest risk, false positives can divert help away from others who could benefit from protection and support (Hoyle 2008).

As discussed in section 2.2.4, women may have difficulty in recognising their experience as abuse and consequently be unaware of the risk of harm from their partner for themselves and their children (Ulrich et al 2006, Campbell 2004).   A study conducted in the USA with an ethnically diverse group of new mothers provides some insight into women's interpretations of risk (Ulrich et al 2006). Researchers used validated quantitative domestic abuse assessment tools to identify women experiencing abuse. They interviewed 30 women to explore their interpretation of the relationship and found that 56% did not consider themselves to be in an abusive relationship, despite the majority describing their partners' use of controlling behaviours and physical violence. Participants in Ulrich et al's study stated their partners were not abusive because the behaviours were not consistent or conversely because it was part of everyday life. Some women stated they were not experiencing abuse because they could cope with, or tolerate, their partners' behaviour (including physical violence).

Campbell (2004) investigated women's perception of risk in cases of femicide (women murdered by intimate partners) or attempted femicide in the USA through interviews with victims of attempted femicide and close family relatives of women who were murdered. Only half of the women involved in these incidents anticipated that their partner would try to murder them. In addition, Campbell observed that almost half of the women had been in contact with health services in the year preceding the murder or attempted murder. Campbell (2004) concludes that women are more likely to under rather than over-estimate risk and therefore, require support from health professionals to recognise the danger posed by abusive partners.

Health professionals can identify domestic abuse when women themselves are unaware. Bradbury Jones et al (2014) conceptualised this in the AWARE model. The model was developed from original research with health visitors and survivors of domestic abuse in Scotland (Taylor et al 2013) and is based on the Johari window (Luft & Ingham 1955). AWARE presents four possible situations: Women are aware of abuse but health visitors are not (hidden); health visitors are aware of abuse but the women are not (blind) and when both are aware (open) or unaware (unknown) of domestic abuse (Figure 3.2). In the "blind area" health professionals have an opportunity to consider risk to themselves and their children and in the "open area" have an opportunity to advise on protection for women and their children.

	Health Professional	
Woman Experiencing Domestic Abuse	**Open Area** Both woman and health professional recognise abuse	**Blind Area** Health professional recognises abuse but the woman does not
	Hidden Area Woman recognises abuse but health professional is unaware	**Unknown Area** Neither woman nor health professional recognises abuse

Figure 3-2 AWARE model (Bradbury Jones et al 2014)

Health professionals who recognise abuse have an opportunity and a responsibility to support women to name their experiences as abuse and consider the risks they, and their children, face (Campbell 2004). Asking direct questions about domestic abuse and discussing indicators of abuse openly with women can support this process (McCloskey 2006, Campbell et al 2004, Lutenbacher 2003). Coggins & Bullock (2003) observed that women set limits of acceptable behavior for their partners and identify actions which, if perpetrated, would make the relationship untenable (e.g. use of violence or threats to their children). As the relationship progresses, women experience distortion of reality and attempt to manage the abuse (section 2.2.4) and the limit of acceptable behavior changes. Coggins & Bullock suggest that this provides an opportunity to engage with women by supporting them to reflect on the changing standards and recognise when boundaries have been breached, to identify abuse and risk (Coggins & Bullock 2003).

3.3.4 Stage Appropriate Responses

Kelly et al (1999) identified stages of exiting an abusive relationship and suggest that responses must be tailored to each stage of this process (section 2.2.4). In the health setting a similar approach has been described drawing on stages of behaviour change models to understand and identify women's changing needs in relation to domestic abuse (Cluss et al 2006, Frasier et al 2001). As in Kelly's model, Cluss et al (2006) define stages from lack of recognition of abuse to separation from their partner; both state the models are not linear and both argue that responses which are not matched to women's stages can be

perceived as condescending, judgmental or not applicable by service users. Behaviour change models predominantly focus on internal factors which influence action but Cluss et al state that, in order to engage and effectively support women, health professionals must also consider external factors which influence decision making, described by Heise 1998 (section 2.2.3).

Frasier et al (2001) provide detailed guidance for practitioners on stage appropriate responses using the five stage transtheoretical model originally developed by Prochaska & DiClemente (1983). Stages include pre-contemplation, contemplation, preparation, action and maintenance stages. Parallels are evident between Kelly et al's (1999) model and the stages described by Frasier et al (Table 3.2). For example, in the pre-contemplation stage Frasier et al describe women's minimising of abuse or explaining abuse (e.g. "if the children hadn't been so noisy") which maps to Kelly et al's Managing Abuse stage. Frasier et al describe women in the contemplation stage as saying "If only I knew what I could do to stop his behaviour", which reflects Kelly et al's description of Distortion of Reality (Figure 3.3). Responses recommended by Frasier et al are also similar to those of Kelly et al (1999) and more recent guidance from WHO (2013) and NICE (2014). Frasier et al did not evaluate the impact of this intervention for women but report that practitioners found this response helpful when working with women (Frasier et al 2001).

Regular review is part of standard health behaviour stages of change models but the authors do not recommend regular review meetings when working with women affected by domestic abuse. Instead they describe assessment and response as isolated opportunistic engagements initiated by women's actions (such as calling the police or presenting to health services). There is consensus between researchers on appropriate responses but again, there is insufficient evidence of a health benefit to recommend this intervention.

Throughout the literature, the responsibility of health professionals to protect and support families affected by domestic abuse is reiterated. A greater understanding of the complex interaction of social expectations, practical considerations, ill health and fear which inhibit engagement of women and health professionals is developing but the evidence on responding to domestic abuse is drawn from relatively small studies which vary in criteria, approach and quality (Feder et al 2009). The views of survivors of abuse, explored in the following section, consistently demonstrate that while an understanding of the complexity of the situation is essential, the service response required is relatively simple.

Stages of Exiting an Abusive Relationship	Transtheoretical Model of Behaviour Change	Appropriate response
Managing the Situation Distortion of Reality	Pre-contemplation	Affirm no one deserves to live with abuse (K, F) Advise women that they will not be forced to make changes (K, F) Provide information on supports (K, F) Support women to recognise the impact of their partners' behaviour on their lives (K). Address statements of self-blame (K)
Naming Abusing	Contemplation	Ask what has helped women make changes previously (K,F) Consider pros and cons of leaving partner (F) Encourage women to think about the cost of continuing to live with abuse (K)
Re-evaluating the Relationship	Contemplation / Preparation	Name abuse and challenge stereotypes of abuse women and abusers (K). Ask how health professionals can help (F) Re-evaluate safety plans (K,F) Provide support for practical issues (housing, finance etc) (K) Provide information on services and supports (K,F)
Exiting the Relationship	Action / Maintenance	Assess resource and support requirement to sustain change (K) Assess for indicators of return to partner (F) Refer to services as required / requested to support women to move on from relationship (K,F)
Ending Abuse	Termination	

Figure 3-3 Aligning stage appropriate response models. (K) indicates recommendations from Kelly et al (1999); (F) recommendations from Frasier et al (2001)

3.3.5 What do survivors of domestic abuse want from health services?

Survivors of domestic abuse state that health service responses do not adequately meet their needs, even when they disclose abuse to workers (Cusack 2004, Lutenbacher et al 2003, Read & Fraser 1998). Survivors identified in clinical, refuge and general

populations, state they want service responses to recognise the complexity of domestic abuse and the wider social factors which limit their options. Studies have found a range of responses women value following disclosure. These include health professionals who:

- Acknowledge women's disclosure of abuse (Keeling & Fisher 2015, DoH 2010, Feder et al 2006, Lutenbacher 2003)

- Understand the dynamics of abuse (Keeling & Fisher 2015, Taylor et al 2013, Feder et al 2006)

- Involve women in decision making about their care and service referrals (Chang et al 2005, Warshaw 1996)

- Empower women and support them to improve their self-esteem (Feder et al 2006, Petersen et al 2003)

- Refer to appropriate services as required. This may be for support with issues other than domestic abuse, for example employment or finance (Curry et al 2006, Petersen et al 2003)

- Provide information about exactly what to expect from other services such as police and refuge (Lutenbacher 2003, Petersen et al 2003)

- Provide information on legal options (Joyner & Mash 2012, Peckover 2003, Petersen et al 2003)

Feder et al (2006) conducted a meta analysis of qualitative studies conducted with survivors of domestic abuse accessing health services. Despite differences in health care provision, survivors in the UK, USA and Australia reported similar health care experiences and requested similar supports. Feder et al (2006) conclude that the response from the health care worker, as a person, was most important to survivors. Specifically women appreciate health professionals who state that abuse is unacceptable and that women are not responsible for abuse. In addition, survivors want workers who are knowledgeable about the barriers to disclosure and exiting a relationship, who understand domestic abuse as a chronic issue rather than individual episodes, who listen, are non-judgmental, provide a safe, space to talk and respect confidentiality (Keeling & Fisher 2015, Feder et al 2006).

These findings suggest that survivors require a relatively simple response where health professionals respond to disclosure professionally and empathically, believe them, locate responsibility for abuse with the perpetrator, involve women in care planning and support their decision making. Much of this is reflected in the WHO (2013) guidance for health professionals such as the direction to use a women-centred approach. Yet women continue to experience disappointing health service responses and some state that health professionals exacerbate their experience of domestic abuse (Keeling & Fisher 2015).

3.3.6 Limitations of health service responses

Health professionals frequently fail to identify women experiencing domestic abuse. When women do overcome barriers to disclosure to health professionals they may receive a limited response or no response at all and despite disclosure their situation is not improved (Peckover 2003a). Both institutional and individual factors can limit the health service response. A fundamental challenge for health professionals is that domestic abuse is a cause of ill health but is not a disease and so does not fit within the traditional medical model of health (Warshaw et al 2006). Warshaw (1996) and Stark & Flitcraft (1996) produced seminal critiques of the health response or "medicalisation" of domestic abuse and identified the potential for this approach to further victimise women experiencing abuse.

3.3.6.1 The Medical Model of Health

The medical or biomedical model of health focuses on the health symptoms, in effect removing the abuser and experience of abuse from assessment and treatment planning. Consequently women are perceived to be the "problem" (Stark & Flitcraft 1996, Warshaw 1996). With a focus exclusively on the woman judgmental victim blaming attitudes can emerge and are reflected in the response that women receive from health professionals (Lutenbacher et al 2003, Stark & Flitcraft 1996). Health professionals who do not respond to women's disclosure or indicators of domestic abuse, or who respond unsympathetically, reinforce the abuser's behaviours by suggesting to women that "no one can help", "you are not important" and confirming women's own feelings of futility of trying to get help (Keeling & Fisher 2015, Tower 2007). As stated (section 3.3.2), blocking disclosure can also result in service user dissatisfaction with the care they receive or provision of inappropriate treatment. Despite the passage of 20 years since publication, the detailed and

insightful analyses of Stark & Flitcraft and Warshaw are of relevance today. Research conducted by Keeling & Fisher (2015) with 15 survivors of domestic abuse in the UK, found that women identified parallels between their partners' behaviour and that of health professionals they encountered, specifically minimising or dismissing acts of violence or abuse. This is referred to as secondary victimistaion and suggests that the deepening understanding of domestic abuse in the intervening years has made little impact on practice.

Survivors state that anticipation of a medicalised response deters disclosure in subsequent health service contacts (Feder et al 2006). Keeling & Fisher (2015) conclude that poor health professional responses silence women and, ultimately, these actions collude with the continued oppression of women. Additional paradigmatical conflict presents when health professionals respond to children exposed to domestic abuse. This is discussed in section 3.4.

3.3.6.2 Individual Factors

Health professionals' personal beliefs about domestic abuse and their ability to respond effectively to survivors of abuse also limit the health service response (Lazenbatt et al 2005, BMA 2007, Furniss et al 2007, Tower 2007, Haggblom et al 2005, Lutenbacher et al 2003, Peckover 2003b). Although many health professionals acknowledge that domestic abuse is a health issue, and believe that health services have a role to respond, most do not feel able to do this and do not wish to ask service users about domestic abuse (Feder et al 2009, Richardson et al 2001). Further, research suggests that health professionals lack knowledge about the extent of domestic abuse (Lazenbatt et al 2005). Lazenbatt et al (2005) found that in a sample of 488 midwives in Northern Ireland, the majority estimated 1 in 8 women would experience domestic abuse where evidence suggests this is closer to 1 in 3 or 1 in 4. De Boer et al (2013) surveyed nurses working in acute care in the USA. Respondents reported high levels of confidence talking about domestic abuse, stated they wanted to support women experiencing domestic abuse but reported limited experience of actually discussing abuse with service users. This suggests that they are failing to identify those at risk and underestimate the extent of this issue amongst service users (DeBoer et al 2013). A survey of 133 Swedish nurses indicates that nurses do not appreciate the reality of living with abuse. Just over a quarter of nurses surveyed (27%) stated that if women found abuse "offensive" they would leave the relationship (Haggblom et al 2005).

Attitudes and perceptions of health professionals can lead to an underestimation of both the extent and detrimental impact of abuse and could result in a poor or absent response.

The literature suggests that awareness, confidence and skills can be addressed through education and supervision of workers (Hamberger & Phelan 2006, McCloskey & Grigsby 2005, Cavanagh et al 2004), with particular focus on the complexities and dynamics of domestic abuse (Haggblom 2005, Lutenbacher 2003) and on the role of gender inequality in violence against women (Haggblom 2005, Peckover 2003).

Victim blaming attitudes are consistent throughout the literature. This may be a product of the medical model but may also simply reflect the attitudes of the general public, a substantial proportion of whom hold women responsible for the abuse they experience (Garcia & Lila 2015). A study conducted with health professionals in the UK (Taylor et al 2013) found that a minority (2 of 27) of health professionals believed that women were complicit in their abuse. Virkki (2015) also found that a minority of health and social care professionals in Finland, blamed women for their abuse. However, many more continued to hold women entirely responsible for exiting the relationship and ending abuse. This suggests that, while attitudes are changing, health professionals still do not have an understanding of the impact of living with domestic abuse and the risk of harm encountered in leaving, or attempting to leave, an abusive partner.

Nicolaidis et al (2005) found that apportioning of blame can also be dependent on other factors such as socio-economic status. In their survey of 278 community health workers (including administrative, nursing and medical staff) the majority of respondents had greater sympathy for women from poor backgrounds who remained with abusive partners than women who had higher educational attainment and income. This suggests a lack of understanding of the dynamics of abuse resulting in greater responsibility being placed on affluent women for being in an abusive relationship. Lazenbatt et al's (2005) research with midwives in Northern Ireland suggests that victim blaming attitudes are generational and report that newly qualified health professionals are less likely to hold these beliefs than more experienced, older professionals (Lazenbatt et al 2005).

Warshaw et al (2006) present further individual barriers to responding to domestic abuse. The first is associated with expectations of professionalism. Warshaw et al (2006) suggest that some health professionals consider emotional detachment to be a positive professional

characteristic and that engaging with women about personal and upsetting issues, such as domestic abuse, is inappropriate (Warshaw et al 2006). The second barrier is a fear of vicarious trauma, specifically concerns about coping with their own emotional responses to women's accounts of domestic abuse such as their inability to resolve the issue or concern for the woman's safety. Joyner & Mash (2012) also suggest that health professionals avoid asking about abuse in order to protect themselves from greater support demands from patients in an already busy clinical area.

An important, emerging issue is nurses' own experience of domestic abuse. Nursing is a predominantly female profession and it is likely that some health professionals expected to identify and respond to service users' experience of domestic abuse are themselves survivors (Al-Natour eta l 2014). However, a UK study found that nurses who had personal experience of domestic abuse felt better equipped to respond to domestic abuse in a professional capacity (Barnett 2005).

Survivors requests for health professionals to engage with them about their abuse and the health professionals' resistance to this is consistent throughout the literature. Whilst there is evidence that attitudes and awareness are changing (Virkki 2015, Lazenbatt et al 2005) a minority of health professionals hold victim blaming attitudes alongside their responsibility to support and protect survivors of domestic abuse. Barriers to engagement include a limited knowledge of domestic abuse, a lack of skills or confidence in their skills to respond (Haggblom 2005, Richardson 2001, Cavanagh et al 2004); lack of awareness of research reflecting survivors' views; an unfounded belief that women will spontaneously disclose (Haggblom 2005); placing responsibility for abuse and exiting relationships on survivors (Virkki 2015) and a focus on health consequences alone (Stark & Flitcraft 1996). These attitudes prevent delivery of the essential response survivors desire to supporting disclosure, and challenging women's feelings of self-blame (Feder et al 2006).

3.3.7 Gaps in the Literature Relating to Health Service Responses

As discussed, much of the literature focuses on the immediate health care response to women and children affected by domestic abuse through identification and onward referral to specialist services. Health professionals have a role to signpost to specialist domestic abuse services but many will continue to work with the same survivors of abuse over a period of time and service users have requested continuity of care provider and follow up

(Feder et al 2006). However, there is surprisingly little literature to guide an ongoing response. Safety planning and legal protection are central to the response from specialist domestic abuse services but rarely feature explicitly as part of the health professional's role.

The role of health professionals in responding directly to the health consequences of abuse is often overlooked, or perhaps assumed, in the response. Research consistently identifies a high prevalence of domestic abuse in clinical populations but the practical implications of this are rarely explicitly described or evaluated, with the exception of Joyner & Mash (2012). They offered screening for mental and sexual issues and onward referral to specialist health services following disclosure of domestic abuse in primary care services in South Africa. Almost half of the women in their sample were referred for psychiatric support and 40% were screened for STDs. Joyner & Mash identified a specific role for health professionals in discussing legal protection orders and in providing practical assistance to women to obtain these.

The literature identifies responses that survivors of abuse believe would be most appropriate but there is little evidence to support the effectiveness of these responses, service users satisfaction on receiving this response or a positive health outcome. Barriers to survivors and health professionals engaging on this issue are clearly identified. While evaluation and research suggests that these issues can be addressed survivors continue to report disappointing health service responses. Further, the pervasive medical model presents some challenges but there is insufficient evidence to challenge or re-evaluate this. There is little evidence on what works for health professionals, such as health visitors, who are required to not only work with families exposed to domestic abuse but to protect and support them.

3.4 The Role of the Health Visitor in Responding to Domestic Abuse

3.4.1 Health Visitors

In the UK, health visitors work within the primary care team to support families with young children. This section will describe the essential role that health visitors play in the

delivery of care to families affected by domestic abuse. In section 3.5 the findings of a structured review of the literature on domestic abuse interventions pertinent to the health visiting role are discussed.

Primary care services are designed to respond to the public health needs of local communities through multi agency and multi-disciplinary teams (WHO 1978). The provision of primary care varies from country to country with developing countries frequently having more established services. In countries with private health care, such as the USA, universal primary care provision is often minimal or absent (WHO 2008). In the UK, the National Health Service (NHS) has a well-developed and highly regarded primary care provision, which is free at the point of care. Services are delivered by General Practitioners (GPs), midwives, nurses, allied health professionals and health visitors (WHO 2008).

A health visitor is a qualified nurse or midwife who has undertaken further training in order to work as part of the primary health care team. Health visitors provide a universal service to families with preschool children to promote health and prevent illness. The role of the health visitor includes health surveillance, parenting advice and delivering immunisation programmes. They provide an enhanced service to families with additional support needs including socially excluded families, disabled parents, parents with addictions and women experiencing domestic abuse (Hall & Elliman 2006). The health visitor role evolved from a public health initiative introduced in the late 19th and early 20th centuries in the UK. The initiative aimed to reduce infant mortality rates by educating working class mothers on home hygiene, nutrition and child care (Davies 1988). Glasgow, Manchester and Liverpool were amongst the first cities to appoint women to work alongside (and in some cases as) sanitary inspectors. Women were selected as it was anticipated that they could "charm" and befriend women, and through this gain access to homes and pass educational messages to women (Davies 1988). When mothers failed to achieve adequate standards of hygiene or care the women reported them to the authorities. Therefore, from the outset, there was incongruence in the role with employees required to present as friend while holding a surveillance role. This work evolved into the modern day health visitor who retains some of these responsibilities, principally advising on, and monitoring care of, children.

In 2001, the Scottish Executive reviewed the contribution made by nurses and health visitors to public health (Scottish Executive 2001). The review reported a "significant shortfall" in the numbers of trained health visitors and identified a need for greater investment (p37). However, the report recommended a new approach, with training provided for "public health nurses", rather than specialist training streams such as health visitors or school nurses. The new public health nurse training would consider health across the life course and in consequence, the roles of health visitors and other specialists, such as school nurses, would be subsumed into the single role of public health nurse. The extent to which this change was implemented is not reported. Anecdotally, health visitors reported that change was nominal and their work continued to focus on pre-school children.

In 2008, the Scottish Government launched the Early Years Framework. In contrast to previous programmes which aim to improve health across the life course, this framework directs most effort towards maximising health outcomes in the earliest years (from pregnancy to three years old) stating that this period has "the greatest bearing on outcomes over the life course" (p16). The Early Years Framework identified specific service responsibilities in relation to child protection in families affected by violence, abuse, neglect or other social issues. Whilst abuse is explicitly included, it is implied that this will occur in families with multiple support needs for example poverty and substance misuse, when domestic abuse affects women and children of all social groups (section 4.2.3). As stated, the onus on the surveillance and protection of very young children placed responsibility with universal health services and increased the focus and demand on health visitors / public health nurses.

In response to the Early Years Framework, health visitor provision was again under review when the research reported in this thesis commenced (2010). A further potential challenge for services was the (then) anticipated Children and Young Persons (Scotland) Bill. The Bill was an attempt to make Scotland's commitment to the United Nations Convention on the Rights of the Child (UNCRC) (1990) more explicit, than in previous legislation (Children (Scotland) Act 1995). Article 19 of the UNCRC is of particular relevance to the current research as it states children's right to protection from violence, abuse and neglect. The Bill was finally introduced in 2013, becoming an Act in 2014. A significant aspect of

the Bill was the introduction of named person for every child with a responsibility to co-ordinate care and assessments where child protection or other issues arise. For all pre-school children the health visitor would be the named person, which potentially placed further pressures on an under resourced service. Therefore, the research reported in this thesis was conducted during a period when health visiting teams had experienced under-resourcing, restructuring and uncertainty about the future of their role.   It was not until 2013 that the Chief Nursing Officer for Scotland issued a directive that the role of health visitor should again be differentiated from role of other public health nurses (Scottish Government 2013b) and made a further commitment to invest in and increase the capacity of the health visiting workforce.

3.4.2 Health Visitors and Domestic Abuse

Home visitation programmes, such as health visiting, are successful in engaging women in health promotion and parenting activities, improving outcomes for children and in promoting behaviour changes (McFarlane et al 2006; Olds et al 2006) but the presence of domestic abuse can limit the effectiveness of these interventions (Sharps et al 2008, Eckenrode et al 2000).   Therefore, it is essential that health visitors recognise domestic abuse and protect families at risk of harm to minimise the health consequences of abuse, and ensure the wider public health aims are achieved.   Furthermore, as all nurses in the UK, health visitors have a statutory duty to identify and reduce the risk of harm from domestic abuse (Nursing & Midwifery Council 2014 / 2004) and can achieve this through three of the core elements of health visiting: co-ordinating services, promoting health and tackling inequalities (Elliot et al 2001).

Domestic abuse may start or escalate during pregnancy or soon after delivery and so health visitors will encounter women who have recently been exposed to domestic abuse and are dealing with their own experiences and associated risk to their children)DoH 2005). Health visitors are well placed to identify indicators of domestic abuse such as delay between injury occurring and seeking help, multiple injuries at different stages of healing, missed appointments, repeated non-specific symptoms and women appearing socially withdrawn or evasive (Scottish Government 2009a).   Working with women in their homes provides an ideal opportunity to observe other indicators of abuse such as damage to furniture, doors and locks (Scottish Government 2009a).

Health visitors have regular contact with families over a five year period and can provide continuity for women who become aware of abuse or plan to leave an abusive partner by providing suitable information or support. In addition, health visitors have increased contact with families who experience issues which commonly co-occur with domestic abuse such as low socio-economic status, disability or substance misuse (section2.3).

Interviews with 56 health visitor service users in the UK found that women described contact with health visitors as less formal than contacts with GPs and believed that health visitors were best placed to provide support and information on domestic abuse (Bateman & Whitehead 2004). Similarly, Bacchus et al's (2003) findings from in depth interviews with a purposive sample of 16 survivors of domestic abuse found interactions with health visitors are perceived as less formal than contact with other health professionals, that health visitors had more time to spend with women and were more able to provide support and information. Women in this study stated that they trusted health visitors to act in their best interests (Bacchus et al 2003). So, health visitors appear well placed to respond to domestic abuse but the dynamics and consequences of domestic abuse, coupled with limitations of the health service (section 3.3.6), present barriers to positive engagement between health visitors and women experiencing domestic abuse. Despite identifying health visitors as an approachable source of support few women in both Bateman & Whitehead's and Bacchus et al's study had actually disclosed experience of abuse to a health visitor.

3.4.3 Child Protection and Domestic Abuse

The Early Years Framework (Scottish Government 2008) highlighted a need to identify and protect children from harm in the earliest years. The main vehicle for this was through the health visitors. So, in relation to domestic abuse, health visitors had a role to assess child development and provision of care provided by mothers who experience domestic abuse and to offer support, information and protection to the women themselves, as survivors of abuse. Whilst no longer explicitly described as a friend to women, the relationship between health visitors and service users is still considered an essential factor in identifying need and safeguarding children (NICE 2012). Brocklehurst (2005) states that health visitors' surveillance of child welfare locates them as "agents of the state" and that this generates mistrust between service users and health visitors which ultimately

prevents disclosure of fear or concerns. In the role as "friend", health visitors would ideally engage with women, listen to their experiences and work with women to plan their supports and care required. However, the health visitor response has been described as controlling (Mitcheson & Cowley 2002) , "authoritarian" (Robinson 2004) and even "the spy with the smile" (Davies 1998) suggesting that the surveillance role has superseded the role of friend. Indeed, Robinson (2004) writing from a service user perspective stated that health visitors who were non-judgemental were the exception. Women who experience domestic abuse consistently state that fear of social work child protection involvement, and ultimately of losing care of their children, is a barrier to disclosure of abuse to professionals (Taylor et al 2013, Mullender 2004, Peckover 2003, McGee 2000b). Perceptions of health visitors as inspectors can lead to concealment of their experiences of abuse (Taylor et al 2013). This is supported by the work of Peckover (2003) who interviewed survivors of domestic abuse in England in 1998/99. Survivors stated that the health visitors' child protection role, and uncertainty regarding confidentiality and information sharing with other agencies, created barriers to disclosure (Peckover 2003).

Health professionals' accountability for child protection can exacerbate victim blaming attitudes and adversely affect service responses as mothers may be considered as a risk to the child, rather than victims of abuse (Radford & Hester 2006). Once again, responsibility shifts from the perpetrator to the women. Women's relationships with the abuser, rather than abusers, are considered at fault in exposing children to domestic abuse (Radford & Hester 2006). Inability to leave an abusive relationship may be viewed as failure to protect children or wilfully place them at risk of harm. As with the medicalisation of abuse, a narrow focus on child protection obscures women's experience of abuse and in addition considers them as a risk, rather than a protective factor in their children's lives (Douglas & Walsh 2010, Humphreys 2010). This is supported by the findings of a UK study in which health visitors described domestic abuse as a child, rather than a woman or family, protection issue, and responded by assessing women's effectiveness at protecting their child from the abuser (Peckover 2003b). Therefore, women's fears that they will be viewed as poor parents and may lose their children and associated attempts to conceal their abuse are not unfounded.

Stark & Flitcraft (1996) described the "battered mother's dilemma" (p91) where women know they cannot fully protect themselves and their children from the abuser but fear of losing their children creates a barrier to seeking protection. Mothers "pretend" to

themselves and to health professionals that they can protect themselves or that the abuse is not happening. Stark & Flitcraft state that workers collude with this, discouraging disclosure through subtle reminders of their child protection role to avoid the need to respond.

Health visitors have a remit to work with the whole family but encounter a dichotomy in responding to the needs of both adult and child victims as the issues of domestic abuse and child protection present conflicting paradigms (Taft & Shakespeare 2006, Edleson 1999). Hester (2004) describes the different professional perspectives of domestic abuse, child protection and the legal field of child contact post separation as three separate planets. Responses in each area evolved independently resulting in three incompatible analyses of domestic abuse. The domestic abuse planet adopts a gendered analysis of abuse and identifies a violent male perpetrator and female survivor with support needs. In contrast the child protection planet views the same situation as an "abusive family" in which the mother is as great a potential risk to the child as the abusive partner (Hester 2004).

Identifying sources of risk in the real world can be difficult. Many women can, and do, parent effectively while experiencing abuse (Radford & Hester 2006, Wuest et al 2002) but for some the impact and nature of domestic abuse may present challenges which limits their ability to parent effectively and requires support from health or social services (Ford Gilboe et al 2011, Humphreys et al 2005, Humphreys & Thiara 2003, Patersen et al 2003). Therefore, women may be viewed as a risk to their children because of the consequences of their experience of abuse. In the child protection sphere there is awareness that the mother is a victim but a child-centred, rather than family centred, policy prioritises the needs of the child and obscures the woman's victim status (Radford & Hester 2006, Wilson et al 2004). This has been described as "walking a tightrope" for professionals who feel compelled to respond to children as a priority but risk excluding the needs of abused women by doing so (Wilson et al 2004).

In the third planet, child contact, the focus is on parental involvement following separation. There is a gender neutral approach and an overall aim to promote parental responsibility. Conflict occurs when fathers who perpetrated domestic abuse, were identified as a risk to children and whom mothers were advised to leave to protect their children, are encouraged and supported to engage with the family following separation. Based on her work in USA family courts, Schwaeber (2010), states that as in other areas, professionals in the child

contact field minimise women's experience of domestic abuse or again, hold victims to be equally responsible for their abuse. Lorza (2010) describes a backlash against women in family courts which clearly reflects gendered expectations. Where previously courts were thought to favour mothers as the primary care giver they now expect higher standards of conduct from women, judge women more severely if they have engaged in alcohol or drug use and may prioritise men's employment over women's (Lorza 2010). Lorza (2010) also found that women's accounts of domestic abuse are less likely to be believed but the evidence suggests that false allegations of domestic abuse are rare (Schwaeber 2010). Despite a call for greater cohesion between the three areas of practice in 1999 (Edleson 1999), little appears to have changed in the intervening years.

However the promotion of resilience and protective factors offers a way forward. The best way to protect a child is by supporting and protecting the non-abusing parent (Berman et al 2011, Home Office 2010, Humphreys 2008a, Hall & Elliman 2006). So health visitors can address the needs of children exposed to abuse by providing an immediate response to mothers, to enable them to support their children.

Given the health visitor role to provide parenting support, and the contribution of positive parenting to children's resilience, it is surprising that survivors of domestic abuse stated health visitors failed to respond to their difficulties in managing children's behaviour (Peckover 2003). Peckover (2003) interviewed a convenience sample of 16 mothers of young children attending a domestic abuse support project. The women perceived that health visitors knew they were experiencing abuse but did not ask about it and did not provide information on support or protection following disclosure.

3.4.4 Health Visitor Responses to Domestic Abuse

In common with other health professionals, health visitors often feel ill-equipped and ill-prepared to engage with women about domestic abuse (Peckover 2003b, Richardson et al in 2001, Frost 1999). Despite their close relationship with families there is a wide variation in health visitors' understanding and awareness of domestic abuse (Haggblom 2005, Peckover 2003b, Frost 1999). A UK study conducted by Richardson et al (2001) used anonymous postal questionnaires to gather the views of 94 practicing health visitors. They found that 97% of respondents thought that domestic abuse was a health issue but only

29% agreed that they should ask women about experiences of abuse (Richardson et al 2001).

Earlier work conducted by Frost (1999) used postal questionnaires and semi structured interviews to assess health visitors understanding of domestic abuse. In total 107 postal questionnaires were completed by practicing health visitors in one health trust in England. The postal survey had a high response rate of 79%. Following analysis of questionnaires 24 health visitors participated in semi structured interviews. Frost found wide variation in understanding of domestic abuse within the sample. Participants reported difficulty in defining and recognising abuse and feared that enquiry about abuse would cause a breakdown in the health visitor and client relationship.

Peckover (2003b) reported on semi structured interviews conducted in 1997/98 with a convenience sample of 24 health visitors in the UK. Again, this study found that health visitors have difficulty in recognising and naming abuse. Responses could be expected to improve in light of policy developments and associated training programmes in the years since this data was collected but more recent research conducted by Taylor and colleagues (2013) suggests otherwise. They found evidence of considerable variation in practice responses to domestic abuse.

Whilst survivors who participated in Taylor et al's study described a range of health professional responses, from poor (inaction) to creative approaches to discussing the issue with women (such as agreeing a code to indicate if women could speak freely), the wider evidence from service users suggests that the health care and health visitor response to abused women is inadequate (Feder et al 2006, Peckover 2003).

Health visitors have a responsibility to identify, protect and support women and children exposed to domestic abuse (Hall et al 2001), and appear well placed to do so (Bacchus et al 2003, Bateman & Whitehead 2004), yet a number of issues prevent effective responses to domestic abuse. These include women's fear of losing care of their children, practitioner attitudes (victim blaming) and institutional barriers such as models of care delivery. The literature discussed thus far has explored the knowledge, attitudes and practice of health visitors and considered the views of survivors of domestic abuse on the health response. The following section presents a structured review of the literature pertaining to health service responses pertinent to the health visitor role.

3.5 Review of Literature Pertaining to Health Visitor Responses to Domestic Abuse

3.5.1 Aims of the Literature Review

The preceding sections of this chapter identified the health visitors' responsibility to respond to domestic abuse, guidance to health professionals and the challenges which may limit this response. Previous literature reviews have focused on eliciting disclosure or the immediate responses to disclosure in a range of health professions and so a structured review of the literature was conducted to answer the following questions:

1. What is the nature of domestic abuse interventions delivered by health visitors?
2. What is the outcome of these interventions?

It was anticipated that findings from the review would indicate best practice and inform the development of this research.

3.5.2 Literature Search Strategy

3.5.2.1 Inclusion Criteria

To ensure that the search identified literature appropriate to the research questions the following inclusion criteria were applied:

- Studies of interventions delivered by community nurses or which could be delivered as part of routine community care.
- Articles which describe an intervention or report on the effectiveness of an intervention.
- Reports of original research

It was anticipated that a relatively small amount of research would be found and so time parameters were not placed on the search.

3.5.2.2 Exclusion Criteria

In Scotland a rolling programme of training is underway to prepare midwives and health visitors to routinely ask new patients about domestic abuse. Systematic reviews, such as that conducted by Feder et al (2009) provide an overview of research in this area (section 3.3.2). Therefore, articles which focused solely on the introduction of asking about domestic abuse were excluded from the search.   Similarly, there is a consensus that exposure to domestic abuse has negative health consequences (section 3.2) and extensive systematic reviews have synthesised many of these findings (e.g. Krug et al 2002). Therefore studies which reported on prevalence or health consequences were also excluded from this search. Further, studies which related to forms of abuse or GBV other than domestic abuse were also excluded.

3.5.2.3 Search Strategy

A search of the literature was initially conducted in December 2012 prior to fieldwork commencing. The search was updated in May 2015. Eight electronic databases were searched: OVID Medline; British Nursing Index and Archive; EMBASE; ERIC; HMIC Health Management Information Consortium; MIDIRS Maternity and Infant Care; PsychINFO and CINHAHL. Searches were conducted from 1950 (or earliest available) to May 2015. In addition, hand searching of references, policy documents and relevant grey literature were also conducted and potentially relevant documents were sourced in full.

Key words and search terms were identified in three main areas: Domestic abuse; Community Nursing and Interventions. To reflect the evolving terminology in this area (section 2.2.1), the following domestic abuse related terms were included: domestic abuse, domestic violence, spouse abuse, battered women, battered wife or wives, partner violence and abused women / woman or abused mother.

The purpose of this research was to explore the health visitor response, however, this title and role is particular to the UK. Therefore, "community nurse" was used to identify international research on services offering support to young families in the community setting. Community nursing terms included community nurs*, health visitor, nurs* role, community health nurs*, practice nurs*" or "family nurs*, family practi*, community care and home visit. (The use of "*", truncates the keyword and widens the scope of the search

by returning words with variant endings. For example searching for "nurs*" will return nurse, nurses, nursing etc)

Intervention and response are broad terms so additional key words such as risk assessment, social support, safety plan, signpost, empower, cross sector / cross discipline were used. In addition, as many specialist domestic abuse services are charitable organisations and may work in partnership with health services the terms voluntary, non-statutory and third sector were also included.

3.5.2.4 Search Results

The initial search identified 477 articles and hand searching identified a further 22 articles, giving a total of 499. Of these, 279 articles were discounted because titles (or abstracts if the title was unclear) did not meet the inclusion criteria. Overall, few studies described a specific response for health visitors as a fundamental part of their role. Instead, studies tested new projects such as introduction of specialist workers or linked with specialist services. As with the wider health literature (section 3.3), the role of health visitors was frequently limited to detection of abuse and onward referral and did not describe or evaluate a response which could be integrated to routine health visitor practice. Following further application of the inclusion and exclusion criteria to abstracts or full text articles, nine relevant articles were identified (Figure 3.4).

Of the nine articles which fulfilled the criteria, four relate to the care of women in the ante natal period. Health visitors in the UK routinely meet with women at least once in their pregnancy and may provide regular support to pregnant women with multiple support needs. They work with women from the early post natal period and therefore, these interventions were considered relevant to health visitor services.
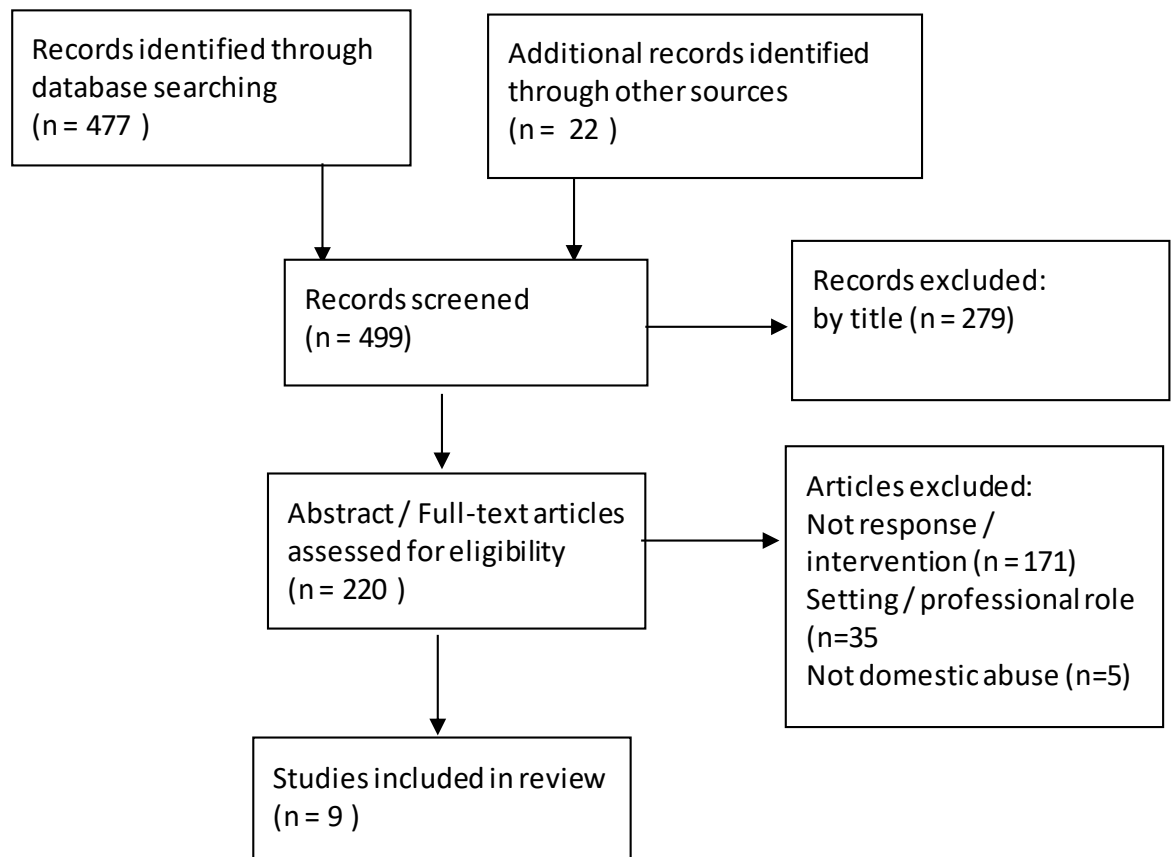
Figure 3-4 Literature search results

3.5.3 Findings of Structured Review of Literature Pertaining to Community Nurse Interventions for Domestic Abuse

Nine articles which fulfilled the inclusion criteria will be discussed in this section. A summary of each of the articles is presented in Appendix 3.1.

The earliest articles were published by Parker & McFarlane on research conducted in the USA (Parker et al 1999, McFarlane et al 1997). In 1994 McFarlane & Parker developed the March of Dimes protocol which described a response to pregnant women experiencing domestic abuse. The protocol was developed from theories of empowerment (Dutton 1992) and power and control in abusive relationships which emerged in the 1980s ("Duluth Power & Control" Domestic Abuse Interventions Program no date). The protocol directs health professionals to work with abused women to enhance awareness of the dynamics of abuse and promote safety planning. More specifically the protocol recommends assessing

for indicators of abuse and asking women direct questions about their experiences of abuse, supporting women to develop a safety plan, presenting support options to women, providing information on specialist domestic abuse support services, developing a follow up plan for reassessing safety of women and making referrals to community supports as required. Information regarding types of abuse, the cycle of violence and specialist supports were available in a booklet which women could work through alone or with support from a worker.   The papers published in 1997 and 1999 reported on the findings of an intervention study which utilised a modified March of Dimes protocol.

McFarlane et al (1997) delivered the intervention to 132 pregnant women who had disclosed physical or sexual abuse in the year before pregnancy. Participants in the intervention group received information on safety planning, the cycle of domestic abuse, legal protection and community resources during three counselling sessions delivered immediately before or after routine pregnancy assessment visits. Half of the intervention group participants were also invited to participate in group sessions but, the authors state only that, "very few did". Participants in the control group received a minimal intervention of an information card with details of local supports on their initial visit only (n=67).   The authors state that to prevent contamination between groups, and drawing on their previous research experience, participants in the control group were recruited first. Therefore allocation to groups was sequential, rather than randomised, which created potential selection bias.

McFarlane et al (1997) reported on the effectiveness of the intervention on engagement with support services. Data on use of community resources and experience of abuse in both groups was collected at 6 and 12 months after delivery of their child. Research nurses conducted structured interviews and used self-report, likert scale tools. Only 17 participants were lost to follow up which, given that participants had young children and were living with abuse, appears a small number. No difference was noted between intervention and control groups at 6 months but at 12 months women in the control group were more likely than women in the intervention group to engage with services other than the police. Both groups had similar engagement with police services. Of the total participants (intervention and control) approximately twice as many women had contacted the police at 6 and 12 months as had contacted other community support services. At six months, 34% of women had contacted the police and 15% had contacted other services. In the intervention and control groups, use of services was associated with severity of

violence and abuse ending was most closely related to contact with police services. McFarlane et al (1997) concluded that the intervention did not significantly affect engagement with services.

Parker et al (1999) reported on the same study considering the effect of the intervention on experience of abuse. Parker et al state that the control group reported higher levels of physical violence and threats of violence than the intervention group and conclude that the intervention is effective. As stated (section 3.3.1), abused women do not have control over the perpetration of abuse, this responsibility lies with the perpetrator. The authors acknowledge that they have measured the behaviour of someone (the perpetrator) who has not been involved in the intervention but state that experience of abuse is an indicator women's safety. Of relevance is Parker et al's finding that women in the intervention group reported greater use of safety behaviours than the control group. This suggests that the use of safety behaviours affords women some protection from violence but may indicate the effectiveness of safety behaviours, rather than the effectiveness of the intervention overall, in reducing experience of violence.

In the study reported by Parker et al (1999) & McFarlane et al (1997), there is limited control over factors, beyond the intervention, which could influence the outcomes measured. For example, domestic abuse can escalate or cease in pregnancy (DoH 2005). Alternatively, as Parker et al noted in 1999, pregnancy can be a window of opportunity for women to seek help. Therefore, pregnancy may be a confounding factor for the findings of McFarlane et al (1997) and Parker et al (1999). Further, the Severity of Violence Against Women scale, one of the outcome measures, considers physical violence or threats of physical violence. As discussed in Chapter 2 abusive behaviour can take many forms other than violence which are not captured with the severity of violence scale.

In 2000, McFarlane reported on a second study, again focusing on pregnant women and adapting the March of Dimes protocol. This study compared the effectiveness of three interventions in reducing severity of abuse. The first intervention was similar to that of the control group in the study reported in 1997 and 1999, where participants received written information on local supports services. In addition, the written information contained advice on safety behaviours. The second intervention group received open ended support services delivered by a trained nurse throughout their pregnancy. The nurse provided emotional support, education and support to access services. The nurse could be contacted

in person or by telephone through drop in or pre-arranged appointments. Health visitors in the UK provide regular appointments for all women with preschool children, drop in sessions at child health clinics and can be contacted on an ad hoc basis by service users, therefore, this intervention could be applicable to health visitors in the UK.

Participants in the third intervention group were offered support from a "mentor mother" in addition to the open ended nurse support. Mentor mothers were lay women (not health professionals) who received training to deliver support to women experiencing abuse by promoting access to services and offering emotional support, in the women's homes. Data from all groups was gathered from 2 to 18 months post-delivery. Again the self-report Severity of Violence Against Women tool was used. In addition, the authors developed a structured tool for measuring engagement with support services in which women were asked if they had made contact with specified services (e.g. addictions services) and how often they had contacted them.

The target sample size was based on a power calculation for a small or moderate difference between study groups and the target sample was achieved. Ninety six per cent of the sample were of Hispanic origin, 90% of whom were monolingual Spanish speakers. This is an artefact of convenience sampling, rather than purposive selection of a Hispanic sample. McFarlane et al (2000) state that findings for non-Hispanic women were unlikely to be representative given the small sample size and report on the outcomes for Hispanic women only.

McFarlane et al (2000), report that threats of violence and experience of violence reduced for participants in all three groups over time. At two months, the group who received the mentor mother outreach support reported fewer experiences of abuse and threats than those who received nurse support only, but not less than those who received written information only. There were no differences between groups at other time periods.   Whilst the secrecy and fear associated with experience of domestic abuse could lead to under-reporting in all groups, the use of a self-reported measure with participants who had more contact, with mentor mothers or nurse support, could result in greater responder bias and further under-reporting of abuse.

There was no significant difference between groups in use of support services. As noted in their previous work (McFarlane et al 1997), severity of violence was positively associated

with use of resources. Details are not provided on the frequency of contact with the support nurse or mentor mothers. Without this, the feasibility of replication of this intervention in other services or other countries cannot be given full consideration.

A Hispanic sample and the high proportion of non-English speakers within this, limits the transferability of the findings on service use to women who do speak the dominant language within a country. However, the study design considered communication needs of non-English speakers (translation of written materials, recruitment of bi-lingual researchers) and in doing so, the researchers have presented some insight to the experiences of women from minority ethnic groups. However, the quantitative research methods adopted in this, and earlier studies, do not provide sufficient flexibility to measure alternative outcomes of the intervention, such as perceptions of support, empowerment etc. McFarlane et al (2000) report on whether services were used, or not, but do not describe enablers or barriers to service engagement, such as language.

Building on earlier studies, McFarlane et al (2006) reported on an RCT with a sample of 360 women who reported abuse in the previous 12 months attending primary care clinics in the USA. The intervention involved a single 20 minute nurse care management consultation during which women could discuss safety planning and legal protection with a project nurse. Women in the control group received an information card only. This study was selected for inclusion in the current review as it is located within primary care and the project nurse role could be adapted to the health visitor role.

Participants were randomly assigned to intervention or control groups using a computer generated randomisation programme. Randomisation strengthens the study by reducing selection bias (Crispino 2013).   The outcome measures included experience of abuse, use of safety behaviours and use of community resources all of which were closed or multiple choice questions. Data were gathered through face to face structured interviews where screening questions were read aloud to participants. Interviews took place at 6, 12, 18 and 24 months. Two years post intervention (20 minute consultation or provision of information on services) both groups reported less abuse, lower risk and similar use of safety behaviours. The findings for control and intervention groups were not significantly different.

The authors state that even enquiring about abuse and highlighting services can be effective in reducing reported experience of abuse, however, this is not explicitly supported by the findings of McFarlane et al (2006). It is not possible to ascertain if changes in both groups are as a result of the minimal intervention of enquiry and information provision or if this is a natural pattern in abusive relationships, or abuse in pregnancy. Given the brevity of the initial intervention, it is surprising that McFarlane et al (2006) did not consider the potential impact of four follow up data collection interviews with research nurses as a confounder for the effectiveness of a single 20 minute intervention. The earliest study indicated a positive impact from the intervention (Parker et al 1999) but later studies have not supported this (McFarlane et al 2006, 2000), yet research continues to build on this approach. Two further studies included in this review adopted and adapted the March of Dimes intervention (Joseph et al 2009 & Katz et al 2008, Tiwari et al 2005).

Tiwari et al (2005) adapted Parker & McFarlane's model to create an intervention for pregnant Chinese women experiencing domestic abuse in Hong Kong. The intervention focused on safety, decision making and problem solving and was delivered as a single 30 minute intervention with optional information brochure for women. Once again, the control group participants were given written information on local services only. Tiwari et al (2005) adapted data collection tools for the Chinese context through inclusion of heavy gambling loss as a trigger for abuse. Culturally, Tiwari et al state, Chinese women experience greater stigma with domestic abuse and this was taken into consideration by research staff during data collection.

A sample of 110 women who had disclosed experience of domestic abuse at an ante natal clinic participated in Tiwari et al's study. A relatively short study time scale resulted in a high retention rate as only four women were lost to follow up 6 weeks post-delivery. All women in the sample remained with their partners at this stage. Overall, the study found that women in the intervention group had improved health outcomes (Health Related Quality of Life (SF36)) and the Edinburgh Post Natal Depression Scale) and reported less psychological and minor physical abuse but no difference in sexual or severe physical abuse. However, Tiwari et al (2005) state that the health outcome measures have not been validated for use with Chinese women. As follow up was conducted only six weeks post-delivery, it is possible that women's recovery from pregnancy and childbirth are confounding factors in health improvement. Further, domestic abuse may have escalated or resumed after the data collection period.

Tiwari et al (2005) state that the single site and relatively small sample of exclusively Chinese women may limit the generalisability of their findings but the study does provide a useful addition to the evidence base for this model. One strength of this study was that measurement of adverse effects of participation was included in the study design. At the end of follow up interviews women were asked if there had been an escalation in violence and if so, if they thought this had occurred as a result of their participation in the research. No negative consequences were reported.

Katz et al (2008) and Joseph et al (2009) both reported on the same study, an intervention which addressed multiple behavioural and psychosocial risks for pregnant African American women in the USA. The risks included maternal cigarette smoking, environmental exposure to cigarette smoke, depression and domestic abuse. Katz et al (2008) reported on the implementation, acceptability and feasibility of the study and Joseph et al (2009) reported on the effectiveness.

The domestic abuse intervention, also based on the March of Dimes protocol, focussed on engaging women in discussion on the dynamics of abuse, safety planning, risk assessment and awareness of community resources. This RCT was conducted across a range of rural and urban primary care sites in the USA. The intervention was delivered by "pregnancy advisors" most of whom were counselors, not registered nurses. This study was included in the review because the intervention is delivered within the primary care setting and adopts a public health approach similar to health visiting services.

The intervention was designed to be delivered over 10 sessions which took place alongside routine ante natal clinic sessions. This is considerably more structured sessions than in the studies described so far which ranged from a single counselling session (McFarlane et al 2006, Tiwari et al 2005) to three counselling sessions (McFarlane et al 1997). It was not anticipated that all women would attend all of the sessions but the researchers stated that at least four contacts between advisors and participants during pregnancy were required to adequately deliver the intervention. Katz et al (2008) conclude that the intervention was feasible as, on average, this was achieved. In addition, Katz reported that the majority of women reported a positive relationship with the counsellor and so state that the intervention was also acceptable. However, feasibility and acceptability were only considered from a service user perspective rather than a health service provider

perspective. Financial implications and workload, in addition to potential issues with staff attitudes and beliefs (section 3.3.6) may impact on the feasibility of sustained delivery of this intervention.

The study achieved a substantial sample of 1044 study participants, a third of whom reported experience of abuse either alone or in conjunction with depression or other risk factor (Joseph et al 2009). Participants were recruited from all patients accessing ante natal clinics in the study sites over a period of three years. Potential participants were invited to complete a computer assisted screening programme. Women who responded that they had issues relating to mental health, tobacco smoking, domestic abuse or environmental exposure to smoke were invited to take part in the research. Follow up data was gathered in the second and third trimesters of pregnancy. Data was obtained for only 850 of the original 1044 participants. Reasons for loss of contact, or characteristics of those lost to follow up and those who continued in the study, were not detailed. A greater number of participants in the intervention group reported reduced risk factors but as the findings report reduction of risk factors overall it is not clear how effective the domestic abuse intervention was. Nonetheless, this approach to multiple public health issues is reflective of the consequences of domestic abuse, such as mental health and cigarette smoking, which health visitors encounter in their work.

Despite substantial variation in samples and outcomes measures, all of the above studies adapted the March of Dimes protocol. Whilst this protocol was developed from a sound theoretical perspective there is relatively little recent evidence that it improves outcomes for women experiencing abuse, yet it continues to form the foundation of ongoing research in this area. The revisiting of the March of Dimes protocol may be due to the overall dearth of research, and resulting lack of specific guidance for health professionals, leaving little else to build upon. On the other hand the common sense approach adopted in the protocol may appeal to those wishing to develop services. Two further studies have adapted the intervention: The Domestic Violence Home Visitation Intervention (DOVE) Project (personal communication with research team) and incorporation of aspects of March of Dimes into an intensive community nurse intervention for young pregnant women, the Family Nurse Partnership, in the USA (Jack et al 2012). Both studies incorporate regular contact with women, discussions on the dynamics of abuse and safety planning. Findings from these interventions have not yet been published and therefore are not included in the current review.

Curry et al (2006) assessed the effectiveness of introducing a nurse care manager role in reducing stress for pregnant women at risk of, or experiencing, domestic abuse. The role of care manager has some parallels with the health visitor role as care co-coordinator and therefore is relevant to the current study. Curry et al (2006) aimed to reduce stress as means to, eventually, reduce the incidence of low birthweight babies. Due to time constraints, and an acknowledgment that a number of factors contribute to low birthweight, Curry et al considered reduction of stress to be an appropriate alternative measure of maternal wellbeing as, if improved, was likely to positively affect the pregnancy outcome. Curry et al (2006) recruited a substantial sample of 1,000 women in the USA, between 13 and 23 weeks gestation over a two year period. Participants were randomly allocated to intervention or control group. Women in the intervention group (n=499) were given the opportunity to watch a video on domestic abuse in private in the clinic building and 24 hour a day access to a nurse care manager, who also delivered all of their ante-natal care. One hundred and thirty women in the intervention group received care management. It is not clear if the other women declined this support, could not be contacted or could not be accommodated by the care manager. Those who were "care managed" (Curry et al 2006) had on average 22 contacts with the care manager, usually by telephone. Most often contact related to provision of emotional support with concerns about their pregnancy, their partner, work or other lifestyle issues (38%). Another common reason for contact was support with basic needs, such as food and shelter, and referral to appropriate services (32%). Face to face contact was largely related to routine ante natal care. The frequency of contacts (n=22 on average), is likely to require investment within the NHS to be feasible.

The outcome measures were the Prenatal Psychological Profile, a multiple choice questionnaire which asks about levels of stress in relation to concerns including family, work, finances, alcohol and domestic abuse, and the Abuse Assessment Score, a three item questionnaire ("Have you been abused by someone close to you? Have you been pushed, slapped, hit or kicked? Are you afraid of your partner?") . Overall, a greater reduction in stress was observed in the intervention group than the control group but this was not statistically significant. A strength of the Prenatal Psychological Profile is that it provides information on one way that domestic abuse can affect women (stress), rather than measuring the number or type of incidents which provide little insight to the cumulative impact. Analysis of highest risk women (determined by highest stress levels or greatest experience of abuse), in both the control and intervention groups, showed a reduction in

level of stress related to abuse with a greater reduction in the intervention group (0.17 and 0.27 respectively). Although not statistically significant, this does suggest some benefit of the intervention.

The authors state that an important finding was that women often wished support with issues other than abuse for example, housing or concerns relating to pregnancy. This is supported by other research with survivors of domestic abuse (section 3.3.5). However, the study sample was of women "at risk" of domestic abuse and participation was open to all women attending the clinic. Only 21% of the intervention group and 20% of the control group disclosed some experience of domestic abuse. However, this is still a considerable sample and, as recruited from a population of health service users as apposed to refuge or specialist services, is likely to have achieved a more representative sample.

A finding pertinent to the current study is Curry et al's observation that women planned to implement safety behaviours, or consider ending the relationship after delivery of their child. This is relevant to health visitors who engage with women following delivery and have an opportunity to support them to implement safety behaviours or exit a relationship.

Reflecting the challenge in producing acceptable evidence of health improvement, Curry et al state they "reluctantly" conclude that the intervention was ineffective. However, data were gathered at two time points, the first before 23 weeks gestation and the second after 32 weeks gestation. Consequently, some women may have received support for only nine weeks between data collection, which may not be sufficient to demonstrably address the complex consequences of domestic abuse. Curry et al (2006) state that the frequency of contact from women is evidence that an intervention is required. Further, they observed that the support interaction provided some qualitative difference to participants but the quantitative study design meant they were unable to empirically evidence this. They suggest that overarching social issues such as poverty and housing limit the effectiveness of health service interventions to improve health outcomes and recommend the inclusion of softer health indicators, such as mother and child interaction, in future studies. Whilst this may demonstrate some qualitative improvement for pregnant women exposed to social stressors, it would not address the greatest risk to the woman's wellbeing, which is exposure to domestic abuse. This intervention has not demonstrated effectiveness in reducing risk or offering protection to women exposed to abuse or demonstrated a statistically significant change in reducing women's stress in relation to this.

The work of Joyner and Mash (2012) was cited in section 3.3.7 as an example of health interventions explicitly responding to health consequences of domestic abuse. As health visitors in the UK have a responsibility to identify and respond to the health and protection needs of women living with domestic abuse, this primary care intervention was included in the current literature review.

This action research study was conducted in rural and urban primary care settings which the authors describe as "typical" of South Africa, delivering free health care to populations with low socio economic status. One hundred and sixty eight adult women who had experienced abuse in the preceding 24 months were recruited. Nurse practitioners were trained to deliver the intervention which included an interview with a project nurse practitioner to obtain a systematic history of the abuse; a comprehensive medico-legal history (previous HIV testing, STD screening, contact with police or legal services); a mental health assessment screen and safety planning. When issues were identified in relation to physical or mental health, referral or treatment was arranged as required. All women were given a follow up appointment one month later and were asked to comment on their experiences of the intervention at this point. Three quarters of participants attended for follow up. Service users responded positively to the intervention stating that their sense of isolation decreased and their awareness of their rights increased.

A professional inquiry group of three project nurses, one doctor and one researcher maintained research diaries and met regularly over the 14 month study period to reflect on the implementation. A content analysis of meeting transcriptions and diaries was shared with the group to support consensus on learning points and recommended response. This was part of a comprehensive evaluation of the intervention which included focus groups with primary care providers in rural and urban areas and interviews with key informants from the Department of Health, academics and Non-Government Organisations (NGO) which specialised in support to survivors of abuse.

Many of the findings are supported by the literature. Primary care health professionals were often resistant to asking every woman about domestic abuse as a result of a biomedical approach. For example, some health professionals stated that questions about abuse "did not fit" with their assessment or the presenting issue. In terms of action research, the development of the protocol to move from routine to selective inquiry about

abuse was driven primarily as a response to professionals who did not wish to engage. The intervention adapted to service restrictions, rather than challenging practice to meet the needs of service users.

The researchers observed that their initial protocol was "forensically focussed". They identified a need to document injury but only a third of participants presented with injury. In response, they strengthened questions about mental health and increased referrals to mental health services, although referrals to the mental health service caused concern amongst the inquiry group who feared that domestic abuse would be overlooked in the biomedically oriented mental health services (section 3.2.2).

Initial identification of abuse and onward referral to community supports are commonly made recommendations. Joyner & Mash go beyond this to explicitly describe actions for health professionals after identification and before referral to another agency. This includes screening for health consequences of abuse and provision of social and legal supports, the latter requiring a health professional with knowledge about domestic abuse. In this study, this was provided by project nurses which is feasible in a clinic setting but less so for care delivered in service users' homes.

In addition to reviewing and revising the response, the reflection stages of action research facilitate recognition of the wider context in which the research occurs. As with Curry et al (2006), Joyner & Mash (2012) state that wider social issues present a challenge to health services and suggest that practical barriers, such as reliance on partner's income, HIV status and alcoholism, limit the effectiveness of the intervention. However, these issues commonly co-occur with domestic abuse and indeed, may be engineered or manipulated by the perpetrator of abuse (Chapters 2 and 3). A strength of the work of Joyner & Mash (2013) is consideration of the health consequences but their conclusion suggests that a wider, holistic, public health approach is required to effectively support and protect women experiencing abuse.

A further strength of this study is, as in Tiwari et al (2005), the authors attempted to capture potential negative outcomes of research participation. Of 124 participants, three reported negative consequences. For one woman discussing the past was upsetting, another reported that she felt afraid following the interview and a third that her partner threatened to kill himself and his children when she advised him she planned to leave.

Joyner & Mash (2012), observed and reported this outcomes but did not alter the research process or comment on what negative outcomes would necessitate ethical review of the study.

The transferability of the findings from Joyner & Mash to the UK context is limited. In the UK, national campaigns to raise public awareness of domestic abuse and to challenge abusive behaviour have existed for many years. In addition, support services for women who experience abuse are widely promoted but this does not appear to be the case in rural South African areas. Further, the high rate of femicide and negative responses from the police (including bribery) in South Africa differ from the context in the UK where much work has been done to improve the police response to domestic abuse. However, the comprehensive assessment and response to the health consequences of abuse is a relevant and practical response. Although Joyner & Mash did not exclusively recruit mothers to their study, some participants stated that addressing the physical and mental health needs of mothers supported positive parenting. Further, health professionals acting as a conduit to police and legal protection could provide support to women who find it difficult to engage with other services. As with other studies (Feder et al 2006, Curry et al 2003) women found the non-judgmental response to be the most helpful aspect of the intervention and this is fundamental to the professional response.

3.5.4 Discussion of Review Findings

This literature review aimed to describe domestic abuse interventions delivered by health visitors, or health professionals in similar roles, to identify effective responses and best practice when working with survivors of domestic abuse.

Of the seven studies (reported in nine papers), five reported a similar intervention based on the March of Dimes protocol, which included a structured discussion with women on the dynamics of domestic abuse, safety planning and local supports (Joseph et al 2009, Katz et al 2008, Tiwari et al 2005, McFarlane et al 2006, McFarlane et al 2000, Parker et al 1999, McFarlane et al 1997). Structured risk assessment, supported by a risk assessment tool, did not feature in any of the interventions discussed in this review, although safety planning is commonly discussed with women. As stated (section 3.3.3), risk assessment tools are not routinely used by UK health professionals and findings of this review suggest

this is also the case elsewhere (USA, South Africa and Hong Kong). Therefore, little is known about how, and if, risk was measured.

The original March of Dimes protocol identified follow up as a key feature of the response. Yet two studies based on the protocol had only one scheduled contact lasting between 20 and 30 minutes (McFarlane et al 2006, Tiwari et al 2005). A comparison of studies which reported positive outcomes provides little guidance. Tiwari et al (2005) delivered a single 20 minute intervention and found an improvement in health status and reduction in minor, but not severe violence. Parker et al (1999) delivered three sessions and reported a reduction in violence. The findings of this review are such that no recommendations can be made on the minimal number of contacts required. However, the single contact interventions described in this review suggest that it is not essential to develop an ongoing, trusting, therapeutic relationship in order to identify women experiencing domestic abuse and provide some information and support. This is particularly pertinent to the health visitor role where much importance is placed on the relationship in policy and practice guidance, yet research suggests that the relationship is not always a facilitating factor for disclosure and engagement with women experiencing domestic abuse (section 3.4.3).

In contrast to the March of Dimes protocol which defined areas for discussion with service users such as safety planning and dynamics of abuse, two interventions offered open ended support in which women identified their support needs in the USA(Curry et al 2006, McFarlane et al 2000). In considering the effectiveness of a prescribed intervention when compared to women identifying their own support needs, it is interesting that the structured approach (Tiwari et al 2005, Parker et al 1999) reported positive outcomes and the less structured did not. Curry et al (2006) and McFarlane et al (2000) both found that women sought support which more commonly related to pregnancy and social circumstances (housing, finance), than issues of safety, protection and fear relating to domestic abuse. Research conducted with survivors of domestic abuse found that women want to be involved in decision making and wish information on a range of services, not just about the domestic abuse, including practical issues (section 3.3.5) therefore, it is surprising that the service which closely reflected the wishes of service users was less effective. In the UK responding to social issues is part of the existing health visitor public health role.

Notwithstanding the difficulties of recruiting survivors of domestic abuse to research (section 2.4), the studies in the current review achieved adequate, and some considerable,

sample sizes with intervention groups ranging from 55 (Tiwari et al 2005) to 180 (McFarlane et al 2006). Recruitment frequently drew on single site convenience samples (Curry et al 2006, Tiwari et al 2005, McFarlane et al 2000) and therefore, the representativeness of these samples may be limited. Methods of randomisation varied between studies with few using computer generated randomisation, thus increasing potential for selection bias. Further, none of the studies discussed blinding procedures to reduce bias. This is likely to be due to small research teams, which overall, enhances reliability of data collection procedures due to consistency of approach.

In terms of effectiveness of interventions, all seven studies primarily reported on quantitative measures. As the studies sought to demonstrate the effectiveness of an intervention this is appropriate but combining quantitative and qualitative measures would have provided insight to any additional or unexpected outcomes. The quantitative approach may reflect a continuing biomedical / positivist dominance within health research (discussed in Chapter 4).

Six studies measured continuing experience of domestic abuse as an indicator of intervention effectiveness (section 3.3.1). Despite having no direct contact with the perpetrator of abuse, two studies reported that the intervention had been effective in reducing women's experience of violence (Tiwari et al 2005; Parker et al 1999). Even with use of similar interventions, other studies did not demonstrate a statistically significant difference (Joseph et al 2009, McFarlane et al 2006, McFarlane et al 2000). Further, five studies recruited a sample of pregnant women. Domestic abuse may commence in pregnancy and, for women who experienced domestic abuse prior to pregnancy abuse, may cease or could escalate during or following pregnancy (section 3.2.3). Therefore, it is difficult to determine if a change in frequency of abuse is the result of pregnancy or the intervention, as some studies noted similar changes between intervention and control groups in both the short and longer term follow up.

Only one study measured health outcomes and concluded that mental health improved as a result of the intervention, despite no difference in occurrence of severe physical abuse (Tiwari et al 2005). Two further studies measured health related indicators but do not demonstrate health outcomes. Curry et al (2006) utilised a psycho-social screening tool to assess stress but did not employ a validated measure of physical or psychological health indicators. Similarly, Joyner & Mash (2012) recorded existing health issues but did not

report on health outcomes following screening and referral for mental or sexual health support.

The findings of the current review on interventions, identified similar limitations in the literature as those of the literature relating to enquiry about abuse (Feder et al 2009) (section 3.3.2), in that there is insufficient evidence of health improvement to recommend a specific response to women experiencing domestic abuse. That said there is some suggestion that prescribed discussions with women are more effective than an open offer of support. A further limitation is that none of the studies described the response delivered to women in control groups or defined "usual care" when domestic abuse was identified prior to the research intervention. The requirement to describe usual care following disclosure, and to generate evidence to inform practice, remains.

3.6 Chapter Summary

The health consequences of domestic abuse are wide ranging. As a result, a high prevalence of survivors of domestic abuse are present in clinical populations and are in regular contact with health professionals. In services such as health visiting, this contact will continue over a period of years. However, there is a little evidence-informed guidance to support health professionals to respond effectively. Available guidance is restricted to identification of abuse, immediate response and referral to specialist services.

Research with survivors of abuse indicates that survivors want a modest response, yet consistently report a disappointing experience of health services. Barriers to effective engagement with survivors of abuse have been identified at an institutional (health service) level, such as biomedically focussed services, and at an individual (health professional) level, such as lack of knowledge about domestic abuse. Health visitors face additional challenges specific to their dual responsibilities to protect children and women experiencing domestic abuse. This can undermine their ability to establish relationships with service users.

A structured review of interventions pertinent to the health visitor role identified nine relevant articles on seven intervention studies. There was little variation in the study design as the intervention in seven of the nine articles reviewed were adaptations of the

March of Dimes protocol developed in the USA in early 1990s. The initial promise of this approach has not been replicated in more recent studies.

Little research has been conducted in the UK, even less relating to Scotland, on health visitors responses to domestic abuse during ongoing routine contacts. Regardless of lack of evidence or guidance, health visitors encounter families living with abuse as part of their day to day work therefore, questions remain: How do health visitors respond to women when they know or suspect they are experiencing domestic abuse? Does this meet the needs of health visitor service users who experience domestic abuse?

This chapter described the literature pertaining to health and domestic abuse, and focused on the health visitor role to provide context for this study. The following chapter (Chapter 4) will describe the literature pertaining to research methodology of the current study.

4 Literature Pertaining to Methods

4.1 Chapter Introduction

The study presented in this thesis utilised a multiphase mixed methods design. In this chapter the philosophical, ethical and practical considerations in the study design are discussed. Traditionally, methodology, the philosophical stance of the research, and methods, the process and procedure, are presented separately. Each phase of the current study presented unique challenges but some issues were pertinent to all study phases. To avoid repetition and describe the evolving study design in a logical manner, methodology and methods are both discussed in this chapter. The conduct of the study and effectiveness of the selected methods in answering the research questions are explored in later chapters (Chapters 5-8).

4.2 An Overview of the Research.

At inception it was envisaged that phase one of the current research would describe the health visitors' response to women experiencing domestic abuse and subsequent phases would evaluate this response or, if appropriate, assess the feasibility of an enhanced response. However the findings of phase one contrasted with the, albeit limited, evidence described in Chapters 2 & 3 on the nature and extent of domestic abuse experienced by health visitor service users. This warranted further investigation prior to greater investment of resources in the health visitor response. Consequently, the second and third phases of this research utilised quantitative and qualitative methods respectively to investigate the nature, extent and impact of domestic abuse on health visitor service users and service users' views on the health visitor response. Hence the research presented in this thesis consists of three discrete but interlinked phases of enquiry. Table 4.1 provides a summary of the study phases, research questions and methodological approach, discussion of which follows an explanation of the overarching philosophical principles of this research.

	Research Questions	Methods
Phase One	- How do health visitors currently respond to disclosure of domestic abuse? - What, if anything, limits this response? - How does the current response address safety and protection of women who experience domestic abuse? - What support do health visitors require to improve their response to abused women?	Qualitative Focus Groups with Practicing Health Visitors
Phase Two	- What is the extent of abuse experienced by women with children aged less than five years involved in police reported domestic abuse incidents? - What is the nature of these incidents? - Did women require medical treatment as a result of the domestic incident?	Quantitative Secondary Analysis of Police Domestic Incident Data
Phase Three	- What is the nature and extent of domestic abuse experienced by health visitor service users involved in police reported domestic incidents? - What are the views of health visitor service users on the current health visitor response to women involved in police reported domestic incidents? - What are the barriers and enablers for women to engage with health visitor support in response to police reported domestic abuse incidents? - What are the support requirements, if any, of health visitor service users involved in police reported domestic abuse incidents?	Qualitative Individual Telephone and Face to Face Interviews with Health Visitor Service Users Involved in Police Reported Domestic Incidents.

4-1 Overview of research

4.3 Feminist Research

The current research was conducted within an overarching feminist approach (Figure 4.1). Feminist research is conducted by researchers from a range of traditions including liberal, Marxist, radical and socialist feminist studies but aspects of research aims and methodology are common to all (Ackerly & True 2010, Bryman 2004, MacPherson 1983). Feminist research is broadly defined as research which is based on the assumptions that gender is important and that women are disadvantaged within societies (Kralik & Van Loon 2008). The ultimate aim of feminist research is to improve the conditions of women and is frequently described as research "for women" (Webb 1993). Feminist research addresses inequality by raising awareness of women's experiences through accurate representation, dissemination of research findings and locating these findings within the social context (Kralik & van Loon 2008, Hansen 2006, Webb 1993). Thus the principles of feminist research are reflected throughout the research process, from establishing a research question to data collection and interpretation of data.

Feminist research questioned the objectivity of the scientific method traditionally employed in research and exposed the potential for male bias. Research questions which emerge from, and whose findings reinforce, theories generated in the male dominated public sphere largely exclude, and silence, women (Dillon 2010). Research which explored women's lived experience and the context in which this occurs has made an important contribution to raising awareness of women's social status, barriers to entering public life and challenging gendered stereotypes. Such research identified domestic abuse as a social, rather than personal, issue; challenged victim blaming, locates responsibility for abuse with perpetrators and identified barriers to help seeking encountered by women who experience abuse and continues to do so (Burman & Johnson 2015, Peckover 2002).

Explicitly or implicitly, theory influences the selection of research questions and the approach to investigation (Holloway & Wheeler 2010; Johnson & Onwuegbuzie 2004; Gilbert 1993). From planning to dissemination, the principles of feminist research were explicitly embedded in this research. Fundamentally, the gendered analysis of domestic abuse used in this thesis recognises the disproportionate number of women who experience abuse from male partners and defines this as a consequence of gender inequality (section 2.2.2). Methodologically, this research has drawn on the voices of women, as professionals, service users and survivors of domestic abuse, to increase awareness of

experience of abuse and improve support for survivors. More specific to the study of health visiting services, feminist researchers have described nursing as a gendered profession. The majority of nurses are women reflecting the socially acceptable and expected role of women to do emotional work of caring (Dillon 2010, Hallam 2000). Furthermore, the interaction between, and potential judgement of, women as mothers by women in professional roles as health visitors, creates an additional gendered dimension to this research (Peckover 2002).
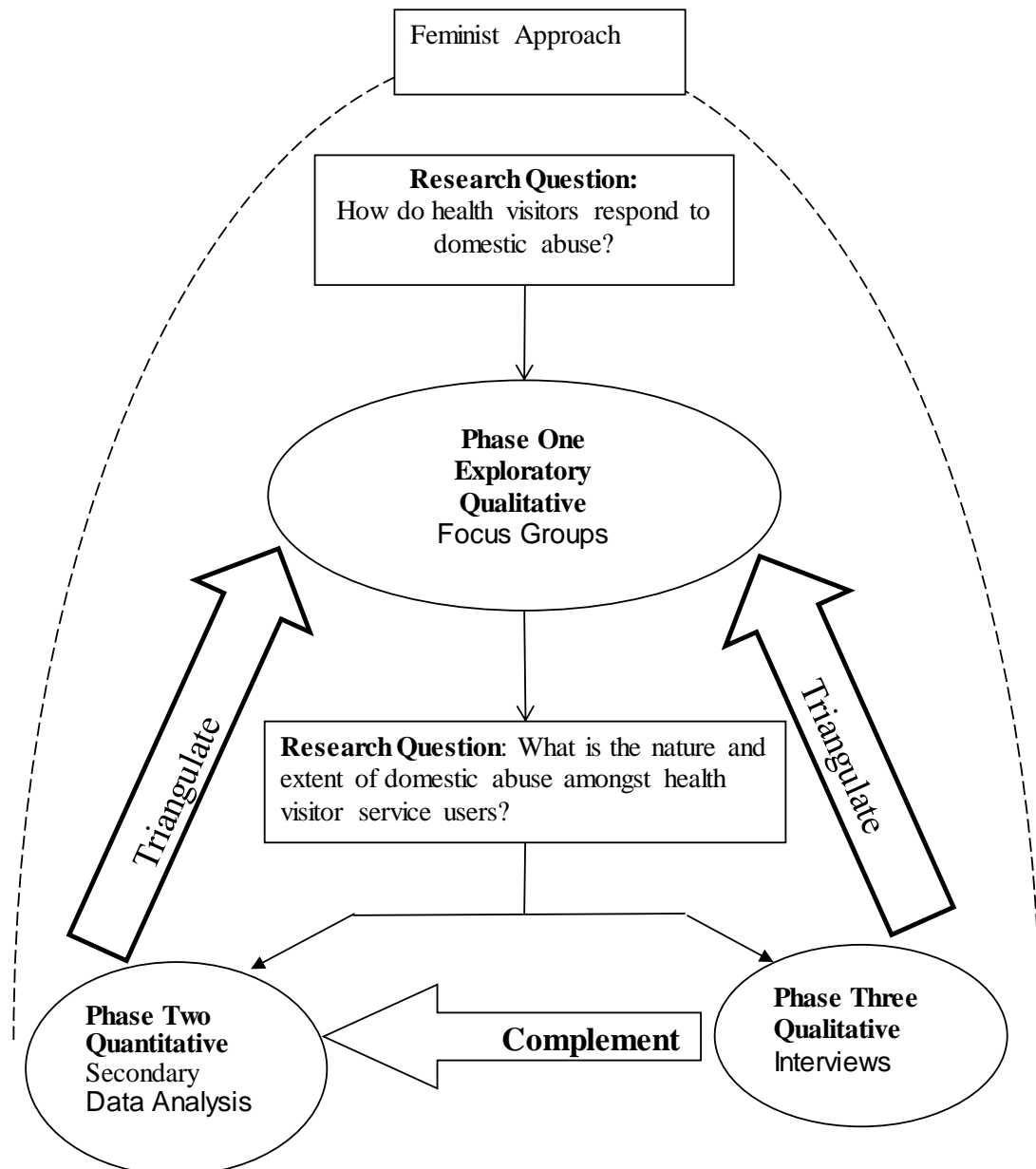
Figure 4-1 Research programme design

4.4 Philosophical Approach

In addition to feminist principles, this research draws on Pragmatism as a research philosophy. Pragmatism is hailed by some as a practical approach which can adapt to the challenges of conducting research (Morgan 2007, Robson 2002) and by others as a methodology which avoids, rather than addresses methodological challenges (Simons & Lathlean 2010). Holloway and Wheeler (2010) define a research paradigm as a set of assumptions which direct the research process and determine the method of investigation. Assumptions are made in relation to ontology (the nature of reality), epistemology (the nature of knowledge), methodology (the study of research methods) and axiology (the study of values) (Rofle 2013, Holloway & Wheeler 2010, Lincoln & Guba 1985).

In relation to the current research Pragmatism was considered appropriate because it focuses on research application and it is congruent with a mixed methods approach required to address the diverse research questions (Cresswell 2014).   Whilst the philosophy, assumptions and values of the research team are recognised, Pragmatism supports a study design based on the data required to address the research questions, rather than those associated with a specific research paradigm (Morgan 2007). This approach accommodates inductive and deductive approaches at different stages in the processes using the term "abductive" to describe this (Johnson & Onwuegbuzie 2004). Pragmatism is compatible with qualitative and quantitative research methods in a single research study, potentially strengthening the overall findings by addressing the limitations of the qualitative and quantitative approaches (Johnson & Onwuegbuzie 2004) (section 4.5). In pragmatism the epistemological assumptions are applied as appropriate to the research methodology of each study phase. Accordingly, researchers will strive to achieve objectivity in quantitative data collection and analysis and will attempt to minimise bias and enhance confirmability and credibility in qualitative research.

The pragmatist philosophy assumes there is a single reality but that individuals will experience and interpret this in different ways, also known as intersubjectivity (Morgan 2007). The transferability of findings is also important with priority being given to asking

what can be learned, rather than focussing on differences (Morgan 2007). The focus on real world research, intersubjectivity and making use of research findings is compatible with the stance of the researcher and the feminist aims of the research.

The pragmatist paradigm was first described in the late 19th century (Onwuegbuzie & Leech 2007) but has received greater attention recently in response to the "paradigm wars" (Holloway & Wheeler 2010, Morgan 2007, Johnson & Onwuegbuzie 2004). This term relates to the long standing debate surrounding the dominant research paradigms: Positivist and Interpretivist. Positivist research seeks to explain events or interactions by demonstrating universal laws or theories (Lacey 2010). Positivism is based on assumptions that there is a single reality which can be observed, measured and accurately represented by researchers. The positivist paradigm is associated with quantitative research methods, favouring experimental studies. Objectivity in the research process is valued in quantitative research and the quantitative scientific method has developed to minimise researcher bias and maximise control over variables (Lacey 2010, Bruce et al 2008). The positivist philosophy conflicts with some principles of feminist research, notably the objectivity of the researcher and objectification of participants (section 4.5). In feminist research the researcher is viewed as part of the research process, fulfilling a role which not only records data but contributes to the generation of data. Further, feminist researchers assume that women will interpret their experiences in different ways (Bryman 2004). Therefore, a positivist approach was not appropriate for this study.

Where Positivist research seeks to explain, Interpretivist research seeks to understand phenomena. Most commonly associated with qualitative research methods, research guided by an Interpretivist approach seeks to uncover the multiple realities that individuals experience resulting in rich data and a deep understanding of the lived experience in a specific context. This presents some challenges in transferability of learning to populations but is possible with groups or individuals with similar characteristics (Holloway & Wheeler 2010). Feminist research is well suited to the Interpretivist paradigm which can accommodate a range of experiences and consider the values of the researcher in determining research questions and in generating data. However, as this research developed, questions specific to quantification of the extent of domestic abuse arose which are not compatible within an exclusively interpretivist paradigm. Therefore, Pragmatism, described by Morgan (2007) as a "middle ground in the quantitative - qualitative continuum", was adopted implicitly in the first phase of the current study but in

the later phases of the study the pragmatic assumptions were explicitly acknowledged in the study design.

However, the need for a third research paradigm is questionable. Both Morgan (2007) and Bryman (2004) assert that research methods can be mixed within a positivist or interpretivist perspective. Indeed Hammersley (1996) argues that the differences between qualitative and quantitative research are not clearly defined in practice and frequently a combination of methods is used, though seldom acknowledged. For example, qualitative methods may be used in a study which aims to uncover *the* truth (one reality), rather than *a* truth (an interpretation), thus using a qualitative method within a positivist approach.

Pertinent to the current research is Hammersley's (1996) observation that the entire research study is often considered a single "unit", but in practice the research approach may vary at each stage. This is evident in the present study "unit" which comprised of three distinct phases. The findings of phase one generated new research questions, and so an adaptable study design was required to produce a sound evidence base of immediate relevance to practice.

4.5 Mixed Methods Research

This research utilised mixed methods to address complex and wide ranging research questions in three main areas: Health visitors' practice response to women experiencing domestic abuse; the extent of domestic abuse experienced by health visitor service users; and the experience of receiving the health visitor response by women who live with domestic abuse. Mixed method research, also known as multi methods, blending or combined methods, utilises qualitative and quantitative research components within a single study (Plano Clark et al 2008).

Research methods may be combined for the following purposes:
> 1) Triangulation – Where qualitative and quantitative methods are used to verify the findings
> 2) Facilitation – where one approach is used to develop a hypothesis or research strategy which is explored further using another approach.
> 3) Complementarity – Different types of data are used to complement one another and provide a complete picture (Hammersley 1996).

As with research paradigms, quantitative and qualitative research have traditionally been differentiated with strengths and limitations associated with each method. The characteristics of each approach are summarised in Table 4.2 (Struebert & Carpenter 2011 p25). Researchers such as Struebert and Carpenter (2011) consider the combination of these methods as an opportunity to strengthen studies as methods can compensate for the limitations of one another.

Quantitative	Qualitative
Objective	Subjectivity valued
One reality	Multiple Understandings
Reduction, control, prediction	Discovery, description, understanding
Measurable	Interpretative
Mechanistic	Organismic
Parts equal the whole	Whole is greater than the parts
Report statistical analysis	Report rich narrative
Researcher separate	Researcher is part of the research process
Subjects	Participants
Context free	Context dependent

4-2 Summary of characteristics of qualitative and quantitative research (Streubert & Carpenter, 2011 p25)

O'Cathain et al (2007a) considered the use of mixed methods in health research and found that the primary reason for combining qualitative and quantitative research methods was to attain "comprehensiveness". Different investigative methods inform or complement one another to provide a more complete or detailed picture. Simons & Lathlean (2010) state that the integration of mixed methods findings produces evidence which is stronger than the solely quantitative or qualitative component parts and this standard is required to address the complex research questions in health care. The findings of each phase of the current research are discussed in Chapters 5-7 and the integration of findings is discussed in Chapter 8.

The flexibility of qualitative research methods enables the gathering of data which provides insight to the meaning of domestic abuse for participants, describes the service

response to this, supports understanding of professional roles and the lived experience of service users who experience domestic abuse. Therefore qualitative methods were most suitable to answer questions in phases one and three of the current study. However, flexibility within the research process is not without criticism from proponents of quantitative research in the field of health research (Millward et al 2003). Criticisms of qualitative methods include lack of clarity on the conduct of studies which reduces replicability; that qualitative research limits opportunities for meta-analysis and the limited generalisability (Topping 2010, Bryman 2004). Despite the WHO definition of health as being much greater than freedom from disease (WHO 1948) greater status is still awarded to quantitative methods, which developed in the biomedical model of health (Polit & Beck 2012, Millward et al 2003). Adoption of qualitative methods may still be considered unscientific and unusual in the health setting (Bourgeault et al 2010).

The flexibility of qualitative methods is valued in feminist research. The interactive nature of qualitative data collection enables researchers to address the power imbalance often present in the research relationship by establishing a rapport and reducing potential for responder bias. Open questions, characteristic of qualitative research, place some control of the interview with participants who choose the focus and extent of their responses. In doing so participants reveal what is important to them rather than responding to pre-determined categories identified by the researcher. Qualitative methods present an opportunity to interact and co-generate data. In contrast feminist researchers have described quantitative methods as exploitative as information is taken from participants who are given nothing in return (Bryman 2004). Feminist researchers have further criticised quantitative research as objectifying participants and perpetuating inequality (Bryman 2004). Quantitative research aims to provide objective numerical representation of subjective experiences (Rofle 2013). It is argued that this action excludes the voice and experience of individuals by reducing data (and participants) to quantifiable units (Bryman 2004). Feminist researchers express further concerns that fields or categories included in research are generated from an evidence base which historically excluded women and therefore may not represent the variables which are important to them (Ackerly & True 2010, Bryman 2004). Yet quantitative research is not incompatible with feminist research and Ackerly & True (2010) argue that feminist principles can be applied in any research. Indeed Bryman (2004) highlights areas where quantitative studies have supported feminist aims in raising awareness of the extent of discrimination or abuse. One example of this is the work of Prof Sylvia Walby (2009) in estimating the cost of domestic abuse (section

2.3). Walby's work presented a strong case for prevention of domestic abuse by identifying the cost to wider society. In the current research quantitative methods were deployed in phase two to describe the extent and nature of domestic abuse experienced by health visitor service users involved in domestic incidents which came to the attention of the police.

As discussed in Chapter 3 of this thesis, domestic abuse is a public health issue but is a social phenomenon; there is no organic cause and no biomedical response to stop the abuse itself. Yet health professionals have a duty to respond through identification of those at risk, provision of support and addressing health consequences. This is a complex area for investigation. To comprehensively describe the interaction between health visitors and service users, and the intervention which results from this, data on the context and lived experience were essential. Therefore qualitative research methods were most appropriate and greater investigative effort was invested in qualitative research, deployed in two of the three research phases. To address the question of extent of domestic abuse amongst health visitor service users, quantitative data was required to triangulate the interpretation of events described by health visitors and service users. Whilst triangulation is commonly presented as a method of verification of findings from various phases of research (Hammersely 1996) it may instead identify areas of disagreement which could provide a greater insight or generate further questions (Simons & Lathlean 2010).

4.6 Qualitative components

4.6.1 Qualitative Approach

Phase one of the current study sought to explore the health visitors' practice response and phase three the experiences of health visitor service users who experienced domestic abuse and the subsequent health visitor response. Qualitative research is most appropriate for exploring new topics as data collection tools indicate areas for investigation but do not constrain participants' responses (Topping 2010). As little research evidence was available on the experiences of either group in Scotland, a qualitative descriptive approach was adopted.

4.6.2 Focus Groups

Focus groups are often described as an interview held with a number of participants at the same time (Gerrish & Lacey 2010). However, a distinction can be made between a group interview where there is a clear question and answer format and a focus group where interaction between participants generates data (Bloor et al 2001). In focus groups, a facilitator or moderator will pose questions, facilitate activities or suggest topics for discussions and participants prompt one another through the sharing of similar or contrasting views and experiences (Morgan 1998). In addition, the researcher's observation of how topics arise in the discussion, the range of beliefs and views presented and responses to hearing the views of others contribute to the analysis and interpretation of data (Kitzinger 2005). Focus groups are effective in exploring participants' roles and in understanding the opinions, beliefs and other factors which influence behaviour (Holloway & Wheeler 2010, Kitzinger 2005, Krueger & Casey 2000) and so were appropriate for phase one of the current research. Group participants usually have a shared knowledge, experience or characteristic (Bryman 2004, Fontana & Frey 2000) therefore, practicing health visitors were selected to participate in phase one (discussed in section 5. 5)

The greatest limitation of focus groups is the potential for responder bias (Griffiths 2009). Within focus groups, views are necessarily expressed in front of other participants which can result in responses which participants believe are correct or acceptable to the group, rather than accurately presenting their own views or experiences (Bryman 2004). In addition, if participants are familiar with one another, such as the teams of health visitors who participated in the current research, pre-existing group dynamics may be reflected in the discussion. Capturing this dynamic is an important part of the research and can provide some insight to the context, understanding or motivation for actions or feelings expressed in the group. It may also result in a false consensus if participants defer to people who hold senior or influential positions such as team leaders (Griffiths 2009, Litosseliti 2003). To minimise this, team leaders were excluded from focus groups in this research, however, dominant voices can emerge in any group. In the current research focus groups were designed such that the moderator was available for a one to one conversation following the group discussion if any participants wished this immediately after the group or at a later stage by telephone, letter or email to present alternative views.

Responder bias can be addressed in part by the moderator whose role includes introduction of the topic; prompting if required; ensuring the discussions remain focussed and recording of data (Bryman 2004, Litosseliti 2003). However, moderators may themselves introduce bias by leading the group or through selective data recording and interpretation. Therefore moderators require specific skills to fulfil this role effectively. These skills include an ability to create a comfortable and relaxed environment to encourage participation; observation of nonverbal behaviours to determine if there is consensus and if required, inviting quieter members of the group to comment (Bryman 2004). In this research the moderator was experienced in facilitating group work and focus group data collection. Given the pivotal role of the qualitative researcher in data generation, data collection and data analysis, reflexivity is an important concept and practice (Litosseliti 2003).

4.6.2.1 Reflexivity

As the qualitative researcher is involved in the generation, interpretation and reporting of data, reflection on the extent to which this has influenced the data and findings is essential to ensure participants' views are accurately represented (Gerrish & Lacey 2010, Lathlean 2010). This is known as reflexivity and can be introduced at each stage in the qualitative research process from study design, to data collection, analysis and reporting of study findings (Lathlean 2010, Onwuegbuzie & Leech 2007, Bryman 2004). In this study, reflexivity was supported by research supervisors and research colleagues through discussion on conduct of focus groups and coding of data. A further method for checking the credibility of findings is member checking, also known as member validation or respondent validation (Bloor 2001, Silverman 2001).

4.6.2.2 Member checking

Member checking is the process of participants, or others from their "social world", verifying the accuracy of transcriptions, themes and research findings (Bryman 2004 p275). Reading transcripts can be a difficult and uncomfortable process for participants if they are not adequately prepared for the transcription format (for example if hesitation or colloquialisms are used) (Carlson 2010). A further challenge to member checking is that participants' interpretation of experiences or events can alter between the time of interview and the time of reading transcription (Bloor et al 2001). In situations where participants have reframed their experiences following interview or when their self-view differs from their perception of the transcribed data, participants may wish to substantially revise their

contribution (Carlson 2010, Bloor et al 2001). Participants desire to delete or revise sections of the transcription does not indicate inaccuracy but rather enriches the context and may identify areas for further investigation (Cresswell 2014).   Transcription verification provides some reassurance that interview content has been accurately captured but does not validate the researcher's interpretation of this hence responder validation of themes or findings are preferred (Onwuegbuzie & Leech 2007, Bryman 2004, Bloor 2001, Silverman 2001).

Member checking of themes or findings identifies potential researcher bias and enhances credibility and confirmability (Cresswell 2014).   To achieve this research themes or a findings report are presented to participants or others who have similar characteristics to the sample (e.g. the same professional group), who are asked if the findings accurately represent their experiences or views (Bloor et al 2001).   This approach is better suited to anonymised focus group transcriptions where participant recollections of what every participant contributed will be less accurate. This process also enables greater participation and contribution from a wider group than focus group participants alone. In the current study member checking of themes which emerged in phase one and the description of the health visitor response was conducted with teams of health visitors in each of the participating NHS Board areas to ensure descriptive validity (Onwuegbuzie & Leech 2007). Some focus group participants were involved in this process. All agreed that the findings were an accurate representation of their working experiences.

4.6.2.3 Sample Selection for Focus Groups

Qualitative research seeks to understand phenomena and ideally data collection would continue until the concept is fully understood. Data saturation is the stage in research where the most recently gathered data does not produce new ideas, bring greater insight or promote a deeper understanding than what is already known (Mason 2010, Guest et al 2006).   Consequently, the ideal sample size can only be established during the conduct of the research. Data saturation is a guiding principle of qualitative research but differing opinions have been presented on when data saturation is achieved (Mason 2010). Guest et al (2006) state that all data offers a contribution to understanding to some extent, even if this is as confirmation of previous findings therefore they define saturation as the point when newly gathered data does not alter existing codes or present new codes in data analysis. Morse (1994) offers a further definition that data saturation is achieved when an

understanding of variation within data has been achieved and understood (p230). However, the resource led nature of real world research suggests that data collection is likely to cease for practical, rather than methodological, reasons (Mason 2010, Guest et al 2006). Mason (2010) states that in order to secure funding or approval for research a data collection period and sample size are commonly defined prior to fieldwork commencing. There is little guidance on when to expect saturation (or indeed what saturation is) and so sample size may be set arbitrarily (Mason 2010). This can result in a continuation of data collection after saturation is achieved or cessation of data collection before researchers are content that saturation has been achieved (Mason 2010, Guest et al 2006, Kreuger & Casey 2000). Similar demands were experienced in securing resources for phase one of the current study and the target sample was based on recommendations in the literature.

It is advised that at least three focus groups are arranged in the first instance (Krueger & Casey 2000, Morgan 1998). In phase one, a focus group was planned in each of three participating NHS Boards in Scotland. Gathering data in three NHS Board areas reduced the burden of participation in each board area and enabled comparison of practice across a wide geographic area. The participating boards were proximal to one another and the researcher's place of work which offered a practical advantage in terms of travel and associated expenses. Groups of between six and eight participants are recommended to enable discussion of a range of views and generate the rich data required to understand context and beliefs of participants (Holloway & Wheeler 2010, Morgan 1998).

To ensure that participants had the knowledge and experience required to provide an informed contribution to the groups a purposive, single category sample was deemed most appropriate. It was anticipated that a homogenous sample would promote deeper discussion within the focus group by sharing similar experiences but with a range of perspectives on these (Kralik 2005). Therefore phase one of the current research aimed to recruit a sample of practicing health visitors.

Feminist research principles were applied to data collection with health professionals and with service users. Feminist researchers aim to reduce the potential power imbalance which can exist between researcher and participants. The nature of focus groups addresses this in part as the researcher is either alone, or with a single scribe, within a larger group of participants who have shared characteristics (Bryman 2004). The researcher attended focus groups alone and, in an attempt to address perceptions of power, commenced groups

by sharing her professional background as a health professional to demonstrate a shared background and ethos with participants.

A focus group guide (Appendix 4.1) was developed from the research questions drawing on the guidance of Silverman (2005) who recommends starting with "how" questions to establish the context of the discussions.   Understanding the ways in which health visitors interact with and deliver a non-medical response to women and children is central to this research therefore an initial question in the current study concerned health visitors' own comprehension of domestic abuse: what it is, the different forms it may take and the ways in which it might be experienced. A second question concerned the ways in which health visitors respond to domestic abuse. For example, how health visitors broach domestic abuse with women and what they offer to women who disclose experience of domestic abuse. Once the "how" is established Silverman (2005) suggests moving to the "why" question. In phase one of the current study this involved exploration of why the response was delivered in this way.

In 2010/11, three focus groups were conducted with a total of 20 participants. This is discussed further in Chapter 5.

4.6.3 Semi-Structured Interviews

Phase three of the current research sought to understand women's experiences of domestic abuse and of the health visitor service response. Semi structured interviews are consistent with feminist and interpretivist approaches but were selected primarily to provide privacy for participants to discuss sensitive issues such as domestic abuse (Ellesberg & Heise 2005). Semi structured interviews were preferable to unstructured interviews as the research sought to answer specific research questions rather than explore women's wider experiences. Semi structured interviews were selected as they provide structure but sufficient flexibility to allow the interview to progress with a conversational flow, for the researcher to respond to new concepts, seek clarification and to provide the participant some autonomy in deciding how to answer questions (Griffiths 2009, Ellsberg & Heisse 2005). McGee (2000a) states that participants may consent to interview as they wish to discuss a specific issue and therefore it is good practice to provide an opportunity for them to add any additional comments, thoughts or topics before drawing the interview to a close.

Semi structured interviews have some limitations. As with focus groups, responder bias may occur. This can present as an inaccurate report of views or actions resulting from misperceptions of power between interviewer and interviewee or participants' lack of confidence in their own views. Participants may decline to disclose relevant information, or in contrast, feel compelled to share information which makes them feel uncomfortable (Robson 2002, Oleson 1998). As with focus groups, this can be addressed by a skilled researcher, and recommendations that researchers share their experiences and advise participants that their experiences are valid and useful, (Oleson 1998) were adopted in the current study.

The interview situation creates the potential for participants to present the way in which they would like to respond to situations which may differ from their actual response in a similar situation (Taylor 2005). Taylor (2005) suggests that whilst this may not accurately reflect behaviours it does present insight to how participants perceive the situation, their role within it and their own behaviours.

When discussing sensitive topics, such as domestic abuse, Griffiths (2009) and Lee (1993) recommend techniques to support women to share their experiences. These include advising women that the researcher would not make a judgement on their responses and, whilst abuse is a difficult topic, the issue and their experiences are not exceptional or unusual. These recommendations were incorporated into the interview process. In advance of interviews the researcher identified some personal information appropriate to share with participants to contribute something of their own life to women who were sharing very personal experiences with them. The extent to which interviewers genuinely share personal experience or simply provide information to interviewees is questionable and introduces potential for interviewer disclosure to cause discomfort in interviewees who anticipated the interaction would focus on their personal experiences (Webb 1993). Thus, the effectiveness of these techniques will not necessarily work in practice and require researcher self-awareness to ensure this is not counter-productive to data collection.

Participants are often familiar with the interview process and may have experienced this in a clinical consultation or counselling relationship (Tod 2010). King (1996) observed similarities between research interviews and the counselling interaction, specifically the use of reflecting and summarising by the interviewer.   Yet there are important differences in the conduct and aim of the research interview.   Ethical research ultimately aims to be

beneficial to the wider group which they represent, rather than the individuals directly (Beauchamp & Childress 2013). Some participants may report that participation has been a beneficial experience or that they gained something positive from taking part (Newman 2008, Becker Blease & Freyd 2006) but research participation is commonly a philanthropic act. Therefore in contrast to a clinical interview or counselling session, research interviews aim to meet the needs of the study, rather than seek to provide a solution or support for the participant. Clarification of the purpose and aims of the interview are an essential part of the interview process. In the current study it was anticipated that the digital recorder used in interviews would provide a visual reminder to participants that the conversation was for research purposes and the use of an interview guide would retain a focus on the research questions.

Semi structured interviews are frequently conducted with researcher and participant face to face in the same room. This enables establishment of privacy, rapport and observation of non-verbal communication. Alternative methods such as telephone, Skype or similar video calls can also be used. From a researcher perspective telephone interviews are more cost and time efficient than face to face interviews as interviews can be conducted from a regular place of work (if private) which removes the need to travel (Tod 2010). Similar rates of disclosure of domestic abuse have been found between face to face and telephone interview methods (Walby & Myhill 2001), although this may reflect the type of interview rather than the medium as structured interviews more commonly associated with the telephone.

From a participant perspective, the telephone can be less threatening and gives control over the interaction as they choose whether to answer a call and when to end the call. In practical terms women do not have to travel or accommodate a guest in their home. Further, the telephone can provide an element of anonymity as women will not be recognised and their address need not be disclosed (Tod 2010, Bryman 2004). Researcher challenges associated with telephone interviews include the absence of non-verbal communication and managing silence (Tod 2010). The researcher must judge when to continue, prompt or pause without observing the participant. Researching domestic abuse presents an additional challenge with telephone interviews as it can be difficult to ascertain if women are safe and have privacy to talk when making contact on the telephone (Ellesberg & Heisse 2005). This can be addressed by the researcher initially referring to the research as a "women's health survey" until privacy is established. In the current

research the use of both face to face and telephone interviews were considered appropriate to encourage overall participation, in particular to access women living in rural areas.

4.6.3.1 Vignettes

An interview guide was developed for semi structured interviews in phase three, which commenced with a vignette (Appendix 4.2). A vignette is a short scenario related to the research topic which participants are invited to comment on. Vignettes are useful in research on subjects such as domestic abuse because they enable participants to comment on their own experiences without the use of direct questions which could be considered confrontational or invasive (Gerish & Lacey 2010, Schoenberg & Ravdal 2000). Participants are more likely to engage with vignettes which are realistic (Jenkins et al 2010) and in this research scenarios were taken from the accounts of health visitors in phase one of the study. A challenge for researchers is to develop a vignette which provides sufficient detail to be plausible, is sufficiently brief to engage participants and enables participants to bring in their own experiences and perspective (Hughes & Huby 2002, Barter & Renold 1999, Finch 1987). Responses to vignette scenarios are hypothetical and, as with any self-reported response can reflect what participants believe they would do as opposed to what they would actually do (Jenkins et al 2010, Hughes & Huby 2002). Again, this has value in providing insight to the understanding and beliefs which participants apply to this issue (Jenkins et al 2010).

A total of 17 interviews were conducted with health visitor service users involved in police reported domestic incidents. Of these 10 interviews were conducted face to face and seven by telephone. This is discussed further in Chapter 7.

4.6.3.2 Sampling for interviews

As discussed in section 2.2, the stigma and secrecy surrounding domestic abuse, fear of violent repercussions to disclosure and women's identification of domestic abuse in their lives presents some challenges in the recruitment of survivors of abuse. Considerable resources would be required to identify a suitably large sample of survivors in a general population study and therefore convenience sampling is most commonly used in domestic abuse research and was the most practical approach to sampling in this study.

The findings of phase one refined the research questions to health visitor service users who had been involved in police reported domestic incidents. Police routinely inform local health visitors when women with children aged under five are involved in domestic incidents reported to the police and so health visitors were well placed to identify potential participants and support recruitment. The inclusion criteria for this phase of the study were women who had been involved in police reported domestic incident in the preceding 3 months, were aged 16 years or older and fluent in English. Access to participants in the current study is described in section 4.8.2.

4.6.4 Managing Qualitative Data

A naturalist approach to transcription enhances the accuracy of representation of participants' meaning and provides transparency for interpretation of data. Participants' responses are transcribed verbatim including pauses, repetition and colloquialisms to closely replicate the intention behind the participants words (Oliver et al 2005). Interview data may be transcribed in full, or sections may be selected for transcription (Carlson 2010). If data are omitted or condensed to correct grammar and remove repetition some context can be lost, particularly when the researcher has not transcribed the data (Carlson 2010). In the current study some interviews were transcribed by an administrative worker but checked in full with the recording by the researcher. To preserve context and most accurately reflect the voice and views of participants all interviews were transcribed naturalistically in full. Data were anonymised at the point of transcription and stored either electronically in password protected files or in hard copy in locked cabinets.

4.6.5 Analysis

Thematic analysis of qualitative data is succinctly described by Burnard (2008) as "comprehending, synthesising, theorising and re-contextualising" data. A qualitative descriptive analysis was applied to data as described by Sandelowski (2000). This approach requires the least interpretation and so, closely represents the participants' views (Sandelowski 2010). This approach complements the feminist approach and the naturalist transcription of data and was applied to data in phases one and three. This process is detailed in Chapters 5 and 7 prior to presentation of findings.

Thematic analysis can be conducted manually or with the support of computer software (Computer Assisted Qualitative Data Analysis Software (CAQDAS). CAQDAS enables researchers to code data and then, conveniently, to retrieve all text associated with each code. Use of software is an area of debate although less contested than others. Bryman (2004) summarises the pertinent points of the discussion: CAQDAS offer convenience and, some researchers state, that software enhances their analysis while other researchers have concerns that nuance and context, so important in qualitative research, are lost. Crucially in relation to focus groups, the interaction between participants central to data generation, may be omitted or lost. In the current research, analysis was conducted without software support as the volume of data was manageable and the researcher felt that manual analysis facilitated greater familiarity with the data.

4.6.6 Quality of Qualitative Research

The quality of qualitative research is assessed in relation to credibility (accuracy of the researcher's representation of participants' experience or views), transferability (application of findings to other groups), dependability (consistency of data gathering and recording) and confirmability (the extent to which researcher's values and beliefs may have influenced data) (Polit & Beck 2014;Bryman 2004, Silverman 2001). In this research, trustworthiness was enhanced by recording interviews and focus groups with consent. This increases credibility as the researcher can listen to recordings when reading and rereading the transcriptions to clarify tone and context of the discussion.

The development of codes (labels which summarise or describe sections of text) and interpretation of data were reviewed by a research supervisor to enhance confirmability and credibility of findings. In addition, member checking was conducted with the findings of phase one (section 4.6.2). Member checking was not feasible following service user interviews in phase three as it could have jeopardised the safety of women, compromised confidentiality if using electronic or postal mail and would be impractical for the researcher to establish contact with individual participants. During interviews the researcher attempted to summarise, reflect and clarify statements made by participants. In later interviews, the researcher summarised emergent themes to participants when similarities occurred between their accounts and those of earlier participants.

To enhance dependability a single researcher (CMcF) moderated focus groups, conducted interviews and analysed data. Transferability will be discussed alongside findings in chapters 5&7.

4.7 Quantitative components

Quantitative research is commonly used to present a descriptive analysis of quantitative variables or the results of a controlled experiment. A quantitative study design was adopted in phase two of the current study as descriptive statistical data is frequently used in public health research to quantify the extent of an issue (Rolfe 2013). Quantitative methods were most appropriate because this phase of the research was deductive, with a hypothesis developed from the literature, that women involved in police reported domestic incidents will be experiencing ongoing domestic abuse.

The nature and extent of domestic abuse can be measured to some extent using quantitative variables (for example, the use of physical violence will either be affirmative or negative; frequency of police reports will be recorded as an integer) therefore a secondary analysis of routinely collected police data was conducted to triangulate the findings of phase one through validation or refutation of statements made by health visitors. The findings of this secondary analysis also complement the findings of phase three by seeking to answer the same research question using a different approach and data source.

4.7.1 Secondary Data Analysis

Secondary data analysis is the "re-analysis" (Mongan 2013 p372) of data originally collected for one purpose to answer a new research question (Griffiths 2009). In the current study, a sample of data originally collected by police officers for crime detection purposes was analysed to address the research questions presented in phase two. The key advantage of secondary analysis is access to a large data set without the requirement for data collection (Vartanian 2011, Bryman 2004, Lee 1993). Notwithstanding, removal of the data collection process presents limitations common to all secondary analysis. The researcher conducting secondary research may be unaware of the processes used for data collection or variations in this process and subsequent limitations of the data (Vartanian 2011). This was partly addressed in phase two of the current study as the researcher engaged with police analysts familiar with common data collection issues. For example,

where possible, data was collected from those directly involved in the incident. This may result in responder bias as women often minimise their experiences, particularly on questioning from police officers or when the perpetrator or other witnesses are nearby, or victims may be distressed and find it difficult to accurately respond to questions (Richards et al 2008). When it is not possible to speak to those involved directly, for example if police officers cannot gain entry to a property, attending officers record their own observations (personal communication to the researcher). The source of the data (victim, accused, witness or police) was not identified in the database. While the data quality could not be improved some insight to potential variation was available.

4.7.2 Selection of Secondary Analysis Sample

Police Scotland define domestic abuse as "any form of physical, sexual or mental and emotional abuse which might amount to criminal conduct and which takes place within the context of a close relationship….between partners or ex-partners" (Crown Office 2005). This definition is similar to that adopted in this thesis in key respects as it recognises a range of behaviours and the importance of the intimate relationship between perpetrator and victim (section 2.2). A fundamental difference is that this will only be recorded in police data if the behaviours "amount to criminal conduct". It is common in secondary analysis for data collectors to work within a different conceptual framework to the researcher conducting secondary analysis (Bruce et al 2008). As medicalisation of domestic abuse can lead to a focus on physical symptoms and problematises the victim (section 3.3.6), so criminalisation may focus on evidencing specific crimes such as harassment or assault and may exclude the dynamics of abusive relationships from their assessment. In the current research this is likely to result in an underestimate of the nature and extent of the abuse. Other limitations of recorded crime data were discussed in section 2.4.1.

The Vulnerable Person's Database (VPD) was identified as the single source of data which could adequately address the research questions. When police officers in Scotland attend a domestic incident they are required to complete a Vulnerable Persons Form which gathers data on the nature of the incident, those involved and the outcome of the incident. The data includes an assessment of risk based on the SPECSS+ risk assessment tool. SPECSS is an acronym for the six key risk criteria associated with domestic abuse; Separation, Pregnancy, Escalation, Cultural issues, Stalking and Sexual assault. This model was

created following analysis of factors associated with domestic abuse incidents reported to the police in Thames Valley (Thames Valley Partnership 2005). In addition, the Vulnerable Persons Form records data on previous victimisation or perpetration of domestic abuse, alcohol consumption by victim and accused and requirement for medical assistance. Data are recorded at the scene of the incident either electronically using handheld Personal Digital Assistant devices or on hard copy which is later entered onto the VPD.

Individuals involved in incidents are allocated a unique identification number. This enables extraction of data by individual or by incident. The VPD was selected for this study as it could be used to provide a random sample of data from a representative group of women involved in police reported domestic abuse incidents with fields pertinent to the research questions. However, some limitations were present in selecting the study sample and are described in section 6.4.4.

A random sample of 100 women, involved in police reported domestic incident in the calendar year 2012, with children aged less than 5 years at the time of the incident was selected for phase two of the current study. In quantitative research, power calculations are frequently used to determine the sample size. As the study aim was to describe the incidents, a simple descriptive and statistical analysis was conducted using Microsoft Excel. This is discussed in section 6.4.7, prior to presentation of the findings.

4.7.3 Response to Research Participation Questionnaire

The Response to Research Participation Questionnaire (RRPQ) (Newman, Willard, Sinclair & Kaloupek 2001) was introduced at the end of interviews with health visitor service users in phase three of the current research. The RRPQ is used to determine the emotional cost of research participation using 27 questions with multiple choice answers. The RRPQ informed and supported the conduct of phase three of this research but did not directly address the research questions but ran in parallel to the main investigation. Therefore, the RRPQ and the findings are discussed in Appendix 4.3 and is referenced in the main text when appropriate.

4.7.4 The Quality of Quantitative Research

The quality, or rigor, of quantitative research reflects the epistemological assumptions of the Positivist paradigm (section 4.4). Quantitative research is assessed in relation to the following criteria; internal validity (the extent to which the data represents the real world), external validity (applicability of findings to the wider population), reliability (accuracy of the measurement tools) and objectivity (bias within the study) (Polit & Beck 2014).

Random sampling reduces bias and increases the external validity of the study, as everyone in the defined population has an equal chance of inclusion (McLaren 2013). This sampling strategy was feasible in phase two with support from police analysts. A simple descriptive analysis was conducted and therefore, there was limited opportunity for researcher bias in this instance. The sample criteria included women with pre-school children. The literature suggests that pregnant women and younger women are at an increased risk of experiencing domestic abuse (section 2.4.3). Further, as stated previously, not all domestic abuse will come to the attention of the police. Therefore, the findings may not be generalisable to all women experiencing domestic abuse. This is discussed further in section 6.7.

The differences in the conduct of qualitative and quantitative research have been discussed. Some factors such as ethical considerations and access to study samples apply throughout mixed methods research and will now be considered.

4.8 Ethical considerations

4.8.1 Ethical Research Principles

Principles of ethical research with human subjects have been clearly defined for many years most notably with the Nuremburg Code (1947); United Nations Declaration of Human Rights (1948); The World Medical Association (WMA) Declaration of Helsinki (1964) and the work of Beauchamp & Childress (2013). Consistent throughout are internationally accepted principles of beneficence (to do good), non-maleficence (do not harm), respect for autonomy and justice (Scott 2013). The Declaration of Helsinki has undergone seven revisions since the original publication in 1964, most recently in 2013. This valuable document is predominantly aimed at medical practitioners but is of relevance to any research with human participants. The declaration clearly defines the tenets of ethical research including the researcher's responsibility to ensure the safety, dignity and

privacy of participants; the requirement for informed consent and confidentiality (WMA 2013). Ellesberg & Heise (2005) developed guidance for conducting ethical research on violence against women. Their recommendations have been incorporated into the current study and are described in this section.

Prior to commencing research, researchers must consider if the investigation itself is ethical. In recognition of the cost of research participation in terms of participant time, emotional impact and potential risk, the WMA state that research involving "vulnerable groups" should only be conducted if the research will provide benefits for that group, address need and cannot be conducted with a non-vulnerable group (WMA 2013). Women who experience domestic abuse may be considered a vulnerable group but their vulnerability can be over emphasised (Becker Blease & Freyd 2006). Following a review of the available evidence Becker-Blease & Freyd (2006) conclude that some women do become upset when discussing their experiences of abuse but for the majority of those who do this is not "unduly upsetting" (Becker Blease & Freyd 2006). Indeed, for some women being asked about their experiences and talking about this can be beneficial (Griffen et al 2003, Benight & Johnson 2003). Nonetheless, it is good practice to consider the availability of support services during the study design phase. In Scotland specialist provision for women experiencing domestic abuse is available through a national helpline and through refuge and advice centres. In the current study the researcher engaged with these services to obtain support and a mechanism for referral of women who wished this.

It was anticipated that the majority of women would report a positive response from participating in the study; however, it was essential that the researcher was prepared to respond if women did become distressed (WHO 2001). The researcher was prepared to respond to immediate distress or help seeking from participants through their work as a health professional, additional training in counselling skills and previous research with people affected by GBV.

Despite the focus of phase one discussion being on health visitors' professional practice, it was recognised that some focus group participants could have been affected by domestic abuse in their personal lives, and that discussions on this issue may evoke emotions. To address this in the current study all participants were offered written information about support services for people affected by domestic abuse. The researcher was prepared to

respond to disclosures of abuse from health visitor participants and to signpost on to supports.

4.8.2 Confidentiality

Participants contribute their experiences and views on the understanding that the information will be utilised for research purposes only, that access to data will be restricted and that their identity will not be linked to the statements they make. Lack of confidentiality may place women experiencing domestic abuse at risk of harm from their partners as punishment for breaking the silence around abuse. Lack of confidentiality could also impact on the care women receive if they provide an unfavourable account of their experiences as service users. Similarly, health visitors may face repercussions from senior staff who identify negative comments about the service or practice from research data.

By necessity focus group participants must contribute to the research in front of other group members so total confidentiality is not possible. However, confidentiality within the group can be agreed with participants prior to the group commencing. In the current study it was not possible for the researcher to determine if senior staff were aware which health visitors had participated. To minimise opportunities to identify participants from quoted statements, the study site and references to service users or local services were removed from the text.

As health visitors may be aware which women participated in this research, similar precautions were implemented in phase three to ensure participant anonymity. Names of children, partners, staff and services referred to during interview were removed at transcription. The researcher had a responsibility to share information with services if concerned about the safety and wellbeing of research participants or their children. This limitation of confidentiality was clearly explained to women prior to obtaining consent for interview. If the researcher had concerns they would have contacted a health visitor after advising the participant of her intention to share information.

In phase two of the current study, anonymised data was provided by the police. The police service applied reference codes and removed the names and addresses of the victims and the accused in domestic incidents. Although data was anonymised there remained a risk to

confidentiality as some potential identifiers, such as the victim's date of birth and the police district in which the incident occurred, were shared. Hence the victim or accused or others close to them may be able to identify them. Care was taken to ensure data was stored securely and examples used in reports did not enable identification of victim or accused.

4.8.3 Safety

The safety of participants and researchers should be paramount in the design of studies investigating domestic abuse (WHO 2001). There is potential that the research process, if poorly executed, could endanger the physical safety of participants through violent retaliation from a partner as punishment for participation (Ellsberg & Heise 2005). Care should be taken to ensure that the purpose of the research is known to the participant but not to the abusive partner or other acquaintances. An example of good practice in this area is to develop some generic interview questions, unrelated to violence and abuse, and use these if the interview is interrupted or if there are concerns that privacy or safety has been compromised (Ellsberg & Heise 2005). This precaution was implemented in the current study and a general health questionnaire was produced (Appendix 4.4).

The safety of participants was addressed at several stages in this study to remove any potential risk of (further) abuse as a result of study participation:

a) When women agreed to participate in the research a mechanism for establishing that it was safe to talk was agreed.

b) If a partner or another person was present when the researcher attended for interview, or if the researcher had concerns about proceeding, they conducted a general health questionnaire only.

c) Both the researcher and the women referred to the research topic as "women's health" or "health visiting services" when discussing with anyone not directly involved in the study.

d) Women were offered a hard copy of the participant information sheet which was retained only if women perceived it was safe to do so.

e) Written information on local and national domestic abuse support services was offered to women but only left if women wished and consider it safe to do so.

If participants appeared distressed the researcher would have:

- Given the participant time to recover or talk further
- Apologised for any distress caused
- Offered to contact a friend or support for the participant
- Offered referral to, or information on, support services
- Offered to remain with the participant for a period of time after the interview
- Ensured the participant is aware of the domestic abuse helpline number
- Advised the participant of the potential to improve services as a result of research.
- Thanked the participant for their contribution to the research

The RRPQ (Appendix 4.3) captures participants' views on the impact of taking part in the research. This supported the researcher's observations of participant distress. From an ethical perspective, any indication of undue distress, whether directly observed or stated in the RRPQ, would result in suspension of the interviews and review of the study design. This supports ethical practice and adheres to the feminist research principles that research is non-exploitative.

It is essential to consider the wellbeing of researchers as well as participants (Ellesberg & Heisse 2005). In phases one and three of this study the researcher gathered data in health centres and in the homes of service users. The researcher complied with the lone working policies of their employer (NHS Greater Glasgow & Clyde) in phase one and The University of Glasgow in phase three. In summary this involved advising a colleague of the time and location of the interview; calling a colleague on arrival at and on exiting the service users' house and when arriving back at their place of work or home. If contact had not been made within a specified period of time, the colleague would attempt to contact the researcher by telephone. If no response was received, the colleague would be able to access securely stored details of the location of the interview and contact the interviewee. If no response or an unsatisfactory response was received, the colleague would alert the police.

The researcher has worked in the field of VAW for a number of years. Despite this experience, some accounts of abuse remain harrowing and disturbing to hear. The researcher has developed a strong professional network with colleagues experienced in domestic abuse work who were available for emotional support if required.

4.8.4 Informed consent

Informed consent is consent given freely by participants who are fully aware of the aims of research and associated benefits or risks (WMA 2013). In order to obtain genuinely informed consent, potential research participants should be fully aware of the study purpose, methods and expectations of participants before deciding whether or not to take part (Bryman 2004).

To ensure informed consent in phase one, written information was circulated to prospective participants in advance of focus groups which stated the purpose of the research, confidentiality and anonymity for participants and that participation was voluntary (Appendix 4.5). This information was restated by the researcher immediately before commencement of the focus groups and participants were given an opportunity to "opt out" of the group. Following this, written consent was obtained (Appendix 4.6).

It is good practice to provide written information to support informed decision making but this may jeopardise the safety of women living with abusive partners (Ellesberg & Heise 2005). In phase three of the current study, written information was prepared but only left with women if they stated it was safe to do so (Appendix 4.7). Women were advised verbally that they would be asked about the police reported incident and their views on the health visitor response. Women were informed that participation was entirely voluntary and they could decline to answer questions or end the interview at any time. This was stated at recruitment and again prior to interview. Women participating in face to face interviews provided written consent (Appendix 4.8). In telephone interviews verbal consent was given to commence the interview.

The use of financial incentives for research participation could influence a potential participant, particularly one to whom the incentive would make a significant difference (Beauchamp & Childress 2013). Manipulation of this nature is unethical as it removes the participants' ability to freely consent. In the current study, a voucher for high street shops or supermarkets, worth twenty pounds sterling was given to each participant. The voucher was given to show appreciation for women's contribution and to demonstrate that their time and experiences were valued by the researcher. The value was decided following consultation with the study advisory group which had representatives from the

police service, health and specialist support agencies. This was considered a substantial enough amount to show thanks but not so great that women would participate unwillingly to obtain the voucher. This was approved by the local Medical Ethics Committee.

4.8.5 Ethical approval

In phase one of the current study, ethical approval was granted by the West of Scotland Research Ethics Service (Appendix 4.9)

In phase two of the study, the Medicine, Veterinary & Life Sciences Ethics Service at the University of Glasgow confirmed that ethical approval was not required as data were anonymised prior to sharing with the researcher (Appendix 4.10).

In phase three of the research ethical approval was granted by the West of Scotland Research Ethics Service (Appendix 4.11)

4.8.5.1 Access

Each organisation has unique processes to provide access to human subjects or data relating to human subjects (Gelling 2010). In order to access a sample of health visitors and service users for the current study, negotiation with NHS and third sector agencies was required.

4.8.5.2 Access in NHS Boards

NHS Boards in Scotland have adopted a uniform process to simplify access and support health research whilst retaining their responsibility to protect potential participants. The process requires approval from a relevant research ethics committee, support from clinical managers and approval from the Research & Development (R&D) departments. In the current study this process was conducted in all participating NHS Boards.

Bryman (2004) has observed that gaining access is a political and practical process. In the current study, the researcher drew on existing professional contacts and engaged with senior managers in each of the proposed NHS Boards to seek support for the study in principle. This was followed by the practical actions of securing multi-site ethical approval, followed by access approval from Research & Development departments in NHS

Boards. The R&D process has also been streamlined with all NHS Boards adopting similar paperwork and processes.

Once access is granted at an organisational level researchers must engage with individuals or groups who control access to participants, referred to as gatekeepers (Gelling 2010, Bryman 2004). Careful negotiation and transparency are required as gatekeepers can support or restrict recruitment. Barriers to recruitment may be presented for altruistic reasons, such as an attempt to protect vulnerable service users, or relate to anxiety that research findings will expose poor practice (Gelling 2010, Lee 1993). Early engagement with gatekeepers can address anxieties about the research aims and processes and can provide valuable contextual and practical advice to inform the data collection process (Gelling 2010). In this study, health visitors and team leaders were consulted during the research planning phase to encourage support for the study and obtain guidance on the practicalities of conducting the research in the local area.

4.8.5.3 NHS Recruitment Strategy

Access to health visitor participants in phase one was initially conducted through senior managers in each NHS Board who have responsibility for leading Gender Based Violence Action plans (section 2.5.2). From this, team leaders were nominated who organised focus groups locally.

Access to health visitor service users involved in police reported incidents required greater effort. Thirty practicing health visitors working in three NHS Board areas volunteered to support the recruitment of service users. In consultation on the study design, health visitors agreed that this was an acceptable approach to adopt. Health visitors reported that they received reports of women involved in police reported domestic incidents every week and aimed to visit each family involved. Therefore, health visitors were well placed to identify potential participants and invite them to hear more about the research with minimal disruption to their day to day work. The process of recruitment is detailed in section 7.5.2. The researcher maintained contact with health visitors by email, telephone and attendance at regular meetings to promote recruitment. This strategy identified few potential participants and after four months a second approach to recruitment was introduced supported by ASSIST.

4.8.5.4 Access through ASSIST

ASSIST is an independent agency, working across Scotland to provide advocacy, information and support to women whose partners are involved in the criminal justice system for domestic abuse. ASSIST workers contact every victim in police reported domestic incidents by letter or by telephone and those who wish support "opt in" to the service. Again, the researcher used contacts within the organisation with whom they had collaborated in previous professional roles to establish contact. Senior management were initially approached to discuss the feasibility of collaboration and to approve researcher access. This was followed by negotiation with team leaders and support workers on the process for identifying potential participants.

The role of ASSIST was similar to that of health visitors. ASSIST workers agreed to contact potential participants, invite them to hear more about the research and sought permission to pass contact details to the researcher. In contrast to the health visitors who incorporated this discussion into routine work, ASSIST workers contacted women specifically to discuss the research and did so in addition to their contracted hours. Therefore, payment was made to ASSIST workers from the research budget for time spent on the project.

As with health visitors, ASSIST workers were consulted on the proposed recruitment processes. They stated it would be inappropriate to make non-essential, unsolicited contact with women within 6 months of a police incident as prosecution could be active at that time or women may feel stressed and distressed. Therefore, women involved in incidents in the previous 6 months were excluded.

This process required greater researcher involvement. Potential participants were identified from searching the service database. ASSIST workers then used their knowledge of the service user, discussions with colleagues and case records to assess the appropriateness of contacting potential participants. They considered the following: if another incident had occurred in the preceding 6 months which the researcher was not aware of; if women had any health or social issues which would prevent provision of informed consent or study participation; if women were in a period of crisis. As these calls were unsolicited and non-essential, and in an attempt to minimise any potential risk to

women, ASSIST recommended that a maximum of two attempts to contact women would be reasonable. The success of this recruitment strategy is discussed in Chapter 5.

4.8.5.5 Access to Police Data

Negotiation is also required to access datasets. Early discussions with police service analysts explored data collection and retrieval processes and were followed by a formal request for a sample of data (Appendix 4.12).

A primary concern is that data will be stored securely and will not compromise the confidentiality of participants (Mongan 2013). In accordance with University of Glasgow's data protection policy (2006), The Data Protection Act 1998, and conditions of Strathclyde Police data sharing, the electronic data were stored on a secure password protected drive. An agreement was made between the University of Glasgow and Police Scotland that care would be taken to limit the potential for people or incidents to be identified in reporting by limiting potentially identifiable data such as location. This dataset is discussed in greater detail in Chapter 6.

4.9 Chapter Summary

This chapter presented feminist theory which underpins the current study and the philosophical, practical and ethical considerations when researching domestic abuse within a health context. A pragmatic approach and use of mixed methods design were best suited to the research questions. Within this the qualitative approach is dominant with quantitative methods deployed to triangulate early findings and complement the findings from the subsequent qualitative phase.

The following chapter details phase one of this study and discusses the findings in the context of the literature.

5 Phase One – The Health Visitor Response to Domestic Abuse: An Exploratory Study

5.1 Chapter Introduction

This chapter presents phase one of the current research. The chapter is divided into four sections. First the study rationale, aims and research questions are stated. The study methods are described, followed by the study findings. The findings are then discussed in relation to the literature described in the preceding chapters.

5.2 Rationale for Phase One

A considerable gap was noted in literature relating to an effective, ongoing response to women with children who experience domestic abuse (Chapter 3). The literature presents a theory based consensus on how to elicit, and respond to, disclosure but beyond risk assessment and onward referral little guidance is available for health professionals working with women exposed to domestic abuse over a longer period of time (NICE 2014, WHO 2013).

Health visitors work in the community and regularly engage with families for five years or more. They are well placed to identify domestic abuse and offer support to women who experience it. Regardless of a lack of evidence based responses, the extent of domestic abuse and increased risk of domestic abuse in childbearing women, suggests that health visitors are required to offer some response to abused women in their everyday practice. Yet, the literature identifies a range of challenges to both identifying and engaging women who experience domestic abuse. Some challenges are common to all health professionals, such as lack of knowledge or skills on domestic abuse but the health visiting role presents additional barriers to engagement as women fear that their children may be removed from their care if they disclose (section 3.4).

Little is known about the health visitor response to domestic abuse in Scotland. This study was conducted to enhance the understanding of health visitors' practice and the context in which it is delivered.

5.3 Phase One - Study Aim

This phase of the study aimed to describe the experiences of health visitors in Scotland in responding to disclosure of domestic abuse.

5.4 Research Questions

The research questions in this study were:

- How do health visitors respond to disclosure of domestic abuse?
- What, if anything, limits this response?
- How does the current response address safety and protection of women experiencing domestic abuse?
- What support do health visitors require to improve their response to abused women?

5.5 Methods

5.5.1 Focus Groups

The strengths and limitations of qualitative research design and the focus group method were discussed in section 4.6. Focus groups are an effective method for exploring health professionals' roles, understanding the context of their work, exploring behaviours and the motivation behind these (Litosseliti 2003, Krueger & Casey 2000, Morgan 1998). The practicalities of arranging a focus group are often underestimated (Holloway & Wheeler 2010). In particular, negotiating time for health professionals to be released from duty during their working day can prove difficult. For this study, the researcher requested time with teams of health visitors during working hours and conducted focus groups as part of, or immediately following, routine team meetings.

All three focus groups took place as planned in 2010/11, in either a hospital meeting room (two focus groups) or in a health centre meeting room (one group). Two groups took place within a scheduled team meeting. In the third, on suggestion of the board contact, a meeting was scheduled specifically for the focus group. One focus group was held in each of the three participating NHS Board areas and a total of 20 health visitor participated.

The researcher (C McFeely) acted as moderator for all three focus groups in this study and followed a pre-determined focus group schedule. The schedule was reviewed and revised after the first focus group (Appendix 4.1).

5.5.2 Ethical considerations

The following information was (re)stated to potential participants prior to focus group commencing; the study purpose and methods; confidentiality of data; that participation was voluntary and participants could withdraw at any time. All of the potential participants elected to continue with the focus group and provided written consent for participation and recording of the group discussion.

Domestic abuse is a sensitive and emotive topic and a number of steps were taken to protect participants (section 4.8) and included provision of information on local and national domestic abuse services, a request that participants respected confidentiality within the group and an opportunity for participants to speak in private with the researcher following focus groups. None of the participants appeared distressed or upset during the focus groups or contacted the researcher following the groups.

5.5.3 Analysis

A general inductive approach was applied to data analysis. The researcher listened repeatedly to the recordings and transcribed the data in full after each focus group. Transcriptions were re-read to familiarise the researcher with data after which, data was coded. Coding is a process of labelling ideas and meaning from the text (Holloway & Wheeler 2010). The label summarises a portion of data and can be used to link comparable or contrasting data (Griffiths 2009). Transcriptions were coded following each group using a process of open coding where the codes are developed during the analysis. The coding framework was expanded or amended to accommodate new ideas as they emerged. Forty seven codes were applied to the text and a full list is available in Appendix 5.1

Further analysis followed the process described by Hansen (2006 p137). Open coding was followed by "axial coding" where connections between codes created categories and "selective coding" where categories were grouped under new headings. From this three

broad themes and 12 sub themes were identified. These are discussed in section 5.6. In inductive qualitative research data collection and analysis typically occur concurrently (Griffiths 2009). Comparison of findings between focus groups commenced during data collection period and continued throughout the coding process.

Quotes are presented throughout this chapter to support and illustrate findings. To ensure anonymity, each focus group was assigned a number and within this each participant was also assigned an identification number. Participants are identified by focus group (FG) and participant (P) following the quote. For example, participant two in focus group one, will appear as (FG1 P2)

5.6 Findings

5.6.1 Participants

The study aimed to achieve a sample of between 18 and 30 health visitors. A total of 20 practitioners participated in three NHS Boards: 17 health visitors, one health visitor support workers and two school nurses (Table 5.1). Focus groups were attended by between 5 and 8 participants and lasted between 60 and 90 minutes.

Participants' experience as health visitors ranged from one to more than 25 years. Experience of engaging with women affected by domestic abuse also varied with some participants discussing frequent contacts and others reporting very little experience of domestic abuse in their caseload. The majority of participants had received some domestic abuse awareness training and two had attended skills training on enquiring about abuse in the months preceding the focus group. All participants were female.

	Health Visitors	School Nurse	Health Visitor Support Workers
Focus Group 1	7	0	0
Focus Group 2	3	1	1
Focus Group 3	7	1	0
Total	17	2	1

5-1 Focus groups and participants

5.6.2 Themes

Three broad themes emerged from the data and within these 12 sub themes emerged (Table 5.2). This section will present findings in relation to each of these.

Theme	Sub Theme
Identifying Domestic Abuse	Knowledge About Domestic Abuse
	Defining Domestic Abuse
	Disclosure of Domestic Abuse
	Notification of Police Reported Domestic Incident
Responding to Domestic Abuse	Making Contact
	Women Led Services
	Signposting to Support Services
	Child-centred Services
	Protection of Women Experiencing Domestic Abuse
Support for Practice	Specialist Services
	Training
	Peer Support

5-2 Phase One themes and sub themes

5.6.3 Identifying Abuse

5.6.3.1 Knowledge About Domestic Abuse

In order to identify and respond to domestic abuse health professionals must be aware of the multifaceted nature and range of behaviours which constitute this abuse. At the beginning of focus groups, participants were asked what "domestic abuse" meant to them. All participants in this study provided a detailed description of domestic abuse, the range of abusive behaviours, the complexities and dynamics of abusive relationships. In particular, they described controlling behaviours and the impact of this on women.

"There are lots of signs of domestic abuse going on – control, everything is there, and I've gave her discreetly the number for Women's Aid. She has no contact, he holds the phone, he holds the money, all that's going on. They are just a young

couple but she doesn't see that going on, there is no insight into this is the cause of it. I don't think there is physical abuse going on. We've tried to open doors with her but she just doesn't seem to see what is happening." (FG1 P2)

"It is difficult because women in that situation often have low self-esteem. They've got no confidence, low self-esteem and are ashamed about what's happened to them." (FG1 P3)

All groups placed responsibility for the abuse with abusers, stating that to end abuse perpetrators' behaviour must addressed. They did not see a role for themselves in challenging perpetrators but stated that few services were available to do this. In one group, health visitors discussed this at length but stated that in practice only one or two men had requested support in addressing their behaviours and that this mostly related to dealing with drug or alcohol misuse. Two participants advised caution in responding to perpetrators as this could inadvertently lead to collusion with the perpetrator but one encouraged colleagues to respond to support needs.

P4: "That can be part of the manipulation as well; because they say that they will do things, and that is why the women stay with them as well, because they are very manipulative, they know the answers you are looking for, they say it'll never happen again, they say they will do this, do that, they will take you on board and perhaps you've just fallen into the same trap as the family have."
P1: [You need to be careful of] Falling into a trap but I think you need to take that, and accept that it's a possibility that they do want to change. (FG2)

5.6.3.2 Naming Abuse

Health visitors stated that often they considered women to be experiencing domestic abuse but women themselves did not perceive their partners' behaviours as abusive or recognise a risk to themselves or their families. Health visitors stated many women did not define their experiences as abusive but considered their partners' behaviour towards them as "normal".

"One of my families there is a mum, and there was domestic abuse with her parents, and now domestic abuse with her; it's letting her know, she thought it was normal

and with just talking through, "your children are seeing that and they're going to think it's normal". She's starting to realise its not normal behaviour and so trying to change that pattern. Because it's very difficult for them once they get into that cycle, to get out of it." (FG2 P4)

While health visitors recognised abuse can take many forms, they stated that some service users perceived that only physical violence constituted abuse.

"The emotional and the sexual abuse, sexual abuse in particular is difficult [to identify] because that is really so tightly enclosed in the family. That is the most difficult to get at if it's there. Emotional abuse it's not, you talk to most women about abuse and they think "He doesn't hit me"". (FG1 P6)

As illustrated above, some health visitors addressed this directly with women but, in contrast to the literature where professionals are encouraged to support women to identify abuse (section 3.3.2) some participants indicated concerns that naming women's partners' behaviour as abuse was subjective and questioned the appropriateness of opening the discussion.

"I've seen that two or three times as well, they don't even know. Or if they do know they don't want to know. Its different standards and you need to think to yourself "Am I trying to put my standards onto her?" Do you know what I mean? You have to try and pull back a bit." (FG1 P1)

A health visitor who had recently attended training on asking about domestic abuse stated that this had equipped her to recognise abuse and to address this with women.

"Suppose you have to listen to what they are saying. Abuse can come in lots of different forms, and what they might think is not necessarily abuse, because that's the norm in their day to day life, we might be picking up, from our training that actually that isn't the norm, and it's down to your communication with that mum." (FG3 P2)

Participants in this same focus group who had not attended this training were asked if they felt equipped to respond. They replied: "We spoke about this, it comes from different

experiences. We all have different life experiences, boundaries, and norms." (FG3 P7)
This suggests that the responses are dependent on the personal views and attitudes of
practitioners rather than the circumstances of service users.

All participants stated that they did not think it was appropriate to continue to talk about
domestic abuse when women denied or minimised their experiences and instead "just
listening to what they [women] are saying." (FG1 P2) In one group participants stated that
when consequences of living with abuse became apparent or health related issues were
diagnosed, this provided another opportunity to raise the issue of domestic abuse with
women.

> P2: "See that even if there is no obvious signs but through that control these two
> wee ones aren't going anywhere. She's lost all self-esteem, if she ever had any,
> lack of confidence, she's not joining the toddler group, she's not leaving the house,
> they're all very controlled. It is really difficult to do anything about that. That's
> her life."
> (All agreeing it's difficult to respond)
> P4: "Unless they get depressed and then you can start an intervention pathway"
> (FG1)

Therefore, health visitors in this sample described reacting to health consequences rather
than proactively working with women to identify risk. Participants in this study were not
aware of the various stages that women living with abuse may experience, such as
distortion of perspectives and rationalising abuse, described in section 2.2.4 of this thesis
and did not identify a role for themselves in supporting women to move between these
stages. Overall participants perceived that women needed to come to a realisation that they
were experiencing abuse by themselves, in their own time and perceived that any
intervention from a health visitor would be unhelpful and may endanger their relationship.

> "It's like what you were saying earlier, she wasn't interested in leaving, or she had
> numerous offers of support, but she just wasn't at the stage to accept it." (FG3 P5)

5.6.3.3 Disclosure of Domestic Abuse

In general, health visitors reported very few disclosures of abuse from women. Health visitors stated that they did not routinely ask all women about domestic abuse but did ask general questions about relationships and supports at home as part of their initial assessment. Most participants considered this sufficient opportunity for disclosure. Others described a funnelling process which started with broad questions about relationships and dependant on the woman's response progressed to more specific questions if required. A minority asked specifically about domestic abuse during this assessment.

> "I think that it depends a lot on the circumstances, if you know them, then you very often you know the other signs that there's something going on; with their body language, and their demeanour. And I think sometimes you do prompt it, but you do have to be very careful how you prompt things like that, very, very carefully." (FG2 P1)

Health visitors frequently referred to the relationship between themselves and service users implying that this develops through regular contact and time spent together.

> "Just through the visits, and building up that relationship, and just being able to sit and talk about things that are going on, and how she deals with things, and what's happened in her past." (FG2P4)

One health visitor stated that in her experience, fewer women disclosed domestic abuse than in previous years. She suggested this was a result of a reduction in routine health visitor visits.

> "I've been a health visitor a long time and health visiting has changed a bit; it used to be easier to build up a strong relationship with the mums than it is now. That's the best way to put it. Just because of the change in structure of the service. You don't see people as much now as we did before." (FG2 P1)

The reduction in routine contact was perceived to have diminished the health visitors' relationships with service users and as a result of loss of relationship, loss of familiarity with families and sensitivity to potential problems in their lives. In Focus Group 1

participants stated that increased contact with families with complex support needs facilitated disclosure of abuse as health visitors and service users developed a trusting relationship.

> "I'm not saying that it doesn't happen in other parts of the community but I don't think it's as easy to get at in [more affluent areas]. I'm not saying that it doesn't happen there but I think they are much less likely to open up and reveal. I think probably in [deprived areas] they tend to be, I think you can get more out of them, probably because you are visiting more often." (FG1 P6)

This represents disconnect between health visitors' understanding of domestic abuse and their response in practice. Health visitors were aware that domestic abuse affected women from all social groups but in practice were more likely to discuss this with women of lower socio-economic status than those of higher socio-economic status.

The majority of participants in all three focus groups stated that health visitors were considered more acceptable and less of a "threat" to families than social workers.

> "In some respects the health visiting service can be less threatening in a way…. That couple wouldn't let social work in. They agreed to attend down at the medical centre to meet with social work because they made them agree to a contact but the door was open for me. It was because of her past history." (FG1 P2)

However, two participants in Focus Group 1 stated that women fear disclosure to health visitors will result in child protection action which will ultimately remove the children from their care. This reflects the dichotomy within the literature where some service users report that health visitors are approachable (Bacchus et al 2003) and others that service users' awareness of the health visitors' child protection role creates a barrier to disclosure (Brocklehurst 2004) (section 3.4.2).

> "I think sometimes that why women don't disclose, because they see you as an authority. People will say "don't take my children away". (FG1 P5)

Health visitors described situations where they suspected women were experiencing abuse but did not have an opportunity to ask about this directly because of a lack of privacy.

Indeed, some described obtaining private time with women as the "most difficult part" (FG3) as partners or other family members were present during home visits. Where possible, health visitors would discreetly advise women that they are always available to talk and provide contact details and clinic times when leaving the house. Alternatively, they would ask women to come to the clinic, or if familiar with the family and community, may seek another opportunity to make contact outwith the home.

> "If you've got suspicion I would always say "I'd like you to come down to use the scales at the clinic" you can always find a reason without giving him [partner] any great suspicion. You could say the scales are better at clinic. There are lots of excuses and they are coming to clinic after 6 weeks anyway. Rarely do the men do clinic visits. So, there is that opportunity for them to find us if they want us once a week on our own, in private. Just you and the baby." (FG1 P6)

> "Sometimes go to nursery, because you know the child's there and being picked up at a certain time, you can be opportunistically passing by, be there at the same time." (FG2 P4)

In all focus groups health visitors reported that women rarely disclosed experience of abuse but that other agencies notified them, in particular the police.

> P1: "We usually get a call from the family protection unit at the police, or social work. It's very seldom that the mums tell us, now."

> P2: "It *can* come via the mums though, but it's not as common." (FG2)

5.6.3.4 Notification of Police Reported Domestic Abuse Incidents

Participants were routinely notified when women with children were involved in police reported domestic incidents. At the time of data collection participants stated that they received between two and four of these notifications per month. The process for notifying health visitors varies between NHS Board areas. In some, health visitors are contacted directly by the Police and in others notification is made through social work services. As a result, those working in areas where information is delivered via social work services may not receive this information for up to a month after the incident.

Health visitors stated that many of the notifications related to "one off" (isolated) incidents, frequently fuelled by alcohol. For example, one health visitor was notified when a woman had become involved in a fight with another woman in the street when her children were not present.

> "It depends on what it is. Some of the things we get through are ridiculous. I had one; they were fighting in the street on the way home from the pub, there was an argument, the children weren't there, it was out in the street, it was ridiculous…. It wasn't the couple, it was the female, and the guys ex-girlfriend" (FG3 P5)

For some, this kind of information diminished the value of the notifications system but a minority considered all notifications an alert to potential ongoing abuse.

> "A lot of domestic abuse is very hidden and you don't know how many times it's happened before that incident that you are aware of." (FG2 P4)

Many participants associated police reported incidents with alcohol use. The associations between alcohol use and domestic abuse and the impact on professional assessment of a situation were outlined in Chapter 3 and will be revisited in the discussion of this chapter.

> "They have a bottle of wine and they have a domestic."(FG2 P4)

> "Well sometimes it's tit for tat isn't it?" (FG1 P1)

Most participants did not associate involvement in a police reported domestic incident with risk of abuse. Instead they differentiated between police reported domestic incidents as isolated or unusual events in a relationship and domestic abuse as a pattern of behaviour. This is a significant finding as the purpose of information sharing regarding police reported incidents is to identify families at risk of harm but in the experience of health visitors in this study, involvement in police incidents was not indicative of families with additional support needs.

"If there's another domestic, well then you know there are problems but quite often they are one offs. Or people get cute to not phone the police, you don't know, do you?"(FG1 P1)

Health visitors reported that repeat notifications were received for a small number of women. In these cases they stated that it was unlikely domestic abuse would be the only issue affecting these families and health visitors would already be in regular contact with the families.

Participants stated that during home visits following a police notification women often denied or minimised the incident and associated this with one of two issues: Domestic abuse was not present or that women did not recognise abuse. Health visitors perceived that for the majority of women the incident which came to the attention of police was not characteristic of the relationship and women were not experiencing domestic abuse. In these situations health visitors did not perceive a need to arrange follow up with families.

"Social work would probably be doing a bit more if the kids were there. So it's not that you're not as concerned, but it's probably going to result in less input and Social Work won't be as concerned because some couples will argue, but they're OK, they're good parents and the kids are not aware of any of that. You're not going to go in there and change their role." (FG3 P3)

Alternatively, health visitors reported that women were experiencing abuse but were not ready to recognise abuse or to consider exiting the relationship. Women's "readiness" to exit the relationship presented a barrier to engaging in further discussions or offering information or support. Again, follow up was rarely arranged. This is explored in the following section.

5.6.4 Responding to Domestic Abuse

Participants all agreed that responding to domestic abuse was part of their role and responsibility and all appeared confident about delivering responses. As participants reported that very few women spontaneously disclosed domestic abuse most of the

discussion focussed on responding to notifications of involvement in police reported domestic incidents.

5.6.4.1 Making contact

Health visitors endeavoured to visit women at home following notification of a police reported domestic incident as this provided an opportunity to meet women and assess the situation. However, health visitors voiced concerns that this could embarrass women or may place them at increased risk of further abuse.

> "It depends a lot on how well you know the family and how you deal with it; because if you can imagine, it's a one off incident, and this women is mortified because the social worker is there, health visitor is there, and police are there. Sometimes it's not really appropriate to go out, it depends entirely on the circumstances. If it's appropriate to go out, of course you go out and offer supports that are there." (FG2 P1)

In all focus groups health visitors identified that responses to domestic incidents focus on the victim and her actions, rather than the perpetrator and stated that women may feel that home visits from a range of professionals are punitive, particularly so when social workers were involved.

> "If social work go, or if you go out on a joint visit, it's mainly always the mum that you do see, and I don't know how much of that the mum sees that they are getting targeted, if the police are involved, dad's at work now and it's me they are speaking to. [Women think] "What are the neighbours seeing?""(FG3 P7)

> "You wouldn't always go down the social work route, because if you did ask the mum something and she did disclose it, and then you say social work need to come in, it's as if she would see that professional as putting a bit of the blame on her, instead of being supportive." (FG3 P5)

Frequently, social work staff will have already made contact with women. Some health visitors regarded their own visit as duplication.

"With a lot of the mums, Social Work are the first contact so they are the first ones going in and doing it all, so by the time I have been out, they say they've already got all that, and they don't really want to talk about it again, because the first contact has been made by the Social Work."(FG3 P7)

A minority of respondents stated that it was still important for health visitors to make contact and make women aware that health visitors can provide support to women experiencing domestic abuse.

"Yes, [I would visit after Social Work] and I think that reinforces our part in the community. Sometimes you might not do very much when you go out, a lot of them say, "I've had all my stuff about Women's Aid, I feel safe, I'm ok." You don't do a lot but it lets them know you are there. You might not do much that visit, but you are part of the care, and they know you can help" (FG3 P2)

As stated, every group highlighted that women prefer health visitor involvement to social work services. In health visitors' experience, women attached stigma to contact with social work services that was not applied to health professionals. Despite earlier statements about the reduction in routine visits and diminishing relationship with service users, health visitors perceived that they had greater access to women than social work colleagues. As a result, health visitors often made joint visits with social work colleagues to encourage women to engage or for worker safety.

"I think Social Work like to do a joint visit; they find it easier because we have that contact so it's easier to go in with us when we know them, and they're more open."(FG3 P4)

Beyond joint visits and initial information sharing, no examples of joint interventions to address domestic abuse were given.

5.6.4.2 Women Led Services

Health visitors initiated a home visit following the police report but once contact was established health visitors in all groups reported that care planning is woman-led. Every woman jointly develops an individualised care plan with a health visitor. Therefore, there

is no "typical" response to disclosures or notifications of abuse. Participants described implementing women and needs led services in practice as presenting open questions and awaiting specific requests from service users. In response to requests, health visitors created an individual care plan for each family. However, further discussion indicated that women rarely request supports and when they do, services are not always able to accommodate them.

> "You'd kind of say "where do you feel that you're at? Where would you like to go?" Try to support her however you can, whether it's giving information about Women's Aid, places like that." (FG1 P1)

> "Also it's assessing what her needs are and what she sees her needs as. It's not for you to come along and say "I'd like to offer you support once a month or once a week." And you are reversing that when it really has upset some of the girls and you say "Are you coping alright?" and she might say "Could you pop in again next week because I found it really useful?" Ultimately needs led." (FG1 P6)

Participants presented an open offer of support to women. Despite describing consequences of abuse such as isolation, disempowerment, lack confidence or access to services (due to lack of finances, access to telephone etc.), health visitors in this study anticipated that women would request support if required but reported that in practice women very rarely did. This represents another area of disconnect between understanding of abuse and the response in practice.

> "And then you can say "look, I'm here to help you, if there is anything I can do, if yous are having problems then you really need to contact me." You really have to leave the ball in their court."(FG1 P6)

Health visitors identified providing emotional support as part of their response to women who have experienced domestic abuse if women requested this.

> "How often do I give emotional support? It depends entirely on how long it takes them to build up, how long they have been suffering domestic abuse, what their support network is like, whether they buy into services or not, and how serious the

abuse is. Very often, it's the emotional stuff that gets them worse than the physical side. It's as long as they need it."(FG2 P1)

In fact participants stated that this rarely happened in practice and described a number of limitations to the service they can provide. Most participants stated that service constraints created a barrier to offering open support.

"I'm being totally honest, sometimes I cannot see this woman for maybe a month or two, sometimes its longer, sometimes it's more frequent, its maybe every week for a couple of weeks. As [colleague] says, its crisis management…. If a crisis happens really; she phones me, needing me to go out. Like last week I spoke to her over the phone, just because I didn't have the availability in the diary to see her. That was enough for her at that point in time, so I said I would phone her the next week and take it from there. I know this is a totally separate issue, but that is where staffing is an issue. Because you don't get to support these women as much as I think that you should be." (FG2 P2)

Even if possible to deliver open, frequent visits, health visitors considered them undesirable and as they perceived that this could encourage dependency.

P1: "I wouldn't be able to see them weekly on a prolonged basis. You wouldn't actually want to do that; because what you're trying to do is, it's like being a parent. You are building them up for so long, and then you're gradually withdrawing away from them to allow them to develop their own coping mechanisms, develop their own social networks, and things like that, so it wouldn't be good practice to see them on a weekly basis over too prolonged a period of time."
P2:" You wouldn't want them to become dependent on you; there is a danger that might happen. Because often they don't have anyone else to talk to."
P3: "We're not there as a friend." (FG2)

Likewise, when planning visits, service limitations can result in less frequent visits than women would wish. Health visitors described managing women's expectations and requests with what they could reasonably achieve within their workloads. In one example a health visitor reported spacing visits to maintain contact over a longer period of time, indicating that they perceive a realistic maximum number of visits they can accommodate.

"You do, as well, make your visits in agreement with them. Like 'How you feeling now, do you think you could wait a couple of weeks before I come back out?' 'Do you want to come out in such in such a length of time?' So you're making an agreement with them, so they feel as if they're in control, which is something they haven't felt in a long while. That's how I usually get to prolong it out a bit, is by doing it that way. "(FG2 P1)

In reality, support options available to women were limited but health visitors presented the plan of action as one which had been negotiated with women from a range of options. Indeed the comments of FG2 P1, a health visitor with many years' experience, likening their role to that of a parent and making women feel "as if they're in control" explicitly demonstrates that women do not lead, and are unlikely to be true partners in the planning.

Within focus group two participants stated that they adopt an empowerment approach when working with women who had experienced abuse. However, there was little explanation of this approach in practice and very few examples of the health visitor actively working to achieve this. Participants stated "we try to empower them" (FG2 P2) and on further questioning described this as highlighting positives and achievements in women's lives and encouraging them to use the same skills and strengths to make changes in their lives.

> P2: Looking at the positives in their life as well; the children. Not just sitting focusing on the negative things like the abuse. Sometimes it's about turning that around and saying "look at what you did do".
> P1: I totally agree with that, that is what you're doing, you're empowering them, looking at the positives. (FG2)

However, in focus group discussions there was little reflection on this from participants who primarily described the intended response rather than that which women received. To contextualise this, health visitors identified two overarching pressures which influence their response to women involved in police reported domestic incidents; outcome focussed working and increasing workload. The first of which was a need to demonstrate that their actions are outcome focussed.

"You need an outcome. Is there a purpose for the visit and why have that plan of action?" (FG1 P7)

"We also have to question ourselves about why are we going out? What are we going out to achieve? Why are you going, going, going?.... What do you really want to give them? There is frustration there for health visitors, there must be. Yes, you can go and have a cup of tea with them but what are you actually giving them?" (FG1 P2)

In two focus groups the moderator asked if women feeling supported, investment in empowering women and safety planning were currently considered as outcomes. Participants advised that these did not match specifically with current outcomes and therefore time spent on this could not be justified.

The second issue was health visitors' reports of increasing workloads. While they stated that reduced routine visits diminished the relationship, they did not consider it feasible to increase this as the number of service users in their caseload had significantly increased. The issue of time constraints permeated through every discussion and heavily influenced the extent to which participants were able to respond to abused women. Health visitors reported managing demanding workloads, responding to families with multiple and complex support needs, responding to child protection issues and delivering a public health monitoring role in the provision of the universal health visiting service. No additional resources were provided to cover annual leave, study leave or sick leave within teams compounding the pressure. As a result, health visitors reported that they spent little time with families assessed as low risk. This in turn meant that they were not in a position to observe the subtle indicators of domestic abuse. When participants were aware of domestic abuse, some could only provide a "crisis" response. They described this as supporting women immediately following abusive incidents or when they were on the point of exiting the relationship.

"Sometimes it is crisis management, sometimes with the workload as well." (FG2 P3)

Health visitors were resistant to the idea of a structured or "prescriptive" response to women who experience domestic abuse, citing the need for individualised care. Despite

statements that there was no typical response, participants did not provide examples of tailored care. Instead, in recent practice, they described a minimal response delivered to women involved in police reported domestic incidents, whether domestic abuse was suspected or not, citing workload and limited engagement from women as factors in this decision.

Participants in two focus groups suggested the establishment of a dedicated team within health services to provide follow up and engagement with families where domestic abuse had been reported and could deliver a structured and intense follow up if required. This mirrors much of the guidance which recommends an immediate response and then onward referral to specialist services. However, participants in all groups had stated that they encountered women affected by domestic abuse frequently in the course of their work and that domestic abuse seldom occurs in isolation from other issues. This suggests that there is a role for universal services to respond, alone or in partnership with specialist services.

5.6.4.3 Signposting to Support Services

Health visitors stated that if they suspected abuse they would check that women were aware of specialist services, such as Women's Aid and some would leave written information with women. A few health visitors stated that they had made appointments for women and accompanied them to Women's Aid centres. These participants recognised that women often do not engage on first contact but regard this as part of the process.

> "Sometimes you will take them to a women's refuge and that's it, they won't go in. There's a bit of see-sawing." (FG1 P4)

However, others viewed this as both a waste of resources and as potentially disempowering for women. They stated women should make the contact themselves when they were ready to engage.

> "You do [help women access services], but I think quite often when you do that, they're in danger of not attending, because they just don't quite feel ready. …. I think that's the danger if you contact an agency on behalf of someone, I think they almost want you to go for them, and you can't do that, they have to be ready to talk about it, and deal with it themselves. I think if you were to do it on behalf of the

women, you're taking all power away from her again, you're giving her no control." (FG2 P2)

"I did contact [local domestic abuse organisation] for one of the mums recently, and she ended up not opening the door to them. So the time can't be right for her just now, and then I liaised again with my colleagues at [local domestic abuse organisation], because it was a waste of their time, as they said, they could have been seeing someone else. Hopefully she will go back." (FG3 P2)

As stated, there was a perception across all groups that women needed to reach a stage of engagement on their own and that they would and could access services when they wished to. That said, the majority of health visitors made reference to supporting women to some extent to overcome practical barriers to engaging with services, for example, allowing women to use the health visitor's mobile phone to make contact with supports.

Participants stated that, in terms of practical support, they were limited as they did not have access to cash, equipment, accommodation, clothing etc. and so they referred to partner agencies who they perceived had a greater range of supports than health visitors could offer, particularly in relation to financial assistance.

"That young girl, the one that all the signs were there was very, very isolated and very controlled. I was working with [Voluntary Organisation] with her over quite a long period of time. They were able to offer her as much help as she wanted when she wanted and they were able to go over that with her. Like financial. And our service couldn't. We weren't able to offer her that same practical support. "I'll take you to the train station and give you the money to go on, go down to your mothers and decide what you want to do." You know where we can through other services but there are restrictions on what we can offer as well. "(FG1 P2)

5.6.4.4 Child-Centred Services

Participants stated that women decided which supports were most appropriate for them, but for health visitors, the safety and wellbeing of children took priority over the needs of women. Participants stated that all services should have child protection as their primary role.

"For every agency who goes into a house where there are children, the children come first always. Whether it's us, community psychiatric nurses, it should be that anybody who goes into a house should be aware that the children come first always. So although we are child-centred that shouldn't just be us, that should be everyone. Everyone should be aware that the children are there and of their specific needs, their safety." (FG1 P6)

The obfuscation of the mother's experience of abuse by focussing on the child was evident throughout the discussions. The initial response to disclosure of abuse or notification of a domestic incident was for health visitors to highlight to women the detrimental effect of this abuse on their children but did not discuss the impact of abuse on the woman herself.

"Part of [the health visitor response] is support, part of it is, I think, highlighting the impact of domestic abuse on the children. I don't think people are aware that their kids are sitting upstairs listening to all this, absolutely terrified, and ridden with guilt." (FG2 P1)

Notwithstanding concerns that the multi-agency responses make women feel that they are responsible for the abuse, participants did not anticipate that advising women of the negative impact on their children as an initial response may also be perceived as placing responsibility on women. In a further example, health visitors stated that they assess the risk posed to children in the household by domestic abuse but not to women who have directly experienced the abuse.

A child-centred approach presents further challenges when the parenting abilities of women who experience abuse raise concern. Health visitors reported that, as the wellbeing of the child is paramount, in some situations a decision would be made not to directly address domestic abuse, demonstrating the challenge of implementing child-centred care to a family exposed to domestic abuse.

"The other thing that I think needs to be brought into consideration with that bail conditions is that there are some families who do not function without the male in the house….I think that needs to be considered that there are some families where the children are more at risk when the male is out the house. Domestic violence isn't

necessarily the biggest risk....With the mother not being the main carer. That may very well be that she is not able to cope because she's been so downtrodden, but it still puts the kids at risk." (FG2 P1)

Some health visitors described supporting the mother within a child focused response, viewing the mother as a resource for the child.   Few participants acknowledged a potential conflict but even those who did utilised the "child as priority" approach to guide their decision making and extent of their assessment.

> "Although you're acting to support the parent, the overriding responsibility is for child protection."(FG1 P7)

> "That is our dilemma. The job is child centred. That is our dilemma. That's it. End of story."(FG1 P2)

Two experienced health visitors (in different focus groups) discussed mothers as a potential protective factor for children. For one, protection could only be provided by mothers who exited a relationship.

> "We're focusing on the child. We're looking after the mum, in order to look after the child. We're looking at all the protective factors there. A protective factor is a sensible mum who is saying "This has happened. I'm not having this happening again - he's out", and who else is there [to help]?"(FG2 P1)

The second participant described protection in relation to assessing and managing risk within the home.

> "Not all women who experience domestic abuse are unable to keep their children safe. That sounds a bit odd. If they've got extended family or family, if they forsee a set of events, he's been out all night and coming home drunk, you'll often find that can be a situation where – the kids are staying with my mother. They are able [to protect their children], although it sounds odd in a way." (FG1 P6)

Despite an awareness of the negative impact of exposure to abuse on children, focus group participants did not describe specific concerns that children would experience significant

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adverse effects as a result of exposure to abuse. In a minority of cases, participants described serious concerns for the safety of women but they did not report regularly arranging follow up for child protection concerns or referral to specialist children's health services as a consequence of exposure to domestic abuse. Responses in one focus group suggest that health visitors' assessment is based on the physical wellbeing of children, rather than psychological.

> "I think as long as the children aren't at risk in any way, if there aren't drugs, and alcohol fuels, from both partners, an increase, the children are relatively safe, maybe not emotionally, but physically there is no immediate risk to them." (FG3P4)

Health visitors reported a responsibility to prioritise the needs of children but rarely described concerns or child specific responses. So, the process of assessment, rather than responses to children, appears to consume the time available to interact with families at the expense of assessment of women's needs. The accounts of participants in this study indicate that child-centred and women led service responses cannot both be accommodated within service constraints. This reflects the dichotomy faced by health visitors described in the literature in section 3.4.2.

5.6.4.5 Protection of Women Experiencing Domestic Abuse

Health visitors have a specific duty to protect women and children who experience domestic abuse. In focus groups, participants were asked if risk assessment, safety planning and protective orders were part of their response. None of the participants routinely carried out risk assessment in relation to further harm to women from their abusive partners. Risk assessment did occur for children's wellbeing with associated inter-agency assessments and care plans. When particular concerns were raised risk assessment was conducted for workers attending the home.

Researcher: Do you have any kind of risk assessment tool or process that you use?

P 7: "We did have a sort of risk assessment years ago about if you felt threatened at all. It was one of the hospital ones, where we would then make a decision whether you would still continue to visit on your own."

P 5: "Was that more about safety of workers?"

P 7: "Yes, it probably was."

P 1: "With trying to keep them [women] safe, you can only do so much." (FG 3)

In each group, at least one participant described safety behaviours such as women preparing an exit plan and keeping important phone numbers with them. Few health visitors contributed to this discussion which suggests that not all were aware of, or regularly discussed, these behaviours with women.

An experienced health visitor with an interest in domestic abuse discussed avoidance strategies with service users. She encouraged women to identify triggers for abuse and take action when these were observed, for example by temporarily leaving the house.

"Some women will be able to identify "it only happens when he does x, y and z." Usually alcohol but not always. So you can talk about avoidance. How can they avoid that confrontational situation? " (FG1 P6)

However, reference to "confrontational situations" suggests some equality in, or shared responsibility for, violent events, and removes the wider context of ongoing coercive control typical of domestic abuse.

Overall, participants reported a limited knowledge of legal and protection order information and stated that they would advise women to contact a lawyer or Women's Aid for information about this. Most health visitors stated they would welcome information and training on this but one group stated that their lack of knowledge in this area may be beneficial to women as it encourages engagement with specialist support services.

P1: "We don't get much training in that, and I kind of briefly talk, and because I don't really know a lot about it. You get an interdict and there's something else but I don't know the difference between them, I suggest they go see a lawyer…."

P3: "Citizens Advice, Lawyer and Women's Aid. I use that as an encouragement to get them to engage with Women's Aid, they are the ones that are really good at giving advice on that sort of thing."

P1: "You're right, maybe it's not a good idea [for health visitors] to know too much." (FG2)

In another focus group, participants provided examples of women who required advice regarding child access following separation. In one instance the partner's abusive behaviour was considered a risk to children while the woman lived with him. After separation social work services advised the woman not to let him spend time with their children but did not place any formal restrictions on his access to the children. Participants stated that greater support should have been given to the woman who continued to receive threats from her now ex-partner but did not offer specific advice or make direct referral to someone who could provide this. Further, they did not contribute their professional assessment of risk to children.

"She's in two camps. Do I let her [daughter] go? If I don't it could fuel the death threats or you know, he's a violent guy. She has been advised not to let him have the child by social services and the police. Not told she's not to but advised not to let him have her. It's not been set in stone so she's looking for advice." (FG1P2)

Therefore, focus group discussions identified the challenges faced by professionals as well as women with children who are exposed to domestic abuse described by Hester (2004) (section 3.4). The child-centred approach presents conflict for health visitors who encounter both women and children in their work. A further conflict is presented in relation to their child protection role when visitation and contact appear outwith their control.

5.6.4.6 Disconnect Between Knowledge and Practice

Analysis of focus group data revealed disconnect between theoretical knowledge about domestic abuse and practice responses to those who experience it. At the beginning of focus groups, health visitors spoke knowledgeably about the nature and consequences of domestic abuse as an abstract issue. As discussions progressed, and health visitors described their engagement with and assessment of women, they presented examples of

assessment and practice which did not reflect their knowledge of domestic abuse. Examples of disconnect have been described throughout this section for example, in relation to the concept of women led services and the practice of child-centred responses. Another example is health visitors' early statements that domestic abuse can affect women from all backgrounds and later associations between domestic abuse and families affected by poverty and addiction. Further, participants were aware that separation from an abusive partner can increase risk of harm but the majority believed this to be the only way to improve safety and few discussed safety and protection of women during focus groups. Another example is participants' description of an empowerment approach. This involved helping women to identify their own strengths as health visitors recognised that the experience of domestic abuse was disempowering, frequently resulting in low self-esteem and low self-confidence. In an attempt to empower women, health visitors in the current study provided an open offer of support thus enabling women to choose what response would best support them. However, no further action was taken to enable women to make choices, to inform them of options or support those who lacked confidence to make decisions. Further areas of disconnect between health visitors' theoretical knowledge of domestic abuse (drawn from their statements in focus groups) and the practice response that they describe, are summarised in Table 5.3 and are more fully discussed in section 5.8.

Participants' Statements on Domestic Abuse	Examples and Issues from Participants' Practice
Domestic abuse is a pattern of behaviour used to control women.	Notified of, and responded to, incidents of abuse. Incidents associated with alcohol use by one or both partners.
Domestic abuse can affect anyone	Vast majority of suspected, reported or disclosed abuse in households with multiple support needs. Easier, and therefore more likely to, discuss with women of lower socio-economic status.
Consequences of domestic abuse include fear, lack of confidence, low self-esteem and limited access to resources e.g. telephone, money.	Women led services – women are required to identify and request appropriate supports in response to open questions. No routine assessment of risk to mother. Service constraints – Insufficient time to address needs of mothers. Outcome driven – supporting and protecting abused women not recognised within current health visitor outcomes. Signposting to services to encourage women to engage.
Empowerment approach	Women are encouraged to recognise their strengths during routine visits but dedicated work to address self-esteem, confidence or engage with other services are not current practice as this is not recognised in service outcomes.
Child-centred services	Primary focus on child assessment (physical wellbeing and immediate danger). Mother's experience of abuse and needs as an individual not assessed as a resource for child. Father's actions considered in relation to observable impact on child only, not as impact on family unit. Co-occurrence of child abuse and domestic abuse not discussed by participants.
Increased risk at separation and abuse after separation.	View women's readiness to exit the relationship as an indicator of recognition of abuse or willingness to engage with supports.
Multi-agency response required.	Visits from multiple agencies are viewed as punitive for women. Little evidence of inter-agency working after initial visit.

5-3 Disconnect between theoretical knowledge and practice

5.6.5 Supports for Practice

There was consensus within and across all groups on resources currently available to them (specialist domestic abuse agencies and peer support) and that further training would be useful.

5.6.5.1 Specialist services

Although all groups identified local agencies which were available to give advice and support this was rarely required or used. Almost all participants reported a good relationship with Women's Aid and local domestic abuse agencies. Most health visitors had contacted a specialist agency for advice in their professional capacity or on behalf of service users at some point.

> "I have found just phoning the refuge on a professional basis has been helpful."
> (FG1 P4)

In some areas, the local child protection units provide an opportunity to discuss specific cases and to provide advice although this was seldom used. Participants reported little contact with Police Family Protection Units but stated that it would be useful to have named contacts in each statutory and voluntary sector agencies to facilitate future contacts.

> "If there was something structured with Women's Aid or the police that would be invaluable." (FG1 P5)

5.6.5.2 Training

All participants had received some training on domestic abuse. A training programme targeted at developing skills of health visitors in asking about domestic abuse had been introduced in Scotland shortly before focus groups took place. Some of the participants, such as FG3 P4, an experienced health visitor, had already attended and found this very useful:

> "I feel we have more information now [after training], whereas before I would be floundering a bit, going through information, thinking "where do I go next with this?" I feel more confident now." (FG3 P4)

All health visitors felt that domestic abuse should be introduced as part of their pre-registration training with most welcoming more information on legal protection available to women.

The idea of a checklist for health visitor reference was considered useful by some participants.

"Having a list of things you can go through with them would help. When it's discussed you can tick it off so you know they're aware of that information. We give information anyway but there might be more detailed information." (FG3 P2)

5.6.5.3 Health Visitor Peer Support

Participants all discussed peer support from health visitor colleagues as their primary source of support when planning care and to debrief in difficult situations. This was presented as the most useful resource as colleagues were easy to access and have a shared understanding of practice approaches and limitations.

"The other thing we would do is, we would go out, come back and we would talk to each other and say right I've been out, we are quite good at doing that." (FG3 P5)

5.7 Summary Phase One Findings

Participants in this study described domestic abuse as a range of ongoing behaviours which included physical, psychological, emotional and sexual abuse and stated that they often recognise domestic abuse when the women experiencing it do not. In the majority of cases respondents expressed caution or reluctance to discuss this with women.

Women rarely disclosed experience of domestic abuse to health visitors, even when directly asked about this and therefore, discussion focused on the health visitor response to police notifications of reported domestic incidents. Health visitors perceived these as predominantly isolated incidents which rarely involved children and often involved alcohol consumption by both abused and abuser.

In response to a police notification health visitors would:

- Visit the woman at home
- Inform women of the negative impact of exposure to abuse on children
- Complete a risk assessment on the child
- Make an open offer of support to women and develop a care plan in response to expressed needs
- Signpost on to specialist services if required.

Health visitors voiced concerns that home visits by a number of agencies could be perceived by women as punitive and removed some of the attention from the actions of the perpetrator of abuse to the victim. Participants reported that women found health visitors more acceptable than social workers and were more willing to engage with them. In practice women rarely requested support but when further visits were required health visitors had to negotiate this within the service constraints (workload and outcome focus).

Overall health visitors' reported that they work with an approach which is both woman-led, in that women identify their own support needs, and child-centred, in that children and child protection are the key priorities, however, discussions identified conflict between the two approaches.

Very little experience or knowledge was shared in relation to risk assessment of women, child and adult protection, safety planning or use of protection orders.

Specialist support and advice was available to health visitors but they valued advice and experience of their health visitor colleagues above other sources.

Data analysis identified areas of disconnect between participants' theoretical knowledge of domestic abuse and service users and scenarios in practice. As a result, there were few examples of application of domestic abuse specific responses following disclosure of domestic abuse, suspicion of domestic abuse or police reported domestic incidents.

The following section will discuss these findings in the context of the wider literature and reflect on the study methods.

5.8 Discussion

5.8.1 Identifying Domestic Abuse

Participants spoke about the range of behaviours which constitute domestic abuse and the wide ranging psychological consequences of experiencing abuse. However, participants stated that they rarely encountered, or identified, women who were experiencing ongoing abuse or the health consequences associated with this. More commonly health visitors reported that they were required to respond to police reported incidents, the majority of which, in participants' view, were not domestic abuse. They described the vast majority of police reported incidents as involving alcohol and use of verbal or minor physical aggression by both partners in isolated and minor events. This distinction, between domestic abuse and police reported domestic incidents, is surprising in the context of the wider literature. It is an important finding as the findings of these assessments, that incidents are isolated and minor events, dictated the extent to which health visitors responded.

5.8.1.1 Police Reported Domestic Incidents

Participants stated that the majority of police reported domestic incidents related to minor and isolated incidents and perceived that the majority of such incidents were not part of a pattern of abusive behaviour meant to intimidate and control. The perception that women bring minor or isolated incidents to the attention of police is disputed in the literature and anecdotally by specialist domestic abuse agencies. Women are more likely to disclose if they fear for their lives, require immediate assistance, if violence is escalating and if children are involved (MacQueen 2013, Richards et al 2008, Peckover 2002) therefore it is unlikely that minor incidents would trigger police contact. That said, considerable efforts have been made across the UK to improve the police response and so it is possible that women are contacting the police sooner. The current study gathered the views of experienced health visitors who spoke knowledgably and confidently about domestic abuse and their ability to respond but from their professional assessment rarely identified domestic abuse. Thus findings of the current study present new research questions about the nature of abuse experienced by women involved in police reported incidents.

Richards et al (2008) state that, traditionally police in the UK were reluctant to interfere in the private domestic environment. Historically, police and call handlers minimised the nature and impact of domestic abuse referring to them as "*Just a domestic*" (Richards et al 2008, P10). The quote from one health visitor in the current study of "*Well sometimes its tit for tat isn't it?"* (FG1 P1), health visitors' perceptions of both victim and accused's use of alcohol fuelling incidents and placement of equal responsibility for incident with both partners echo this historical view. Since 1995, police forces in the UK have been instructed to respond appropriately to the "seriousness" of domestic incidents (Richards et al 2008 p11) but, other than Jaffe & Burris' work conducted in 1979 (published in 1984), there is no large scale empirical evidence on the "seriousness" of reported and unreported domestic incidents. Jaffe & Burris (1984) conducted structured interviews with 62 women who had reported assault or threatened assault by a partner or ex-partner to the police. They found that participants experienced an average of 35 assaults before they involved the police. This study introduced much needed evidence on the interaction between women experiencing domestic abuse and the criminal justice system but the transferability to current health visitor service users in the UK is limited by the time that has passed and the difference in criminal justice processes between Canada in 1979 and the UK in 2011. Furthermore, this study does not present conclusions on which circumstances are more likely to result in police report.

Crime survey data demonstrates that women are more likely to under-report domestic abuse than over-report as less than a quarter of women who stated they had experienced domestic abuse had brought this to the attention of police (Scottish Government 2014b). The survey findings suggest that some women will report a number of incidents to police whilst others will never report. However, it is not known whether women who do report to the police only report the most extreme incidents or if they report all incidents.

Measuring "seriousness" of incidents poses methodological and ethical challenges. First, this would require ranking of abusive behaviours (e.g. physical, psychological, sexual), all of which carry negative consequences for victims of abuse (Porcerelli et al 2006). Whilst physical violence creates an immediate, and often obvious, impact on well-being, abused women report that physical abuse is "not the worst part" of their experiences when compared to psychological trauma (Williamson 2010). Secondly, women experience domestic abuse as a pattern of behaviour, not as isolated incidents and therefore the nature of the police reported event would need to be considered within the wider context of the

relationship. For example, a threatening text message can have different implications for the recipient if it is a single occurrence than if it takes place following an assault or as part of a series of threats.

With reference to health visitors' perception that many police reported incidents are isolated events, routinely reported police statistics suggest otherwise. The annual summary of domestic incidents reported to police in Scotland in 2012/13 states that 61% of domestic incidents reported to the police involved victims who had previously been victims in police reported domestic incidents (Scottish Government 2013). This challenges the observations of health visitors and suggests that women involved in police incidents are likely to be experiencing ongoing abuse. Again, this indicates that health visitors are not identifying women and children at risk of harm from abuse nor offering appropriate protection and health care.

That said, Johnson's (2008) typology of domestic violence (2.2.1) may explain the discrepancy between health visitor experience, reported in the current study, and police data. Some police reported incidents will be instances of situational couple violence. In this case, both partners use violence and aggression and there is no consistent effort on the part of one partner to control another. Therefore, some repeat incidents which come to the attention of police may be discrete episodes. Nonetheless, in cases of situational couple violence women are more likely to report feeling afraid of their partners; more likely to experience injury as a result of the incident and more likely to experience violence from their partner more often than they use it (Johnson 2008). Therefore, women who experience situational couple violence are at risk of harm which was not identified by participants in this study.

A higher prevalence of alcohol dependence and excessive alcohol consumption has been noted in dual perpetrator incidents (Hester 2004) (section 2.2.2). This offers some supporting context to the health visitor observation that they would be in regular contact with families with repeat police reports due to alcohol misuse and potentially both parents using violence. However, this is tenuous and the association between women's alcohol consumption and victim blaming attitudes appears a more likely explanation for health visitors' minimisation of police reported incidents. Victim's alcohol consumption has been associated with an assumption of shared responsibility for abuse, rather than a coping mechanism or a cause of increased vulnerability to abuse (Foster 2014). Risk persists for

women who have perpetrated verbal or physical abuse of their male partner. This may be an act of violent resistance in the context of ongoing domestic abuse. Alternatively, the incident may have taken place within the context of situational couple violence. As discussed, this also presents a risk to women.

Health visitors' perception of police reports may be indicative of an overall underestimate of the extent of domestic abuse. Health professionals' lack of knowledge of the extent of domestic abuse was noted in work with nurses (Lazenbatt & Thompson-Cree 2009) and health visitors (Haggblom et al 2005) (section 3.3.6). Therefore, health visitors' expectations may limit their identification of domestic abuse.

5.8.1.2 Disclosure

Health visitors in this study reported that in their experience, women rarely spontaneously disclosed experience of abuse even when asked directly about this. This contrasts with the wider literature which states that enquiry increases disclosure (Feder et al 2009, MacMillan & Wathen 2003). The lack of disclosure to health visitors in this sample is surprising in view of one in four women in the UK experiencing domestic abuse in their lifetime and the increased risk of abuse starting or escalating in pregnancy (DoH 2005).

The relationship between health visitors and service users, and approachability of health visitors can be a strength of the service (Bacchus et al 2003; Bateman & Whitehead 2004). However, the literature and the findings of the current study indicate that health visitors are not in a stronger position than other professionals to elicit disclosure of abuse. In all three focus groups participants associated lack of disclosure or discussion of domestic abuse with a reduction in routine health visitor contacts and diminished opportunity to establish a relationship with families. The literature suggests that even when a relationship is established few women will disclose to health visitors (Bateman & Whitehead 2004, Bacchus et al 2003) (section 3.3).

Participants in all three focus groups visited women following police incidents although few service user disclosures or health visitor concerns resulted from these visits. In earlier research, conducted with survivors of domestic abuse, women stated that home visits were more conducive to disclosure but disclosure was more likely if the health visitor made contact soon after an incident (Peckover 2003). In the current study, health visitors

reported that it could be some weeks before they were advised of police reported domestic incidents. Often when health visitors met with women other agencies such as social work and the police had already visited. Health visitors reported that women considered the incident had been dealt with and were disappointed and uncomfortable that health visitors re-opened the discussion. Peckover's (2002) service user participants concluded that the immediacy of the response increased disclosure for the practical reason that women's injuries were still obvious or women still appeared upset which enabled the health visitors to open the conversation about domestic abuse.   The effectiveness of an early response in facilitating disclosure is consistent with the earlier work of Kelly et al (1999) where service users received support within 24 hours of a police incident. Service users reported that they would have been reluctant to disclose or engage if a longer period of time had passed before they received support (Kelly et al 1999). Therefore, delayed contact reported by health visitor in this study may further inhibit disclosure.

In the current study focus group participants identified two reasons that women did not disclose abuse or request support following police reported incidents: that the police reported incident was an isolated, minor event and women were not experiencing ongoing domestic abuse or that women did not recognise their experience as abuse.

5.8.1.3 Women's perception of abuse

Participants in this study stated that they often identified women experiencing domestic abuse when women themselves had not. This has been described as women "normalising" their experience of abuse (Wykes & Welsh 2009, P34). Ulrich et al 2006, Campbell 2004, Kelly et al (1999) and more recently Bradbury Jones et al (2014) have highlighted the potential for professionals to recognise domestic abuse before women themselves are aware of it (section 3.3). Health visitors have a duty to protect those at risk and Campbell (2004) and Ulrich et al (2006) state that all health professionals should support women to recognise abuse and the associated risk of harm. However, for health visitors in the current study, women's lack of recognition of abuse presented a barrier to further engagement. This is concerning given the extreme and potentially fatal consequences of abuse described in Chapter 3.

Participants in this study described two stages for women experiencing abuse; lack of recognition of abuse and preparing to exit. They perceived that women had to recognise

abuse, decide to leave, and take action to do so, independently and that intervention from health visitors would not support women to make these changes. They therefore appear unaware of the different stages that women living with domestic abuse may experience, that service responses which are not stage appropriate can be harmful or that health professionals can play a role in supporting women to move between the stages to recognise risk and contemplate a life without abuse. However, the work of Kelly et al (1999) and others (Cluss et al 2006, Frasier et al 2001) suggests that stage specific interventions could be delivered at this point and importantly that failure to provide a stage specific response may discourage service user engagement (sections 2.2.4 and 3.3.4.). The health visitor perception of women's ability to recognise abuse, plan to exit a relationship and engage with specialist support services unaided is surprising and indicates that they hold women responsible for ending the abuse. As discussed in earlier chapters, similar attitudes have been observed in the general public (FRA 2014) and in health professionals (Virkki 2015). In the current study, placing responsibility for abuse with the victim (or "victim blaming") can result in little or no service response, even when abuse is identified.

The literature presents a further explanation for health visitors' limited identification of domestic abuse. Joyner & Mash (2012) concluded that health professionals avoided asking about or identifying abuse to avoid additional work burden. Participants in all focus groups made reference to the challenge of service constraints and increasing workloads; so the concept of subconscious or deliberate lack of identification appears relevant to the current discussion. In addition, it has been suggested that health professionals avoid identification of domestic abuse to protect themselves from the requirement to respond to child protection concerns (Stark & Flitcraft 1996) or the emotional burden of responding to women living with abuse (Warshaw et al 2006). Therefore, lack of consideration of these issues may not reflect a lack of knowledge but a lack of willingness to respond.

5.8.2 Responding to Domestic Abuse

Focus groups in this study were conducted in 2010/11 but the response described by participants was similar to that subsequently recommended by both NICE (2014) and WHO (2013). When health visitors suspected that women were experiencing abuse or had been notified by police about a domestic incident they would talk about domestic abuse with women, assess risk to children in the family and signpost to further services. In addition health visitors in the current study always advised women about the negative

impact of domestic abuse on children.   Participants reported that few women requested further support.

Barriers to women requesting support are similar to those relating to disclosure of abuse such as stigma, fear of the perpetrator and fear of losing their children (McGee 2000b). However, survivors of abuse state that they want to be asked about abuse and want support to manage the consequences and exit the relationship (section 3.3.5).   Research with survivors of abuse often involves recruitment through specialist domestic abuse agencies (for example Peckover 2002, Bacchus et al 2003, Taylor et al 2013) whereas discussions in the current study primarily related to women involved in police reported incidents. Therefore it is possible that the support needs of women involved in police reported domestic abuse incidents differ from those of women who have accessed specialist domestic abuse services and this would benefit from further investigation.

5.8.2.1 Talking to Service Users About Domestic Abuse

In the current study, health visitors reported increased comfort in responding to domestic abuse with women of lower socio-economic status, despite their awareness that women from any social class can experience domestic abuse. Taylor et al (2013) also reported that health professionals in primary care found it easier to ask women of lower socio-economic status about domestic abuse than women from more affluent backgrounds but the reasons for this differed between studies. There are similarities between Taylor et al's study and the current study in terms of time frame, professional groups and location. Taylor et al conducted semi structured interviews with 16 health visitors, 11 midwives and two GPs in Scotland in 2011. The overall aim of Taylor et al's work was to describe health professionals' beliefs about domestic abuse. They used a critical incident technique in interviews which focused on actual responses delivered to service users and so, provides a useful comparator for the present study which explored current practice.   Participants in Taylor et al's study stated that questions about abuse were less acceptable to women from affluent backgrounds. In contrast, participants in the current study stated that domestic abuse was easier to discuss with women of low socio-economic status as they were more likely to be affected by other issues and in receipt of an enhanced health visitor service, thus creating a greater opportunity to establish a relationship.   The perceptions of participants in both studies appear founded on very broad assumptions about large groups of service users, particularly the assumption that less affluent women will experience

multiple social problems and therefore the accuracy of either explanation is questionable. The statements of participants in the current study are consistent with Schwaeber's (2010) description of assumptions of professionals in the legal field where domestic abuse is associated with dysfunctional families. In the context of the current study this suggests that abused women in affluent areas are not offered the same service response as other service users.

5.8.2.2 Failure to Respond to Disclosure

The majority of participants in the current study stated that domestic abuse rarely occurred in isolation and associated it with families affected by multiple and complex issues. Within this context, health visitors were required to prioritise the needs of the family and in some cases this resulted in a decision to respond to other issues and postpone (indefinitely) responding to the needs of the abused woman regardless of police report or disclosure. As stated in Chapter 3, lack of response from health services compounds the woman's experience of abuse reinforcing negative messages that they are not important and that no-one can help them (Tower 2007, Stark & Flitcraft 1996). This in turn presents further barriers to women seeking support from services in the future (Feder et al 2006).

In their research, Taylor et al (2013) recorded the experience of a woman who was physically abused in front of a nurse. The nurse did not discuss abuse or offer any support to the woman in following contacts. They conclude that this is uncommon as other service user and health professional participants described engagement. However, their research was conducted with a self-selected sample of professionals who may have been motivated to respond and therefore, may over represent responsiveness across health professionals. In contrast only one group in the current study was entirely self-selected and therefore, the sample is more likely to represent the extent to which responding to abuse is part of everyday practice or not.

The current study aimed to address a gap in the evidence base regarding health visitor engagement with women experiencing abuse over a period of years. However, discussions focused on the immediate response to incident reports or disclosure. While the option of further support was presented to service users, ongoing support for experience of domestic abuse was seldom delivered whether women requested this or not. More experienced participants described working with women exposed to extreme, ongoing violence. Even

in these cases, participants stated they would provide information and encourage women to discuss their situation but beyond this, and despite personal concern for women involved, health visitors perceived their role to be restricted to leaving an open offer of support and monitoring for child protection concerns. Although a negative finding (there is no ongoing response), this study makes an important contribution to evidence regarding the protection and support of families exposed to domestic abuse, more specifically the absence of this response from health visiting services. Interventions described in Chapter 3 commonly featured routine follow up visits for women who disclosed domestic abuse but health visitors in the current study rarely perceived this as a requirement or feasible with current resources. However, the recurring question of the actual extent of domestic abuse amongst health visitor service users involved in police incidents identifies a need for further research in this area before conclusions about the adequacy of current responses can be drawn.

5.8.2.3 Multi-Agency Responses

Participants in the current study described little ongoing interaction with other agencies. They received information regarding domestic incidents from the police or social work colleagues; occasionally participated in joint visits to women's homes with social workers and signposted to specialist services but did not describe regular contact, information sharing or joint support planning. Multi-agency responses are identified as best practice for responding to domestic abuse from national policies (Scottish Government 2008b) to guidance for health sector workers (NICE 2014). While some initial steps have been taken to introduce multi-agency working, such as information sharing, the minimal response delivered by health visitors does not appear to have enhanced the response to women.

5.8.2.4 Health Needs of Women

A considerable omission from focus group discussions in the current study is a response to health needs of women exposed to domestic abuse. It is surprising that only two brief references were made across all three focus groups to health issues. Both references related to depression; as a possible consequence of abuse limiting parenting ability and as an opportunity to explore domestic abuse as a factor affecting mental health. Participants did not describe onward referral or directly responding to the physical or psychological health needs of women and children. The substantial body of evidence on domestic abuse and health, outlined in Chapter 3, highlights that abused women frequently require health

care (Scottish Government 2009b). Given the criticisms of the health service's biomedical focus (Stark & Flitcraft 1996) (section 3.3.6) the absence of discussion on women's health in the current study is striking. Again, this relates to health visitors' assessment and perceptions of women as victims / survivors of domestic abuse or as individuals involved in isolated incidents which have come to the attention of the police.

5.8.2.5 Addressing Consequences of Domestic Abuse

Health visitors in the current study identified a range of domestic abuse behaviours which inhibit disclosure and help seeking but they did not describe attempts to address this in their practice. The open offer of support described by participants as a "women led" approach did not explore the relationship dynamics, offer women protection or actively increase their confidence to engage with services. It is unsurprising that in most cases, women declined support requiring no further action from health visitors. Health visitors interpreted this as confirmation that women were not experiencing domestic abuse. If women did request support, such as emotional support, health visitors did not fully meet the request citing service constraints or a wish to discourage dependency. Furthermore, health visitors recognised that women may require practical support in relation to finance or protection orders but stated that this was outwith scope of the health visitor role. Despite women asking for this help, some health visitors decided not to gain knowledge in these areas, stating that it encouraged women to engage with other services. Controlling behaviours used by perpetrators of abuse can include limiting and monitoring women's activities. This can result in emotional and psychological isolation and entrapment (Pain 2012). Consequently, health visitors may be the only accessible source of information available to women. Signposting to additional services may be ineffective and lack of knowledge about options and resources available to women from this single source of support may present an additional barrier to exiting abuse. Therefore, the response described in the current study did not fully respond to requests for help.

Two studies conducted with survivors of domestic abuse accessing health service in the USA highlighted the need for service users to receive support in areas other than health, for example employment. Petersen et al (2003) perceived the health role as signposting to specialist agencies. In contrast, Curry et al (2006) identified a role for health professionals to support women with social needs. Curry et al found that abused women prioritised practical issues such as employment or education over discussing their abuse. Offering

support in areas which women identify as important can empower women to ultimately exit an abusive relationship and can encourage development of a relationship between the nurse and service user (Curry et al 2006). However, participants in the current study stated that time spent supporting and empowering women could not be justified as it did not meet specified service outcomes.

Health visitors in the current study stated that barriers to engagement included women's readiness to exit the relationship and service constraints but considered in the context of the literature these findings indicate that health visitors' practice limits the interaction. Furthermore, discussion on women's "readiness" to leave and the assumption that women must come to define their experiences as abuse before receiving support suggests limited knowledge of the complexity of domestic abuse. Whilst participants demonstrated knowledge on the types of abuse and main health consequences, further training on the impact of living with abuse may enhance the service response.

5.8.3 Child-centred Responses

5.8.3.1 Incompatibility of child focused and women led approaches.

Participants in the current study stated that, in all responses to police reported domestic incidents, child protection was their priority and assessments of the incident and its impact were conducted from a child-centred perspective. As stated, this could result in health visitors deciding not to respond to the woman's experience of abuse and brings into question health visitors fulfilment of their responsibility to protect anyone they encounter in the course of their work (NMC 2015).

In the current study, participants clearly defined their role and responsibility for child protection. Whilst they acknowledged a role to respond to women this was presented as secondary and boundaries were placed around interactions to prevent dependence from female service users *("We're not there as a friend"* FG2 P3). In contrast, within the literature, conflict between the role of a friend and support to women and the role as a child protection agent has been identified (Brocklehurst 2004, Peckover 2002). When health visiting was established, health visitors were introduced as a support to mothers and were encouraged to develop a friendship in order to gather information and engage with women in relation to child surveillance and child protection (Brocklehurst 2004). This conflict is

discussed by Peckover (2002) who observed that health visiting is child-centred but is "mediated" through the mother. In contrast, health visitors in the current study did not describe any conflict but instead clearly identified their role in terms of child protection. This may reflect a growing focus on child protection and greater professional accountability in this area in the years between Peckover's research and the current study for example the Children and Young Persons (Scotland) Act 2014.

Health visitor participants in this study stated that assessment and care planning is guided by Getting It Right For Every Child (GIRFEC) (section 2.4.3). GIRFEC promotes a holistic approach to assessing and working with families to protect and support children (Scottish Government 2010a). GIRFEC aims to position the child at the centre of decision making and clearly directs staff to consider child protection as the priority (introduced in section 2.5.3). In the current study health visitors reported that they used GIRFEC assessment tools such as "My World Triangle", a holistic assessment of the child's relationships and practical resources, and the GIRFEC resilience matrix, which considers vulnerability, adversity, protective factors and resilience, when responding to families involved in police reported domestic abuse incidents. Assessments considered the child's exposure to the domestic incident and how the child presented during the visit.

In theory, the ethos of GIRFEC could address the paradox described by Peckover (2002) and others. The current study suggests that GIRFEC has been interpreted by health visitors in such a way that it has resolved the conflict by making the responsibility to protect women secondary to that of protecting children. However, the service response involved an open offer of support placing the locus of control with women. If women did not identify any support requirements no further action taken. The health visitors stated that this was an empowering approach. However, no further support was provided in terms of raising women's awareness of services, access to services or of developing their self-confidence.

5.8.3.2 Prioritising Protection of Women or Children

Participants in the current study reported that due to time constraints there was often little or no time to discuss the needs of women following initial assessment of the child, despite assessments rarely resulting in child protection action. Participants expressed their understanding of GIRFEC as considering the needs of the child first. Due to service

constraints participants reported that they only had time to address one concern at each visit and workload prevented intervention beyond the first priority

This was evident in the example when domestic abuse was not addressed because the health visitor considered the mother's mental health and ability to parent to be a greater risk to the children than the father's perpetration of domestic abuse, even though she linked the mother's poor health to her experience of domestic abuse (section 5.6.4). In relation to domestic abuse, protecting the non-abusing parent strengthens a protective factor in the child's life, thus benefiting the child and creating parity between protection of survivors of domestic abuse and their children.

Findings of the current study indicate that the needs of the wider family are ignored or that women who have experienced abuse are considered as a risk to the child, rather than a positive resource. This is supported by Hester's three planet model used to describe the clash of discourses in the spheres of domestic violence, child protection and child access described earlier in this thesis (section 3.4) (Hester 2004). Hester concludes that a child protection focus can result in woman's experience of violence being overlooked and therefore no response or support are delivered to her as a victim of abuse or an individual with health needs which could limit her ability to parent.

As part of the routine response, participants in the current study advised women of the negative impact of exposure to domestic abuse on children (but not on the health of women). Participants shared this information with women to increase their awareness of risk to their family but doing so could be an expression of health professionals' belief that women have some responsibility for the violence and place their children at risk (Radford & Hester 2006; Hester 2000).

Peckover (2002) also found that health visitors focused on the needs of children over those of women, even when women had disclosed their partner's use of extreme violence. One health visitor participant in this study referred to considering the implications for children as the "real issues" which Peckover describes as "privileging" the welfare of children over abused women. This explicit precedence will reinforce women's awareness of health visitors as child protection agents and is likely to increase fears of losing care of their children and inhibit disclosure.

The findings from the work of Peckover (2003, 2002), Taylor et al (2013) and the current study suggest that the health visitor response has moved from a biomedical focus to a child protection focus and, despite a significant change in approach, the needs of abused women continue to be overlooked. Further, the current study has found that a child-centred and woman-led approaches are contradictory in practice.

5.8.3.3 Assessing Child Wellbeing

Participants in the current study described the impact of exposure to domestic abuse on children, including emotional distress when discussing domestic abuse theoretically but, following police reported domestic incidents, their assessment of children focused on physical wellbeing and risk of physical harm. Again the findings are consistent with Taylor et al (2013) and Peckover (2002) who also found that assessment of impact of abuse on children focused on physical abuse. Yet, children may experience harm from exposure to abuse which is not physically evident, particularly in young children (Peckover 2015). An association between exposure to domestic abuse and psychological and developmental harm, as well as physical harm, has been identified in children (Humphreys et al 2008a).

Participants in the current study stated that they rarely identified significant child protection concerns following parental involvement in a police reported domestic incident and, other than occasional information sharing with social work colleagues, did not describe any responses specific to the needs of children. Further, there was no discussion on resilience or protective factors, therefore, child protection assessments appeared to focus on imminent physical assault.

In view of the range of consequences for children, and the estimate that between 30% to 60% of children in families where domestic abuse occurs will also be directly abused (Eckenrode et al 2000), a greater number of child protection concerns would be expected. This may be a consequence of assessments which do not identify domestic abuse in the household or lack of knowledge on the extent of child abuse which occurs alongside domestic abuse. Lazenbatt et al (2009) used a questionnaire to measure awareness of co-occurrence of child abuse and domestic abuse with a sample of midwives in Northern Ireland. They found that just over a quarter (27%) of community midwives suspected child abuse when they knew the mother had experienced domestic abuse and over a third

(37%) suspected child abuse when they suspected the mother was a victim of domestic abuse. Although not directly transferrable, this study allows some comparison between groups of health professionals who provide a universal service to all families with young children in the community, in the UK. It is interesting that over a third of community midwives suspected direct abuse of children when this was rarely a concern for health visitors in the current study. In turn, this suggests that risk assessment by the practitioners in the current study may not accurately identify children at risk of harm from domestic abuse and therefore do not implement appropriate child protection actions.

This study presents an important finding on the interpretation and implementation of policy in practice. In this instance a policy which aimed to consider the needs of the family unit, appeared to obscure the needs of abused women when implemented. However, GIRFEC is not the only influence on practice and as registered health professionals, health visitors have a duty to protect anyone they come into contact with in their professional capacity who are at risk of harm (NMC 2015). So, health visitors have a role to work with families, to prioritise children but not at the exclusion of other family members who are at risk of harm. Lack of response to either women or their children following police reported domestic incidents suggests that this duty is not being met. However, participants in the current study state that, following an assessment of the situation, they did not identify domestic abuse and therefore, women and children were not thought to be at immediate risk.

5.8.4 Supports for health visitors.

The current study sought to identify additional support needs for staff to enable them to respond appropriately to families affected by domestic abuse. In general, participants felt adequately supported to deliver their current response to women experiencing domestic abuse. The response could be enhanced to provide greater support to women, particularly in relation to addressing the consequences of abuse and increasing awareness of the impact of abuse and potential risk (Ulrich et al 2006, Campbell 2004, Kelly et al 1999) and in fully participating in multi-agency responses (WHO 2013). Therefore, additional supports may be required to deliver best practice response.

5.8.5 Methods

5.8.5.1 Credibility of Study Findings

Three challenges were encountered during data collection: Dominant voices within the focus group, participants who did not meet the inclusion criteria and moderator control of the group.

In two focus groups dominant voices emerged. This is reflected in the presentation of findings. Although 14 of the 17 health visitors who participated are quoted directly the majority of quotes are from two individuals. In the first focus group Participant 6 described considerable experience in actively engaging with survivors of abuse. Responses from others in this group suggested they had little practice or experience in responding to domestic abuse and it is possible that they deferred to Participant 6's experience. However, on a number of occasions there was general consensus in the group which Participant 6 fully articulated making her the most "quotable" in the group but not truly reflecting the participation of others in the group through non-verbal or incomplete responses. In the second focus group, the dominant voice was from the member of staff with the longest clinical experience. The moderator invited less experienced or junior members of staff into the discussion by inviting them to comment or seeking agreement or disagreement with statements but they indicated that others' comments reflected their views and declined to comment. All participants were given the researcher's contact details and invited to make contact if they wished to contribute any additional ideas following the focus group but none did. It is possible that the findings from the second focus group did not represent the views of all participants; however, the findings were similar to those of other focus groups where all members participated more fully.

Despite clear guidance on inclusion criteria circulated before focus groups two groups were attended by school nurses and in one group a health visitor support worker. Health visitor support workers work closely with families, most often providing parenting support. They often have child care experience but are not registered nurses or allied health professionals. Support workers may spend longer periods of time with some families than health visitors and it was anticipated that their experience could enrich the discussion. The researcher encouraged support worker participation in the focus group by inviting comment and posing questions (e.g. "How have you found this as a support worker?") but

they contributed little in the group. This may reflect their position within the staff team and deference to senior colleagues.

School nurses fulfil a different role to health visitors often working with children outside the family home but they were keen to participate in the research. This increased the numbers in the smaller groups and had the potential to support the focus group dynamic in sharing experiences, or highlighting contrasts in their practice, thus prompting exploration of the health visitor response. Again, they contributed little to the discussion but on reflection, the researcher invited fewer comments from the school nurses attempting to focus on the health visitor role.

Registered staff nurses also work within the health visiting teams. Staff nurses fulfil much of the health visitor role but do not have responsibility for case load management.   The care of families with multiple and complex support needs is managed by health visitors but staff nurses continue to visit and support these families. In relation to domestic abuse, staff nurses have the same opportunities to identify and support women affected by domestic abuse. Therefore staff nurses' contribution to focus groups was as valuable as that of health visitors. Due to the similarity of roles the researcher did not record which members of staff were health visitors and which were staff nurses during focus groups or transcriptions, referring to all as health visitors.

In the first focus group, participants raised the issue of men as victims of domestic abuse and responding to perpetrators of abuse, despite either rarely occurring in their experience. Although this provided an interesting insight to the perceived priority of this issue (participants were initially more willing to discuss this than responding to female victims of abuse), it was not the focus of the research and therefore, reduced the already limited time available for focused discussion.   In subsequent focus groups the researcher introduced the purpose of the session and highlighted that the focus was on women who experienced abuse from a male partner but, if participants had experience of responding to either men experiencing domestic abuse or male perpetrators who had approached them for help, they would be interested in hearing about that.

5.8.5.2 Data Saturation

As recommended, three focus groups were scheduled in the first instance (Krueger & Casey 2000, Morgan 1998). It was anticipated that gathering data across three NHS Boards would provide representation from different geographic areas and enable a comparison of practice between areas. In practice similar responses were provided by health visitors in all areas and similar themes emerged from all sites. No new themes or codes emerged following the second focus group and so the researcher judged that saturation had been achieved.

Member checking of emergent themes and description of the health visitor response to domestic abuse was conducted with groups of health visitors (described in Section 4.6.2). These sessions were conducted within NHS Boards at team or area meetings and a summary of findings was circulated. The summary paper presented the findings in the context of the evidence base to highlight areas of contrast between the literature and health visitors' experience and to explain the rationale for subsequent research. In all groups, at least one focus group participant was present and others were representative of the participants' social world. In addition, the findings were presented and discussed in a workshop held with health visitor representatives from all three participating boards following completion of all phases of this study at which some of the focus group participants were present. All health visitors reported that the findings accurately reflected their experience, practice, views on the extent of domestic abuse within their service user group and of the constraints they encountered. This enhances the credibility of the study, demonstrates that the views of participants were representative of health visitors in this geographic area and, from a feminist research perspective, ensures accurate representation of study participants' contribution.

5.9 Conclusion

Throughout this discussion the question of whether or not health visitors are accurately identifying abuse recurs. It is not possible to draw firm conclusions on the adequacy of the health visitor response described in the current study until accuracy of identification of abuse is established. The literature suggests that in general health professionals fail to recognise survivors of abuse who attend their service (Feder et al 2009). However, there is no recent or UK based exploration of the nature of abuse in police reported domestic

incidents and therefore the current wisdom that women involved in police reported incidents are experiencing domestic abuse can be challenged by the experience and assessment of health visitors in the current study.

Despite routine contact with families over a period of years, the response described by participants in this study focused primarily on the immediate response following disclosure or, more commonly, police notification of a domestic incident. Key findings from the current study relate to the loss of relationship between health visitor and service users. Participants stated that this is a result of reduced routine visits, however the literature identifies aspects of the current health visitor response which could diminish the relationship such as the child protection focus, lack of stage specific engagement and support, lack of response to issues other than those relating to health such as protection, legal advice and social issues and a delay in establishing contact after a domestic incident.

The current study challenges a number of important assumptions expressed in literature and policy:

- Health visitors regularly encounter women for whom abuse has recently started or escalated.
- Domestic incidents which come to the attention of police are indicative of domestic abuse.
- Health visitors establish a close working relationship with all families in their care.
- Health visitors are well placed to identify domestic abuse.
- Health visitors assess and respond to the needs of families affected by domestic abuse on an ongoing basis.
- GIRFEC promotes family-centred and holistic assessment in practice

This study suggests that health visitors in Scotland have theoretical knowledge about domestic abuse however, this is not reflected in practice responses to women involved in police reported domestic incidents as participants described a limited response to disclosures and to families involved in police reported incidents. This limited response reflects a perception that the majority of health visitor service users involved in police reported domestic abuse and their children are not exposed to domestic abuse and are not at ongoing risk of harm.

The literature identifies a number of factors which prevent women seeking help such as fear of the perpetrator, fear of losing custody of their children, lack of self-esteem, not recognising abuse or risk and lack of knowledge about available supports. The current service response does little to overcome these barriers and when combined with health visitors' perception of the extent of abuse within their service user group reduces opportunities for abused women and health visitors to actively engage, identify and address women's needs. This is illustrated in Figure 5.1.
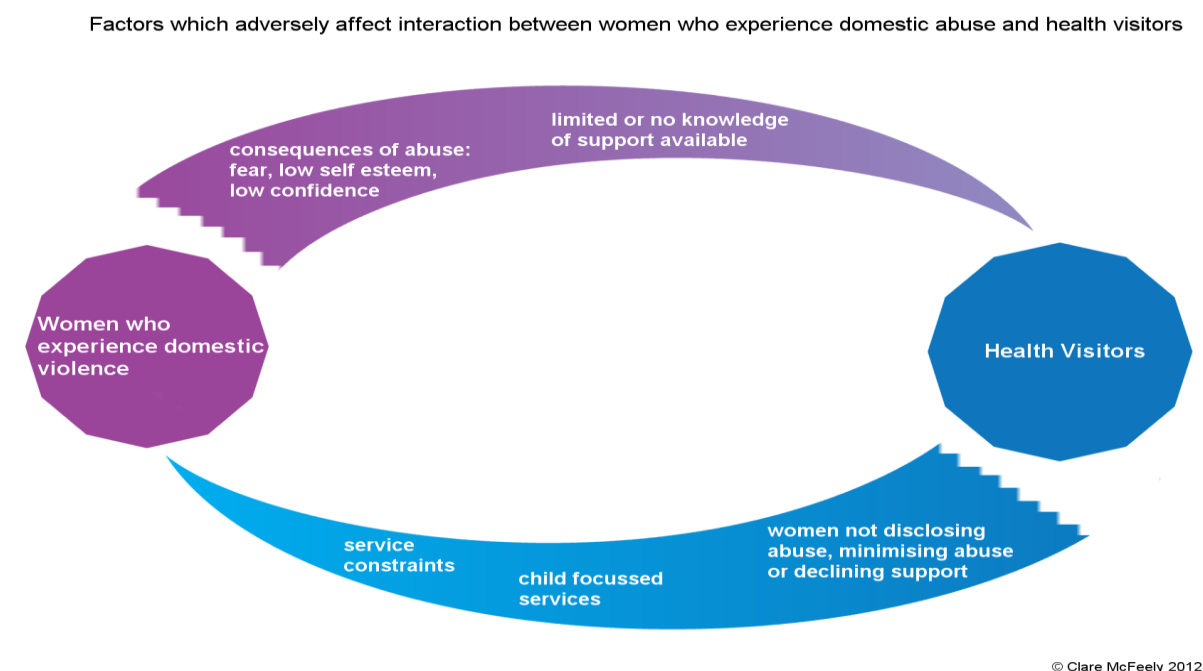
Figure 5-1 Factors which adversely affect interaction between women who experience domestic abuse and health visitors

This study has provided an insight to the health visitor response to domestic abuse in Scotland in early 2011. Griffiths (2009), states that "in healthcare we cannot isolate ourselves from constant change". Indeed, since data collection, a programme of training on enquiring about domestic abuse has been delivered to health visitors in the participating health boards. This is likely to have altered practice to some degree although informal feedback from health visitors suggests otherwise.

This chapter described an exploratory study on the health visitor response to domestic abuse. This study successfully addressed the research questions by describing the health visitor response and the limitations of this; the extent to which this response addresses safety and protection issues and health visitor support requirements.

Initially it was anticipated that this study would describe a response to women living with domestic abuse. Instead the most common response was a minimal response to incidents. Health visitors report that they rarely identify specific concerns for children in their structured assessment. Similarly, concerns are rarely identified for women involved in police reported domestic incidents although no formal assessment is conducted. This brings into question the requirement for any response beyond this and whether or not a support need, suggested in the wider literature, exists amongst health visitor service users in Scotland.

5.10   Next Steps for this Research

The findings of phase one of the current study suggests that the needs of women who experience domestic abuse are unrecognised and unmet if health visitor service users involved in police reported domestic incidents are indeed experiencing domestic abuse. Therefore, further research is required to determine the nature and extent of abuse in this group of service users.

The focus group findings raise the following research questions:

- What is the nature and extent of domestic abuse experienced by women involved in police reported domestic abuse incidents?
- What health visitor response, if any, do women who are involved in police reported incidents wish?

These research questions are addressed in the following chapters.

6 Phase Two - A Secondary Analysis of Data Routinely Recorded by Police Following a Domestic Abuse Incident

6.1 Chapter Introduction

This chapter presents the second phase of the current research. The chapter is divided into four sections. First the rationale for the study, aims and research questions are presented. The study methods are described, followed by presentation of the results. The results are then discussed in relation to the literature and the preceding phase of the study.

6.2 Rationale for Phase Two

Health visitors who participated in phase one of the current study were notified when women with children aged less than 5 years were involved in police reported domestic incidents ("police notifications") and the response to these notifications dominated the focus group discussions. Health visitors stated that their assessments, conducted after police notifications, rarely identified domestic abuse or suspicion of domestic abuse. Instead they considered the majority of police notifications to relate to isolated or minor incidents, frequently associated with alcohol consumption by the woman and her partner. This is contrary to the generally held view that women are reluctant to involve the police but are more likely to contact the police when they fear for their safety (section 5.8.1).

The literature states that women want to talk about domestic abuse and wish support from agencies in relation to domestic abuse (Feder et al 2009, Lutenbacher 2003) but, in the experience of health visitors in phase one, women rarely requested support and declined to engage in discussion about domestic abuse. Phase one participants stated that women declined support following police notifications because they were not living with ongoing domestic abuse and therefore, support was not required. In addition, health visitor participants in phase one reported that children were usually unaware of the incident and, in many cases, incidents occurred outside the family home. They therefore rarely raised concerns about child protection. This is a further contrast with the literature which

suggests that children are often aware of, and adversely affected by, domestic abuse (section 3.2.4). Research questions emerged from these findings in relation to the nature and extent of abuse experienced by women involved in police reported domestic incidents, specifically if police reported incidents are isolated events, as described by health visitors, or part of ongoing abuse, as described in the literature, and to consider risk associated with these incidents. Phase two and phase three (reported in Chapter 7) sought to answer these questions.

6.3 Study Aim

To use routinely collected police data to describe the nature and extent of domestic abuse experienced by health visitor service users involved in police reported domestic incidents.

6.4 Research Questions

- What is the extent of abuse experienced by women with children aged under 5 years involved in police reported domestic abuse incidents?
- What is the nature of abuse perpetrated in these incidents?
- Who reported the incident to the police?
- Did women have acute health needs as a result of the incident?

6.4.1 Methods

6.4.2 Study Design

This phase of the study is a secondary data analysis of an anonymised sample of routinely collected police data (section 4.7.2). The results will triangulate the findings of phase one and complement the qualitative findings of phase three (Chapter 7). A quantitative study design was adopted as this phase of the research is deductive with a hypothesis (sections 4.5 and 4.7), developed from the literature, that women involved in police reported domestic incidents will be experiencing domestic abuse.

6.4.3 Accessing data

A data request was submitted to Strathclyde Police Force in August 2012. Strathclyde police force was selected as the boundaries were coterminous with the NHS Boards that

participated in phase one of the study. Following submission of the request the police service in Scotland restructured, moving from regional forces, such as Strathclyde, to a single national force, Police Scotland. The resulting organisational changes resulted in a delay in the production of the dataset which was received in March 2013. Data were provided in a Microsoft Excel spreadsheet.

6.4.4 Study Sample

Health visitors provide a universal service to families with children aged less than 5 years old. Therefore, any woman involved in a domestic incident who has a child aged less than 5 years will receive regular health visitor appointments, can contact health visitors at any time through drop in clinics and, in Scotland, will receive a visit from health visitors following involvement in a police reported domestic incident.

The following selection criteria were applied; 100 female victims randomly selected from all adult female victims of childbearing age (16 to 45 years), with a child aged less than 5 years resident in their home at the time of the incident, involved in a domestic abuse incident recorded in the calendar year 2012, in the Strathclyde police force area.

Fields relevant to the research questions were identified by the researcher from the Vulnerable Persons Form. The selected fields included those related to the context of the incident (involvement of alcohol, relationship between victim and accused, reporter of abuse to police, presence of children), the nature of abuse (physical, sexual or emotional abuse and injury resulting from abuse) and the extent of the abuse (previous reports of abuse). The full request submitted to Police analysts is provided in Appendix 4.12 and the rationale for the request is summarised in Table 6.1.

VPD Data Field	Purpose
Risk factors from SPECCS assessment	Indicative of nature of incident and risk
Currently co-habit	Provide context of the relationship
Children present (Yes/No)	Indicative of risk to children
Incident type (physical / sexual / verbal)?	Indicative of nature of incident
Victim or accused under the influence of alcohol	Alcohol use by victim and accused.
Injury to victim	Indicative of nature of incident and risk
Was a crime recorded?	Indicative of nature of incident, risk and police response / assessment.
Previous reports of abuse to woman	Extent of abuse
Who called police?	Indicative of women's engagement with services
Referrals by police officers (e.g. child protection)	Impact of abuse
Was victim taken to a safe place by police?	Indicative of nature of incident and risk

6-1 Summary of Vulnerable Persons Data and Rationale for Selection

6.4.5 Limitations of the data

It is common practice to present the study results before the limitations. Here they are presented first to enable the reader to fully understand the dataset and consider the findings within this context. The challenges related to use of police data in domestic abuse research, specifically under-reporting of domestic abuse, and of conducting a secondary analysis, such as lack of control over the data collection process, were introduced in sections 2.4.1 and 4.7.1. Two issues specific to the current study are now described: Identifying mothers of children aged less than 5 years old and retrieval of data from police systems.

6.4.5.1 Identifying mothers of children aged under 5 years

No single field in the VPD identifies victims of domestic incidents who have children aged less than 5 years. The ages of any children present at the time of incident and of any children resident in the household (whether present or not) are recorded. To increase the likelihood that women involved in incidents were the mothers of the children present (and

not relatives, childminders etc) the sample was restricted to women of "childbearing" age, defined as 16 to 45 years of age by police analysts.   Although likely, it cannot be ascertained that women involved in the domestic abuse incident are the mothers of children resident or present during a domestic incident.

6.4.5.2 Retrievable data.

It was not possible for police analysts to retrieve data from every field requested. From the original request, the following could not be provided:

- Type of incident (physical / sexual / nonphysical)
- Risk assessment
- Referral to support agencies
- Other police action taken (for example referrals in relation to child protection or taking the victim to a safe place.)

This limited the level of detail which could be drawn from this secondary analysis on the nature of abuse perpetrated in police incidents however, the available fields do provide some insight into these incidents.

6.4.6 Previous Incident Data 2002-2012

The initial sample produced data on 100 individual women involved in 100 police reported domestic abuse incidents in 2012, from here referred to as "index incidents". In addition, data relating to all police reported domestic incidents in which these 100 women were involved in the preceding 10 years were provided giving data on a further 421 incidents and a total data set of 521 incidents, from here referred to as "total incidents".

6.4.7 Analysis

Descriptive statistical data is appropriate to quantify the extent of public health issues (Rolfe 2013) therefore a descriptive analysis of the 100 index incidents and 521 total incidents was carried out using Microsoft Excel. When inconsistencies occurred between the results of the current study and the relevant literature, purposive subsamples were analysed to provide further detail and investigate potential relationships between variables. When required, data were re-coded for cross tabulations to explore potential associations

between variables (for example creating a variable for total number of incidents experienced between 2002 and 2012).

Pearson's correlation co-efficient (r) was calculated using Microsoft Excel to determine if there was a linear relationship between age and number of reported incidents (section 6.6.3). The coefficient value ranges from +1 which indicates a strong positive relationship, to -1 indicating a strong negative relationship. A coefficient in the region of zero suggests no relationship (Cominskey & Dempsey 2013).

6.5 Results

Police officers use the term "victim" to describe the person reported to have experienced the abuse and "accused" to describe the reported perpetrator and terminology relevant to this dataset will be used in this chapter.

6.5.1 Sample Characteristics

As requested, data were obtained for a random sample of 100 female victims of police reported domestic abuse incidents in 2012, aged 16 to 45 years old, who had a child aged less than 5 years old present or resident at the time of the incident. Ages ranged from 18 years minimum to 45 years maximum with a mean of 27 years (SD 5.8 years). Age was grouped into five year categories and the distribution is summarised in Figure 6.1.
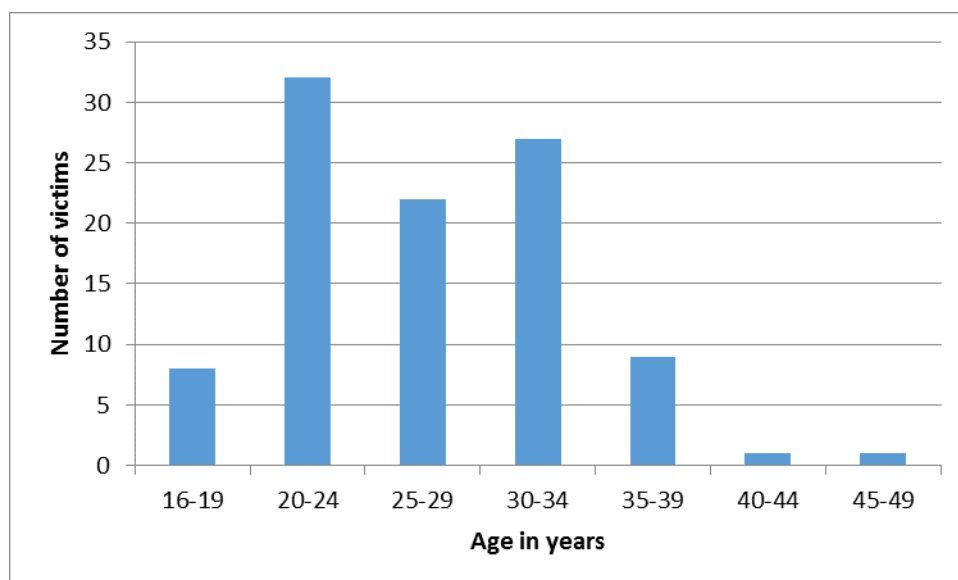
Figure 6-1 Age of victims at time of incident

Attending police officers ask victims to state their ethnicity. Of the 100 victims:

- 92% were White British / White Irish

- 5% were Asian

- 2% "other Black"

- 1% unknown ethnicity.

All 100 victims were English speakers.

6.5.2 Overview of Index and Total Incidents

6.5.2.1 Relationship between victim and accused

Relationships between victim and accused were recorded as:

- Cohabitee (i.e. Living together as husband and wife)

- Spouse (i.e. husband and wife)

- Partner (not co-habiting, including boy/girlfriend)

- Ex-spouse (including spouses no longer co-habiting)

- Ex-partner (not including ex-spouses)

- Not stated

In just over half (56%) of the 100 index incidents the accused was a current partner or spouse of the victim and in 44% was an ex-partner or spouse (Figure 6.2). The reverse was noted in total incidents where more women reported abuse from an ex-partner (52%) than a current partner (47%), with the relationship not stated in the remaining 1%).
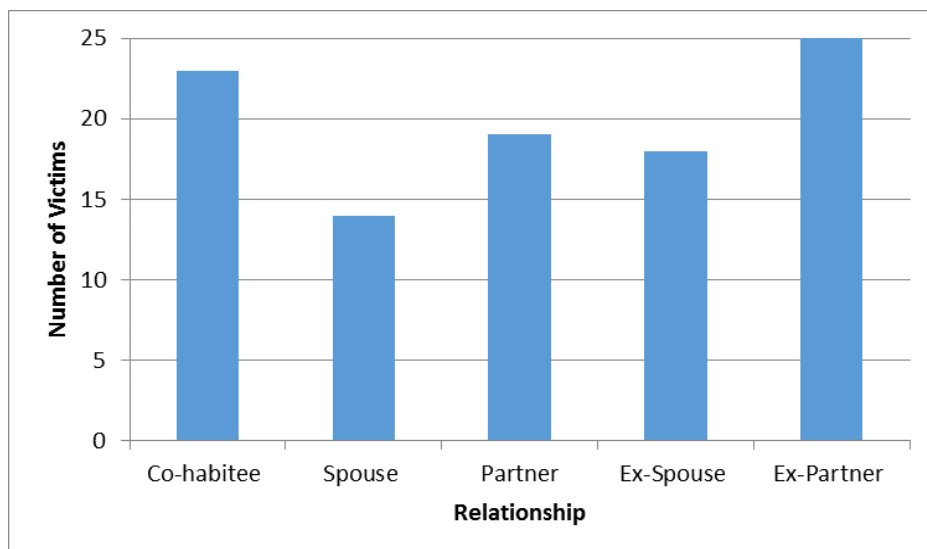
Figure 6-2 Relationship between victim and accused in index incidents

6.5.2.2 Age of victim compared to the accused

The accused was older than the victim in 58% of incidents (maximum 20 years older than the victim) and younger in only 24% cases (maximum 6 years younger than victim). The age range of accused was from 18 to 53 years old, slightly older than that of victims (16 to 45).

6.5.2.3 Gender of victim and accused

In the index incidents, and as dictated by the sampling criteria, all victims were female. Of the accused 99% were male. In one index incident both the victim and accused were female. Almost a third of victims in the index incidents (n=31) had been accused in previously reported incidents. Of the total incidents 89% featured a male accused and female victim, 10% a female accused and male victim and 1% female victim and female accused (Table 6.2).

The sample selection criteria included female victims and so there were no cases of female on male violence in isolation. In this data set women who had been accused of perpetrating domestic abuse had all been the victims in domestic incidents more often than the accused.

Gender Dynamic	Of Index Incidents (n=100)	Of Total Incidents (n=521)
Male Accused and Female Victim	99%	89%
Female Accused and Male Victim	0	10%
Female Accused and Female Victim	1%	0.5%
Insufficient Information or Unknown	0	0.5%

6-2 Gender dynamic of incidents

In 17 cases where there was a female accused the woman had also made an allegation of abuse at the same time as her partner, referred to as counter allegation and it is not clear who the primary perpetrator is in these incidents. Counter allegations made up 6.5% of the total incidents.

6.5.2.4 Location of Incident

Over three quarters of the index incidents (77%) and total incidents (72%) occurred in the victim's home. A minority of incidents occurred in pubs (1%) and in the street (11%). Further detail is provided in Table 6.3.

Location	Of Index Incidents (n=100)	Of Total Incidents (n=521)
Dwelling House - Victim's Home	48%	48%
Dwelling House - Joint Home	29%	24%
Dwelling House - Accused / Other Home	10%	13%
Street / Public Place	11%	11%
Licensed Premises / Public House	1%	1%
Shop / Business Premises	1%	1%
Not Known	0%	1%

6-3 Location of incident

6.5.2.5 Time of Incident

Incidents occurred more frequently at weekends, with 48% of index and 40% of total incidents occurring on Saturdays or Sundays. The majority of incidents occurred in the evening or at night but as illustrated in Figure 6.3, they occurred across the 24 hour period.
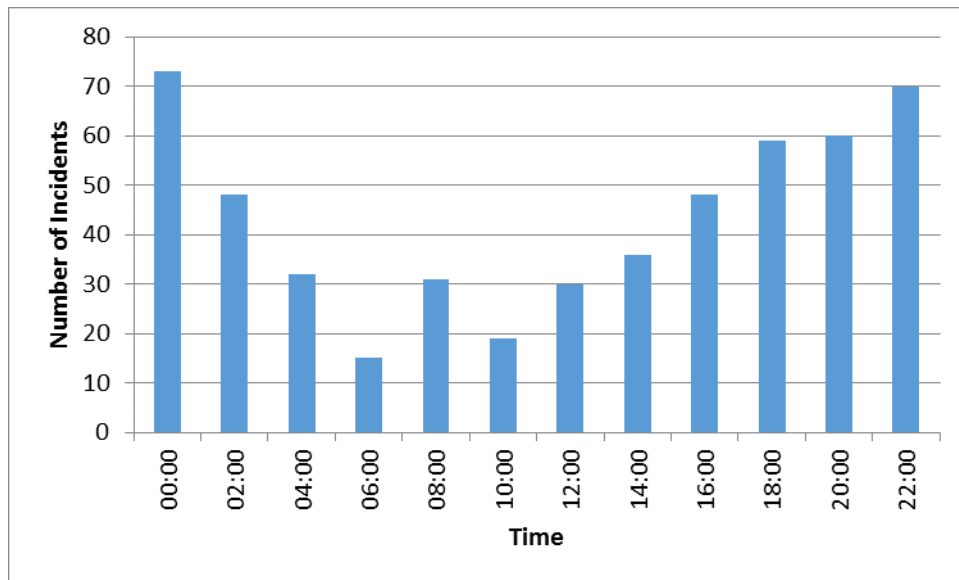
Figure 6-3 Time of incidents (Total incidents n=521)

6.5.2.6 Alcohol

Data in this field can be gathered from the victim, accused or police observation. "Insufficient data" most commonly refers to incidents where police officers had not gained entry or may not have been able to interview the accused. In almost half of the total incidents (45%) neither victim nor accused had consumed alcohol. In almost a quarter (23%) both the victim and accused were under the influence of alcohol (Table 6.4).

Involvement of Alcohol	Of Index incidents (n=100)	Of Total incidents (n=521)
Neither party under the influence of alcohol	47%	45%
Both parties involved under the influence of alcohol	25%	23%
Accused under the influence of alcohol but not the victim	18%	24%
Victim under the influence of alcohol but not the accused	7%	4%
Insufficient data	3%	4%

6-4 Involvement of alcohol in incidents

6.5.2.7 Incident Reporter

Most incidents were reported to police by the victim of the incident (62% of index incidents) and around a third (38% of index incidents) were reported by others (Table 6.5). Ten of the total 521 incidents were reported by the accused, half of which were counter allegations. All 10 incidents occurred in a context of repeat incidents where a greater number of reports had been made by the victim or an agency.

Reported By	Index Incident (n=100)	Total Incidents (n=521)
Victim	62%	66%
Family, Friend and Neighbour	24%	17%
Other (including the Police)	8%	8%
Witness	5%	7%
Accused	1%	2%

6-5 Incident reporter

To provide insight as to whether the nature of the incident was associated with seeking police help, a subsample analysis was conducted to identify change in reporter patterns dependant on type of crime, use of weapons and injury to victim. Regardless of use of weapons, injury or type of abuse, police contact was most likely to be established by victims (Figures 6.4 to 6.6). Reports by agencies appear more likely if weapons or violence are used and if the woman is injured.
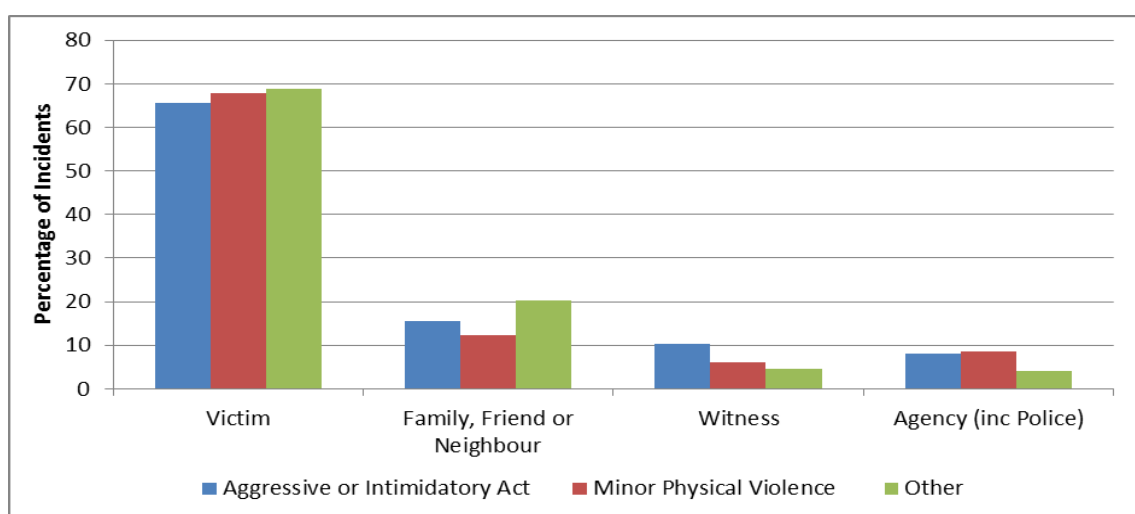
Figure 6-4 Incident reporter and type of crime

In addition to the incidents described in Figure 6.4 three incidents were recorded as crimes of serious assault (too few to include in Figure 6.4). The victim contacted the police in all three incidents.
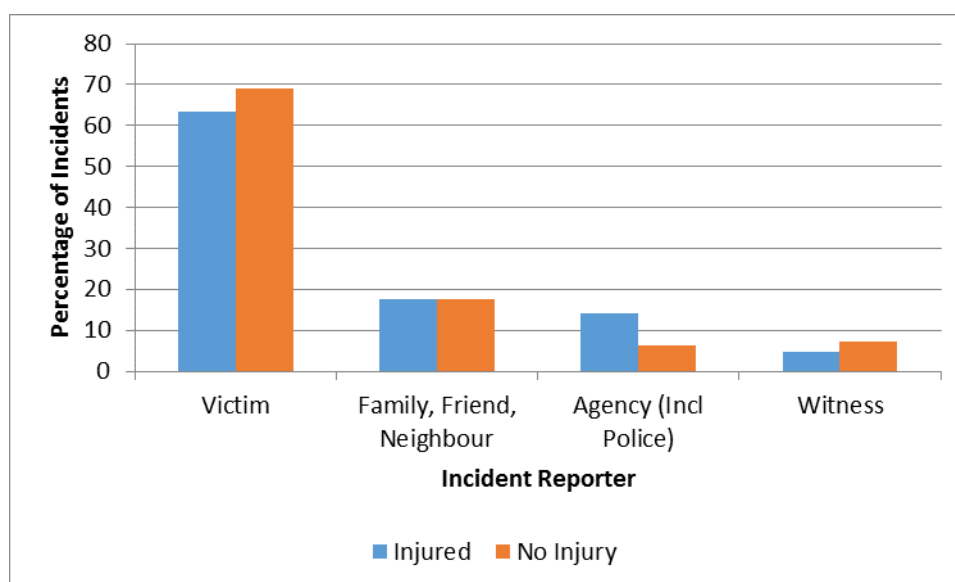
Figure 6-5 Incident reporter and injury to victim

For reporting, injury status was categorised into "Injured" which includes incidents where the victim required a casualty surgeon, hospital outpatient or was injured but declined medical attention. "No injury" is used for incidents where there is no obvious injury recorded. Of the total incidents, in 44 injury status was unknown. In addition to the incidents reported in Figure 6.5, nine were reported by the accused. Of these only one had resulted in injury.

In addition to the incidents detailed in Figure 6.5, the victim required medical attention from a "casualty surgeon" in five incidents. Of these, the police were contacted by the victim in three incidents, by the accused in one incident and by a witness in one incident.

Overall, only 13 of the 521 total incidents involved the use of single or multiple weapons (2.5%). Of these incidents the victim contacted the police in most cases (n=9), family, friends or neighbours in three incidents and an agency in one incident. More common was use of physical contact which is detailed in Figure 6.6.
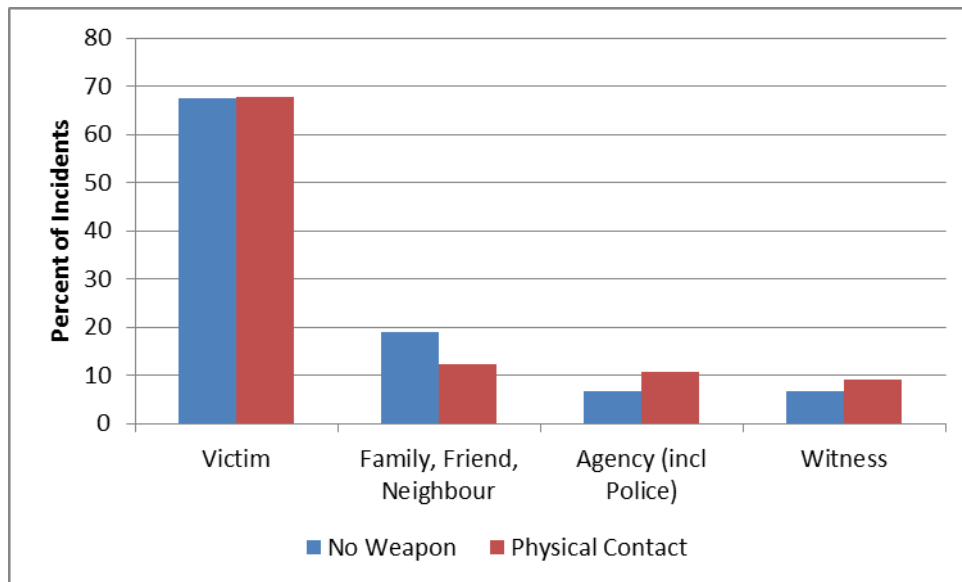
Figure 6-6 Incident reported and use of physical contact

6.5.3 Extent of Abuse

The index incident was the only incident recorded by police between 2002 and 2012 for 21% of the sample. In around three quarters of index incidents either the victim or accused had been involved in other domestic incidents reported to the police. Of the 100 index incidents 79% involved a victim who had previously been involved in a police reported incident (ranging from 2 to 31 incidents) and 66% involved an accused who had previously been reported to the police.
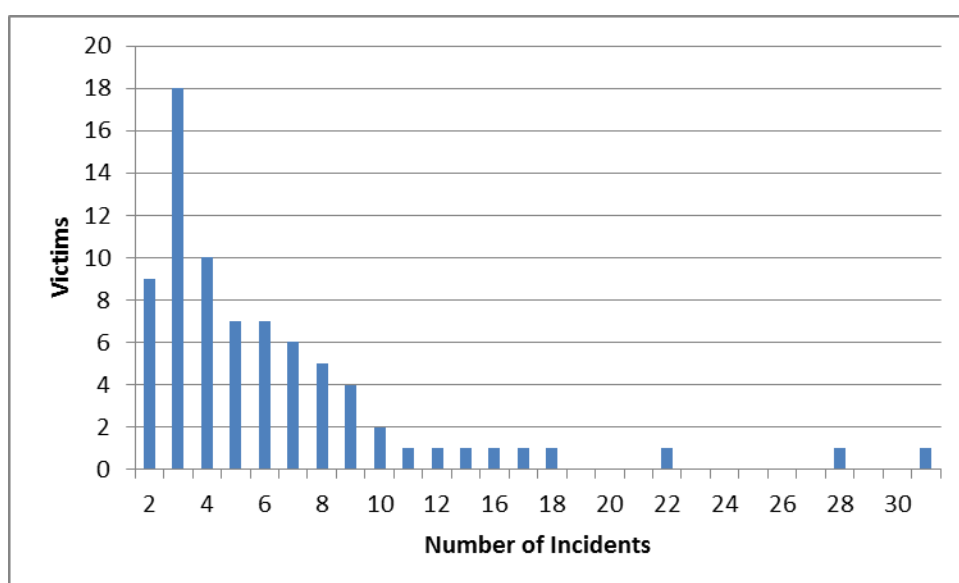
Figure 6-7 Previously reported domestic abuse incidents between 2002 and 2012

Analysis was conducted to determine if there was a linear relationship between the age of victim and the number of incidents reported with a hypothesis that older women would have been involved in more incidents. There was no evidence of a strong relationship for the 79 women who were involved in two or more incidents in the preceding 10 years (r=-0.03, no evidence of relationship) or in the 11 women involved in 10 or more reported incidents (r=-0.19). Indeed, eleven victims were involved in 10 or more incidents, five of whom were from the youngest age categories and were aged between 19 and 26 years (Figure 6.8).
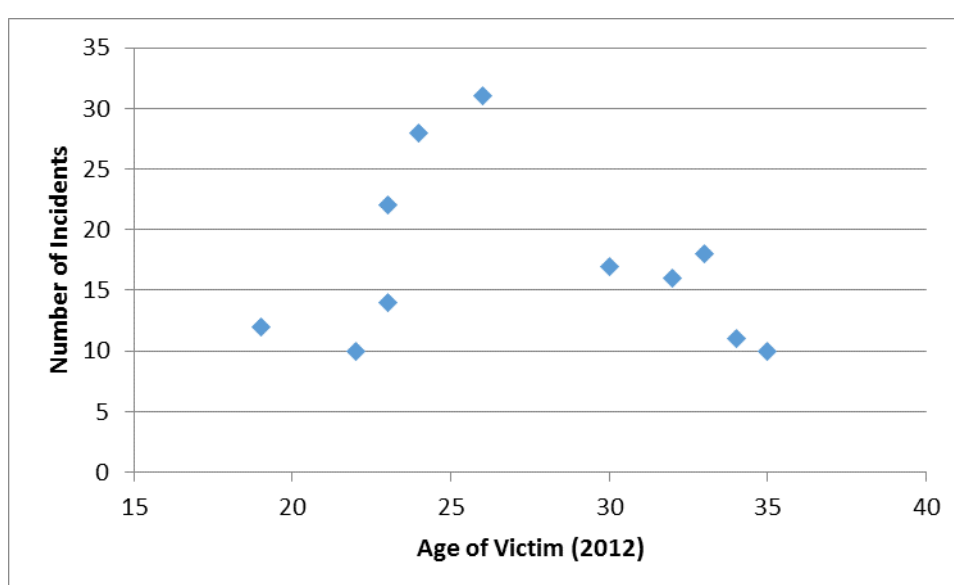
Figure 6-8 Age of victims with 10 or more previously reported incidents

Analysis of previous incidents did not identify patterns but a wide range of individual experiences. For example, some women were regularly involved in reported domestic abuse incidents over consecutive years while others reported single incidents several years apart. This is illustrated in the examples below. As data were anonymised by the police service to preserve anonymity and confidentiality pseudonyms have been applied in the following examples.

<u>Example 1 - Rhona</u>

Incident Date	Type of Crime	Relationship to Accused
2nd Oct 2002	Minor Physical Violence (Simple Assault)	Ex-Spouse
6th Aug 2007	Other form of Crime or Disorder	Ex-Spouse
29th Dec 2007	Other form of Crime or Disorder	Ex-Spouse
7th August 2010	Serious Assault	Ex Spouse
23rd Feb 2011	Aggressive or Intimidatory Act (Harassment, Breach of the Peace, Threats)	Ex-Spouse
24th May 2011	Other form of Crime or Disorder	Ex-Spouse
14th Jul 2011	Breach of Bail Conditions Offence	Ex-Spouse
19th Aug 2011	Breach of Bail Conditions Offence	Ex-Spouse
23rd Aug 2011	Aggressive or Intimidatory Act (Harassment, Breach of the Peace, Threats)	Ex-Spouse
17th June 2012	Threatening or Abusive Behaviour	Spouse
28th Jul 2012	Other form of Crime or Disorder	Ex-Spouse

Rhona was involved in 11 separate reports of domestic abuse in the period between 2002 and 2012. It is possible that she reported abuse prior to this but the details are not included in this dataset. Children have been in the household at each incident and were aware of, or involved in, six of these incidents. There is a period of five years between the first and second reports of domestic abuse but the second and third reports are only six months apart. This is followed by a period of almost three years before a single incident reported in 2010. From February 2011, five reports were made in quick succession. Again this is followed by a period of almost a year and then two reports made only a month apart.

It is not possible to say if the same perpetrator has continued to abuse Rhona over the years or if she has experienced abuse from different partners. However, this example does suggest that abuse continued after separation and, in view of breach of bail conditions, persisted after criminal justice involvement.

<u>Example 2 – Eileen</u>

Incident Date	Crime type	Relationship to accused
10th Nov 2004	Other form of Crime or Disorder	Co-habitee
4th Sep 2005	Other form of Crime or Disorder	Partner
30th Sep 2006	Other form of Crime or Disorder	Partner
23rd May 2007	Other form of Crime or Disorder	Partner
08th Jun 2007	Other form of Crime or Disorder	Partner
24th Jul 2007	Other form of Crime or Disorder	Partner
29th Jul 2007	Aggressive or Intimidatory Act	Partner
29th Aug 2007	Other form of Crime or Disorder	Partner
31st Aug 2007	Aggressive or Intimidatory Act	Partner
1st Sep 2007	Aggressive or Intimidatory Act	Partner
29th Jun 2008	Minor Physical Violence	Partner
30th Jun 2008	Aggressive or Intimidatory Act	Partner
1st Jul 2008	Aggressive or Intimidatory Act	Partner
12th Aug 2008	Aggressive or Intimidatory Act	Partner
11th Oct 2008	Other form of Crime or Disorder	Partner
12th Oct 2008	Other form of Crime or Disorder	Partner
15th Oct 2008	Aggressive or Intimidatory Act	Partner
2nd Nov 2008	Minor Physical Violence	Partner
2nd Nov 2008	Other form of Crime or Disorder	Partner
21st Jan 2009	Aggressive or Intimidatory Act	Partner
23rd Jan 2009	Aggressive or Intimidatory Act	Partner
25th Mar 2009	Aggressive or Intimidatory Act	Ex-Partner
25th Mar 2009	Breach of Bail Conditions Offence	Partner
25th Aug 2009	Minor Physical Violence	Partner
11th Dec 2009	Other form of Crime or Disorder	Partner
1st Mar 2010	Breach of Bail Conditions Offence	Partner
10th Jul 2010	Other form of Crime or Disorder	Partner
9th Feb 2012	Other form of Crime or Disorder	Partner
10th Sep 2012	Aggressive or Intimidatory Act	Partner
29th Sep 2012	Minor Physical Violence	Partner
25th Dec 2012	Other form of Crime or Disorder	Partner

In another example, Eileen first reported domestic incident in this data set occurred in 2004 when she was 18 years old. Reports of domestic abuse were made consistently over 8 years but within this there was a period of 21 months when no reports were made. The crime type shows consistent aggressive and threatening behaviour with occasional physical violence, however, the data provided here, and in the previous example is insufficient to estimate escalation of abuse.

There are a number of potential explanations for long periods between reported incidents such as a change in the behaviour of the accused, the victim living in another area for a period of time, a change in partner or non-reporting of continued abuse. There is insufficient contextual data in this dataset to make firm conclusions. However, long periods between reports in the examples of both Eileen and Rhona may explain the health visitors' perception that incidents are isolated. This will be explored further in the discussion of this chapter (section 6.6).

To provide a contemporary picture of the extent of involvement in police reported incidents, a subset analysis of incidents was conducted. In 2010 health visitors reported that it was routine practice for police or social work services to share information on police reported domestic incidents which involved their service users (Chapter 3). Therefore the period from 2010 (when first focus groups were conducted) until 2012 (index and most recent indecent) was selected for a subsample analysis. In the period 2010 to 2012, the 100 victims reported 274 incidents. Of these 54% of victims reported more than one incident, ranging from 2 to 16 incidents (illustrated in Figure 6.9). Only 7% of incidents in this period were unrelated to previous reports. This finding challenges the observations of health visitors in phase one of the current study that police incidents are frequently isolated events.
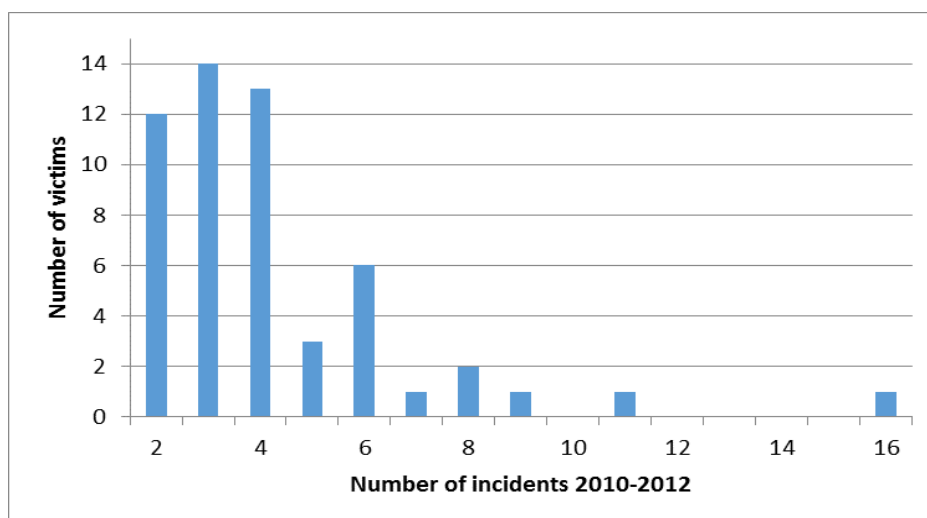
Figure 6-9 Victims involvement in two or more police reported domestic incidents from 2010 to end 2012

6.5.4 Nature of the Incident

6.5.4.1 Crime type

In the VPD two fields record crime type. The first describes the broad crime category and the second, a specific crime, which provides more detail on the nature of the abuse (Table 6.6). When there is insufficient evidence that a crime has been committed, this is recorded as "none" and referred to as a "non-crime incident".

A crime was recorded for 66 of the 100 index incidents. Of these the majority were acts of intimidation or aggression (n=27). Nineteen incidents involved use of "minor" physical violence, classified as "petty assault". Analysis of the total incidents showed similar proprtions of type of crime as the index incidents however in addition, there were three serious assaults in the total incidents.

Approximately a third of index incidents (34%) were recorded as non-crime incidents. A subset analysis was performed for victims of non-crime index incidents to establish if they had ever been the victim in a domestic incident when sufficient evidence of a crime had been reported between 2002 and 2012. The majority had been the victim in previous incidents when a crime had been recorded:

- 21 had previously been victims in incidents where a crime had been recorded (range from one to 13).
- 9 only had the index incident recorded by police
- 4 had between 3 and 4 previous incidents, all recorded as non-crime incidents

While analysis of index incidents alone suggests that 66% of the sample were victims of crime, the 10 year history identified that 87% of women in this sample were victims of domestic abuse related crime in the preceding 10 years. This is illustrated in Figure 6.10. Index incidents did indicate that the majority of women were victims of crime but underestimated the overall experience of domestic abuse related crime of the women in the sample. In terms of gender in almost half of the incidents (47%, n=24) with a male victim and female accused there was insufficient evidence of a crime.

Crime type / Offense		Index Incidents (n=100)	Total Incidents (n=521)
Aggressive or Intimidatory Act	Threatening or Abusive Beha	28%	14%
	Breach of the Peace	4%	21%
	Threats and Extortion	1%	1%
Minor Physical Violence	Petty Assault	19%	16%
Breach of Bail Conditions Offence	Bail Offences Other	8%	6%
Severe Physical Violence	Serious Assault	-	0.50%
Other form of Crime or Disorder	None	34%	38%
	General Post Office/Telecommunications	3%	>1% (n=1)
	Offences relating to Roads	1%	2%
	Failure to Appear for Trial	1%	>1% (n=1)
	Sexual Assault	1%	>1% (n=1)
	Other (including theft, malicio	-	1%
Total		100	100

6-6 Crime type
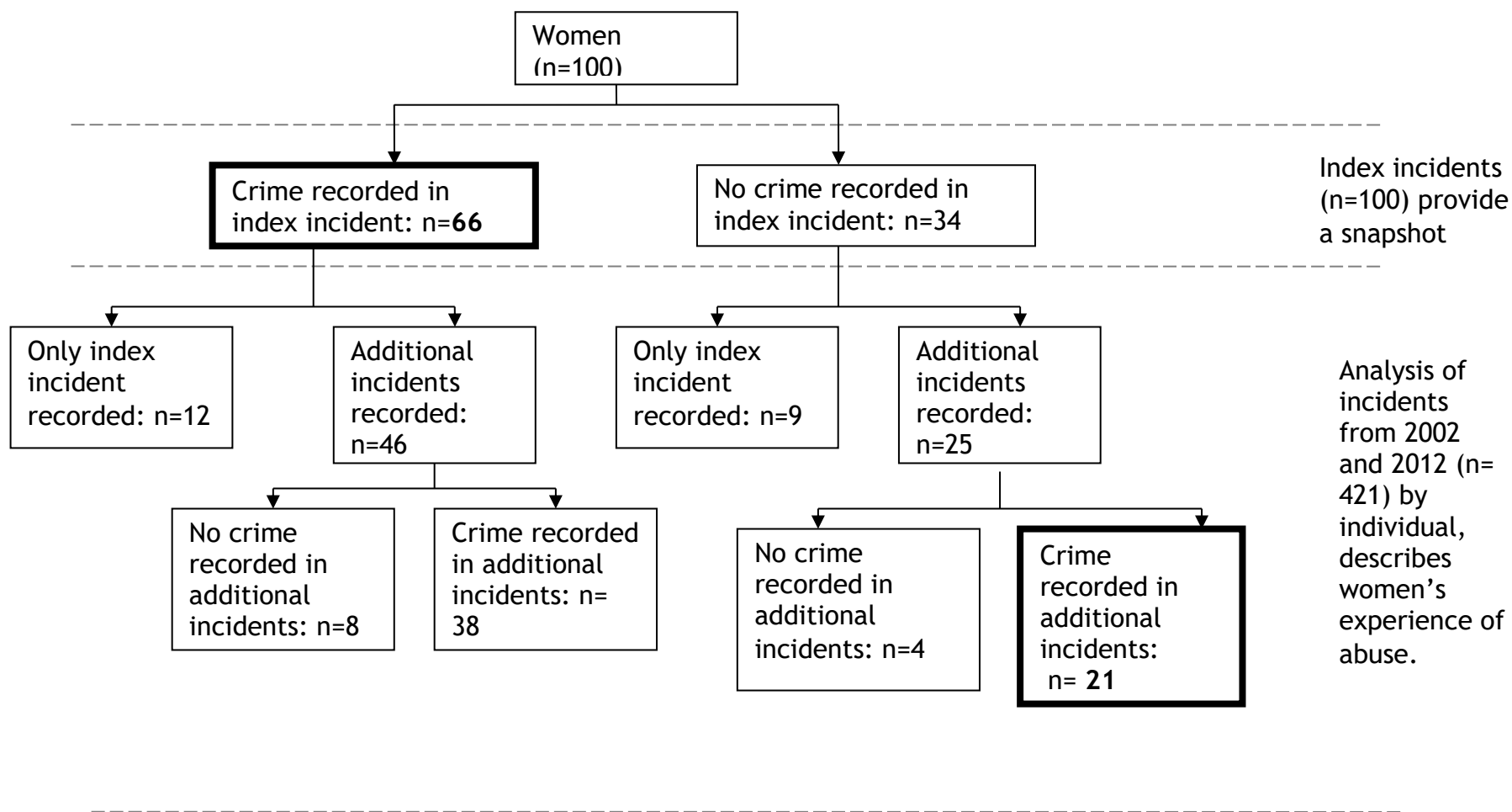
Figure 6-10 Victims of recorded crime 2002-2012

6.5.4.2 Use of Weapons

Use of weapons was recorded in one of four categories ranging from no weapons to multiple weapons. Use of physical contact was also recorded in this field (Table 6.7). It is possible that physical contact was used by the accused but this was not recorded within the "weapons" field and therefore, this may be an underestimate.

Weapon	Index Incidents
No Weapon	69%
Physical Contact	29%
Multiple Weapons	1%
Other Weapon	1%
Total	100%

6-7 Use of weapons and physical contact in index incidents

Of the index incidents 31% involved use of weapons or physical contact. Further analysis was conducted to determine how many victims in this sample had ever been involved in incidents where weapons or physical contact was used against them. This identified a further 31 women who had weapons or physical contact used against them and doubled the incidence of weapons or physical contact to 62%. This highlights, as with experience of crime incidents, that consideration of the index incidents only can result in under estimation of the nature and extent of abuse experienced by this service user group (Figure 6.11).
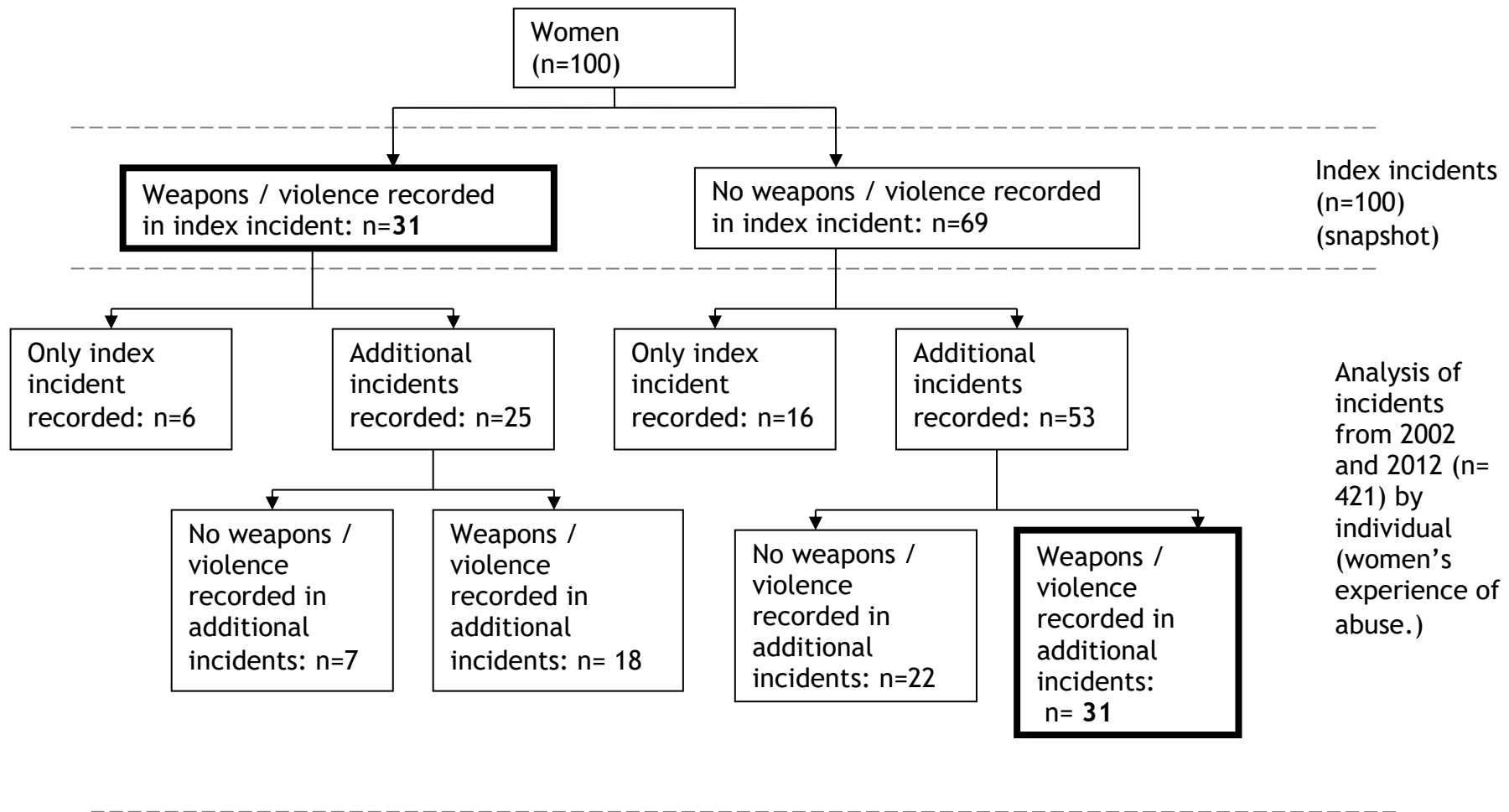
Figure 6-11 Use of weapons or physical contact index and total incidents

Of the total incidents (n=521), 29% involved use of weapons or physical contact. Less than a third of total incidents involved use of weapons or physical contact but two thirds of victims had weapons or physical contact used against them at some time in the period 2002-2012. This demonstrates that women were experiencing and reporting a range of abusive behaviours to the police.

Of the total incidents which involved use of weapons, 10% involved a female accused (14 incidents with 12 individuals accused) (Table 6.8). In all but 2 cases, the women had been victims in previous incidents where weapons or physical contact were used against them.

Weapon	Male Accused	Female Accused	Total Incidents
Physical Contact	124	11	135
Other Weapon	3	2	5
Multiple Weapons	3	1	4
Knife	2	0	2
Blunt Instrument	2	0	2
Total	134	14	148

6-8 Use of weapons by male and female accused

6.5.4.3 Injury to victim

Injury to victim was assessed by attending police officers by direct observation and by asking victims if they had sustained an injury. Some women will sustain physical injuries which are not obvious and which they will not disclose to police officers, therefore under-reporting is likely in this field. Further, data were missing in this field for 8% of total incidents.

In 18% of index incidents and 12% of total incidents, victims sustained some injury. Of the total incidents, eight resulted in injury following "minor physical violence". In a further 8 incidents the victim sustained injury following an "aggressive or intimidatory act"

and an additional two women following an "other form of crime or disorder" (Table 6.9). The presence of injury following an aggressive or intimidatory act suggests a limitation of the data due to under-reporting or under-recording of use of physical violence or physical assault.

Injuries to Victim	Index Incidents (%)	Total Incidents (%)
No Obvious Injuries	80	79
Injured - Declined Medical Attention	14	9
Injured - Hospital Outpatient	3	2
Injured - Casualty Surgeon	1	1
Not Recorded	2	9
Total	100	100

6-9 Injuries to victim

Again, analysis was conducted to determine if any women not injured in the index incident had been injured in domestic incidents reported in the preceding 10 years. This analysis identified a further 22 women who had sustained an injury as a result of a domestic incident. Therefore the proportion of women who were injured by a partner was double the incidence of injury in analysis by incident (Figure 6.12). Non-identification of physical injury could result in an under estimate of the extent of physical and mental health consequences for victims of abuse and risk of further harm.

Of the total incidents (n=521), 12% were known to have resulted in injury to the victim. Of all incidents with a female victim 13% resulted in injury to the victim compared to 6% (n=3) of all those with male victim.
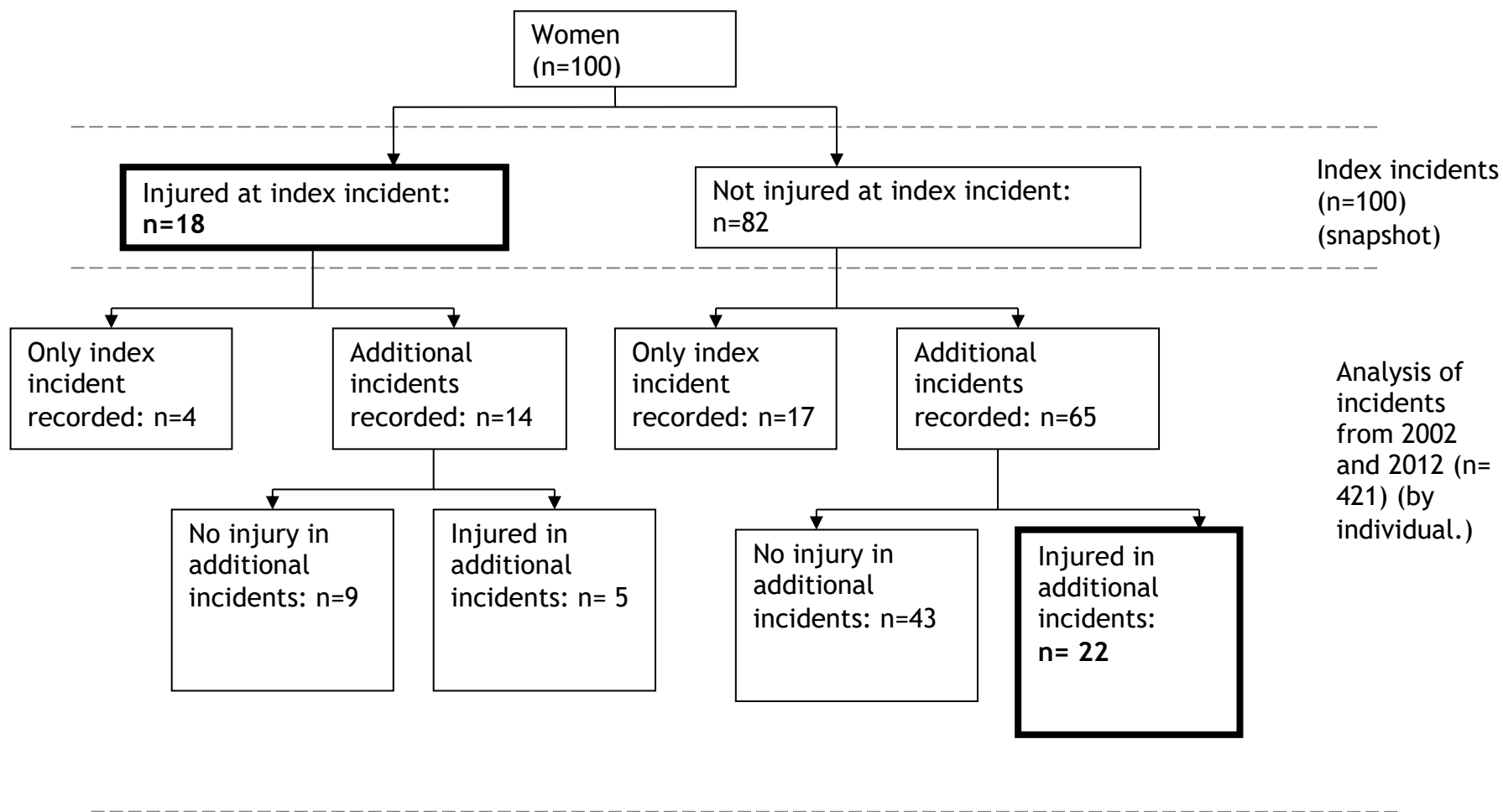
Figure 6-12 Injury to victim

Assessment which uses only index incident data is likely to underestimate the extent of abuse experienced and the potential health and social consequences which result. When analysis was conducted by victim, rather than incident, this revealed greater experience of abuse. For example, 18% of index incidents resulted in injury; 12% of the total incidents resulted in injury but analysis by victim found that 40% of women in the current sample had been injured in a police reported domestic incident. This is summarised in Table 6.10.

Analysis :	Index Incidents	Total Incidents	Victims
Victim of a recorded crime	66%	62%	87%
Weapons or physical violence used against them	31%	28%	62%
Injury to victim	18%	12%	40%

6-10 Analysis of characteristics of abuse by incident and victim

6.5.5 Presence of Children

The status of children at the time of the incident is recorded in one of 5 categories:

- o Child Present (In room and involved in incident)
- o Child Present (In other room aware of the incident)
- o Child Present (In another room unaware of incident)
- o No Children Present
- o Child Presence Not Known

In a quarter of index incidents a child was involved in the incident and in a further seven incidents the child(ren) were in another room but aware of the incident, giving a total of 31% of index incidents where children were involved in, or aware of, the incident (Table 6.11). Of the total incidents for the period 2002-2012 children were present in the home or involved in more than half of the incidents (57%; n=295).

Status of child(ren)	Index Incidents (n=100)
No Children Present	42%
Child Present (Other Room Unaware)	25%
Child Present (In Room and Involved)	24%
Child Present (Other Room Aware of Incident)	7%
Child Presence Not Known	2%
Total	100

6-11 Status of children during index incident

As before, total incidents were analysed by victim to determine the extent of children's ever being aware of, or directly involved in an incident. The most significant level of involvement was recorded. For example, if a child had been in the room and involved in an incident on one occasion and in another room and aware in another, only the in room and involved incident would be selected.

The subset data analysis was limited to incidents reported between 2010 and 2012. Limiting the analysis to more recent events focused the investigation to the period when health visitors were made aware of incidents and increases the likelihood that children involved were aged under 5 years at the time of the incident. This analysis identified 52% of children were at some point in the period 2010 to 2012 involved in, or aware of, a domestic abuse incident (Figure 6.13).

Children were in the same room and involved in 24% of index incidents and 23% of total incidents. Of the victims, 41% had been involved in a domestic incident which their children had either also been directly involved in or aware of between 2010 and 2012. These findings demonstrate that children are often directly and repeatedly exposed to the abuse.

A limitation of this data set was that children do not have a unique identifier number therefore it was not possible to identify how m many children were present. If there were siblings it is not clear if all were present at each incident or if individual children were

present at separate incidents.   Further, in relation to the SPECSS risk assessment it is not known if the accused is the father of the children or if they are from a previous relationship, nor if the victim was pregnant at the time of the incident.

At Index Incident		Child in Room & Involved	Child in other room - aware	Child in other room - unaware	Not present	Not known
		25	7	24	42	2
In previous incidents (2010 – 2012)	Child in Room & Involved	8	**1**	**5**	**9**	**1**
	Child in other room - aware	3	0	1	4	0
	Child in other room - unaware	1	1	5	8	1
	Not present	0	1	2	3	0
	Only index incident recorded	13	4	11	18	0

Figure 6.13 Summary of Children's Exposure to Domestic Abuse Incidents 2010- 2012 (Bold Type Indicates greatest level of exposure)

6.5.6 Risk Factors

The SPECSS risk assessment identifies a number of indicators of risk of further harm, these include previous abuse, escalation of abuse, pregnancy, presence of children from previous relationship, recent separation, sexual violence and threats to kill. These are routinely recorded by police officers but unfortunately, these data could not be retrieved from the VPD for analysis.   Findings in relation to previous abuse, escalation of abuse and presence of children have already been presented (sections 6.5.3 & 6.5.4). In the following sections, data from other fields is considered as a proxy indicator of risk.

6.5.6.1 Recent Separation

The data set provided for this study details the relationship between victims and accused. In 44 of the 100 index incidents, the accused was an ex-partner / ex-spouse. Of these 38 victims had previous experience of abuse (ranging for 2 to 28 incidents in preceding 10 years) however, the following examples illustrate the difficulties in using this dataset to speculate on separation around the time of the reporting incidents.

<div align="center">Example A - Sarah</div>

Incident Date	Relationship to Accused
January 2003	Ex-partner
January 2005	Ex-partner
August 2011	Partner
November 2011	Partner
February 2012	Ex-spouse
March 2012	Ex-partner

Sarah reported four separate domestic incidents in 8 months between August 2011 and March 2012. It may be that this was perpetrated by the same individual and that the relationship ended after November 2011. It is also possible that the ex-spouse or ex-partner referred to in 2012 is the original perpetrator of abuse dating from 2003/05 or may refer to a relationship between November 2011 and February 2012.

<div align="center">Example B - Jennifer</div>

Incident Date	Relationship to Accused
June 2004	Partner
April 2009	Ex-partner
April 2010	Partner
September 2010	Ex-partner
January 2011	Ex-partner
September 2011	Ex-partner
October 2011	Ex-partner
December 2011	Ex-partner
November 2012	Ex-partner

In both examples, it is possible that women have been abused by more than one partner. Alternatively, the nature of the relationship may have changed over time with separation and reconciliation or the abuse may have continued unreported between, or prior to the incidents above. A unique identifier for the accused was not provided in the current dataset and so, it is not possible to explore further in this study or consider the impact of separation on the nature of incidents.

6.5.6.2 Threats to Kill

Threats to kill can relate to threats to kill the woman, her children or others close to her or for the accused to threaten to kill themselves. Aggressive or Intimidatory Acts comprised around a third of all incidents (32% of index incidents and 36% of total incidents). The data recorded does not indicate the nature of the threats and so it is not possible to estimate the extent of "threats to kill".

6.5.6.3 Sexual Abuse

Sexual assault was recorded in only one of all incidents. This is likely to be the result of under-reporting as sexual abuse remains a taboo and highly stigmatised issue. The limited reports in this sample cannot be used as a proxy measure for risk in the current analysis.

6.5.6.4 Indicators of risk of further abuse

To present an overview of the factors associated with risk of further harm in women's recent experience, fields which indicated the severity of abuse (use of weapons, injury to victim), the extent of abuse (repeat victim) and harm to children (involved in or aware of the incident) for the period 2010 to 2012, were collated for the sample of 100 victims. The researcher considered an indicator present if it was documented in any of the incidents reported between 2010 and 2012. In this period:

- 51 victims' children were involved in, or aware of, the incident
- 32 victims were physically assaulted (minor and severe)
- 30 victims were injured during incidents
- 51 victims had weapons or physical contact used against them
- 54 victims reported more than one domestic abuse incident, ranging from 2 to 16 incidents.

Overall 81% of victims in index incidents had at least one of the risk factors (repeat incident, child present and aware of incident, assault, use of weapons or physical contact, injury), 60% of victims had two or more indicators of further harm and 9% had all five indicators present (Table 6.12).

Risk Factors	Number of victims
0	19
1	21
2	21
3	8
4	22
5	9

6-12 – Indicators of risk in the sample of 100 victims

This dataset is insufficient to complete a structured risk assessment tool, however, health visitors do not currently use tool when assessing risk to women and so this provides a useful illustration of the information they are presented with in their general assessment of the situation.

6.5.7 Summary of Results

This study found that of 100 women in sample:

- The majority had been involved in more than one domestic incident reported to the police
- 81% had at least one indicator of risk of further harm based on data from period 2010-2012 (use of weapons or physical assault, repeat incident, child involved in or aware of the incident)
- 62% had weapons or physical contact used against them in the preceding 10 years.
- 52% had children who were involved in or aware of the domestic abuse between 2010 and 2012.
- 40% had been injured in a domestic incident in the preceding 10 years.
- In only a quarter of incidents were both the accused and victim under the influence of alcohol and almost half did not involve alcohol (45%)
- 77% of incidents occurred in the victim's home

The findings of this study will be discussed in the following section in the context of the wider evidence base and in relation to the findings of the exploratory study with health visitors in phase one (Chapter 5).

6.6 Discussion

6.6.1 Linking to the literature

This secondary analysis was conducted to describe the nature of police reported domestic incidents following the observation of health visitors in phase one who challenged the association between domestic incidents and ongoing domestic abuse. To identify research relevant to this secondary analysis, a search of criminology databases was conducted with guidance from a subject specialist university librarian. Databases included the International Bibliography of the Social Sciences and Socindex and used the keywords "domestic violence" and "domestic abuse". This produced only one article (Bland & Ariel 2015). Therefore the current study which describes characteristics of police reported domestic incidents involving female health visitor service users by individual (victim) and by incident appears unique in the literature. While direct comparison cannot be made it is essential to provide context for the findings of this study and seek other research which

supports or refutes the findings it is important to make explicit the caveats of comparisons made throughout this discussion.

Survivors of abuse report similar barriers to disclosure regardless of the setting, however, additional barriers are specific to the police service such as anticipation of a negative or ineffective police response (Scottish Government 2014b) (2.4.1). Therefore, disclosure to professionals in other settings or to researchers is not comparable and results must be compared with sources which relate to incidents which come to the attention of the police. There is little evidence which explores the nature and extent of police reported domestic incidents and little detail provided in regularly produced statistical reports, however the following sources provide a useful background to the findings of this phase: annual Scottish statistical bulletins on police recorded crimes and the Scottish Crime & Justice Survey (SCJS described in section 2.4.3).

Statistical reports of police crime data enable comparison and consideration of the needs of health visitor service users (this study sample) with the general population. However, there are differences between the national reporting and the dataset used in this study. The Scottish Government produces annual statistical bulletins on all reported domestic incidents in the 12 month period from the beginning of April to the end of March the following year. These reports are incident based and do not detail the total number of victims and accused. This differs from the current study sample where index incidents are a random sample from the calendar year 2012. Further analysis has been conducted on the historic data by victim from January 2002 to the index incident in 2012. Despite differences in time frame and focus on either incident or individual, useful comparison can be made. Reports produced by police in England Wales are also incident based but fewer details are reported, for example, repeat victimisation, making UK wide comparison impossible. Data reports in England and Wales are complimented with findings from the British Crime Survey (BCS) which includes experience of crime whether reported to the police or not. Detail on the extent to which experiences of abuse were reported to the police are not provided in the BCS and so, cannot be used for UK wide comparison with the current study (ONS 2015). However, the Scottish Crime & Justice Survey (SCJS) (Scottish Government 2014b), is useful in this discussion as it enquires specifically about incidents reported to the police in addition to overall experience of abuse. The wider literature, particularly that which explores the dynamics of domestic abuse can be helpful

in interpreting these findings and in exploring the discrepancies between these and the findings of phase one and will be referenced as appropriate through the discussion.

The work of Bland & Ariel (2015), identified in the literature search, was a secondary analysis of 36,000 consecutive domestic incidents reported to the police in a single constabulary in England. This is a useful comparator as it has a large sample, was conducted in the UK, contemporaneously with the current study and analysed data by incident and by victims.

6.6.2 Extent of Domestic Abuse

The majority of women (79%) in this sample had been involved in more than one domestic incident reported to the police between 2002 and 2012, ranging from 2 to 31 incidents. This is higher than the repeat victimisation rate of 61% all domestic incidents reported to police in Scotland 2012/13 (Scottish Government 2013). The higher incidence of repeat victimisation in this study is not unexpected as the study sample comprised women with children aged less than 5 years old. Research has identified a higher prevalence of abuse in younger women and the increased risk of abuse commencing or escalating in pregnancy and following childbirth (Barter et al 2009, DoH 2005; Taft et al 2004; Gielen et al 1994).

The Scottish Crime & Justice Survey conducted in 2012/13 found a slightly higher proportion of victims of domestic abuse disclosing repeat victimisation. Eighty three per cent of participants who had reported domestic abuse to the police in the last 12 months had previously done so. A higher proportion of repeat victimisation in a crime survey than in police reported data, utilised in the current study, is to be expected as a result of under-reporting. In addition, data in the current study sample is from a ten year period, whereas the crime survey asks about lifetime experience.

Bland & Ariel (2015) report 32% of female victims had previously been the victim in a reported domestic incident which is substantially lower than that in the current study. They defined a repeat victim as a person involved in three or more incidents in a five year period. The present study reported on two measures of repeat victimisation. The first was any victim involved in more than one incident in the 10 year period 2002-2012 which identified 79% of the sample. The second, calculated to identify contemporary risk factors, was any victim who reported more than 3 incidents in a two year period (2010-2012) which identified 42% of the sample as repeat victims (section 6.5.6). Again, the greater

incidence could be explained by the younger, childbearing sample in the current study as only a third of the sample in Bland & Ariel's study were aged between 18 and 29 years old and in the current study this age group accounts for 61% of the sample.

In the current study, repeat victimisation presented as a wide range of individual and irregular experiences, rather than a pattern of reporting. In many cases periods of months or years passed between incidents with insufficient data to suggest why this occurred. Bland & Ariel (2015) the accused also had a unique identifier which enabled analysis by dyads (couples). They found that of repeat victims almost a third had been the victim of different accused.

The literature on intimate terrorism and coercive control would suggest that incidents, even those separated by considerable periods of time, are linked (Stark 2010, Johnson 2008). Seemingly isolated incidents occurring months or years apart may be part of ongoing abuse, much of which is not brought to the attention of the police. Alternatively, they may represent all incidents of this type of abusive behaviour punctuating longer periods where the perpetrator uses other tactics of control and fear. The understanding of the dynamics of domestic abuse (Chapter 2) suggest that whether women experience additional unreported assaults over this period or not, they may live in a state of chronic fear (Pain 2013), compounded by emotional and psychological abuse (Stark 2010) which is less likely to come to the attention of police (Johnson 2008).

Ariel & Bland (2015) categorised dyads involved in police incidents by the most "harmful" incidents. Harm was determined by the length of custodial sentence awarded to the perpetrator. Dyads were categorised into three groups: "chronic couples" who report five or more incidents in a three year period; "intermittent couples" who report more than one but less than five times in a three year period and "Never called before couples" whose first and only incident is considered serious. The presence of "never called before" demonstrates that frequency of reporting is not a useful indicator of harm, as apparently isolated events pose high risk of harm due to use of severe violence.

Some women in this study had been involved in domestic incidents reported across the 10 year data range. The infrequent and irregular reporting may contribute to the health visitors' perception that incidents were isolated. However, analysis of more recent experiences of abuse, from 2010 to 2012, found a high incidence of women being

repeatedly victimised in this period. Within this shorter timescale, 42% of victims reported three or more domestic abuse incidents.   This suggests that even when individuals are brought to the attention of health visitors on a number of occasions in a relatively short period of time the extent of abuse is underestimated.

This study found evidence that health visitor service users rarely experience police reported domestic incidents as isolated events and it is not uncommon for women in this group to experience ongoing incidents over a period of years. This new evidence can inform assessment by health professionals and ultimately, improve recognition of the ongoing impact of current or former abuse on the health of women and children.

6.6.3 Nature of abuse

6.6.3.1 Incidents and Individuals

A strength of the current study is the description of victims' experience in police reported incidents over a 10 years period which more accurately represents women's experience of an ongoing pattern of abusive behaviours perpetrated against them.   When the analysis was conducted by individual, rather than incident, a greater degree of exposure to harm and risk of further harm emerged, demonstrating that the impact of abuse is underestimated when viewed as incidents rather than the experience of the individual. For example, in the current study an incident based analysis found that two thirds of incidents resulted in a crime being recorded but 87% of victims had been the victim of a recorded crime. Consistent with the findings of Robinson & Howarth (2012), the current study found that assessing the safety of women and children on incident by incident basis is likely to underestimate the harm which has already occurred and, as importantly, the continuing risk of further harm in the future. The findings of the current study support a holistic approach which looks at the families overall experience, rather than responding to individual incidents in isolation.

6.6.3.2 Nature of abuse

The VPD fields used to describe the nature of abuse in this analysis pertain to the use of violence, weapons and physical injury. These fields reflect the conditions under which women contact the police such as the need for immediate assistance or when they fear their lives are in danger (Richards et al 2008) and in no way aims to minimise the harmful effects of less frequently reported psychological or emotional abuse (Porcerelli et al 2005).

Police data does not routinely capture fear or psychological distress as a consequence of the incident and while this is a limitation of this data set, it is addressed in part in the third phase of this study conducted with service users (Chapter 7).

As discussed in section 5.8.1, it is difficult to quantify the seriousness of domestic incidents. Bland & Ariel (2015) used the Cambridge Crime Harm Index (CCHI) to assess harm. The CCHI uses the length of potential custodial sentence associated with each crime as a proxy of harm. Whilst this is a more considered approach than counting incidents it does not assess actual harm to the victim. Even so, Bland & Ariel (2015) conclude that the majority of domestic incidents reported to the police are "low harm" and a minority, 1.7% of their sample, were "high harm". In relation to domestic abuse an apparently minor or "low harm" crime such as a silent telephone call may result in considerable harm to the victim who is placed in a state of fear or alarm and so there are considerable limitations of this measure.

This study identified that in at least 1 in 8 domestic incidents which involved health visitor service users, the victim sustained an injury and that 40% of health visitor service users involved in police reported incidents had sustained an injury from a partner during an incident which was reported to the police. Incidence of injury to victim is not included in statistical reports produced by police in Scotland but the SCJS (2013) findings indicate that physical injury is a common experience for victims of abuse. SCJS respondents most commonly reported the following physical consequences of domestic abuse; minor bruising or black eyes (26%), minor scratches and cuts (16%) and severe bruising (8%). Participants in phase one of the current study reported that they seldom observed physical injury. This may be a consequence of the delay in health visitors' being made aware to the incident and making contact with women (section 5.8.1).

In the current study almost two thirds (62%) of victims had experienced physical abuse in police incidents. When compared to total domestic incidents reported to the police in Scotland for 2012/13 (Scottish Government 2013), this study found a similar rate of common assault (21% and 19% respectively) but a considerably higher rate of threatening or abusive behaviour (9.5% of national reporting and 28% of index incidents). Over a third of the total incidents in the current study sample involved intimidatory or threatening acts. Some of these incidents resulted in injury to the victim and therefore, must have involved some physical contact or possibly missiles thrown at the victim, although they

were not recorded as such. This inconsistency in the data demonstrates a limitation of secondary analysis. Secondary data relies on data fields designed to answer the original question which in this case, focussed on evidence of criminality. Further the inconsistency may result as an artefact of a data recording system which limits the number of incident descriptors entered. Alternatively this could be a consequence of victims' fear of consequences of disclosing assault (responder bias).

Only one of the 521 total incidents in the current study made reference to sexual abuse (0.2%). A similarly low incidence of 0.4% (n=248) of all domestic incidents reported to police in Scotland in 2012/13 related to sexual offences. Research suggests that the sexual violence is common in abusive relationships but disclosure remains low as rape and sexual assault remain taboo issues (WHO 2005, Krug et al 2002). In reported crime datasets this could be compounded through the recording process where sexual assault or rape committed by an ex-partner may not be recorded as a domestic incident and may not appear within the vulnerable person's database, creating an overall underestimate of the extent of sexual violence by current or former partner.

The findings of the current study demonstrate that health visitor service users often experience violence and intimidation during police reported domestic incidents. Forty per cent of women had sustained an injury at some point and the wider literature indicates that women will have further health needs as a result of this experience (Krug et al 2002). As the current findings relate to police reported incidents, the extent of violence and injury are likely to be an underestimate due to lack of visible injury, non-disclosure of violence or concealment of injury at the time of incident. In reference to the findings of phase one of the current study, the findings of this secondary analysis dispute the health visitor observation that incidents are frequently minor and relate to arguments rather than assault. Although a relatively small proportion of incidents resulted in injury, two thirds of incidents resulted in a crime being recorded indicating that police officers considered it to be a significant event.

6.6.3.3 Evidence of Crime

In two thirds of index incidents attending police officers found sufficient evidence of a crime. This is considerably higher than all reported domestic incidents in Scotland in 2012/2013 where only 50% of incidents resulted in a crime being recorded (Scottish Government 2013). The current study provides a valuable addition to these figures

through the analysis of previous reported incidents which show that 87% of the sample were victims of a recorded crime. This again demonstrates a greater impact on the lives and wellbeing of health visitor service users and their children than incident alone suggests and refutes the health visitors' observations in phase one that the majority of police reports were related to minor incidents.

6.6.3.4 Perpetrators of abuse - Ex-partners

In this study, the accused was an ex-partner in just under half of the index incidents (44%), the same proportion as that of all domestic incidents reported to the police in Scotland in 2012/13 (Scottish Government 2013). The accused was an ex-partner in just over half of the total incidents (52%) and although not directly comparable because of the time scales (10 years in the current data set and "since age 16" in SCJS), the SCJS also estimated that around half of those who experienced domestic abuse did so from an ex-partner. Whilst Bland & Ariel (2015) identified dyads, they did not detail if the couple were currently, formerly or had ever been in an intimate relationship. The significant proportion of abuse perpetrated by former partners, in the current study and in recorded crime statistics (both 44%), contributes to the understanding that exiting an abusive relationship does not end the abuse (Kelly et al 1999) and further challenges the belief that victims have control over their exposure to abuse (Hester et al 2009).   In phase one, health visitors responses suggested that exiting a relationship would increase safety and described a limited response in terms of safety and protection planning for women whether living with or separated from abusive partners. Phase one participants were also unaware of processes to obtain legal protection orders which may be of greater relevance following separation. Therefore, triangulation of findings from the first two phases of this study identified a gap in the current response to women who have separated from an abusive partner but remain at risk of further harm.

6.6.3.5 Perpetrators of Abuse - Female accused

This thesis is concerned with the response to female victims and so the inclusion criteria applied in the current study restricts inference on female perpetrators and male victims of abuse yet some observations are supported by the wider literature. Analysis of previously reported incidents found that almost a third of female victims in this sample (n=31) had been the accused in domestic incidents in the preceding 10 years.   Of the total incidents, 10% (n=52) had a female accused and male victim. However, each of the female accused

had been the victim in a police reported incident more often than they had been accused. This is supported by the work of Brooks & Kyle (2014), Johnson (2009) and Hester (2009), who conducted secondary analysis of samples of police recorded data in Scotland, USA and England & Wales respectively, exploring dual perpetrator incidents. They found that in relationships where both the male and female partner have been reported to the police, men are more likely to use violence and more likely to use it more often than women.

A third of the incidents with a female accused, the woman had also reported abuse from her male partner. These dual reports accounted for 6.5% of total incidents in this sample were counter allegations where both partners made an accusation of abuse about the other at the same time (section 2.2.1). This is similar to Brooks & Kyle's (2014) estimate that 5.4% of all police reported domestic incidents in Scotland are counter allegations. Counter allegations may contribute to the (mis)perception that incidents are arguments and that women are often equally to blame, rather than victims of abuse (for example *"They have a drink and they have a domestic"* section 5.6.3). Police officers and health visitors must consider women's use of violence in the context of the relationship, specifically if this is violent resistance to ongoing abuse from a male aggressor, situational couple violence or if the woman is the perpetrator of intimate terrorism (Johnson 2009). The findings of the current study indicate that the majority of women are more frequently victims in these incidents.

6.6.4 Alcohol and abuse

The relationship between alcohol and domestic abuse was explored earlier in this thesis (section 3.2.2). In the current study the accused had consumed alcohol in almost half of the index (46%) and total incidents (47%). Involvement of alcohol in domestic incidents is not routinely reported at a UK level (Foster 2014), however, the BCS (ONS 2015) reported that, victims of all violent crime estimated that the perpetrator had consumed alcohol in 48% of incidents. This was higher in Scotland, where the SCJS reported that perpetrators had been under the influence of alcohol in 59% of all violent crimes (violent crimes range from pushing to serious assault) (Scottish Government 2014c). As stated, few studies have explored the association between alcohol consumption and domestic incidents, most likely as a result of concerns that the findings of such research would excuse abusive behaviours (Foster 2014, Galvani 2004). That said, Gilchrist et al (2003) focused on alcohol and domestic abuse incidents in case records of 336 men convicted of

domestic violence in England and found that 62% of perpetrators had consumed alcohol at the time of the incident, again higher than the current study. Yet the findings of Gilchrist et al (2003) are not directly comparable with the current study as Gilchrist et al (2003) investigated incidents where a conviction had been secured where the current study used data gathered at the time of the incident. Potentially, incidents which result conviction may be more likely to be associated with alcohol consumption as this can increase the risk of more severe violence (Humphreys et al 2005).

In relation to phase one of the current study, focus groups participants stated incidents reported to the police commonly occurred while the couple were on a "night out" and away from home. (For example "*I had one* [incident]*; they were fighting in the street on the way home from the pub, there was an argument, the children weren't there"* (FG3P5)). In contrast, this secondary analysis identified that the majority of incidents (77%) occurred in the victims' home. In addition, survivors of abuse report that partners who are violent under the influence of alcohol are also violent when they have not consumed alcohol (Galvani 2004) and therefore, incidents which occur while the accused is under the influence of alcohol may indicate risk of harm at other times.

Therefore the presence of alcohol increases the risk of harm and does not reduce the likelihood that women are experiencing ongoing abuse. The findings of this study have a direct application in challenging perceptions about the influence of alcohol in domestic incidents.

6.6.5 Children's Exposure to Domestic Abuse

In the current study children were involved in, or aware of, a third of index incidents (31%). Overall 52% of victims had children who were involved in or aware of a domestic incident between 2010 and 2012. Once again this demonstrates the potential for an incident based approach to mask risks to children exposed to domestic incidents.

Involvement of children in domestic incidents is not routinely reported by police in Scotland. The researcher is not aware of other studies which have considered the extent of involvement of children aged under 5 in police recorded domestic incidents, therefore this study introduces new knowledge about the experiences of children in this age group. Findings of health visitor assessments reported in phase one of this study, that children were unaware of and commonly unaffected by, suggest that this finding on the extent of

children's exposure to domestic abuse is much needed to expose an unrecognised need for support and protection.

When compared to the findings of this study, the SCJS (2012/13) found a higher proportion of children in the home when domestic incidents occurred (67%) with almost three quarters of these children aware of, or involved in, the incident. This could be due to the inclusion of a wider age range of children (under 16 years old) and a longer time period (victim's adult lifetime) than the present study. Further, women's fear of losing their children and of being "policed" by social services can limit disclosure to statutory organisations such as the police (McGee 2000b). Therefore, recorded crime is expected to be lower than the SCJS which is collected anonymously for research purposes. In addition, the SCJS utilises a self-completion computer assisted package to ask about experiences of domestic abuse which has been shown to increase disclosure (Walby 2004).

6.6.6 Seeking Help and Engaging With Support

In phase one health visitors stated that women do not wish to engage with specialist services, do not wish support from health visitors and often do not name their experiences as abuse. In many cases this was perceived as confirmation that the incident was isolated and not indicative of ongoing domestic abuse. However, in this second phase of the research the majority of women (66%) had initiated the police contact themselves despite the barriers to reporting abuse, such as fear of the loss of their children or loss of control of their own situation (McGee 2000b), and a historic police response which had been described as "insensitive, unprofessional and ineffective" (Richards et al 2008 p10). In the current study, the extent of repeat victimisation and finding that 81% of victims had at least one indicator of risk for further abuse and 39% had three or more indicators of further abuse indicates that many women do have support and protection needs. Yet the findings of phase one suggest that very few women go on to seek help from health visitors. This may reflect the needs of women at that time who may only wish immediate police protection when they fear for their safety, or that of their children, but do not wish support when not in crisis.

Only 10% of survivors of domestic abuse had disclosed to a health professional compared to 21% who had reported an incident to the police (Scottish Government 2014b). Despite having a good relationship with their health visitor, survivors stated they declined to disclose abuse until their situation was unbearable or at a crisis point (Peckover 2003).

Calling the police can be one such crisis point and abused women may be more open to support at this time (Kelly et al 1999).

Only a third of calls to the police in the current study were made by witnesses, family, friends, neighbours or agencies. Without further contextual data it is not possible to speculate what prompted witnesses to contact the police. However, this finding does highlight that in a sizable proportion of incidents, victims have not sought help and so may not yet wish, or be able, to seek help from any agency. This reinforces the need for an effective response from universal services, such as health visiting, who may be the only source of support and information available (DoH 2005).

6.6.7 Strengths of the Current Study

The limitations of this phase of the study were introduced in section 6.4.5 of this chapter. On exploration of the literature, a further limitation of the data was the lack of information about the accused, which could have provided further insight to the relationships in which the police reported incidents occur by enabling analysis similar to that of Bland & Ariel (2015). Equally, this could be considered tangential to the original research questions and is more appropriate for consideration in future research.

A limitation of secondary analysis which affects both the current study and that of Bland & Ariel (2015) is a lack of opportunity to introduce alternative measures of harm such as asking victims to rate the seriousness of, or harm which results from, incidents. Limitations of the data set are anticipated to some extent in almost all secondary analysis research (Vartanian 2011). VPD data was originally gathered to aid crime detection and the focus of the data collector (police officer) was on the nature of the act and criminal intent rather than the context and consequences of the incident (Walby 2004). Importantly, the definition of domestic abuse used by police in Scotland is comparable with that used in this thesis in that a range of behaviours utilised by perpetrators (physical, sexual, psychological and emotional abuse), the intimate relationship between victim and accused (current or former partner) and the gendered nature of domestic abuse are all recognised (Scottish Government 2008a, Crown Office 2005). Therefore there is some consistency in the definition of domestic abuse between phases one and two.

Building on the findings of phase one (Chapter 5) this phase investigated the experiences of women involved in police reported domestic incidents, with children aged less than 5

years. The use of a randomised sample increases the likelihood of achieving a representative sample of women involved in police reported incidents and reduces the potential for researcher bias (Corrigan 2013). However, the findings cannot be generalised to all abused women as many never report their experiences. The characteristics and needs of this "hidden" group are unknown (Scottish Government 2014b, Wykes & Welsh 2009).

The sample was drawn from women living in a police force area coterminous with the NHS Boards that participated in phase one and so is geographically relevant to triangulate with findings of the exploratory study.

6.6.8 Triangulation

The findings of the current study are supported by much of the literature reviewed in Chapter 2 and the limited literature introduced in the discussion of this chapter. Comparison between the results of the crime survey, recorded crime and research data suggests that health visitor service users experience a higher incidence of threatening and intimidatory behaviour and are victims of a recorded crime more often than the general population.

This second phase refutes a number of assertions made by health visitor participants in phase one of this study, specifically that police reported domestic incidents are frequently isolated, minor events and do not indicate domestic abuse. Consequently, the results of this second phase of the study question the adequacy of the health visitor response, described in phase one, in relation to protection of women and children at ongoing risk of harm. Indicators of risk of further harm were present for the majority of women in this sample and the characteristics of incidents indicate that a considerable proportion of women involved in police reported domestic incidents are experiencing ongoing, domestic abuse from a partner or ex-partner. Therefore a duty of care remains for health professionals who encounter them. The integration of findings from all three phases of the current study is discussed in Chapter 8.

6.7 Conclusion

In conclusion, the findings of this analysis suggest that police reported domestic incidents are indicative of ongoing abuse. When considered alongside the findings of the

exploratory study in phase one this suggests that risk is not recognised by health visitors and may result in unmet support needs for women and children exposed to domestic abuse.

This is the first study to examine the extent and nature of abuse experienced by health visitor service users from police data. This study found that the majority of victims of police reported domestic incidents had been involved in previous domestic incidents and the majority of victims had indicators of further harm from domestic abuse. This study suggests that ongoing abuse and risk are present in the lives of many health visitor service users involved in police reported incidents.

6.8 Chapter Summary

This chapter described the methods and findings of a secondary analysis of routinely recorded police data relating to police reported domestic incidents which involved women with children aged less than five years old and so are eligible for the universal health visiting service.

This phase of the study found that the majority of police reported domestic incidents did not occur in isolation. A large proportion of the random sample of 100 women had experience of having weapons or violence used against them (62%); injury from an incident (40%) and children involved in or aware of a domestic incident (41%). Thischallenges the findings of phase one of this study.

The following chapter, Chapter 7, will describe the third phase of this study which aimed to further explore the nature and extent of abuse experienced by interviewing health visitor service users involved in police reported domestic incidents, to identify their support needs (if any) and gather their views of the current health visitor response.

7 Health Visitor Service User Experience of Police Reported Domestic Incidents and the Health Visitor Response.

7.1 Chapter Introduction

This chapter presents the third phase of this research. As in previous chapters the rationale, aims, research questions, study methods and findings are presented. The findings of this phase of the study are discussed in the context of the literature. Integration of the findings of all three phases of the study are discussed in Chapter 8 and conclusions and recommendations are presented in Chapter 9.

7.2 Rationale for Phase Three

The findings of the literature review and phases one and two of this study suggest that domestic abuse is often not identified by health visitors. As a result the potential contribution of health visitors to address support needs and reduce the risk of further harm to women affected by domestic abuse is not fully realised. Phase one gathered the views of health visitors who stated that police reported domestic incidents were not indicative of ongoing domestic abuse (Chapter 5). However, the findings of phase two, a secondary analysis of police data, support the limited evidence that the majority of incidents involved repeat victims and repeat perpetrators; that victims had frequently been physically assaulted and injured by partners and that children were often directly involved in the incident (Chapter 6). The third phase of this study aims to understand the nature and extent of abuse experienced by women involved in police reported incidents from the perspective of health visitor service users.

In phase one health visitors also stated that women seldom requested support following a police incident, reporting that women declined support because they were not living with abuse (the police reported incident was an isolated event) and therefore did not require additional support. They stated a minority of women who were living with abusive partners declined support because they were not ready to recognise or name their experiences of abuse or ready to exit the relationship. A further finding of phase one was health visitors' statement that they were no longer able to establish relationships with service users because of reduced routine visits and increasing workloads. Health visitors stated, women were less likely to disclose experiences of abuse as a result. Therefore, this

phase of the study also sought to understand women's experience of the health visiting service following a police reported domestic incident.

It was anticipated that the findings of this phase would complement the findings of phase one by confirming or refuting the suggestion of unmet need presented in Chapters 5 and 6. The findings from this phase of the study can be triangulated with the results of phase two to increase the trustworthiness of the overall study.

7.3 Study Aim

This study aimed to describe the nature and extent of domestic abuse experienced by health visitor service users involved in police reported domestic incidents in Scotland and to gather service user views on the health visitor response.

7.4 Research questions

The research questions for this phase were:

- What is the nature and extent of domestic abuse experienced by health visitor service users involved in police reported domestic incidents?
- What are the views of health visitor service users on the current health visitor response to women involved in police reported domestic incidents?
- What are the support requirements, if any, of health visitor service users involved in police reported domestic incidents?
- What are the barriers and enablers for engagement with health visitor support for women involved in police reported domestic incidents?

7.5 Methods

7.5.1 Study Design

The study design was described in Chapter 4. The current phase was a qualitative study which utilised individual face to face or telephone interviews to gather data from 17 health visitor service users who were involved in police reported domestic incidents.

7.5.2 Recruitment

7.5.2.1 Recruitment Through Health Visitors

The study aimed to recruit 20 health visitor service users living in the West of Scotland, who had been involved in a police reported domestic abuse incident

The recruitment strategy built on the researcher's relationships with practicing health visitors developed in stage one of the current study and previous professional roles. Health visitors were consulted at an early stage of the study design and agreed that this was an acceptable approach to adopt (section 4.6.3). A total of 30 practicing health visitors working in three NHS Board areas agreed to support the recruitment process and a protocol was developed (Figure 7.1).

In phase one of the current study health visitors reported that they each received between two and four notifications of police reported incidents per week and that they usually visited service users when they received this information. This enabled identification of potential participants and an opportunity to support recruitment with minimal disruption to health visitors' day to day work.

Inclusion criteria were women who had been involved in a police reported domestic incident in the preceding 3 months, were aged 16 years or older and fluent in English. Health visitors were encouraged to invite every woman they visited following a police reported domestic incident to take part in this research whilst using their professional judgement to assess the safety and appropriateness of discussing research at that time.

The researcher maintained contact with health visitors by email, telephone and attendance at regular health visitor team meetings to promote recruitment. Health visitors agreed to ask women to participate in the research but they anticipated that most women would decline and indeed, after four months only one participant had been identified using this strategy. The majority of health visitors stated that they had not identified potential participants for two reasons: the number of police notifications they received had reduced considerably and they had not had privacy to discuss the study with women.

On receipt of Police Notification of Domestic Abuse Incident:

Will you visit the woman at home?	**NO** - No further action required for research

YES
Is woman:
Aged 16 or over
Able to consent to study participation
Able to communicate in spoken English
Do you think it is appropriate to advise her of the study?

NO TO ANY OF PREVIOUS QUESTIONS - No further action required for research

YES TO ALL ABOVE
At the end of the visit:
Describe study to woman (Notes below)
Seek permission for researcher to make contact

NO, permission not given - No further action required for research

YES, Permission given
Pass contact details to Clare McFeely
Tel 0141 330 4053 or
clare.mcfeely@glasgow.ac.uk

Example of study description:
"One of the reasons I visited today was because your recent incident with the police.
There is a researcher, Clare McFeely, working in this area at the moment. She is trying to find the best way for us to respond to women after these reports. People who take part would be interviewed for about an hour in a place and at a time that suits them. Travel expenses and transport can be arranged if required.
Clare works for the University of Glasgow, not the health board. Anything you say in the interview will be confidential; I won't know how you respond to the questions.
 It is entirely up to you if you choose to take part and whether you take part or not, the care that you receive will not be affected.
If you would consider taking part, I will send your details to Clare who can make contact and tell you more about it. Could I pass your details to Clare?"
If agreement:
"What is the best way / time to contact you?

Figure 7-1 Health visitor protocol for recruitment of service users

Health visitors could not explain the reduction in notifications. Some health visitors reported that they had not received any notification in months but had not investigated why this was the case. The researcher contacted senior managers in each of the three NHS Boards supporting the study and was advised that the protocol for sharing information on police reported domestic incidents with health visitors had not changed. Senior managers in NHS Boards were not aware that there had been a reduction in notifications of police reported domestic incidents to health visitors and did not know why this had occurred. The second issue, a lack of privacy to discuss the research, suggests that health visitors were unable to discuss the police reported incident to any extent and to assess the woman's safety and support needs. This is an important finding and is explored in Chapter 8.

The researcher continued to encourage health visitors to identify potential participants and extended the inclusion criteria from women who had been involved in a recent (within three months) police reported incident to include women who had been involved in a police reported domestic incident in the preceding 12 months with whom the health visitors maintained contact or felt comfortable approaching to discuss the research. In addition, the study design was amended to involve the specialist domestic abuse agency, ASSIST, in the process of recruitment (section 4.8.5). Ethics committee approval was obtained to alter the recruitment strategy and to extend the data collection period. A protocol, similar to that agreed with health visitors was implemented (Appendix 7.1).

7.5.3 Participants

7.5.3.1 Health Visitors

There is no mechanism within NHS Boards to record the number of police notifications made to health visiting teams and so it is not possible to estimate how many potential participants there were during the data collection period. During the 11 month recruitment period health visitors identified six potential participants, four of whom were identified by a single health visitor.

7.5.3.2 ASSIST

From the period 1st April to 31st May 2013 the researcher identified 191 women with children aged under 5 years old who had been referred to ASSIST following a police reported domestic abuse incident between 6 and 12 month previously. Of these, ASSIST workers excluded women who had been involved in subsequent incidents; for whom they

were aware of other issues or concerns; those who did not answer calls on the first or second attempt and those who declined to speak with the researcher. To minimise the burden ASSIST workers were only asked to record the details of women who agreed to be contacted. Data is therefore not available on the reasons that ASSIST workers excluded women from the study. Anecdotally, ASSIST workers advised that very few women that they established contact with declined to hear more about the study. They identified 23 women who agreed for their details to be shared with the researcher.

7.5.3.3 Completed Interviews

In total, contact details of 29 women were passed to the researcher from ASSIST (n=23) and health visitors (n=6) in the period 1st April 2013 and the 30th May 2014. Of these 17 participated in interviews. In some cases (n=7), the researcher was unable to establish contact with the potential participants for an initial discussion about the study. The researcher attempted to make contact with women on three separate occasions, calling at different times and on different days and if women had specifically advised it was safe to do so, leaving voicemail messages. Twenty two women agreed to participate in interview but 4 were not available at the arranged time and one woman was unwell. Of the 17 participants, 10 took part in face to face interviews and seven in telephone interviews. Table 7.1 details participants by NHS Board area and interviews type and participant recruitment is illustrated in Figure 7.2.

NHS Board	Face to face Interviews	Telephone Interviews	Total
Board 1	2	5	7
Board 2	6	0	6
Board 3	2	2	4
Totals	10	7	17

7-1 Participants by NHS Board and interview type

```
┌─────────────────────┐
│ 29 women agreed     │
│ researcher could    │
│ contact them        │
└─────────────────────┘
         │          ┌──────────────────────┐
         │          │ 7 did not answer the │
         ├──────────│ telephone            │
         │          └──────────────────────┘
┌─────────────────────┐
│ 22 agreed to take part │
│ in interview and    │
│ arranged time and   │
│ location            │
└─────────────────────┘
```

┌──────────────────────────────────────┐
│ **4** women were not available at time of │
│ interview (3 telephone and 1 face to   │
│ face)   │
│ **1** woman was unwell at time of   │
│ interview and possibly under the   │
│ influence of alcohol so telephone   │
│ interview not completed   │
└──────────────────────────────────────┘

```
┌─────────────────────┐
│ 17 women completed  │
│ interview           │
└─────────────────────┘
      │
 ┌────┴─────┐
```

┌──────────────────┐   ┌──────────────────┐
│ **10** face to face │   │ **7** telephone   │
│ interviews   │   │ interviews   │
└──────────────────┘   └──────────────────┘

Figure 7-2 Recruitment summary

The mean age of participants was 26 years old (range 18 to 39 years). The majority of women were aged between 20 and 29 (n=10), five were aged 30 – 39 and two women were aged 18 or 19. Participants had between one (n=10) and four (n=2) children. All participants were white and were born in the United Kingdom. Three participants lived in remote areas. The researcher assigned a pseudonym to all participants during data analysis. Participant details are summarised in Table 7.2.

All but one of the women had separated from their partner at the time of interview. One had never co-habited with her partner. Following the police reported incident she separated from her partner but they subsequently reconciled.

Woman	NHS Board	Recruited through	Age	Type of interview	Children	Ethnicity
Anna	2	Health Visitor	19	Face to face	1	White Scottish
Beth	3	ASSIST	35	Telephone	2	White Scottish
Caroline	1	ASSIST	24	Telephone	1	White Scottish
Debbie	1	ASSIST	30	Telephone	1	White Scottish
Emma	2	ASSIST	22	Face to face	1	White British
Fiona	1	ASSIST	18	Telephone	1	White Scottish
Grace	3	Health Visitor	39	Face to face	3	White Scottish
Helena	2	ASSIST	25	Face to face	3	White British
Irene	3	ASSIST	20	Telephone	1	White Scottish
Jenny	1	ASSIST	21	Face to face	1	White Scottish
Kate	2	ASSIST	28	Face to face	2	White Scottish
Lynne	1	ASSIST	20	Telephone	1	White Scottish
Maria	1	ASSIST	36	Face to face	4	White Scottish
Nicola	3	Health Visitor	27	Face to face	3	White Scottish
Olivia	2	ASSIST	27	Face to face	3	White Scottish
Pauline	2	ASSIST	22	Face to face	1	White Scottish
Rachael	1	Health Visitor	33	Telephone	1	White Scottish

7-2 Summary of participants' characteristics

7.5.4 Analysis

Codes which were similar or contrasted with one another were grouped together in categories. From these sub themes were identified. Ultimately two overarching themes emerged as "Living With and Leaving Domestic Abuse" and "Service Responses to Domestic Abuse". Within these are six sub themes which are detailed in Table 7.3.

There were striking similarities in participants' stories and no new concepts emerged after interview 14, therefore the researcher judged that data saturation had been achieved. Interviews adhered closely to the interview schedule (Appendix 4.2) and consequently the findings are presented in themes which closely reflect the research questions.

Themes	Sub -Themes	Example Categories
Living with and Leaving Domestic Abuse	Nature of Abuse	Violent, Psychological Involvement of Children Duration
	Experience of Abuse	Impact on Women (stigma, fear, health) Impact on Children Awareness of Abuse (Women aware or unaware; reframing, resistance) Disclosure of abuse and barriers. Exiting abusive relationship and barriers
Service Responses to Domestic Abuse	Health Visitor Responses - Positive	Practical support Regular contact Personal interest
	Health Visitor responses - Negative	No relationship between health visitor and service user Child focussed (child protection) Biomedical focus (exclusion of parenting advice) Lack of support regarding child contact (impartiality) Lack of support for women's health needs
	Responses from other agencies	Social Work ASSIST Police
	What women want from HV response	To be asked about abuse and to explore relationship dynamics Support to discuss abuse with children Confidentiality To hear about other women's experience Awareness raising

7-3 Summary of phase three themes

7.6 Findings

7.6.1 Overview of Findings

In this section the study findings will be presented by themes and sub themes. Despite the geographical distribution of service users in this sample the majority of women described similar experiences and consequences of abuse. They also shared similar concerns for their own well-being and that of their children and reported similar responses from health visitors.

At the beginning of the interview, when women were reminded that participation was entirely voluntary, it was suggested that if they did not wish to respond to any question they could say "next question" and the researcher would move on. Similarly they were asked to inform the researcher if they wished to end the interview at any point. None of the participants declined to speak about their experiences or expressed a wish to end the interview before all the questions had been asked. Although participants described difficult and often traumatic situations they were not obviously upset during the interview and following the interview all stated it had not been unduly upsetting and with hindsight would still have agreed to participate in the current study.

Face to face interviews lasted between 60 and 90 minutes. Telephone interviews were considerably shorter lasting between 20 and 30 minutes. All participants consented to interviews being recorded. In practice the telephone interviews yielded less information than face to face interviews. Participants in the first three telephone interviews provided brief responses and subsequently all women were offered a face to face interview in the first instance with the option of a telephone interview if they preferred.

7.6.2 Living With and Leaving Domestic Abuse

This theme encompasses women's descriptions of their experiences of abuse. In interviews, women were asked about the most recent police reported incident and then about their partners' behaviour throughout their relationship. They were not asked direct questions about their experiences of different forms of abuse (physical, sexual, emotional) therefore, women may have experienced a wider range of abuse which was not disclosed in the interview.

7.6.2.1 Nature of Abuse

Sixteen of the seventeen women who participated in interviews reported experience of a range of abuse and all but one of the women in the sample (n=16), Anna, reported being physically assaulted by their partner. Anna stated that although not physically violent her partner used continuous threats of violence and was psychologically and emotionally abusive in an attempt to control her behaviour.

> Anna: "He always said to me that he would never hit me, but the look on his face when he was angry, it made you think "he is going to hit me", but then he never did. He made me think because he wasnae hitting me that everything was alright. He made me think it was just words, he's not actually hurting me so he's not did anything wrong."
>
> Researcher: "Were you afraid?"
>
> Anna: "Aye, he made me scared to leave him because he threatened me. "If I ever see you with anybody else, I'm gonnae batter him, I'm gonnae batter you in the street.""

Several of the women described incidents of extreme violence. Nicola, a 27 year old woman with three children described the progression of her partner's abuse from psychological abuse to life threatening physical assault.

> "First of all it started with the odd kind of hitting and spitting and name calling it was more ehm mental abuse for the first 8 years. When that wasn't working any more that's when hands kind of started to get lifted but as I said the main incident was a weekend that he'd been away and it was quite intense. I ended up in hospital for 4 days and got brain scans and the children were there, the children were always there when these incidents were happening." (Nicola)

Women who had experienced extreme violence appeared comfortable talking about this during the research interview but did not present this as the worst aspect of their experiences. Physical assaults were often disclosed after women described their loss of self-confidence and a sense of hurt, betrayal and shock. Lynne stated that prior to the police reported domestic incident her partner had never been violent or aggressive but first "kicked off" when under the influence of alcohol. She was shocked when he assaulted her

and her response suggests that the emotional impact of the assault was greater than the considerable physical harm which resulted. When asked if she was hurt she replied:

Lynne: "Yes, I was hurt that he would do that, I didn't think he was that kind of person."

Researcher: "Were you physically hurt?"

Lynne: "A black eye, concussion, bruised ribs and bruises all over my body and I had a cut on my arm. He locked me out of the house and took my daughter off me and told me he was going to hurt her."

Like Lynne, other women described being physically separated from their children during an assault. This created even greater anxiety as women were afraid that their children would be harmed by their partner or, if left alone in the home or a room, could come to harm without supervision. Emma recalled being afraid of serious injury during a violent assault from her partner but her primary concern was the safety of her child. In one incident her partner dragged her from their flat and threw her down the concrete steps. She stated:

"It was terrifying, especially knowing that my baby is in the house and I'm getting flung about all over, so it was horrible, horrible, horrible." (Emma)

All participants described psychological abuse including threats, undermining of their self-confidence, attempts to isolate them from family and friends and controlling behaviours such as telling women what to wear and when they could leave the house.

"[Ex-partner would say] "You're fat and you're ugly and your family's the same. Your maw and your sister they're fat and ugly" all of that rubbish. It happened for a long time and everybody else realises round about you. I got rid of all my pals. [He'd say] "I don't like her, don't talk to her anymore" and I didn't. [He'd say] "You used to go with her brother so you can't talk to her anymore, because you'll end up back with him" or ehm, "You're too close to him as a pal. I don't believe that's just a pal, don't talk to him anymore." So I ended up with naebody." (Anna)

Emma lived in a small town with her partner and first child. She described her partner controlling her movements and effectively preventing her from leaving their home for a month following the birth of their daughter. Despite the fact that she was physically well he insisted that she was not fit enough to go out.

"I felt controlled, I felt you know, I couldn't go out, I never took [daughter] out until she was nearly a month old cause I wasn't "well enough". So, you can kind of see how controlling he was over me. I was absolutely fine. I wanted to go out and show the world my baby but he was constantly at me you know, "You aren't well enough, you just need a few more days."" (Emma)

Some participants described the considerable effort their partner invested in psychological abuse. In interview Nicola described years of psychological and physical abuse from her long term partner and father of her three children. She stated that her partner's behaviour could be erratic and manipulative and described the negative effect of this on her mental health and self-esteem. She also shared examples of him consistently criticising her by placing the blame for their relationship problems on her, actively undermining her self-confidence, her ability to parent or threatening, and using, violence.

"There were times when he would say "I'm going to kill you" but he would try and put it into my head for me to go and do something silly so like he would always say "You're a nut job, nobody wants you here" like he was trying to push me to do the dirty work for him so he could go "See I told you it was all her".....I would sit and contemplate suicide. I would never go ahead but I would sit and think "Yes, he's right, I've changed, I am a nut job. Why do I give him a hard time? Would my kids be better off without me?" You know? It was really, really intense psychological stuff." (Nicola)

Women also described intimidation and fear as a result of more subtle threatening behaviours. Maria experienced domestic abuse from an ex-partner, the father of her two older children aged eight and twelve at the time of interview. The abuse continued sporadically in the seven years since they separated. At the time of the interview Maria lived with her daughters, her new partner and their two young children. In the months preceding a report to the police Maria's ex-partner had seriously assaulted the younger of his daughters and then stopped all contact with the family. After a period of months, he

unexpectedly left flowers at the family home addressed to his older daughter. Both Maria and her daughter felt that the message was "morbid". They believed the flowers were meant to frighten them and contacted the police. "The message was more like you've just died, like [daughter] had died and it was like "you're always in my heart"." (Maria)

The response of both Maria and her daughter suggests that this is the most recent in a campaign of behaviour to intimidate and frighten the family. Another example of intimidating behaviour was given by Rachael. Rachael lives in a remote area and had been in a relationship with her abusive ex-partner for over 10 years. Her partner was considerably older than her and had exhibited controlling and possessive behaviours from early on in their relationship, becoming violent in later years. Following separation Rachael had moved to a new home with her four year old son. She described an incident where her ex-partner requested entry to her new home which she initially denied. He then requested access to the toilet stating it would be unreasonable for her to deny this. She allowed him to come in but he went to her bedroom and lay on the bed.   Although he tried to present this as a joke, Rachael perceived this as a violation of her personal space. She felt uncomfortable, intimidated and that his intention was more sinister.

"When I first moved in to the new house he would do the stupid things like lie on my bed….. when he was meant to take [son] and 'cause of course he moved out and he was like 'oh, I haven't got a proper bed' do you know? He was doing it as a joke but it was so, I don't know, it was done to provoke you know what I mean? It was done like a "I can still get you. I mean it's your bed but yes I'm here" you know that kind of thing." (Rachael)

Helena, a mother of three young children, was one of only two women in this sample who spoke about experience of sexual abuse from her partner. She described him using sleep deprivation to coerce her into having sex.

"Sometimes my ex, he used to force me to have sex with him because he would keep me awake. I wouldn't be allowed to sleep for three, four nights because he'd keep me up talking about how he wanted to have sex and he'd keep me up arguing about it until eventually I would fuck him, just to make him let me sleep. That was rape, that was forced sex, he was basically making it to where I had no choice out of sheer exhaustion." (Helena)

Grace, a mother of four children described her partner's deliberate and considered physical assaults and his attempts to place the blame for these incidents onto Grace. Grace had sustained an injury and lasting impairment in one of her ears following a violent sexual assault when she was a teenager. She stated her partner purposely targeted this area when assaulting her and saw this as evidence of his calculated intent to hurt and indeed, punish her rather than an uncontrollable outburst.

> "So like he was pulling on my left side, no sorry the right side on my ear which did cause me pain, and he knew that and sometimes there's more thought there with these people [abusive partners] especially if you open up about your past partners and stuff like that. My mum told me play your cards close to your chest, man I've learned that lesson." (Grace)

> "[After an assault] I've obviously passed out, the next thing I got up just packed my bags, grabbed my stuff and I heard him outside on the phone to my mum saying I'd OD'd [overdosed] "she's taking hundreds of pills" so that's the only reason I'm passed out. He's locked me in and he's at the neighbours saying "she's a psycho, she's mental" you know." (Grace)

Examples of partners' use of children through physical involvement in the incident or through threats to harm them recurred throughout women's accounts of abuse. As seen from the examples already provided this manifested in a number of ways including physical separation of the mother and child (Emma), a direct threat to harm children (Lynne) or indirect intimidation (Maria). Threats to children were both subtle and explicit.

> "He pled guilty [in court] to the threatening texts he sent to me and the kids, it wasn't just me, it was me and the kids." (Olivia)

Grace described her daughter's use of violence in an attempt to protect her mother following an assault during child contact.

> "Due to [child] contact he had an opportunity for assault…. He smashed my head of the cooker, it wasn't on, and tried to strangle me again. I went out the front [of the house] in broad daylight and my wee girl is 10 years old and she's out there. I

saying on the phone "he's trying to kill me again". He is outside saying "she's mental". When he went to walk in the front door my girl picked up a swing ball and she smacked it across his head cos she knew that there was abuse going on." (Grace)

Rachael shared a number of examples of her partner using child contact as an opportunity to continue to contact and abuse her. In one example Rachael described a distressing incident where her ex-partner's actions first placed her son and then Rachael herself in immediate physical danger which resulted in fear and distress for both.

"I went to open the door to take [son] out of the van, I opened the door and took his seatbelt off and [partner] then started driving the van. So I thought my son was going to fall out. I couldn't shut the door because the handle was kind of out the door….so I was kind of running on the outside of the van, you know what I mean, really stupid. He then stopped the van and screamed "I'll fucking kill you" and jumped over the top of our son and grabbed me by the hair and threw me on the ground so obviously we ran off from him again and phoned the police." (Rachael)

Women stated that their partners demanded to spend time with their children as a way getting access to the women, not their children. Hand over times presented opportunities for partners to continue to intimidate and abuse their former partners. Jenny reported feeling uncomfortable with her partner in her home and, with the services of a lawyer had arranged for handover of their child to take place in a safer setting.

"It used to be here [Jenny's home where handover took place] but then he got pure creepy and tried to touch me and stuff so I phoned my lawyer and said "I don't want him back in my house" so we had to meet up somewhere local so he couldn't try anything." (Jenny)

Beyond the hand over times women stated that partners would use access to children to continue abuse and control them for example, saying they would look after the children but cancelling if the woman made plans of her own. For example, Jenny described her partner showing little interest in their child or little concern for her safety but instead attempted to engage with Jenny herself. For example Rachael stated that when her ex-partner has their

son *"he spends more time on the phone to me and coming round to the house to pick things up than he does with his son."*

For all but one participant the police reported incident occurred in the context of continuing abuse perpetrated by their partners.

> "There was one [assault] reported but it happened multiple times before that."
> (Fiona)

For two women the incident which was reported to the police was the first incident of abuse and one woman, Caroline, described it as "coming from nowhere". Caroline stated that she and her partner had "argued" but he had never been violent before the police reported domestic incident. She separated from her partner immediately but stated that she was on good terms with her ex-partner. Caroline participated in a telephone interview and gave very brief answers to a range of questions but the researcher did not perceive that Caroline was uncomfortable during the interview. Caroline stated that until recently she had maintained regular contact with her partner through child contact. Child contact was subsequently stopped by social work due Caroline's ex-partner's other criminal behaviour but the nature of this behaviour was not disclosed.

The second woman, Lynne, contacted the police during the first violent assault. She stated that she had not experienced psychological abuse prior to this incident but following the incident received threats, was harassed by her partner and felt afraid of him.

> "[After first incident] He got granted bail on the condition that he didn't contact me and he contacted me and got arrested again, granted bail and then he got six months in the jail but only done three….I'm terrified cause he's been in the village I stay in, I've seen him quite a few times since then, that's why they [police] are installing an alarm for me." (Lynne)

Two women in this sample had been contacted by police regarding their experiences of abuse from ex-partners. Pauline was not involved in a police reported incident whilst in her relationship but was approached by the police when her ex-partner's subsequent partner reported abuse. She then described the abuse she had experienced and formally reported to the police with support from police officers. Grace stated that she had sought

help from the police whilst in an abusive relationship but received a disappointing response and did not contact the police during subsequent assaults. She was also contacted when her ex-partner assaulted another woman.

For the vast majority of women who participated in interview, the police incident was one of many incidents perpetrated by their partner or ex-partner. Within this relatively small sample two women disclosed lifelong experiences of abuse including physical and sexual abuse in childhood, rape and domestic abuse.

7.6.2.2 Experience of Abuse

This sub theme captures the women's perceptions of the impact of abuse on their own lives and those of their children; their experience of disclosure, help seeking and of exiting the abusive relationship.

- Impact on women

Participants described the negative health impact of living with domestic abuse. Women rarely reported ongoing problems with their physical health even when they experienced physical assault which resulted in loss of consciousness or required hospital treatment but occasionally referred to scarring.

> "I came away with two black eyes every now and again, most of bruising was around my neck when he strangled me, there was few times when I did think he was actually going to kill me when he wouldn't let go but I've got a scar on my head now there for where he kicked my legs away and I hit my head of the radiator and it bled for a long time. Ehm, there was another time where he split my eye open I've got a wee scar I can't remember exactly one of them ehm with my handbag it caught my eye I think that's the two major ones." (Pauline)

Most women reported some deterioration in mental health such as stress, anxiety and depression as a result of their experiences. Four of the women stated that they had experienced post-natal depression. However, as the women were also caring for a young child or children, they often found it difficult to know what would feel "normal".

"[I was] maybe tired obviously 'cause I was very worried about everything and ehm I didn't suffer from post-natal depression or anything like that, no I mean I was I was obviously very stressed out you know and obviously with a new born kind of suffer lack of sleeping and things like that. Probably escalated things for him as well I suppose." (Rachael)

Women described the stress of living with an abusive partner and of the stresses which followed separation. They described stress related to concerns about their partners' ability to care for their children when they had unsupervised access following separation.

More often women described the negative impact of abuse on their self-confidence and self-esteem. This was frequently accompanied by substantial weight loss. Four of the women stated they lost a considerable amount of weight as a result of stress and declining self-esteem. This was noted and commented on by their friends and family but rarely by health visitors.

"He used to call me fat and stuff. I went right down to size 4. Originally I'm size 10, I'm back up to my normal size now but that took me a whole year to put back everything on again." (Jenny)

Two women talked about use of alcohol and non-prescription drugs as a coping mechanism. Of these, one woman reported a lifetime of abuse and associated alcohol and drug misuse. The second woman described using alcohol as a comfort but also consuming alcohol and illegal drugs in an attempt to manage her partner's abuse. Nicola stated that when her partner went out with friends he consumed large quantities of alcohol and non-prescription drugs and his behaviour was often unpredictable, frightening and violent when he returned home. In order to encourage him to stay at home, reduce his alcohol intake and ultimately reduce the likelihood of abuse, she consumed alcohol and non-prescription drugs to "keep him company" and encourage him to stay in with her.

"It was like my coping mechanism was drink, a bottle of wine, a glass of wine just and sometimes when he was taking drugs I would just to keep him happy and keep him in." (Nicola)

During interviews women most often described the impact of abuse in terms of their recovery. For example, they discussed rebuilding confidence and social supports after exiting the relationship. There was a clear indication that this had been lost during the relationship as a result of partners' behaviour. For most of the participants the distress, trauma and fear they experienced while living with abuse had a greater impact on their mental health in the longer term. Whilst only a few of the women had been diagnosed with depression, almost all reported some psychological consequences. This was not reflected in the health visitor focus groups in phase one of this study and will be discussed further in section 7.7.

- Impact on children

The impact of domestic abuse on children is well documented and was explored in section 2.3 and 3.2.4 of this thesis. In interviews women reported that their children were often witness to or directly involved in the incidents. Nicola stated that her ex-partner was more violent when their children were present. In one incident, as she lay on the floor following an assault he told one of their children that he was going to murder their mother stating "*I'm going to finish your mummy off.*" Nicola felt that as a result of this particular incident, this child had required greater support than her siblings to recover from these experiences and, at the time of interview, continued to attend specialist counseling. Grace described one incident where her baby, who was lying beside her on the couch, was crushed by her partner while he raped her.

> "He went to sit on me but I drew my knees up so he ripped my leg out the way and sat on the baby." (Grace)

Women described the wide ranging impact of exposure to abuse on their children's health which compromised their lifestyle and wellbeing. While some women stated their children were upset or distressed after observing an incident, the majority of women reported few direct consequences for their children. Three women stated that their children had behavioural problems, two of whom directly attributed this to their exposure to domestic abuse.

Women also provided examples of indirect impact of abuse on children's health. Helena's partner had forbidden the immunisation of their children despite Helena's wish for this to

be done. Olivia stated that she was so afraid that her ex-partner would attempt to make contact with their children she only allowed them to play in the garden, not in the street or at the homes of friends and would only allow them to walk somewhere if accompanied by herself or her mother. This considerably restricted her children's opportunities to socialise and exercise, and her own freedom.

> "When his bail will be done he'll approach me or approach the kids. But the kids have hardly been out. [Daughter] goes to nursery and back I'll maybe take them out once a month if I'm feeling brave enough." (Olivia)

- Awareness of abuse

For many women their partner initially used psychological abuse and controlling behaviours. If partners used physical violence they would attribute this to a specific situation. As with the model by developed by Kelly et al (1999) (section 2.2.4) women stated that they did not always recognise these experiences as abuse and were not aware of the impact of the experience on themselves and their children or the risk of further harm.

> "He isolated me from my family. I didn't speak to my mum and dad….If I went out I had to take my kids with me but at the time it was just, I thought it's just normal. I didn't get that [it was controlling]at all. I was isolated, I lost a lot of weight, I looked dreadful, I looked really ill but at the time it was just, I just thought it was nothing [laughs] I just thought it was nothing, just thought it was people trying to break my relationship up." (Olivia)

Beth was physically assaulted by her ex-partner when he brought their daughter home after an access visit. She stated that at the time she "didn't think it was a big thing". The following day her daughter walked into her nursery and announced that "her dad hit her mum". The response of her daughter and those who heard the disclosure made her re-evaluate the incident.

Some women stated that discussions with ASSIST workers had enabled them to reflect on and often to reframe their relationships prior to the police reports (as described by Kelly et al 1999, section 2.2.4). For many, this supported reflection resulted in women recognising

and naming their partner's behaviour as a pattern of control and abuse or to move between the stages of Kelly's model.

> "It wasn't until ASSIST got involved when I realised it was all mental abuse." (Kate)

The majority of women reported that they knew their partner's behaviour was not "normal" or acceptable.

> "You know, I could see it after the first beating. I could see this is not right, this is intense, this could happen again." (Nicola)

Nicola stayed with her partner for a further four years after the initial violent assault, requiring hospital in-patient treatment for her injuries on four occasions.

Kate also recognised that her partner's behaviour was unacceptable and had planned to leave when she became pregnant with her second child. She had planned to live with her parents but felt unable to do this with a second child and with nowhere to move to felt she had to remain with her partner.

> "I had had enough actually, I was going to leave him and stay with my mum when I found out I was pregnant with my wee girl." (Kate)

Another woman, Debbie, stated that her friends noted, and had concerns about, her partner's overly attentive behaviour from early on in the relationship. She had also noted this and had discussed it with them where they joked that his behaviour would escalate to abuse.

> "Yes, that was the first time it [violence] happened but I could see the way he was going on he was quite intense, for just meeting me and stuff like that."(Debbie)

Although aware of the abuse some of the women felt unable to leave their partner immediately but gave examples of attempting to manage their partner's behaviour and to resist the control. For example Helena's husband wished her to have more children. She had already started to plan her escape from the relationship and did not want another child

and so attended her General Practitioner (GP) for long acting contraception without her husband's knowledge.

Anna described her partner's behaviour developing into a pattern where he would exclude Anna and their baby daughter from the family home for periods of time.   This involved disruption, anxiety and upheaval. Anna stated that she could be "spiteful" in response to this exclusion but this could be perceived an attempt to exercise some power or agency in a situation where she had little control.

> "When I was living there it was like packing everything up and piling it into the car, then moving my stuff out and then moving it back, out and back and out and back. It was everything but I could be quite spiteful as well when I moved out because he never bought anything for the house. Food, I bought it. Toilet paper, I bought it. Everything, cleaning products, I bought it. So when I left I took it all wi' me. I didn't even leave him with a bit of toilet paper to wipe his backside. I took it all wi' me. At one point I even put a roll of toilet paper down the toilet just to be spiteful. And I thought that was me getting even but it wasnae. "(Anna)

Helena and Anna's action demonstrate resistance within the relationship when immediate exit does not appear to be a feasible option for them. In contrast to health visitors' observations in phase one of this study the majority of women were aware of domestic abuse or were willing to reflect and identify this in their lives.

- Barriers to Disclosure

Participants in this study identified stigma, fear of their partner, fear of losing their children, fear of losing control of the situation and concerns about confidentiality as barriers to disclosing abuse and engaging with supports. These will now be explored in turn.

- o Stigma:

Jenny , a young woman living a small village, stated that she was reluctant to tell anyone about her experiences because she would be judged and blamed for allowing the abuse to happen to her. Similarly Kate, living in an urban environment, expressed concerns about labelling as a "victim" and a sense of shame associated with that.

"I don't want tae walk about and let people think "oh aye you're the idiot that let her boyfriend walk all over her."" (Jenny)

o Fear of losing their children:

A recurring theme in the literature and the current study is women's concerns that they will lose care of their children. Often this was compounded by lack of trust in statutory organisations and concerns about confidentiality (discussed later in this section).

"The social work, you couldn't really talk because you knew what they were doing. It was just like you knew that they were there to make sure you were capable of looking after your baby and it's quite daunting." (Anna)

Throughout interviews women identified concerns that their children would be removed from their care. Women were told by partners, relatives and by professionals that if they lived with domestic abuse their children could be removed from their care. This created a significant barrier to disclosure and following disclosure remained a major cause of anxiety for women. Often women were too afraid to ask about this and so their anxiety persisted. Fiona stated that she was afraid her son would be taken from her in her initial visit from the health visitor. She asked about this and was immediately reassured by the health visitor who stated she was "a good mum and there's no worries." Pauline described a positive response from ASSIST when her parents told her she may lose care of her child.

"Like a lot of time I used to blame myself for it, like not for what he done, nobody should be blamed for that, at the end of the day it's their fault and problem but it's the fact that I stayed for so long, knowing, because when my mum and that found out they were like " if social work got word that you were there and they knew everything they would take your child off you." I was like, "well maybe I shouldn't have stayed with him I wouldn't want them [children] taken off me" and [ASSIST worker] is like: 'no, but that's not true, they will help you, they cannot take your child off you for that unless they think your child is in immediate danger" ….but they were good at that, when you feel you're not alone kind of thing." (Pauline)

o   Fear of the Perpetrator:

Women feared that their partner would become aware of their disclosure and they would suffer violent repercussions. Fiona, the youngest woman in the sample (18 years old) was assaulted by her partner, the father of her child, in the street. The assault was witnessed by a neighbour who called the police. Although there had been police involvement, Fiona had not willingly made a disclosure and denied experience of abuse in discussion with a health visitor.

> "There was just the fear of telling and [partner] finding out because I couldn't even say to my friends or my family….the punishment would have been 10 times more than before". (Fiona)

o   Concerns about confidentiality:

Concerns about confidentiality significantly inhibited women's willingness to disclose experience of abuse or seek help. These concerns predominantly related to information sharing about child protection and the risk of partner's discovery of discloure. Some women were aware of routine information sharing between agencies and felt that this was not always appropriate. Lack of trust in any one agency prevented them from sharing information with health visitors as this could be passed on to social work colleagues.

> "I have never ever told health visitors [about feeling depressed] because I thought they will then tell the social work who then will just use it against me in a report, you know. Not kind of, social work, they're meant to help you. You know but since everything got changed in 2011, so that she lived with her dad, I have never trusted social worker again, you know." (Emma)

However, two women, one with experience in health care and the other with experience in education, stated they thought information sharing was a positive thing for child protection.

> "I work in childcare so I know how it all works. So I knew that this [police sharing information with school and health visitor] is all going to happen anyway. Obviously they had to take under consideration the health of the child and the safety of the child So it didn't actually bother me because I knew I wasn't doing anything wrong and it wasn't my fault that this has happened….it didn't bother me cos I had nothing to hide." (Debbie)

For both these women information sharing was acceptable because they were aware of the rationale for doing so and were aware that this happened in every case, not just their own.

ASSIST workers explicitly state the limitations of service confidentiality as part of their introduction to women, that is, if women share information which leads the worker to be concerned about the safety of the woman or her children, they will alert other agencies. Despite this, and in contrast to their views of health visitors and social workers, participants described a sense of trust in ASSIST workers which enabled them to disclose information and discuss their experiences.   Fiona and Emma, both quoted above describing concerns about confidentiality both felt able to speak freely with ASSIST workers.

> "I don't know if that was just who I had [ASSIST Worker] but it was, I felt that I could talk to her about anything and she knew what to say back. I knew that she wasn't going to tell other folk like, what was wrong and stuff." (Fiona)

> "Yeah, because I knew it [ASSIST] is confidential. 'Cause I knew it was confidential whoever was on the other end of the phone." (Emma)

Further, this trust enabled an effective working and supportive relationship with ASSIST staff.

o   Fear of loss of control

Closely associated with fear of losing care of their children and concerns regarding confidentiality, women were concerned that disclosure would result in agency involvement and ultimately, agency control of the situation. Women perceived that, primarily due to child protection issues, agencies would push women to exit the relationship immediately. A few women described a wish to move at their own pace, to have an exit plan in place including appropriate accommodation and to maintain some control over when and how they exited the relationship. Helena described waiting until her exit plan was fully in place before disclosing abuse.

"You don't want to make a mess you can't fix. You want to escape, you want to get to the shore but you don't want to jump out of the boat unless you think you can swim it and especially when you have kids involved. You feel the responsibility of not making that jump unless you are absolutely sure and I really wasn't sure. It wasn't even just the situation, it was my self-confidence. I was worthless, I was stupid, I was hopeless, everything I thought, every idea I ever thought or had was a bad one and I really shouldn't be having any other ideas." (Helena)

These issues presented a barrier to spontaneous disclosure of abuse and to disclosing abuse following a police reported domestic incident. Women stated that they minimised or denied abuse and described efforts to hide abuse from health visitors.

"I think if the women love their partner so much and they don't want to see trouble coming at the door and the involvement of social work or health visitors constantly coming I think they would hide things and just say: no, it was just a once off maybe just it wasn't like as bad as it sounds and I think they do that because maybe they are also scared from their partner and the outcome of it all." (Debbie)

"Maybe its jus cos I'm, I don't, I would rather do things on my own rather than have people trying to help me." (Fiona)

To retain control of the situation women attempted to conceal their experience of abuse. Both Nicole and Anna described taking care over their own appearance and that of their home before health visitor visits and presenting themselves as contented and happy in conversation.

"I would go [takes big gasp, puts on bright face, louder voice and says] "No, everything's fine, it's brilliant so it is!" It would be a jump, like as if, trying to emphasise that everything was all right when it wasnae." (Anna)

This study found that, rather than view health visitors and social workers as a source of support and information, women were concerned about agency responses to their experiences of domestic abuse. In interviews, concerns about agency responses, in particular in relation to child protection, were greater than fears of violence from their partners.

- Exiting an Abusive Relationship

Almost all women described the negative impact on mental health and self-esteem; living in fear and the barriers to engaging with supports or seeking help. Yet 16 of the 17 participants had separated from abusive partners and they were asked what had enabled them to do this.

Some women identified specific events or stages where they decided to exit. For example Anna had hoped that her partner's behaviour would change following the birth of their daughter. When this did not happen she decided that she did not want her daughter to grow up witnessing this and decided to end the relationship.

> "I thought maybe having her [baby] would make him see sense, but it didnae….from when she was born nothing really changed. I gave him about a week or two." (Anna)

Anna and some of the other women stated that they needed to feel "ready" to leave and no one could have influenced that process.

> "Everybody was asking how's things and I was just "Aye, everything's brilliant" when it wisnae really. But, if anybody had got more involved at that point in time it would just have made life more difficult because I was still under the impression that everything was actually fine and it was all just, it only happened for a certain reason. So if anybody had got involved without me speaking out, saying "right I'm ready for this" it would just have made life more difficult." (Anna)

In contrast other women stated that if health visitors had supported them to recognise domestic abuse and the associated risks they could have exited the relationship sooner.

> "I think that if somebody had asked [about abuse] 'cause it's different when my mum was asking I'd argue with her. But to have an outsider who doesn't know me, if somebody would ask I'd have probably opened up more, and probably wouldn't be in the situation I'm in just now." (Kate)

Debbie initially separated but then resumed her relationship following the police reported domestic incident when her partner physically assaulted her. They do not live together but Debbie had considered moving house to escape him before they reconciled. When asked if she felt safe in her relationship she responded "sometimes".

> "Nothing else has happened since that incident but he's, ah, he's very jealous and controlling and that does get on top me every once in a while." (Debbie)

Some women discussed gaining employment, returning to education or preparing to do so as indicators of how they had recovered after separation. Helena stated that employment had helped her exit the relationship. She began volunteering while she was living with her abusive partner and described this as an important part of re-building her self-confidence, reducing isolation and developing some practical skills.

> "I [volunteered] for quite a bit which helped me to meet people and out of the blue I had people telling me that they thought I was quite clever, that they thought I was okay, that they didn't think I was stupid at all, and that 'no, no, you're fine, you're good, hey you're a quick learner' and I'm like [mimes surprised] because it was like nobody ever told me that stuff and I was just like 'wow, they must be on something, right?!' [laughs]….I was really like shocked that people actually thought that I was worth something and actually happy to see me when I turned up and thought that I was good at stuff. I eventually opened up to like a staff manager a bit about my relationship because my ex used to call the shop all the time." (Helena)

All women were asked what they thought health visitors could do to help them. Most women did not see a role for health visitors other than as child protection agents and so few suggested specific supports. That said, Olivia who had sought help from health visitors for support with her child's behavioural problems requested that health visitors "Help a bit more".

7.6.3 Service Responses to Domestic Abuse

This theme describes participants' views of the responses they received from health visitors and other agencies following a police reported domestic incident. At the beginning of interviews women were asked about the most recent police reported incident and agency

responses which followed this. As almost all the women described a history of abuse or subsequent abuse from their partners which was not always reported to the police, they were also asked about the ongoing response from health visitors and other support agencies. This included the health visitors' awareness of participants' experiences of domestic abuse, whether a disclosure had taken place or not.

The majority of participants described similarly disappointing experiences of the health visitor response. Only three women reported a positive experience.

7.6.3.1 Positive Health Visitor Responses

Three women reported a positive response from their health visitor. All three were recruited to the study through the ASSIST service. They described similar elements of the response which they found helpful. These included health visitors who talked openly about the police incident; expressed concern for the woman and intimated that the abuse was not acceptable; appeared knowledgeable about domestic abuse and maintained regular contact.

> "I think it's just the fact that she understood, or seemed like she understood what I was going through." (Irene)

Jenny is a 21 year old woman who lives with her only child in a small village. She described feeling isolated after separation from her partner and particularly valued the health visitor's regular contact and practical support such as provision of a baby bath and seat.

> "Well she helps. She got stuff for me…..just because she knows I don't get help off anybody." (Jenny)

Women who described positive experiences often commented on the health visitor either making a statement about the injustice of the abuse or appearing to react on a personal level to women's disclosure of abuse. Jenny disclosed her experience of abuse when her health visitor asked if she was with her partner and why they had split up. Jenny told her about the abuse and appreciated that the health visitor appeared to be angry and concerned on her behalf. This in turn encouraged Jenny to share more information with the health visitor.

"She was really, really angry with the situation [partner's abuse]. And then she knows about court and all the lawyers' letters that he sends me out. Stuff like what he wanted to do [threats to Jenny] and she was really upset about it." (Jenny)

Nicola also reported a positive response from her health visitor. She described the health visitor discussing the dynamics of Nicola's relationship after an assault which resulted in Nicola's admission to hospital. On subsequent visits, the health visitor again talked to Nicola about her relationship. After meeting Nicola's (then) partner the health visitor shared her observation that Nicola's partner did not appear interested in the family in an attempt to draw Nicola's attention to his behaviour and engage her in a discussion about the relationship. This was significant moment for Nicola who began to reframe her relationship.

"She had seen my partner about three times so she could see [what he was like]. She said "you are trying your best and you are doing this but he's not interested." It was strange to hear somebody from the outside saying "everybody can see this except you." (Nicola)

At first this made Nicola want to try harder in her relationship but had evidently planted a seed that Nicola did not have to live with this behaviour.

Nicola had attempted to conceal her partner's abuse from the health visitor but she believed the health visitor suspected abuse and continued to create opportunities for disclosure. She described it as the health visitor asking if she was "all right" but underlying this she could sense the health visitor saying "please, please tell me."

All three women valued regular contact with the health visitor which gave a feeling of support and enabled them to build a relationship. Women could not describe what happened in the visits in terms of actions or discussions but overall found the contact and time spent together beneficial.

Interviewer: What happens when she comes to see you?
Nicola: "She just comes to make sure, to assess the kids but she's always been brilliant."

Maria separated from her ex-partner seven years ago but continues to experience threats and intimidation. When she separated from her partner her second child was aged less than five and so the health visitor was still involved with the family. This health visitor frequently visited the house and provided practical assistance such as helping to complete forms and acting as a character reference to get Maria into employment. The health visitor also communicated with Maria in a frank and open way about her health and her situation.

> "I couldn't eat when everything was spiraling out of my control, I can control my food. So I wouldn't eat and then eventually she would say "look, if you start to lose any more weight we are going to have to seriously start thinking about what is going on here." Things like that. She'd say "you've got two beautiful children to look after" and she was just kind of there to get me back, back to normal." (Maria)

Maria has since met a new partner and has two young preschool children. Although the father of Maria's younger children is not abusive, health visitors are alerted by police or social work colleagues when Maria is involved in police reported incidents with her former partner, such as the delivery of flowers described earlier in this chapter. Maria also reported a positive response from her current health visitor, in particular, that the health visitor has taken the time to understand her particular family situation. Maria feels that the health visitor stands alongside them and again, this positive response has encouraged Maria to share information with her health visitor.

> "When we went to see the health visitor with my son, she knows all about my family situation. She knows that it's not my fault. It's not my fiancée who is doing it, it's my previous partner so I don't feel as bad about disclosing any information so she did just ask how things were. It was quite good to just be able to sit and talk about it." (Maria)

7.6.3.2 Negative Health Visitor Responses

The majority of women stated they had little contact with, and received little support from, their health visitors in response to either general parenting support needs or in relation to their experiences of domestic abuse. While most women were disappointed at the lack of parenting advice, they expected little support from health visitors in relation to their own situation and so were mostly ambivalent about the lack of response to domestic abuse.

Often women stated that they "wouldn't even think" (Olivia) of health visitors when looking for support.

Most women stated that both before and after the police reported incident they had little contact with their health visitors. When contact occurred it focused on the routine checks on the development of the child or on the immunisation programme.

> "I've not seen my health visitor. No she came for my one year checkup and that was about it." (Lynne)

Women perceived that all their contact with health visitors focussed on child development and following police reported domestic incidents, on child protection.

> "When it came down to it, it was all about the wean [child]." (Debbie)

Beyond a child focus, women described a specifically bio-medical focus where health visitors would concentrate solely on the child's physical health and development. Emma had experienced severe physical assaults and continued to experience intimidation from her now ex-partner which she disclosed to her health visitor. She disclosed concerns about her own and her daughter's safety during contact with her ex-partner following separation. However, the health visitor did not discuss these issues and remained focussed on the physical wellbeing of the child, specifically on a skin condition. Indeed Emma reported that her health visitor maintained an impartial position stating in correspondence only that the child was well cared for by both parents.

> "All they put in [case notes] is what they are there for, about her skin. If they write a letter [to social work] it's only about her skin. There's nothing else, they don't want to be involved." (Emma)

Olivia's attempts to gain general support and advice from health visitors for her daughter's behavioural problems were ineffective, despite contact with specialist services. This only improved shortly before the interview as the result of GP intervention.

> "The only time I see my health visitor is if I phone her or if she needs to come out and do the assessment for something but the doctors at the health centre have asked

her to come and see me at least once every fortnight. They demand she comes out and see me because they've said she should be because of [daughter]." (Olivia)

In another example, Kate described a series of events which failed to raise the concerns of her health visitor. Kate reported a period of psychological abuse and controlling behaviour from her partner which he blamed on the stress of living with "noisy neighbours". Kate's son had behavioural problems which meant that he was difficult to control and demanding of her attention. During this period he stopped eating and she attended the health visitor for advice and monitoring of his weight. The health visitor advised that this was likely to be related to the stress in the household. His refusal to eat continued for some weeks with Kate, her partner and their son regularly attending the health visitor clinic. Kate stated that during one clinic visit her partner was reluctant to discuss his son's condition and became very aggressive towards the health visitor and ultimately, the family had to leave the clinic. On reflection Kate felt this was an over-reaction which the health visitor did not comment on or discuss with Kate at subsequent visits. Her son subsequently presented with an anal tear and rectal bleeding which the health visitor advised was likely to be the result of constipation, which in turn was attributed to not eating.

At the time of interview, some months after Kate had separated from her partner, her son had started to make sexual references about his father. Kate immediately alerted social work. With hindsight and no longer living with psychological abuse, she fears that his behavioural problems and anal tear, alongside her partner's behaviour and her son's sexual references suggest that her son was sexually abused by his father. This caused Kate considerable distress. She stated that she feels guilt that she didn't recognise these indicators herself but feels especially let down by the health visitors' lack of concern.

> "When [son] wasn't eating anything and he cut his bum because of the constipation I kind of think "Is that because he was abused and they've missed that?" It was two, three months [son] was seeing the health visitor every couple of weeks. We had put it down to a noisy neighbour keeping him awake….but at the same time they are trained professionals. Should they have noticed anything or? I mean his dad kicked off in the surgery because of it one time, he got really, really angry, he was really cheeky to the health visitor and looking back well, I would have questioned that. Why did he get angry? She should have maybe but they were either too scared because it's a big accusation or, I don't know." (Kate)

Kate also described a disappointing response to her requests for support with her son's behavioural problems. She had requested referral for an assessment of her son's behaviour, referral to specialist services and for additional nursery time for respite. She was advised that health visitors requested a referral to specialist services but that social services had decided this was not required and did not to proceed with the referral. Kate had not received feedback on progress (or otherwise) of any other requests for support.

Kate had support with childcare from her mother who was supportive of her situation but found her grandson's behaviour difficult to manage. This caused tension between Kate and her mother and stress for both of them so it was particularly disappointing when health visitors suggested that her mother could provide more support.

> "So there's nothing, there's no help or support there. When I have been really, really stressed I get "Well phone your mum". My mum watches them when I'm at work." (Kate)

Olivia also reported feeling unsupported in managing her child's behavioural problems. Frustrated by the health visitor response and desperate for support, Olivia approached a social worker. The social worker directed Olivia back to health services and provided support and information which enabled Olivia to get support with her child's behaviour and for her own mental health.

> "No, I actually went to social worker last year, I'd had enough I really couldn't handle [daughter], didn't feel that I was getting support from my health visitor. My social worker actually came out and she asked what was going on and she actually told me what to do. To "see a doctor 'cause you're feeling very depressed and it's just going to get on top of you". She actually told me and I ended up on antidepressants, from the doctor but it was through social work." (Olivia)

In other examples of the focus on children's physical health, two women had concerns about bonding with their children which were not addressed by the health visitor. Pauline was diagnosed with a major health condition during pregnancy and required major abdominal and chest surgery immediately after the birth of her child. This meant that she was physically unable to do any of the basic baby care in the child's first months of life.

She lived with her parents during this period and so all her child's feeding and hygiene needs were met, but not by her. This satisfied the health visitor who, assessing the child's physical well-being as satisfactory did not visit the home any more frequently.

> "I know it's not their job to come out all the time to see you but when I went for my surgery that's probably when I needed the most support from them in terms of what I can do with my child. I wasn't allowed to hold him for the first 4 months in case he hurt me which was quite hard. I needed them [health visitors] there because I felt my bond with him had disappeared. I still don't have, I have a bond with him but I don't think it's as great as it would have been if I'd spent the whole time with him. So I kind of needed them back then and they weren't there" (Pauline)

The combination of infrequent, child-centred visits, limited opportunity to get to know health visitors and build a relationship with them and often poor response to parenting support needs led women to view health visitors as an agency which assessed their ability to parent rather than a resource for them. Therefore women did not expect or seek support from their health visitor in relation to their experiences of abuse.

> "If I had been worried about her [daughter] then the health visitor would have been a good thing but I wasn't so it wasn't really an issue. I didn't really think about my health visitor to be honest, she'd have been my last person if I think about it." (Beth)

For most women the nature and frequency of responses from health visitors did not change following their report of a domestic incident. The deleterious effect of abuse on women's mental health was discussed earlier in this chapter. Beth had been receiving monthly visits from her health visitor because of depression. Beth was assaulted by her partner during a police reported domestic incident a few weeks before the final scheduled visit. The health visitor received a routine notification of the incident but this did not alter her plan of care. She did not visit sooner, the visits stopped as planned and the impact of abuse on Beth's health was not explored.

> "My health visitor was coming out regularly to see me anyway, because I had problems with my mental health. So she was coming to see me anyway. She didn't come out purposely because of the incident but she came a little bit after that

obviously to do a visit which she would normally do but it wasn't related to incident." (Beth)

- Support with Child Contact

Women described their partners' exploitation of child contact post separation as a means to continue to the domestic abuse. In addition to the risk to their own safety, women expressed significant concerns for the well-being of their children while under the care of their fathers or their fathers' relatives. In one example Jenny's had concerns about her ex-partner's parenting skills, criminal behaviour and the conditions of the house he shares with his mother and his younger brother. He assaulted his mother, was arrested and spent a "weekend in the cells". On release he was not allowed to return to his mother's home because police and social workers considered him a risk to his brother but his supervised access to his daughter with Jenny continued. In another example, Emma had concerns that her ex-partners' criminal behaviour placed her child at risk.

> **Emma**: "No, I'm not like concerned of him looking after her or feeding her or making sure she is getting what she needs. But I'm concerned about other things like he's on bail and has been charged with rape and sexual assault on another girl which was his girlfriend at that time…. His trial is coming up soon you know so I think about all kind of stuff like what if her family goes through his door you know?"
>
> **Researcher:** "Have you spoken to the health visitor about your concerns?"
>
> **Emma:** "I sat and I cried my eyes out to her and I said "you know this is just getting too much for me" but they don't put any input in all."

Women reported that health visitors seldom took note of or responded to their concerns about their children's safety and identified this as a substantial omission from the health visitor response. However, women felt similarly unsupported in relation to child contact from social work services.

> "I was talking to somebody, I think it was ASSIST I was talking to, and they said to me get a hold of social worker cos I says I don't trust him, the house is disgusting they smoke hash and stuff it's not even child friendly. I don't want my daughter there but I tried my hardest….I got hold of the social worker, she just came here to

see me and just asked me like basic information and I've never heard from her since." (Jenny)

7.6.3.3 Responses from agencies other than health

In the UK a range of statutory and third sector agencies have a role to respond to domestic abuse including health, social work, police and education and so women described interactions with agencies other than health visitors. In doing so, they identified areas of practice which they valued and some which they did not.   These views are useful in more fully understanding the role of the health visitor within the multi-agency response, how services work together and can inform recommendations to improve, strengthen and enhance the health visitor response. Participants from the various geographical areas reported similar responses from agencies including social work, ASSIST and the police.

In most cases social workers were the first agency to respond to police reported domestic incidents. Women stated that these visits were focused on the child and the woman's ability to care for them. Although women understood the importance of ensuring the safety of children they often felt upset and angry that they were being assessed and not the abuser.

> "I felt like it was me that was under scrutiny, sort of thing. It's like they were getting reports from the school and the nursery and I felt like saying "but I haven't done anything wrong." He [partner] came to my door and started [abuse]….I understood but I didn't like it at the time, I got quite upset to be honest." (Beth)

Women reported that, as with health visitors, social workers did not recognise or respond to their concerns in relation to child contact and appeared to consider the child protection issues resolved when the partner left the family home.

> "The house is disgusting they smoke hash and stuff it's not even child friendly. I don't want my daughter there but I tried my hardest. According to my lawyer I can't just make accusations I need to prove stuff so I got hold of the social worker, she just came to see me and just asked me like just basic information and I've never heard from her since….He had to get removed from the house because he's got a little brother, at the time he was only 13." (Jenny)

This created a sense of frustration and anger for most women. Women stated that where health and social care professionals were aware of their concerns but did not take action to prevent their partner's access to their child women were placed in a difficult situation as sole arbiters of access with men who intimidated and frightened them. Maria described one such situation and stated that she felt let down and "abandoned" by social workers who stated that, as the partner was not living in the home, he was not considered a risk. The social workers did not take any action to prevent Maria's ex-partner from having access to his children but advised Maria that she would be held responsible and considered to have put her children at risk if she "allowed" her daughters to visit him.

"I don't have a social worker I mean she said the home, they are happy that the home is safe but if I choose to send them there [to ex-partner] you know, that would be a different situation, the social work would be involved….but apart from that that's it and I did feel a bit abandoned at first once I spoke to this women who said "look your children are safe there's no a major concern"…. Well I did think it's quite surprising but they [social workers] said was that he had parental rights and now it would have to go to court to try to get to them, to get access to them, there's no way he could come and see them….and the health visitor said to me under no circumstances should you send your children to that man and she said to me that if you did send them then you would be *[child interrupting]* I don't know if she was, it was some kind of word she said like not colluding something like that like I'll be helping towards this she said so if you send them there it will be me who will get into trouble as well." (Maria)

While women wanted some agency support to protect their children, social work involvement was stigmatized and women associated social work involvement with an inability to care for children. Therefore, social work involvement was undesirable and unwelcome. Women who had regular social work visits described a sense of relief when this ceased as it indicated that social workers were content that the child was safe.

"The children were put under social work because they were there at that time [of violent assault from partner] so I've managed to fight to get them taken out from under social work." (Nicola)

However, women's fears about their partners' behaviours remained following separation and following withdrawal of social work involvement. Women were concerned about their own safety and that of their children. They did not want to see their partners but were also concerned about their partners spending time with their children when they were not there to protect the children. In these cases women would have welcomed agency support to supervise access, monitor their partners' behaviour and safeguard their children. The anxiety this caused women was evident in the interviews.

> "He can go get like passports and things without my permission, there's quite a lot he gets, quite scary actually and he is the type of person to do that." (Olivia)

Interaction with social workers during visits was minimal and women stated that this usually involved a home visit and checking that the children were "okay". Occasionally women would become confused between the agencies who visited: social workers, police and health visitors. This resulted in a lack of clarity about who was visiting the woman's home, which agency was leading on specific activities, who would contact them next and when that contact would take place. Women were aware that they were being assessed but not why or by whom.

> "And I think that someone else got involved, somebody to do a report, I'm not sure who that was. I'm not sure if it was a social work report she had to do but she was separate from the two that visited before. I can't remember I think her name was ….. She did a report and then she had to report back to social work." (Beth)

Women reported conflicting feelings about involvement with social work services as they were concerned about stigma but also wished for statutory support and protection. Overall they perceived social work involvement as negative as it indicated to others that their children were not cared for. It was therefore undesirable and women perceived the end of social work involvement as a positive achievement.

Perhaps unsurprisingly, given the recruitment method for this study, most women spoke very highly of the support they received from ASSIST. Fourteen of the seventeen women in this sample had been in contact with ASSIST at some point.

"I think they were brilliant. They were the only folk that really helped me throughout, I don't think I would be able to do that [keep going] if it wasn't for them and my family support." (Fiona)

ASSIST workers clearly define the limitations of confidentiality at the outset of their relationship with service users but in contrast to women's concerns about health visitors sharing information, this did not appear to present a barrier to women disclosing and discussing their experiences with ASSIST. Other elements of the response that women valued from ASSIST were similar to those valued in health visitors such as regular frequent contact; open discussions about abuse; staff who were knowledgeable about domestic abuse; workers who made value statements about the women's experience of abuse, specifically, naming partner's behaviour as abuse when discussing the relationship with women.

"She [ASSIST worker] helped me to realise that I didn't need to take him back….but at the same time she was making it clear that it was my decision." (Irene)

Debbie stated that ASSIST provided a useful role as an independent observer or "outsider", someone other than a friend or relative, who helped her to reflect on her situation. Although Debbie and several other women, described health visitors as being "outside" their network and unfamiliar with their family life they did not consider health visitors to have a role in reflection or observation about the relationship which again highlights perceptions that health visitors only provide a service for children.

Debbie: "It was actually somebody from the outside who didn't actually know the situation. When I spoke to [ASSIST] and told them what happened they actually made me see it wasn't my fault but I was always blaming myself. And it was actually good just to have somebody else to listen and tell me their point as an outsider and not like somebody who was involved in some way, and close to me, do you know what I mean?"

Interviewer: "Would the health visitor count as someone familiar? Did you have a relationship with your health visitor?"

Debbie: "Ehm no, not really. I just know them from obviously coming out to when my son was younger ehm and that was it."

All of the women who had contact with ASSIST reported that they provided clear, easily understandable information about the court process but also about the dynamics of domestic abuse, the consequences of abuse for women and children and for four of these women, provided information and support to access health services.

"[ASSIST worker] would say "right, what's going on?" and I ended telling them the issues and they'd phone the social work and say "right Emma's had this off you….what's going on?" and [ASSIST worker] phoned me back and explained properly in the way that I could understand without big words and stuff you know explained what was going on and they said "right what do you think you need to do now?"....And I'm like "I don't know I haven't got a clue all I know is that I'm a good mum and I put [daughter] first before myself" and they went "you know that's the start….call your solicitor and see what she has got to say about it and then I'll give you a ring back next week and we'll see how things are going" you know. And then they phoned me back and said right "what have you done since last week?" Pointing me in the right direction to keep myself right so I knew where I was going and I knew exactly what was going on." (Emma)

ASSIST's primary aim is to provide advocacy in relation to the criminal justice system but it was evident that women utilised the advocacy beyond this. As in Emma's example above, part of the ASSIST response involved encouraging women to make contact with health services. While it is positive that the multi-agency response includes signposting to other agencies it is concerning that women required a level of support or empowerment to access primary care services.

"Just last week their dad put on facebook that his bail was up in two weeks and [he wrote] "this should be fun" and I automatically phoned ASSIST 'cause I thought that was a threat to me and she was quite good she told me to show it to social workers and my health visitor so if anything does happen next week there's back up to prove…..I don't think about my health visitor or social work I phone ASSIST that's my first thing." (Olivia)

The ongoing contact with ASSIST was highly valued by participants in this study. In contrast with other agencies ASSIST frequently initiated contact and would keep women informed of developments with other agencies. Kate stated that she had to wait for weeks for a response from her health visitor, social worker and local specialist children's mental health team. In contrast the ASSIST worker "*phones every couple of weeks to see how I am doing and to chase any referrals that have been put in."*

As a result of this responsiveness, and a perceived lack of responsiveness from health visitors, women often contacted ASSIST for issues which sit within the remit of health visitors. For example, two women had approached ASSIST for advice on managing their children's behavioural problems. Other women had contacted ASSIST in relation to concerns about child safety and parenting. This was not actively encouraged by ASSIST who define the purpose of their service before engaging with women. However, provision of advocacy, flexibility of response, ability to establish a relationship with women and accessibility meant that women would often approach them in the first instance.

The majority of women reported a positive response from police. As with health visitors and ASSIST workers it was often the response of the police officer themselves which women valued. Women appreciated when police officers behaved in a supportive, non-judgmental way and took women's accounts seriously. In most cases police attended at the time of the incident and then visited the woman at home for a single follow up visit.

> "Amm it was a bit of a worry because I realised how big it was going to be because I called [the police] but they were so nice, the way they dealt with it, they were really good. They were really good with my daughter, making sure she wasn't in the room when I was speaking to them. They were just so nice." (Beth)

However, a few women reported a negative response from individual officers. One area of contention was when women contacted the police to ensure a record of ongoing abuse was kept. For example, if a partner sent threatening texts following a previously reported police incident. Whilst women had been advised to report all incidents, the officers who responded often indicated that this was not of sufficient magnitude to involve the police and on occasion, placed responsibility back on the woman for example, advising them to change their phone number.

"Yes the police have been fantastic. Don't get me wrong there's been some officers in my house who I wanted to say just "you know what? Just away you go!" They've not taken it serious because it was all emails. My ex is very manipulative, he was able to threaten me via emails without even knowing you know to look at it to the outside person. That "what do you want us to do with that?" That was kind of attitude sometimes with police but the majority of them have been fantastic. The domestic abuse worker can't fault her at all." (Kate)

Anna described largely negative responses from the police and stated that she would not advise anyone to contact the police. She described incidents where she felt that she was held responsible for her partner's behaviour.

"They do nothing for you. The guys that I saw initially, they were fine, the first two officers. Then the second time it was another two beat officers and then it was the domestic officers and the domestic guy was quite rude. [He said] "Listen hen, you know this isnae gonnae go away. Any intentions of getting back with him?"

I says "No, I've got a wee baby."

He said "Aye but a lot of times people get back with him."

I says "Well I'm not getting back with him."

[He said] "Aye well, if you do get back with him just know that you are wasting police time."

 I says "listen, I'm no getting back with him and I don't appreciate the way you are coming about this to me. I am a victim here."" (Anna)

Grace also described an unhelpful response from police. Grace had experienced several traumatic events in her life including sexual assault, abuse from her partner and the death of one of her four children. Grace stated that she had poor mental health and used alcohol as a coping mechanism. In interview Grace's story was often incoherent and it was at times difficult to ascertain the chronological order of incidents or identify separate incidents. She stated that when police attended domestic incidents early in her

relationship, they would assume that she had been equally abusive to her partner if she had used any retaliatory violence despite evidence that her injuries were more severe. As a result, she stopped contacting them for help.

> "The first time he did hit me I retaliated back and then I blacked out. So when the police came I said I'd hit him but my mum said lift your top at the back and it was obvious he had kicked me but the police just left at that."(Grace)

Sometime after Grace had separated from her partner the police contacted her as he had assaulted another woman and encouraged her to make a statement. Grace complied, however, other women declined to report and Grace is again in fear of her ex-partner who is aware that she had provided evidence to the police.

In most cases the police officers who visited women were not in uniform. Women preferred this as they were concerned about the stigma associated with police involvement in the home.

> "It was the other folks thinking "why is the police coming to the door" when I have not done anything wrong." (Fiona)

The current study found some evidence that victim blaming and a lack of understanding remain an issue in some individual officers' practice. The response to a woman with complex support needs was consistently disappointing over a period of years but the majority of women reported a positive response from the police overall.

7.6.3.4 What women want from health visitors in response to a police reported domestic abuse incident.

Women were asked to describe an appropriate health visitor response to police reported domestic incidents but as the majority of women perceived the health visitor role to be limited to assessing child development they suggested little or no involvement beyond this. So, even women who had reported that they were disappointed by health visitors could not clearly envisage how this could be improved. For example Lynne asked simply for health visitors to "*Help a bit more*" and Olivia suggested that they could "*Ask how you are feeling*" (Olivia).

In addition, but less frequently, women suggested health visitors could provide access to survivors of domestic abuse or to support discussions with their children about domestic abuse. Two women stated that they wanted to hear about other women's experiences of abuse. One suggested that health visitors bring a survivor of domestic abuse along to their visit and say words to the effect of "I'm not saying that you experienced abuse but this is what it was like for me." (Anna) However, this contradicts Anna's previous statement that it is not appropriate for health visitors to push women to talk about abuse and should be considered with caution. Nonetheless, there are a opportunities to introduce survivors of abuse to women's groups for example parenting classes, breastfeeding support and toddlers.

Two women stated that they found it difficult to discuss abusive incidents with their children. Children are usually excluded from conversations about abuse which take place between women and health visitors, social workers or police despite children having witnessed the abuse directly. Beth requested some support in addressing this.

> "I mean it's OK for me because I'm her mum and obviously she believes me when I tell her stuff but I think having someone else who can explain, this is a bad thing that happened and ask "how do you feel? Are you angry at your dad?", things like that. Its questions I asked her but I think having someone outside of me would have been helpful. Someone to say "This wasn't your fault, daddy still loves you", kind of explain the situation a bit more. She was really terrified at the time." (Beth)

Elements of good practice have been inferred as the converse of women's negative experiences and positive responses from other agencies which are relevant to health visitors. This identifies elements which are expected as fundamental to the health visiting role yet the majority of participants did not experience this. Most have already been explored in this chapter. In summary, women's responses indicate that they would like:

- Regular contact
- Reassurance that children would remain in their care
- Confidentiality (an understanding that only essential information is shared, only when necessary.)

- Staff who understand the dynamics of domestic abuse
- A response which acknowledges their experience of abuse
- To be asked about abuse and to explore the dynamics of their relationship
- Recognition of ongoing risk to children following separation from an abusive partner and support with child contact
- Information, advice and referral for their own and their children's mental and physical health problems

7.6.4 Summary of Findings

Sixteen of the seventeen women in this study reported experience of ongoing domestic abuse during which partners perpetrated a range of abuse including physical, psychological and sexual abuse. The majority of abuse experienced by women in the current sample did come to the attention of the police. Sixteen of the 17 participants had separated from their partners at the time of interview but for most, abuse continued following separation.

Women reported that children were frequently exposed to or directly involved in the domestic abuse. Women shared examples of partners' threats to harm the child; the woman or their partner holding a child during a violent incident; children's attempts to protect their mothers; children exposed to a controlling regime in the home and having their freedom of movement limited. Women identified a number of consequences of children's exposure to abuse such as children being distressed and upset by their fathers' behaviours (Nicola & Rachael); displaying behavioural problems (Grace & Olivia) and experiencing psychological problems (Nicola & Kate).

Many of the women recognised their partners' behaviour as domestic abuse and were afraid of further harm to both themselves and their children but were reluctant to disclose this to health visitors.

Regular contact was a key factor for all three women who reported a helpful response from health visitors. However, the majority of participants reported having little contact with their health visitors even after a disclosure of abuse or police reported incident. When contact was made, it related directly to a child's physical health and child protection. Despite this approach, women reported that their requests for help with children's behaviour or health concerns were rarely met. In consequence, women contacted alternative agencies for support with these issues such as social work or ASSIST.

Child contact following separation was a major cause of concern for participants who identified risk of harm for themselves and their children. Women shared their concerns with health visitors who did not act on this. Even women who reported a positive experience of the health visitor response identified this as an area where greater attention could have been paid to their concerns. Failure to respond left women feeling unsupported in their efforts to protect their children.

The majority of service user participants did not consider the health visitor as a source of support but rather, tried to conceal their experiences of abuse and concerns from health visitors. In contrast to the frequently disappointing response from health visitors, participants reported positive experiences of engaging with ASSIST. Women valued the regular contact, accessibility of telephone support, workers' awareness of domestic abuse and willingness to discuss abuse with women. This enabled the development of trusting and supportive relationships. Women described receiving support from ASSIST to engage with health and other agencies involved in the multi-agency response.

The following section will discuss the key findings and consider these in the context of the current literature and phases one and two of the current study.

7.7 Discussion

7.7.1 Discussion

The findings of this phase address the research questions relating to the nature and extent of abuse experienced by women involved in police reported domestic incidents, their support needs and views on the health visitor response. In this section, the findings will be discussed in the context of the literature.

The findings of this phase provide insight to the differing perspectives of service users and those of health visitors (Chapter 5) who report similar interactions with one another but described different understandings, and therefore experiences of, these interactions. In the following chapter (Chapter 8) the integration of findings from all three phases of the research will be discussed.

7.7.2 Living With Domestic Abuse

7.7.2.1 Nature of Domestic Abuse

The nature and extent of abuse described by health visitor service users involved in police reported domestic incidents were typical of the experiences of domestic abuse described in the wider literature. Women in this study stated that their partners perpetrated a range of abusive behaviours against them and experienced physical and psychological harm as a result. This is consistent with the Scottish Government definition of domestic abuse which includes physical, sexual and emotional abuse, including isolation (Scottish Government 2008a) and is observed in UK crime surveys (Myhill 2015; Scottish Government 2014b). The abuse described by women in the current study is similar to reports of domestic abuse from women across the globe (WHO 2005) and concepts of coercive control and intimate terrorism described by Stark (2010) and Johnson (2008).

Sixteen of the 17 women who participated in interviews in phase three stated that their children were aware of or directly involved in abusive incidents. Again this is supported in the literature. Humphreys et al (2008a) and Stanley (2011) conducted literature reviews to inform policy and service development. Humphreys et al (2008a), worked closely with a national policy group in Scotland. The authors searched databases for the period 1998-2007 but did not provide detail on assessment of study quality nor any specific inclusion or exclusion criteria. Stanley (2011) conducted a "research review" aimed at practitioners, utilising a similar search strategy to Humphreys et al but with a 15 year timescale (1995 to 2010) and referenced the work of Humphreys et al (2008a) within this. Again, Stanley did not detail inclusion or exclusion criteria but, in both reviews, it is likely that methodological description was omitted to increase accessibility for a non-academic audience. Both reviews conclude that the incidence of children's exposure to domestic abuse is "alarmingly high". Humphreys cites a range of research which identified between 45% and 85% of children in households where there is domestic abuse being aware of, or involved in, the abuse (Humphreys et al 2008a).   Similarly, the Scottish Crime & Justice Survey (SCJS) in 2012/13 found that three quarters of children living in homes with domestic abuse had witnessed or been involved abuse (Scottish Government 2014b) supporting findings at the higher end of the range. Therefore, the findings of this

qualitative research would appear comparable to the wider experience of women and children exposed to domestic abuse.

7.7.2.2 The Extent of Domestic Abuse

The majority of abuse experienced by participants in the current study did not come to the attention of police. This finding is consistent with those of UK crime surveys where survivors of domestic abuse reported that not all incidents of abuse were reported to the police (Myhill 2015, Scottish Government 2014b). When police were involved in incidents, most women in the current study reported positive experiences of the police response. Yet there were examples of police officers' minimisation and trivialisation of women's experience of abuse (section 7.6.3) and one participant reported that she would not contact the police again in future as a result of this experience. Similarly, a minority of women in the SCJS reported a negative response from police (18%) and a third of SCJS participants were deterred from contacting police as they did not anticipate a helpful response (Scottish Government 2014b).

It was not possible to quantify the proportion of all incidents of domestic abuse which were reported to the police in the current study as women commonly described their partners' ongoing abusive behaviour rather than individual incidents. This is a long standing challenge in quantifying the extent of domestic abuse, which in women's lived experience, is a process rather than a series of discrete events (Walby 2005).

7.7.2.3 The Experience of Living with Abuse

Women in the current study associated their experience of domestic abuse with poor health, predominantly poor mental health. As previously discussed (Chapter 3) research has demonstrated a strong association between experience of domestic abuse and poor health (Krug et al 2002). Krug et al (2002) conducted a comprehensive review of evidence on health consequences of domestic abuse and concluded that experience of domestic abuse is associated with wide ranging health problems in the immediate and longer term and subsequent literature reviews have concluded that domestic abuse is a major public health issue (Feder et al 2009). This is evident in the consistently high proportion of women in clinical populations who have experienced domestic abuse (Feder et al 2009, Loke et al 2008, WHO 2005, Krug et al 2002, Golding 1999). While some women did describe substantial acute injuries following assault, they did not report long term physical

health consequences of abuse. This may be because this is a relatively young sample, with a mean age of 26 years old, and longer term consequences have yet to present. Health visitor responses to either mental, acute physical or chronic physical health issues were notably absent from the accounts of service users in the current phase of this study.

References to alcohol use recurred throughout interviews in phase three of this research. Two women spoke frankly about their use of alcohol to mediate the impact of abuse and consequences of trauma. The literature (section 3.2.2) describes an association between alcohol and domestic abuse which suggests that women with alcohol dependence may be more vulnerable to domestic abuse and, for women not previously dependant, alcohol can become a mechanism for coping with the abuse (Galvani 2009).

One participant in the current study, Nicola, provided an important insight into women's use of alcohol as an attempt to manage their partner's behaviour and minimise the risk of violence by drinking to "keep him company" and keep him at home (section 7.6.3). This was described by Kelly et al (1999) as the stages of living with abuse where women seek to explain or excuse their partners' abusive behaviour (managing the situation) and attempt to alter their own actions to pacify a partner and avoid abuse (distortion of reality) (section 2.2.4). In addition to alcohol increasing women's vulnerability to abuse or use as a coping mechanism for ongoing abuse, this finding presents a third function of alcohol in relation to domestic abuse where it is used by women who modify their own behaviour in an attempt to mitigate perceived causes of their partners' abusive behaviour. Women's consumption of alcohol to manage their partners' consumption is little explored but is important when considered alongside the assumptions of health and other professionals' propensity to minimise abuse and hold victims responsible for the abuse when they have consumed alcohol.

7.7.3 Service Responses to Domestic Abuse

This study aimed to describe the ongoing response to women experiencing domestic abuse. Only three women in the current sample reported a positive and helpful response from health visitors following a police incident. The majority of women reported either a negative response, where they requested support and did not receive it, or a non-response, where health visitors did not recognise or engage with women about their experiences of abuse and women did not spontaneously disclose. In interviews, health visitor service users identified factors which prevented engagement with health visitors. These included

the relationship between themselves and health visitors and perceptions of the health visitor role. These will be discussed in turn.

7.7.3.1 Relationship between health visitors and service users

As discussed (sections 3.4 and 5.8), the health visitor and service user relationship is regarded as a strength of the health visiting service and an important factor in facilitating identification of domestic abuse and women's engagement with services (Bacchus et al 2003; Bateman & Whitehead 2004.) Health visitor participants in phase one of the current study stated that women found health visitors more approachable than social work colleagues and this is supported in some of the literature (Bacchus et al 2003; Bateman & Whitehead 2004). The positive experience of a small number of women in the current study suggests that good relationships can still develop but more often in the current study, supported by the work of Peckover (2003), the majority of women reported that they did not have a relationship with a health visitor (for example Beth's statement that "*I didn't really think about my health visitor to be honest, she'd have been my last person if I think about it*.") Moreover, women stated that fear of losing care of their children was the greatest barrier to disclosure and so knowledge of the health visitors' child protection role is a considerable deterrent to disclosing or discussing domestic abuse. More specifically, service users' were concerned that they would be held responsible for their partners' abusive behaviour and children's exposure to this. This was closely linked to anxiety about information sharing between organisations. Women feared that if other agencies were aware of their experience of abuse the potential for their partner to become aware of disclosure would be greater and could result in further violence. In addition, women feared losing control of the situation following involvement of multiple agencies. These concerns are commonly cited by service users as a reason to hide or deny abuse from health professionals (Petersen et al 2003; Curry et al 2006; Feder et al 2006).

In the current study women reported concerns about health visitors' maintaining confidentiality but did not report the same concerns in relation to discussing their relationship or experiences with ASSIST workers. ASSIST workers routinely advise potential service users of their responsibility to share information when they believe a service user, their children or a vulnerable adult is at risk of harm suggesting that women have specific concerns about disclosing to health visitors.

Consequently, most women in the current study did not find health visitors more approachable than social workers or other services and most attempted to conceal their experience of domestic abuse. Despite more than 10 years between studies the findings of the current study are similar to the findings of research conducted with health visitors and service users in England (Peckover 2003, 2002). Peckover gathered data in 1998/99 and reported similar barriers to disclosure such as concerns about confidentiality and fear of losing care of their children (Peckover 2002). As in the current study, service users in Peckover's research described attempts to hide their experiences of abuse and present a façade of normality and happiness to health visitors by taking care with their appearance and ensuring the house was clean for health visitor visits. Likewise, a more recent study conducted with health professionals and survivors of abuse in Scotland also found reports of women's attempts to hide their experiences of abuse from health professionals (Taylor et al 2013), again associated with fear of losing care of their children.

Despite service users in the current study and Peckover's research reporting similar concerns, there are important differences in the description of the interaction between health visitors and survivors of abuse between the studies. Peckover (2002) applied the concept of "discourse of the social" to the interaction between health visitor and service users. This term describes the use of subtle enquiry techniques, through which health visitors' establish a relationship with women and gain their confidence over time, to gather information about women and their social supports. In turn, service user participants stated that this resulted in discomfort and distrust as they were unsure if health visitors were genuinely interested in them or attempting to elicit information which could be used to criticise their parenting in future and declined to disclose their experiences of abuse (Peckover 2002). In contrast only one woman in the current study observed a health visitor attempt to elicit information over time using indirect questions. In this instance the woman found it supportive, rather than intrusive but still declined to disclose through fear of her partner and of losing her children. However, this approach does not appear to be characteristic of the current health visitor response in Scotland as neither health visitors nor service users in the current study described regular contact over a prolonged period of time, ongoing assessment or a subtle approach to exploring the situation, rather women were asked outright about police incidents or it was not mentioned at all.

7.7.3.2 Positive Health Visitor Responses

The three women in the current study who reported a positive experience of health visiting appreciated health visitors who spoke openly about the police reported incidents; expressed concern for the woman and stated that the abuse was not acceptable; appeared knowledgeable about domestic abuse and maintained regular contact. This is supported by a systematic review of qualitative research (Feder et al 2006) which concluded that the personal response of the health professional was most important to survivors of domestic abuse. In particular, Feder et al (2006) found that women want health professionals who understand the dynamics of abuse and the complexities of the situation, advise women that abuse is not their fault and give women time to make decisions.

In the current study women valued regular contact with health professionals and perceived that this contact demonstrated health visitors' interest in and concern for their wellbeing. Service users stated that regular visits, when they did occur, were to check that they were "all right" but did not describe any formal structure or assessment of the wellbeing of women or children.   It is possible that health visitors were conducting an assessment through observation and used conversation to gather information on risk which women did not recognise. However, women did not report advice or information about safety planning or protection for themselves or their children which suggests that these visits provided emotional support only. Therefore, if health visitors had conducted "subtle" risk assessment described by Peckover (2002) it did not translate into safeguarding action.

Regular contact is a consistent feature of interventions designed to address domestic abuse in the health setting described in Chapter 3, with the purpose and structure of visits clearly defined and typically involving exploration of the dynamics of the relationship, identification of risk and safety planning discussion although there is little evidence that these interventions improve safety or health outcomes (Katz et al, 2008, McFarlane et al, 2006, Parker et al, 1999, McFarlane et al 1997). The findings of this phase of the current study suggest that visits are unstructured but that contact of any nature with women who have experienced domestic abuse is beneficial as the contact in itself fosters a relationship and demonstrates concern.

Findings from service user interviews in the current study suggest that positive responses were rare and more commonly women reported a non response, when health visitors did not enquire about abuse or respond to women's disclosure or women themselves declined

to disclose their experience of domestic abuse. Most women in this study stated that the health visitor did not ask about the police reported incident and did not enquire about the relationship or the woman's health. However, women had such low expectations of the health visiting service that they did not describe this as a negative or disappointing response. As stated, they anticipated that health visitor involvement would compound their problems by introducing child protection measures and so despite women's awareness of abuse, risk and health needs they declined to engage with health visitors. This is consistent with the reports of survivors interviewed by Peckover (2003a).   There is a striking similarity between a statement Peckover's study (2003a) with health visitor service users that "*I could have done with just a little more help*" and that of Olivia in the current study who wanted health visitors to "*help a bit more*". The findings of the current research indicate that women's support needs are modest, yet they rarely receive an adequate response from health visitors.

7.7.3.3 Risk Assessment

A notable omission from the experiences described by women in this phase of the study was assessment of risk of harm to women and when risk was identified, an absence of action to minimise or prevent further harm. Women were not advised about safety planning or legal and civil protection orders, even when they disclosed domestic abuse to health visitors. Risk assessment forms a core component of health based domestic abuse interventions. The March of Dimes protocol (Parker et al 1999, McFarlane et al 1997) and subsequent adaptations of this (section 3.5.3), placed risk assessment and safety planning at the centre of interventions. Similarly, guidance for health care workers in Scotland issued in 2003 and again in 2009 directs every health professional to assess risk and discuss safety planning with women after a disclosure of domestic abuse (Scottish Government 2009a).   Domestic abuse specific guidance aside, health visitors hold a professional duty to raise concerns about people in their care (NMC 2015). Therefore, omission of risk assessment is a substantial limitation of the current response.

7.7.4 Strengths and Limitations of Phase Three of this Study

7.7.4.1 Study Sample

The representativeness of the sample achieved is a strength of this phase of the research. The sampling criteria aimed to identify a range of women who had experienced domestic abuse. While all but one woman had exited the relationship the sample included a diverse

group in terms of age, geographic location, number of children, disclosure of domestic abuse to health visitors and the nature and consequences of abuse experienced. The strategy of participant recruitment through health visitors was not successful and yielded only 4 of the 17 interviews conducted in this phase of the study. Health visitors reported that they did not have the opportunity to invite many women to participate. However, the approach of those who did may have deterred potential participants. The current study focussed on police reported incidents and sought to understand the context of isolated incidents, described by health visitors in phase one of this research, and the support needs of women involved in these incidents,. Therefore the study aimed to recruit women who had been involved in a police incident but may not have defined their experience as abuse or indeed, had not experienced ongoing domestic abuse. However, some health visitors presented this research to service users as a "domestic abuse study" and at least two potential participants declined to participate as they stated they were not experiencing domestic abuse. This was a missed opportunity to explore the relationship context and the experience of the health visitor response in this circumstance. It is possible that other health visitors had presented the research in a similar manner, thus creating selection bias. The wider implications of the health visitor engagement with recruitment are discussed in the following chapter (section 8.3).

The support of ASSIST provided a helpful alternative to recruitment through health visitor services. ASSIST receive notification of all victims of police reported domestic incidents. So, unless contraindicated by involvement in a recent incident or crisis at the time of recruitment, all women were invited to participate by ASSIST workers whether they had opted into the advocacy service or not.

A further strength of this sample is that it enabled data collection in a geographical area coterminous with data collection in phases one and two of the study and within three years of the initial health visitor focus groups to enable triangulation and complementarity of each component of the research (discussed further in Chapter 8).

7.7.4.2 Data Collection

In the current study interviews successfully elicited the views and experiences of women in relation to a sensitive subject of domestic abuse; however, telephone interviews were typically shorter than face to face interviews. In part this is attributable to the experience of the researcher; in particular their concerns about privacy and willingness of participants

to respond to some issues when they were unable to observe the environment or non-verbal communication.

Location and facilitation of face to face interviews aimed to create an environment where women wished to share their experiences. The observation of the researcher and rich data provided by participants in face to face interviews suggests that this was achieved. From an ethical and feminist perspective the interviews successfully enabled women to contribute their views to the evidence base without undue burden on them as participants. Indeed some women found the experience to be a positive as supported by the findings of the Response to Research Participation Questionnaire (RRPQ, Appendix 4.3). In summary, responses to the RRPQ indicated that all service user participants agreed that, with hindsight, they would still take part in the research and the majority stated that they had gained something positive from participating. Even though three women stated that participating had made them think about things that they did not want to they agreed that the experience had been positive.

7.8 Chapter Summary

This chapter presented the findings of phase three and discussed them in relation to the existing literature. Findings on women's experience of abuse and of the health visitor response are supported by current evidence and provide further insight to challenges of engaging with services and the impact of a poor service response.

The following chapter (Chapter 8) will revisit the key findings, integrating them with the findings of the two earlier phases of this research reported in chapters 5 & 6.

8   Integration of Findings

8.1 Chapter Introduction

The findings of each phase of this research were discussed in the context of the literature in chapters 5, 6 and 7. The study employed a mixed methods design in which the findings of each phase complement or triangulate the findings of other phases (section 4.3). Researchers such as Simons & Lathlean (2010) and O'Cathain et al (2007a) state greater insight and understanding of a subject is obtained through the integration of qualitative and quantitative findings as this provides a more comprehensive understanding thanthat obtained from each individual research component (Simons and Lathlean 2010; O'Cathain 2007a, O'Cathain 2007b). However, Bryman (2007) states that researchers encounter a range of difficulties in achieving "genuine integration" of mixed methods research findings. These include underlying ontological and epistemological assumptions about the incompatibility of qualitative and quantitative approaches; pressure to clearly present findings to specific audiences, for example, quantitative data for funders; and study design, for example if sequential, the method of initial phase may dominate subsequent phases. As a result, findings are often presented alongside one another rather than as the findings of a single study. To some extent, the pragmatic approach to research, and the interdependence of the research questions in the current study, facilitated integration of qualitative and quantitative findings. This provided a rich description of the service response to domestic abuse, enabled findings about the extent of domestic abuse to be challenged and through this demonstrated a limitation of the service response, and, further, developed a deeper understanding of the behaviours of health visitors and service users.

Phase one and phase three both employed qualitative methods which complement one another and reveal contrasting perceptions of two participant groups. As a result, this study increases the understanding of the ways in which barriers to addressing experiences of domestic abuse are created, sustained and impact on the interaction between women experiencing domestic abuse and health visitors. In this chapter, the integration of findings from all three phases is discussed.

The research questions in the current study sought to describe the health visitor response to women experiencing domestic abuse, in particular, describing protection and safety and the response over time (phase one). The study also sought service users' views of this

response and their support requirements, if any (phase three). Beyond this, the research aimed to understand limitations, if any, in the provision of support to women experiencing domestic abuse. In the course of the study, further questions emerged regarding the nature and extent of domestic abuse experienced by women involved in police reported domestic incidents (phases two and three). A mixed methods study design was initially adopted to enhance credibility of findings and present a complete picture of the interaction between health visitors and service users through triangulation (Bryman 2006). Bryman (2006) states that additional benefits of integration can be found during the research process, as was the case in the current study.

In this study consideration of different perspectives uncovered a dynamic which accommodates, rather than addresses, the structural, personal and abuse-specific barriers encountered by women living with domestic abuse and health visitors who have a role to support and protect them. The integration of findings has exposed a cycle which sustains preconceptions of both women and health visitors, falsely affirms health visitor assessments and perpetuates delivery of a service response which does not adequately meet the needs of women living with domestic abuse. In this chapter evidence from the current study is presented to support these assertions.

8.2 The Nature and Extent of Domestic Abuse Experienced by Health Visitor Service Users Involved in Police Reported Domestic Incidents.

8.2.1 Nature of Abuse in Police Reported Domestic Incidents

The need for contemporary, service specific evidence arose when health visitors in phase one created a distinction between women involved in police incidents and women experiencing domestic abuse. Integration revealed a key finding of this research; health visitors' underestimate the nature and extent of abuse experienced by women and children in their care. This first emerged from triangulation of findings of phase one with those of phase two. Divergence was found between health visitor observations in phase one and the characteristics of domestic incidents described in the secondary analysis in phase two. Health visitors, in phase one, substantially underestimated the extent of repeat victimisation as the majority of police reported incidents (phase two) and accounts of women involved in police reported domestic incidents (phase three) highlighted.

The use of mixed research methods has provided a richer description of the background to police reported domestic incidents. The quantitative analysis, in phase two, demonstrated the extent, and to some degree the nature, of police reported incidents. Qualitative research in phase three complemented this by providing insight to woman's experiences during and between incidents, providing important contextual information on reported and unreported abuse. Thus health visitors' statements that incidents were isolated events was unsubstantiated.

Similarly, in phase one health visitors stated that police reported incidents were frequently minor however, phase two found that a considerable proportion of women involved in police reported incidents had been victims of a recorded crime (87%), had been injured as the result of a domestic incident (40%) or had physical violence or weapons used against them during an incident (62%) (section 6.5.7). Interviews with service users involved in police reported domestic incidents also found numerous examples of use of severe violence and resulting injury which again indicate that police reported incidents are often major, rather than minor, events. Phases two and three both found that police reported incidents of domestic abuse occurred within the context of ongoing domestic abuse for the vast majority of women. From the work of Jaffe & Burris reported in 1984, to more recent findings from the Scottish Crime & Justice Survey (Scottish Government 2014b) (Chapter 2), the literature supports the findings of phases two and three in reporting high levels of repeat victimisation and of physical injury resulting from domestic incidents. Although unsurprising, this finding is a useful contribution which can inform the health visitor response to domestic abuse.

Sexual abuse is often under-reported as it is associated with shame and stigma for victims and for some, difficulty in identifying sexual abuse as such within relationships (Ellesberg & Heise 2005). It is notable that, although relatively small samples in the current study, two of 17 service users (12%) in phase three disclosed experience of sexual abuse from their partners, only 1% of women in phase two (n=1) reported sexual violence to the police and disclosures of sexual abuse were absent from focus group discussions with health visitors. Rather than demonstrate convergent validity (Sandelowski 1995), this finding demonstrates limitations of each of the three phases in eliciting disclosure of sexual abuse. Research has demonstrated that sexual abuse frequently co-occurs with physical abuse, with between one fifth (Scottish Government 2014b) and two thirds (WHO 2005) of

women who have experienced domestic abuse reporting they had experienced sexual abuse from a partner (section 2.4.3). However, this is frequently under-reported, particularly to the police, due to stigma and shame experienced by survivors of this abuse and, for some, difficulties in recognising this as abuse (Ellesberg & Heise 2005). Therefore, the single report of sexual abuse in phase two police data is predictable. Likewise, lack of disclosure of sexual abuse to health visitors due to aforementioned barriers (lack of relationship, fear of loss of children, stigma) is also predictable. Walby & Allen (2004) state that asking specific questions about sexual assault and providing self-completion questionnaires can facilitate disclosure of sexual abuse. This is the method used in the Scottish Crime & Justice Survey (Scottish Government 2014b) and could explain the higher disclosure rate compared to the current study where open questions about their partner's behaviour were used to give control of the level and nature of disclosure to women. Therefore it is possible that other service user participants had experienced sexual abuse and declined to disclose but the sample size (n=17) did not allow robust conclusions to be drawn.

The findings of phase two and phase three agreed that while violence was a common feature of domestic abuse, for the majority of service users ongoing abuse was primarily controlling and psychological in nature. This is supported by phase two data which showed the majority of police reported incidents involved intimidatory or threatening behaviours (for example 16.5% of incidents involved physical assault and 35% threatening or intimidatory acts) (section 6.5.4). In addition, the secondary analysis found around half of the incidents were perpetrated by an ex-partner (52%), again supported by the findings of phase three where service user participants described ongoing abuse from partners after separation. In contrast, discussion on responses to women experiencing psychological abuse in isolation or continuing domestic abuse following separation were absent from focus group discussions and indicates that health visitors do not often recognise or respond to this.

Further inconsistency was found between phases one and two in relation to the involvement of children and use of alcohol in police reported domestic incidents. On the question of involvement of children, the integration of findings enhances the understanding of children's exposure to domestic abuse. In phase one, health visitors rarely identified risk to children whose parents had been involved in police reported incidents. Health visitors reported that domestic incidents often occurred outwith the family home were children when not present. Phase two found that three quarters of domestic incidents

occurred in the victim's home and 41% of women had children directly involved in, or aware of, abusive incidents. Further, in phase three, all but one participant stated that their children were aware of, or directly involved in, abusive incidents. Consequently, children were exposed to abuse more frequently than health visitors perceived.

The discrepancy between the lower reported rates of children's exposure in phase two and the higher in phase three may be explained by recorder or reporter bias. In interviews with service users, women made reference to young babies being in the same room or elsewhere in the home during the incident and reported concerns for their children's safety and wellbeing as a result of this exposure. However, observers, such as police officers, may not consider babies or very young children to be sufficiently aware of an incident to record this as exposure. It is also possible that, due to concerns about child protection procedures, fewer incidents involving children are brought to the attention of police. Further, the findings of phases two and three were drawn from different samples, therefore, there is insufficient evidence in the current study to draw conclusions.

Integration of the research findings indicates that while children were a priority for health visitors', indeed "children are priority" formed a mantra to guide practice, health visitors rarely identified a need for child protection action. However, the means for assessing the wellbeing of children appeared minimal and did not assess the wider behavioural or psychological impact. Risk and wellbeing was assessed as a snapshot rather than consideration of potential physical and psychological impact from ongoing risk (section 5.8.3). Again, integration of findings has provided a richer context for findings and exposed a gap in the service response.

Although alcohol use was recorded in around half of the domestic incidents in phase two, this was not consistently associated with police reported domestic incidents. In only a quarter of police reported domestic incidents, both partners had consumed alcohol and in almost half (47%), neither partner had consumed alcohol. Similar to the findings of Galvani (2004), service user participants in the current study stated that their partners were abusive whether they, or their partners, had consumed alcohol or not (phase three). Therefore, it seems that health visitors misjudge the nature of police reported domestic incidents, but as discussed in section 3.2.2, it is common for women who have consumed alcohol to be assigned some responsibility for their abuse and for abuse itself to be minimised (Leonard 2001, Harrison & Willis-Esqueda 2000).

Integration of findings from all three phases of this study showed that health visitors make a clear, but unfounded, distinction between domestic incidents and domestic abuse. In minimising domestic incidents, health visitors considered responses to domestic abuse to be unnecessary for women involved in incidents. Yet the findings of phase two and phase three suggest that involvement in police reported domestic incidents is indicative of ongoing domestic abuse. Therefore, in contrast to the health visitors' views and practice, responses to domestic abuse, such as discussing the dynamics of domestic abuse, safety planning etc. was appropriate for many women involved in police reported domestic incidents.

8.2.2 Impact of Domestic Abuse

The findings of phase three of the current study indicate that women's experiences of serious assault, and subsequent requirement for hospital treatment, are under-represented in the secondary analysis of police data. From police data analysis in phase two, it was noted approximately one fifth of women reported a physical assault and only 4% of women required hospital attention for injuries. In contrast, all but one of the service users, interviewed in phase three, described a serious violent assault by their partner. As noted, few incidents are reported to the police and so disparity between qualitative and quantitative phases is to be expected. Again, findings were drawn from different samples. However, this provides an important contribution to the discussion on the seriousness of incidents that come to police attention (sections 5.8.1 and 6.6.2). In phase three participants described frightening and violently abusive incidents which resulted in injury but did not come to the attention of police. Although a small qualitative sample, this suggests that incidents reported to the police are not necessarily the most serious in terms of immediate physical risk.

8.2.3 Women's Awareness of Domestic Abuse

The integration of findings presented a new insight to women's awareness of abuse and the potential for health visitors to support women to recognise risk from abuse. In phase one of the current study, health visitors reported that women were often unaware that they were experiencing domestic abuse and declined to talk about their relationships or the police reported incident. For health visitors, this presented the greatest barrier to engagement. They stated that women had to become aware of the abuse themselves and did not believe

that they could support women to recognise the abuse or risk. Health visitors placed responsibility on women to disclose and prepare to exit the relationship and did not work to elicit a disclosure even when they as professionals were aware of, or suspected, domestic abuse.

This view was also expressed by three service users in phase three who stated they did not anticipate there was anything health visitors could do to help them recognise abuse in their lives. The majority of service user participants in phase three stated that they did not immediately name their partner's behaviour as domestic abuse.   Most often, lack of awareness occurred in periods when partners emotionally or psychologically abused them and attempted to control their behaviour. They described difficulty in viewing their situation objectively when exposed to psychological abuse. Three women concurred with the health visitors, stating that they needed to see their partners' behaviours as abuse in their own time. However, women who engaged with the ASSIST service stated that they were able to re-evaluate their relationship and identify domestic abuse with support from ASSIST workers.

Women's difficulty in recognising abuse is well documented in the literature and was described in section 2.2.4 and 2.3. With reference to the six stage model of exiting abuse developed by Kelly et al (1999) (section 2.2.4), service user participants in this study, described moving from stages one or two (managing the situation and distortion of reality) to stages three or four (defining abuse and re-evaluating the relationship) through telephone conversations with ASSIST workers. Women described the role of ASSIST workers in supporting them to identify patterns in their partners' behaviours and the impact of these behaviours on the woman's behaviour and wellbeing which ultimately supported them to recognise and name domestic abuse. It is possible that criminal proceedings and the involvement of criminal justice professionals such as the police and procurator fiscal also helped women to define their experience as abuse and that ASSIST's intervention was timely. Nonetheless, the experience of ASSIST suggests there is potential for other services to support women in this way and health visitors may be able to learn from ASSIST's approach and practice.

Despite health visitor reports (phase one) that they were often aware of abuse when women were not, data from phases two and three of this study suggest that more often women had become aware of the abuse when health visitors had not. Indeed health

visitors' differentiation between police reported incidents and ongoing domestic abuse substantially underestimates the impact of abuse in the lives of their service users.   More commonly, women in the current study did, quickly recognise abuse.   Women demonstrated their awareness of abuse by describing fear (Emma), attempts to prevent further abuse (Grace), acts of resistance against abusive partners which included retaliatory violence (Helena, Grace), secretly preparing to exit (Helena), defiant actions to make their partner uncomfortable (Anna) and attempts to conceal their experiences of abuse from others (Olivia, Nicola) (section 7.6.2). Therefore, the majority of women had defined their experience as abuse but declined to disclose to the health visitor. Bradbury Jones et al (2014) presented a conceptual framework, AWARE, to illustrate levels of awareness of domestic abuse between health professionals and service users (introduced in section 3.3.3). Bradbury Jones et al (2014) used the term "openness" to describe when both the health professional and woman are aware of abuse. Beyond awareness, Bradbury Jones et al (2014) state that openness must also include a discussion between a health professional and service user about domestic abuse. The findings of this study suggest that a meaningful discussion or shared understanding of the situation is not common, even when both the woman and health professional are aware of the abuse. Both health visitors and service users described a denial of domestic abuse and limited response from health visitors but each attributed different causes.   Exploring this interaction from both a health visitor and service user perspective highlights the well documented barriers to disclosure, such as fear of losing children and of violent retribution from abusive partners, and a service response which places responsibility on women to overcome these without recognising a service role to support this.

The findings of this research suggest that health visitors underestimate the severity and ongoing nature of abuse experienced by service users. This in turn suggests that women who are eligible for, and require support do not receive this. However, it is important to understand why this occurs.

8.3 Responses to Domestic Abuse

8.3.1 Describing Health Visitor Practice

At the outset, this study aimed to describe the health visitor response to domestic abuse but health visitor participants provided few examples of this. Therefore, focus group data gathered in phase one, predominantly explored the health visitor response to women

involved in police reported domestic incidents which they discussed in different terms to domestic abuse (section 5.8.1). Whether there was disclosure of domestic abuse, or suspicion of abuse, the response provided by health visitors was similar. In brief, the response entailed a visit to the home of the woman, asking the woman about the incident, advising women of the impact of domestic abuse on children, signposting to other services and an open offer of support. Few women disclosed or requested further support and therefore follow up was rarely arranged. Thus, an ongoing response was rare and, when it did occur, responsibility was placed on women to take action and determine which supports they required. In contrast, women described the difficulties in negotiating living with an abusive partner (also described by Pain 2012 and Williamson 2010), lack of awareness of supports available to them and a perception of health visitors as children's nurses. The findings of phases two and three of this research suggest that the most common response provided to women involved in police reported domestic incidents does not adequately address the consequences of abuse to meet the needs of service users.

In phase three of the current study, women valued regular contact with health professionals who displayed a genuine interest in the woman's well-being. However, accounts of health visitors and the majority of service users in the current study suggest that this is rarely the case. Data from phase one provided insight to the health visitor perspective and provides some understanding of why more frequent visits are not part of the routine response to police reported domestic incidents. The majority of health visitors stated that frequent or regular visits were not feasible for several reasons: visits had to be outcome focussed and they could not identify an outcome which fitted with their priorities; they did not have sufficient time to conduct these visits and they did not want women to become emotionally or socially dependant on health visitors. Therefore, the positive elements described by a minority of women in phase three do not reflect the usual response described by health visitors in phase one, nor the experience of the majority of women in phase three.

In the limited contact that did occur, service user participants reported disappointment in health visitor response to their requests for help in relation to health issues for themselves or children and to service users' concerns about their children's safety. Again, integration of the findings of phases one and three show a divergence in health visitors' and service users' interpretation of the interaction between them and the role of the health visiting service. Phase three data showed that women were frequently disappointed when they disclosed domestic abuse and associated problems relating to their own health or their

children's behaviour (section 7.7.3). Child health surveillance and addressing concerns of parents are at the core of the health visiting role (Scottish Government 2005) but service users reported that their concerns for their children were rarely acknowledged or acted upon. The service users' expressions of need contrast with the findings of phase one, where health visitors reported that women most commonly declined, or did not require support. Hence, this study presents a greater insight to the health visitors' rationale for limited follow up when domestic abuse is suspected or disclosed. In turn, this presents an opportunity to inform health visitor decision making by presenting potential benefits of visits.

Many women in phase three described their partner's attempts to isolate them from family and friends and restrict their contact with anyone outside of the immediate family. As health visitors provide a service to all families, and can provide this within the family home, they were often the single service women could contact without arousing their partners' suspicion that they were seeking help. Yet, health visitors in phase one of the current study reported that they did not perceive a role for themselves as a source of support or information beyond their health remit. Rather, they signposted to other services stating that women who were ready for support would engage with services independently. Indeed, some health visitors reported that their inability to provide this information encouraged women to engage with other services. Therefore, the response described by health visitors did not acknowledge or aim to address controlling and isolating behaviours (such as freedom of movement), described by survivors of abuse, and the very real risk of violent repercussions for women (section 7.6.2). This is a further example of disconnect between knowledge and practice, identified in phase one where knowledge of the dynamics of abuse was present, but no attempt was made to address the consequences of abuse in practice (section 5.6.4). Rather, health visitors interpreted women's lack of freedom or ability to contact services and their attempts to conceal abuse as a lack of readiness to engage with services.

In phase three, five service users were dissatisfied with the health visitor response to child protection concerns relating to contact post separation. Most service user participants stated that domestic abuse persisted following separation, and that children continued to be involved in, and exposed to, abuse during this time. Women were concerned about their partners' behaviour towards them at the time of handover and their partners' ability to care for children. They reported that health visitors did not respond to these concerns and

maintained a "neutral" stance, supporting the mother and father equally even in cases where social workers had become involved. Service users reported that neutrality was maintained even when child protection measures had been instituted due to the extent of the domestic abuse. Given the priority assigned to child protection by health visitors in phase one, this is an unanticipated finding which indicates an inconsistency in the application of child-centred care. Health visitors are the first point of contact for any women concerned about their children's wellbeing, safety and development and have a responsibility to initiate support for any child who requires "extra help" (Scottish Government 2011b p4). Health visitors are explicitly directed to consider additional risks to children from exposure to domestic abuse (Scottish Government 2005).

Service users were frustrated that, after separation, services continued to visit their home but did not consider their partners a risk to children once they left the family home. They interpreted this as services viewing them, rather than their abusive partners, as a risk to the children as their ability to parent was monitored but there appeared to be no repercussions for their abusive partner. Therefore, the fear that their children would be removed from their care continued post separation, maintaining barriers to disclosure and seeking help from health visitors. Post separation contact was discussed only once in health visitor focus groups in an example which indicated sympathy for the woman's concerns but a lack of opportunity to raise concerns about child protection beyond the family home.

This finding is consistent with the three planet model, developed over 10 years ago by Hester (2004), which described disconnect between child protection, child contact and domestic abuse agencies which adopt three, incompatible, approaches (section 3.4). The model states that domestic abuse agencies consider men responsible for the abuse and aim to protect women and children; child protection workers hold mother and father equally responsible for placing the child at risk and services engaged in child contact perceive the involvement of both parents to be of most benefit to the child. In the examples provided by service user participants in this study, only the ASSIST service (a specialist domestic abuse agency) appears to recognise and respond to the risks for both women and children. After separation, health visitors and social workers continued surveillance but only in the family home, even when women identify an external risk. Therefore, integrating findings from phases one and three reveals that disconnect persists. The service response described in phase one (Chapter 5) attempts to place child protection at the centre of assessment and

decision making when, in practice, this only extended to assessing the mother's care of children.

8.3.2 Establishing Relationships

Underlying women's concerns about confidentiality and losing the care of their children is a lack of understanding of the health visitor role and the absence of a relationship with a health visitor. As stated, service users reported little contact with health visitors. When contact did occur women observed that health visitors focussed on the physical wellbeing of their child. Therefore, they perceived the health visiting services to be child health services rather than a resource for the health and social needs of the family. Despite long standing guidance to health visitors to move to a holistic approach (Hall 1996) health visitors in the current study also described a child-centred response and biomedically oriented service outcomes; thus, women's perceptions of the health visitor, drawn from their own observations, were an accurate interpretation of the service delivered in practice but differed from the defined role of health visitors as a family support.

Whilst there was concurrence in the views of health visitors and service users, that they did not have a relationship, once again there was divergence in the understanding of why this occurred. Health visitors associated the lack of relationship with reduced routine visits and increasing workloads. In addition, they described pressure to justify any time spent with service users and to demonstrate they used time to achieve service outcomes. Health visitors stated there would be little benefit to visiting women without a clear objective. In addition, they stated that softer outcomes of support visits could not be aligned with defined service outcomes and therefore, could not be justified. Yet, service users in phase three appreciated contact, even when visits appeared to have no predefined purpose.

This divergence of views has implications for policy makers and planners in health services, who expect the organisational duty to identify and protect families at risk to be addressed through a health visitor service. In the current study, this was often not the case. Women did not anticipate any benefit to disclosing to health visitors but did anticipate negative repercussions. They perceived health visitors to be a threat to their family unit which led to concealment of abuse. Health visitors perceived lack of disclosure as confirmation that women had not experienced domestic abuse or had not defined their experiences as abuse, consequently they did not offer further contact or support, and so a cycle develops which reinforces misconceptions. The cycle continues as lack of contact

deters requests for help and health visitors view this as confirmation that support was not required (Figure 8.1).

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┌─────────────────────┐              ┌──────────────────────────────┐
│ Health visitors     │              │ Health visitors lack of       │
│ underestimate extent │    why?     │ knowledge on extent of        │
│ and nature of abuse  │ ═══════►    │ domestic abuse.               │
└─────────────────────┘              │ Health visitors lack knowledge │
                                     │ on stages of abuse (phase 2)   │
                                     │                               │
                                     │ Women conceal experiences of   │
                                     │ abuse and decline offers of    │
                                     │ support (phase 3)             │
                                     └──────────────────────────────┘

┌────────────────────────────┐                      │ why?
│ Health visitors interpret   │                      ▼
│ policy as child- focused    │              ┌──────────────────────────┐
│ approach                    │              │ Women fear of loss of     │
│ Time constraints prevent    │              │ children, further violence,│
│ addressing mothers' issues. │              │ loss of confidentiality and│
│ Lack of disclosure and      │              │ loss of control (phase 3).│
│ request from women supports │              └──────────────────────────┘
│ belief that domestic abuse  │
│ is not an issue (phase 3)   │
└────────────────────────────┘
                    why?        ┌──────────────────────┐    why?
                                │ Women observe health  │
                                │ visitor role as        │
                                │ exclusively for        │
                                │ children and child     │
                                │ protection (phase 3)   │
                                └──────────────────────┘
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Figure 8-1 Negative Interaction Cycle

However, women did establish positive relationships with and accept support from ASSIST. Through this relationship, women often sought support with issues which were outwith the remit of the organisation. The role of ASSIST is primarily to support women in relation to their partner's prosecution for domestic abuse offences; however, women reported the advocacy role extending beyond this to support their access to health services and respond to women's concerns about their child's health or safety. Experience, or anticipation, of an inadequate health visitor response deterred women from seeking health visitor help. Instead service users in this study sought support for health and parenting issues from ASSIST, a resource which they perceived as more accessible and responsive, but which was not designed to fulfil this role. This in turn, removes an opportunity for health visitors to engage with women on parenting, health promotion and health protection which are part of the essential universal health visitor service. Consequently, this study concludes that the presence of domestic abuse, and the health visitor response to this, prevented fulfilment of the universal health visitor service aims. Women's approach to non-health services further obscured their support needs from health visitors and contributed to the cycle described above.

Survivors of abuse may seek support with practicalities, such as finance or housing, rather than support in dealing with their experiences of abuse (Curry et al 2006, Petersen et al 2003). Curry et al (2006) and Petersen et al (2003) recommend that services respond to the priorities set by women when possible. From the accounts of women in phase three, ASSIST workers engaged with women on issues such as child contact. The findings of phases one and three describe a different and less effective approach from health visitors who work within the limitations of a prescribed response focussed on immediate risk to children.

Nevertheless, two service users stated that a health visitor had provided practical support for issues indirectly related to their experience of domestic abuse. For one this was provision of baby equipment. Whilst the equipment itself was appreciated, the woman stated that the health visitor's gesture of support and familiarity with her situation was of greater importance. Health visitors in phase one provided some examples of delivering practical support but reported that they were usually unable to offer this and referred women to other services for this support. Again, this suggests that the positive experience of practical support enabled a trusting and supportive relationship but this appears to be an example of one individual practitioner exceeding standard practice.

8.3.3 Health Visitor Engagement with Domestic Abuse

Integration of findings in the current study suggests that the health visitor response, described in phases one and three, creates barriers to engagement with women experiencing domestic abuse. In this study, issues arose at the level of individual practitioners (e.g. knowledge, placing responsibility on women to exit an abusive relationship) and at operational and organisational levels (workload and service outcomes). The discussion in Chapter 7 drew on the literature to consider motivation not identified by health visitor participants such as self-protection from vicarious trauma and attempts to maintain manageable workloads. Silverman (2000) states that research on health professionals' practice can develop from underlying assumptions that participants' practice will be substandard. Researchers may focus on errors or omissions in the accounts of participants in an attempt to uncover poor practice and assign blame for issues which emerge. Therefore, Silverman (2000) urges researchers to seek to understand the context in which these actions occur, rather than simply describe the action, and allocate blame. In the current study, the potential to direct blame exists in relation to health visitors where,

alongside exceptional examples of good practice (such as provision of practical support to service users), individual attitudes also appeared to limit the health visitor response.

The findings of phases one and three of this study demonstrate that, even when women believed to be at risk of abuse are brought to their attention, health visitors provide a minimal response. Health visitors stated that barriers to asking women about domestic abuse included lack of relationship and conversely, fear that asking would jeopardise a relationship if established. These concerns are common amongst health professionals (section 3.3.6). Further, the literature suggests that health professionals may be reluctant to engage with survivors because of concerns about their ability to respond, personal beliefs about domestic abuse or, in more recent literature, because of their own experiences of abuse (section 3.3.6). The findings of phase one indicate that the health visitors did not fully understand the impact of domestic abuse on women and are unaware of the stages of exiting an abusive relationship, and importantly, were unaware of the opportunities to engage with women at each stage. However, responses regarding use of alcohol and assigning responsibility to women to recognise and exit abusive relationships suggests that victim blaming attitudes may restrict the response to abuse, rather than a lack of knowledge or confidence. The extent to which personal beliefs influence the level of identification of domestic abuse, and the extent to which a response is delivered, by health visitors is beyond the scope of the current study.

The recruitment of service users in phase three of this research provided supplementary evidence regarding health visitors' perceptions of domestic abuse and their role to respond. In a four month period only one potential participant was identified by 30 health visitors who had agreed to support the study. Health visitors reported that they had received very few notifications of police reported domestic incidents in this period and that, when received, they had not had privacy to discuss the research with the majority of women. These barriers to recruitment indicate health visitors' lack of willingness to engage with women about domestic abuse and contribute much to the debate.

Despite reporting a considerable reduction in the number of notifications of police reported domestic incidents (from two to four each week to weeks without a notification), none of the health visitors had questioned why this change occurred. On investigation, the researcher was advised that protocols remained the same and that health visitors should still be aware of and responding to families involved in domestic incidents. Therefore,

women and children continued to be exposed to domestic abuse during this period and health visitors were still expected to respond but at a practice level were not doing so. This provides further insight to health visitors' perceptions of police reported domestic abuse incidents. If notified of all police reported domestic incidents, health visitors' own records should demonstrate the extent of repeat victimisation which could inform their assessment of the situation. Inconsistency in the information sharing mechanism, and irregular reports of domestic incidents (phase two) could hinder health visitors' awareness of an indicator of domestic abuse.

Health visitors who had received notification of police reported domestic incidents in the recruitment period stated that they had visited women but had not been able to discuss this research with women in private. This suggests that they had not had privacy to discuss the police reported incident with women either. Without the woman's input it is not possible to assess risk to the woman or her child accurately, and to incorporate the woman's views of support and protection needs (Scottish Government 2009a; Campbell et al 2009). This brings into question the value of a visit in terms of safety and protection if the actual incident is not discussed and the context of the relationship not explored.

In this section, the health visitor response has been considered in relation to the experiences of women in phase three, the research process and the literature. While it is not possible to draw firm conclusions on the extent to which organisational or individual factors limit the identification of, and responses to, women experiencing abuse, the current study does identify that service improvement can only be achieved by addressing challenges on a number of levels.

8.4 Strengths and Limitations of the Study

Some limitations of data collection were discussed in chapters 4 to 6 of this thesis to enable consideration of issues pertinent to each phase of the study. These limitations included dominant voices in the focus groups in phase one of the study (section 5.8.5); identification of health visitor service users and data recording processes in the secondary analysis in phase two (section 6.4.4) and recruitment of participants in phase three (section 7.5.3). In this section limitations and strengths of the overall study design will be discussed.

In the current study, a comparison of data gathered from groups of health visitors were made with a group of service users. The groups were recruited separately and so the service user participants may never have had contact with the health visitor participants. This study could have been strengthened by gathering data from service users who had experienced domestic abuse or been involved in a police reported domestic incident and the health visitors who had visited them at home. Matching of health visitors and service users would have enabled a direct comparison of health visitors' assessment of health needs and risk following a police reported domestic incident with the experience reported by women. However, health visitor gatekeeping and limited engagement with women who are experiencing abuse suggest that recruitment would be challenging. Data gathered from health visitors and service users indicates similar experiences and suggests that, despite the lack of pairing, the sampling strategy was sufficient to accurately answer the research questions.

All data was gathered within three NHS Board areas to enable comparison and integration between each of the three phases. This enabled some comparison in practice and experiences. However, the impact of policy direction on the approach of health visitors indicates that some findings may be limited to a Scottish context. Participants were predominantly of white British or white Scottish ethnic origin with only 7% of the sample in phase two from Asian or other ethnic backgrounds. Therefore, transferability of some findings, particularly in relation to service users' access to supports and nature of abuse experienced, may be limited. However, some diversity was achieved to produce a varied sample. Phases one and three of the current study successfully recruited participants from a range of geographic areas, including rural and urban settings. Service user participants had a wide range of age, number of children and differing experiences of domestic abuse, while health visitor participants had wide ranging experience in terms of both responding to domestic abuse and in years in health visiting practice.

Sample sizes were determined with guidance from the literature and using a pragmatic approach to identify a feasible sample size. Although small, qualitative samples were sufficient for the researcher to judge that data saturation had been achieved in the qualitative phases of the study as no new themes emerged towards the end of data collection. Guest et al (2006) found that saturation can be achieved in as little as 12 interviews and that overarching, or "parent" themes can be identified in as few as six interviews.

The three phase study design enabled comparison of views of differing groups with further context provided through the analysis of quantitative data. The use of a flexible mixed methods study design enabled emerging research questions to be addressed using the most appropriate methods and was successful in answering all research questions.

8.5 Chapter Summary

A mixed methods approach enriched the study findings, identifying areas of divergence and convergence in the findings of study phases. Overarching themes which have emerged through this process include health visitors' lack of awareness of domestic abuse and risk associated with police reported domestic incidents; a minimal and usually brief response to women living with domestic abuse and the lack of relationship between health visitors and service users resulting from a child focused approach and service constraints.

The majority of findings are confirmatory in nature but this study has identified some new and emerging issues regarding the health visitor response. Key findings from the integration of this mixed methods study indicate that health visitors often do not recognise or adequately respond to women experiencing domestic abuse; the absence of relationship between health visitors and service users; service users' misconception of the health visitor role. Further, the findings reveal convergence in health visitors' and service users' description of interactions between them, but divergence in the understanding of the interaction itself, and the outcome. This provided new insight to the negative dynamic between health visitors and service users. In addition, integration identified the omission of some aspects of care assumed to be "core" to the health visiting service such as establishing a relationship; responding to the whole family; assessing risk; protection of vulnerable adults and children and responding to health needs of women and children. The following chapter (Chapter 9) will present the conclusions and recommendations of the study.

9 Conclusions and Recommendations

9.1 Chapter Introduction

This chapter presents the conclusions of the study and defines the contribution that this research makes to the evidence base. Findings of this study have relevance to both clinical practice and future research. Recommendations for each will be presented.

9.2 Conclusions

This study concludes that police reported domestic incidents are likely to occur within the context of ongoing domestic abuse and that women involved in these incidents have health and support needs associated with survivors of domestic abuse. Therefore health visitors have a duty to identify this risk and respond to support and protection requirements. However, this study has found that health visiting services provide little ongoing support to families affected by domestic abuse. Barriers to health visitors delivering appropriate support include:

- Child-centred practice and policy
- Service constraints / workload
- Lack of routine contact and relationship between service users and health visitors.
- Women's concealment of abuse
- Disconnect between knowledge of domestic abuse and practice
- Disconnect between policy and practice

Barriers for women in accessing support include:
- Health visitors not recognising or acknowledging experience of domestic abuse
- Non identification of health and support needs by health visitors
- Health visitor responses which do not address the consequences of living with domestic abuse such as fear of losing children and fear of perpetrator.
- Health visitor assessment of risk on an incident rather than the wider context in which they occur
- When women who have not defined their experiences of abuse.

Health visitors are considered an essential part of the health service response to families affected by domestic abuse (Scottish Government 2008b), however, the current study suggests that often health visitors do not recognise domestic abuse and rarely adequately address the health and support needs of women and children, even when alerted to families at risk. As a community based universal service, health visitors have a unique opportunity to observe, assess and respond to families affected by domestic abuse and may be the only point of professional contact for women experiencing domestic abuse yet women choose not to disclose domestic abuse to them.

The finding of this research suggest that the health visiting service does not achieve some of the core aims such as promoting health, supporting parents to care for their children and conducting child health surveillance for families affected by domestic abuse. The relationship between health visitors and service users is viewed as a key enabler for delivery of these aims but both health visitor and service user participants in the current study stated that routine contact visits were infrequent and insufficient to establish a relationship. Therefore health visitor assessments and interactions are not informed by familiarity with the service user or their social circumstances. As a result, indicators of poor health, such as weight loss, go unnoticed. In addition, health visitors reported that due to time constraints, large workloads and child focussed policy, much of their contact with families focussed on the surveillance of children. . This study concludes that there are limitations of the health visiting response before the additional support needs relating to domestic abuse are considered.

Service users observed the health visitors' child focus during contact and perceived that this to be the full extent of the health visitor role. Consequently service users did not consider health visitors as a resource to support them with issues pertaining to their experience of abuse or health needs. Health visitors' policy-directed change in focus from biomedical to child-centred approach appears to have been interpreted and implemented in practice in such a way that the needs of women who experience domestic abuse remain hidden. Health visitors reported that lack of relationship with women made broaching sensitive issues, such as domestic abuse, an even greater challenge which resulted in limited identification and response to this issue.

A further conclusion of the current study is that assessment of risk based on individual incidents is likely to underestimate women's experience of domestic abuse. In addition, the findings of this study suggest that the incidents which come to the attention of police are not necessarily the most severe or extreme incidents and therefore assessment of risk or extent of the abuse based on a single incident will be inaccurate.

This study found little evidence of ongoing to support to women living with domestic abuse and further, that lack of response is not always due to lack of awareness on the part of health visitors. Indeed both women and health visitors may be aware of domestic abuse yet both are unwilling or unable to engage. A substantial barrier to engagement is that the health visitor response described in the current study does not address the known barriers to disclosure of domestic abuse or to engaging with support services.

Three women reported a positive experience of an enhanced health visitor response following a police reported domestic incident. Positive responses facilitated disclosure of abuse and provided support and information to women. The most important aspect of the response was maintaining regular contact. Women valued this contact but health visitor participants in this study considered additional visits to be unfeasible, due to work load, and undesirable, as they perceived it would be of little benefit to service users. The findings of this research indicate that this is the practice of a few individuals and not the standard service response. Positive experiences suggest women's support needs, whether following a single incident or living with domestic abuse, are modest and so little enhancement would be needed to meet the needs of survivors of domestic abuse if the essential health visitor response was achieved.

Despite barriers to engagement with health visitors, service users involved in police reported domestic incidents did engage with a specialist domestic abuse advocacy service called ASSIST. Discussions with ASSIST workers enabled women to recognise domestic abuse, the impact of this on their health and the continuing risk to themselves and their children. Therefore, this study concludes that there are specific barriers to engagement with health visitors. Health visitors and other professionals could learn approaches or techniques to overcome barriers to engagement from specialist agencies.

9.3 Contribution to the Evidence Base

This section will describe the ways in which this research contributes new knowledge and builds on the existing evidence base on the health visitor response to women who experience domestic abuse and more specifically on the health visitor response to women involved in police reported domestic incidents. Although conducted with health visitors and health visitor service users in Scotland aspects of the findings are generalisable to wider groups of women experiencing domestic abuse.

This research addressed a gap in the evidence in relation to describing the health visitor response to women who experience domestic abuse. A mixed methods approach provided a new understanding of the interaction between health visitors and service users following a police reported domestic incident, highlighting the limited response from health visitors and, importantly, the differing perspectives in these interactions between women and health professionals. The majority of women wished to hide their experiences of abuse from health visitors, primarily through fear of losing their children, demonstrating a fundamental mistrust of the health visitor service. This study reveals that women's attempts at concealment are often ineffective. Health visitors' recognise concealment of abuse but associate this with women's readiness to name abuse or exit the relationship. Health visitors perceived that women did not disclose and declined support because they were not experiencing abuse or had not recognised abuse in their lives. If health visitors believed that women did not recognise their experience as abuse, they considered this to be a barrier to further engagement. They did not see a role for themselves in supporting women to do this but rather place of responsibility for exiting an abusive relationship with the victims of abuse. In addition to deepening understanding of behaviours, this provides further insight to health visitors' underlying assumptions about domestic abuse and those who experience it.

This research contributes a rich description of the health visitor response in practice and identified that there is little or no ongoing response to women living with domestic abuse. Further, the current study enabled exploration of the reasons why health visitors respond in such a way. This provided evidence of the time pressures experienced by health visitors and the resultant impact of this on their ability to identify, engage with and respond to women and children exposed to domestic abuse.

In view of the literature, the second phase sought to test the hypothesis that domestic incidents reported to the police were significant, placed victims at risk of harm and occurred as part of ongoing domestic abuse. This phase of the study presented a deeper understanding of the incidents and to the wider experience of women involved in them. This research provides empirical evidence of the strong association between involvement in police reported domestic incidents and experience of ongoing domestic abuse, where previously anecdotal or crime survey data was available. The second phase of this research contributes evidence with which to challenge the perceptions of health visitors and the adequacy of the current response.

This study effectively employed the underutilised methodology of secondary analysis to identify the needs of health service users, from data gathered by partners. The findings demonstrated the great extent to which women involved in police reported incidents have experienced physical violence or use of weapons against them (31% of incidents, 62% of women) and that half of women involved in incidents had children who were involved in, or exposed to, the incident. The secondary analysis also builds on existing theory that incident based analyses underestimate the experiences of abused women (Walby 2005). By analysing police data by individual victim, this research provides evidence of greater exposure to violence, injury and victims of recorded crime.

This research supports and builds upon earlier work in this field providing contemporary evidence in relation to the nature and extent of abuse, barriers to engagement with services and limitations of services in addressing these. Women's fear of losing care of their children is well documented (sections 2.2.4 and 3.4). This research demonstrates that the health visitors' child-centred response further exacerbates this and is a deterrent to disclosure.

This research has identified limitations in essential aspects of the health visitor service, such as lack of relationship, and limitations of the domestic abuse specific responses. With the exception of Peckover (2002), the literature described in Chapter 3 found that service users perceived health visitors as an approachable and acceptable source of support in relation to domestic abuse, although few women actually disclosed. This research supports the findings of Peckover (2002), that health visitors can be perceived as a threat to the family unit, rather than a source of support.

This study has demonstrated a gulf between policy and guidance documents and the health visitor response in practice such as the continuing focus on children's physical wellbeing, rather than the policy-advocated holistic approach. This research challenges policy expectations that health visitors detect domestic abuse; that women want to talk to health visitors about this; that health visitors are equipped and eager to engage with women experiencing domestic abuse and ultimately that NHS services and individual practitioners are meeting their duty to protect families at risk. Therefore, this research contributes a new perspective on the ability of health services to meet responsibilities for vulnerable people.

An important aspect of this research is the contribution of the voices of survivors of domestic abuse. The findings of phase three provide an understanding of the nature of abuse and the impact of this abuse on women's health and their interaction with health services which can inform service development. Since the 1970s a body of research evidence on the experience of domestic abuse and the health impact has emerged. However, much of the research on how this impacts on contact with health services is theoretical, with little empirical research (for example Stark 2010, Stark & Flitcraft 1996). The current research provides rich, contemporary, findings on abuse of, and consequences for, women who were overlooked by service providers.

Women's views are an essential contribution to the evidence and in the current study, the nature and extent of domestic abuse within this group would have been significantly underestimated without the inclusion of service user interviews. Findings from interviews have provided original insight to the understanding of the shared interaction but differing perceptions of staff and service users. Previous research has presented survivors' dissatisfaction with service responses and health professionals' concerns about their ability to respond. In this study, points of divergence between service users and health visitors have been exposed as behaviours and (mis)interpretation of these. This presents barriers and indicates how these can be addressed to improve the safety and liberty of women who experience domestic abuse.

Survivors' accounts challenged the expert health professional opinion of the nature and extent of domestic abuse and the resulting health needs and in doing so has identified a need for service improvement. Of particular relevance to policy and practice is the finding that what women want from health visitors, but failed to receive in the majority of cases, are basic responses such as interpersonal communication and demonstration of concern for

women. Overall this study makes an important contribution from a feminist perspective by taking action to explore a sensitive and traditionally hidden issue (Ellsberg & Heise 2005), without adverse consequences for participants some of whom reported that participation had been a positive experience (Appendix 4.3).

9.4 Recommendations

9.4.1 Changes to Health Visiting in Scotland

In 2009, NHS Boards were directed to deliver training for health visitors on asking about domestic abuse and to introduce routine questions about domestic abuse as part of the health visitor assessment (CEL 41 2009). This was an incremental process and at the time of research with health visitors in phase of the current research (2010/11) very few health visitors had attended training. In 2012 further guidance was issued to health boards to continue this work (CEL 2012).

Since phase one data collection commenced in 2010, the Scottish Government have revised the pathway for health visiting, released in October 2015, which aims to address some of the limitations of the service response described in this thesis. For example, health visitors reported that reduced contact limited opportunities to establish a relationship with families. The new pathway introduces a greater number of contacts in the first year of a child's life which may improve relationships between health visitors and service users. There has also been investment in health visitor training and employment to increase the number of health visitors which could address issues relating to workload. The "refocussing" of health visiting directs NHS Boards in Scotland to provide a consistent response across Scotland which establishes relationships between health visitors and service users, responds to vulnerable people and conducts strengths-based needs assessment (Scottish Government 2015b). The latter would identify women experiencing domestic abuse as a protective factor for their children and involve them in the assessment and decision making process. However, a disconnect between policy expectations and practice have been identified in this research and therefore, effective evaluation is essential to ensure that implementation is successful. An approach similar to the current study, which involved both practitioners and service users, would provide a helpful overview and insight to the effectiveness of service changes.

9.4.2 Recommendations

The following recommendations are drawn from the findings of the current study directly, as requests or recommendations from service users and health visitors, or indirectly by considering the findings in the context of professional guidance. Recommendations which are already addressed in the revised health visiting pathway (Scottish Government 2015b) and associated guidance, such as strengthening relationships, are not included.

9.4.2.1 Recommendations for Health Visitor Training and Education

Recommendation 1: Domestic abuse and responding to women experiencing domestic abuse to be included in Health Visiting or Public Health nurse pre-registration training.

Recommendation 2: Health visitors should be prepared to respond to the wide ranging needs of women who experience domestic abuse, for example to provide financial or housing advice.

Recommendation 3: Health visitors should be aware that involvement in police reported domestic incidents is indicative of domestic abuse and consider this in assessment.

Recommendation 4: Health visitors and other health professionals should engage with specialist agencies to increase skills and techniques in actively engaging with survivors of abuse

9.4.2.2 Recommendations for Practice

Recommendation 5: Service users should be made aware of health visitor's duty to respond to anyone in need of support or at risk of harm within the family, including mothers.

Recommendation 6: Child protection procedures should be presented to service users to allay fears about removal of children rather than as a threat.

Recommendation 7: Health visitors should clarify the boundaries of confidentiality, highlighting that only essential information is shared when necessary.

Recommendation 8: Structured risk assessment should be introduced for women involved in police reported domestic incidents as part of the health visitor response. Assessment should consider the experience of women, rather than discrete incidents, to establish a comprehensive overview of risk and should consider wider health risks to women and children.

Recommendation 9: Deliver enhanced health visiting service when there is disclosure or suspicion of domestic abuse. An enhanced service would include maintaining regular contact, exploring the dynamics of the relationship with women and working to address the physical and mental health consequences of domestic abuse.

Recommendation 10: If health visitors are unable to fully respond to the needs of women, for example financial or legal advice, they should act as a conduit for information for women who may be unable or unwilling to access other services directly.

Recommendation 11: Health visitors should engage with women's concerns about the safety of their children and themselves during contact post separation as child and adult protection issues.

9.4.2.3 Recommendations for Policy Makers

Recommendation 12: Evaluate the implementation of policy and guidance, with a focus on responding to vulnerable families, as the current study has demonstrated that practice interpretation of policy may differ from the intention of policy developers.

9.5 Recommendations for Future Research

Further research questions have emerged in the course of this research relating to health visitors' attitudes to domestic abuse, impact of training on service response, assessing impact of abuse on children and in responding to women at different stages of exiting a relationship.

The findings of the current study indicate underlying assumptions and beliefs of health visitors influence their assessment and engagement with women who experience domestic

abuse. Research into health visitors' attitudes to domestic abuse and the impact of these on assessment and judgement may identify underlying attitudinal influences on the health visitor response. Domestic abuse is a complex and emotive issues, however, health visitors engage with a number of equally complex and sensitive issues such as abuse or neglect of children and adults and children with addition support needs. Further qualitative research could explore the parallels between these areas of work to explore whether the response to other issues is more effective and if so, to consider why domestic abuse is "different". In addition, further exploration of the ways in which theory informs health visitors' assessment may provide a fuller understanding of the disconnect between knowledge and practice identified in phase one.

The vast majority of health visitors are women and may have been exposed to domestic abuse in their personal lives. Investigation of health visitors' own experiences of domestic abuse and their willingness to engage with survivors in their professional role may provide greater understanding of the dynamic between professional and service user.

A natural progression of this work would be to repeat the qualitative phases of the current study with health visitors and with service users in 12 months to assess the impact of policy changes and continuation of the national training programme on asking about domestic abuse on the effectiveness of the response in addressing the needs of health visitor service users.

Despite the substantial evidence base on the negative impact of exposure to domestic abuse on children, health visitors in the current study rarely reported concerns about children's wellbeing following police reported incidents. Therefore, research which seeks to describe the impact of abuse on children, both physical and psychological, focussed on younger children may inform the health visitor response and enable earlier detection of children who are adversely affected.

Service users described interaction with ASSIST supporting them to move between the stages of exiting an abusive relationship described by Kelly et al (1999). A large scale mixed methods study of approaches, techniques and the effectiveness of these when delivered by health visitors would provide evidence to support an ongoing response to domestic abuse.

Finally, the latter phases of the current research focussed on the experiences of health visitor service users who were involved in police reported domestic incidents. Further analysis of police data with more information on the accused could provide greater understanding of the relationship history and context of police reported domestic incidents. In many cases domestic abuse will never be brought to the attention of the police and therefore, research to identify women living with abuse who have not engaged with services other than health visiting would be beneficial. The lessons in recruitment from the current study indicate that this could be time and resource intensive and may require a population wide approach involving a large sample of health visitor service users.

9.6 Final Conclusion

This research aimed to describe the health visitor response to women experiencing domestic abuse. The findings demonstrate that experience of domestic abuse is prevalent amongst women involved in police reported domestic incidents. This research indicates that women involved in police reported domestic incidents have frequently been exposed to severe, ongoing abuse and face risk of further harm. However, conflicts between theory, policy and practice result in minimal or no response from health visiting services. This research concludes that, despite investment in the health service response to domestic abuse, the health visitor response described in this research does not meet the needs of service users. Plans for further investment in health visiting appear promising in addressing the challenges described by health visitors in this study. This research provides a baseline for assessing service improvement and practice change and identifies the factors which women value in service responses, many of which are fundamental to the health visitor role. This research created an opportunity to reflect the lived experiences of health visitors and for survivors of abuse to be heard and, in doing so makes a valuable contribution to the evidence base.

9.7 Reflection on PhD process

Prior to starting this PhD, I had some research experience and had studied research methods at Masters Degree level. As stated in the introduction to this thesis, I hoped that completion of a PhD would increase my confidence as a researcher through enhancement of skills and knowledge. In addition, and rooted in my experience as a health professional, I felt a responsibility to produce work which was relevant and useful by identifying unmet health and support needs.

This was not a journey of continuous improvement. A successful period of reviewing literature was followed by a long period of uncertainty about the value of this research and my understanding of domestic abuse. In particular, challenges from colleagues, acquaintances and service providers regarding the extent and impact of domestic abuse created an anxiety that an industry had developed from this injustice, from which I was profiting. In addition, I felt conflicted over the concepts of empowering women, peer support and the role of professionals as "protectors".

So, rather than build on previous experience, the PhD process challenged my assumptions and the evidence from which I had developed my research proposal. Whilst difficult, this was an essential, and ultimately rewarding, part of the process. My studies provided an opportunity to reconstruct and strengthen my understanding through exploration of the evidence base, consideration of different theoretical perspectives and discussion of ideas with my PhD supervisors. Therefore, I emerge from this process with a stronger understanding of my topic, greater respect for rigorous research and increased confidence. I am confident in my knowledge of this topic and my skills as a researcher. The unexpected and disappointing findings in relation to the health service responses have fortified my commitment to disseminate the research findings and achieve something useful for service providers and survivors of abuse.

Throughout my studies I engaged with other researchers in my own and other disciplines. This revealed a host of approaches and methods of which I was not previously aware but which may enhance my work in the future. Therefore, instead of reaching the end of a learning process, I feel that I am beginning. To draw on the words of Nelson Mandela (without suggesting journeys of similar significance) "After climbing a great hill, one only finds there are more hills to climb."

10 Appendices

Appendix 3.1 Summary of Articles Included in Structured Review.

Reference: McFarlane, J., Soeken, K., Reel, S., Parker, B. & Silva, C. 1997. Resource Use by Abused Women Following and Intervention Program: Associated severity of abuse and reports of abuse ending. *Public Health Nursing,* 14 (4) p244-250

Intervention	Study design	Outcome measures (incl timescale follow up)	Findings	Demonstrate an effective intervention?
Intervention group – 3 prenatal counselling sessions, delivered before or after routine visits, which focussed on presenting options to women who had experienced abuse, encouraging them to engage with community resources and providing a brochure with information on dynamics of domestic abuse, safety behaviours and supports available. Half of intervention group were also invited to attend additional session at shelter for counselling and info but few engaged and so findings for both intervention groups were combined. Comparison group – Brief written information on community resources only.	Randomised clinical trial. Country :USA Abused women identified through the Abuse Assessment Screen in routine prenatal visits. 126 women participated in intervention group and 67 in comparison group. Sample representative of ethnically diverse service users. Target sample size achieved.	Engagement with community supports Severity of Violence Against Women scale. Data collected at 6 and 12 month post delivery.	Resource use was significantly related to severity of abuse whether or not women had received the intervention.	No difference between intervention and control group.

Reference: Parker, B., McFarlane, J., Soeken, K., Silva, C. & Reel, S. 1999. Testing an Intervention to Prevent Further Abuse in Pregnant Women. *Research in Nursing & Health Care*, 22 p59-66				
Intervention	Study design	Outcome measures (incl timescale follow up)	Findings	Demonstrate an effective intervention?
NOTE – same study as McFarlane et al 1997. This article reports on the severity of violence following intervention.	As above.	Ongoing experience of abuse: • Index of spouse abuse • Severity of Violence Against Women scale Follow up at 6 and 12 months post delivery.	Control group experienced more ongoing physical and non physical abuse at both 6 and 12 months.	Yes, the intervention group reported fewer incidents of violence and threats of violence than control.

Reference: McFarlane, J., Soeken, K. & Wiist, W. 2000. An Evaluation of Interventions to Decrease Intimate Partner Violence to Pregnant Women. *Public Health Nursing* 17 (6) p443-451				
Intervention	Study design	Outcome measures (incl timescale follow up)	Findings	Demonstrate an effective intervention?
Intervention 1 – Wallet sized card with information on local support services for domestic abuse and information on safety planning. Intervention 2 – Open support 24 hours a day from specialist nurse. Intervention 3 – Open support 24 hours a day from specialist nurse and support from "mentor mother".	Randomised control trial. Hispanic women in USA. Sample: Intervention 1 - 329 Intervention 2 - 98 Intervention 3 – 118 Non random allocation.	Follow up at 2,6,12 and 18 months post delivery. Measures: Severity of Violence Against Women Access to community resources (developed by team).	Experience of violence and threats of violence reduced for all groups. No significant difference between groups over time.	No significant difference between control and intervention groups.

Reference: McFarlane, J.M., Groff, J.Y., O'Brien, J.A., & Watson, K. 2006. Secondary Prevention of Intimate Partner Violence. A Randomised Control Trial. *Nursing Research* 55 (1) p52-61				
Intervention	Study design	Outcome measures (incl timescale follow up)	Findings	Demonstrate an effective intervention?
Intervention 1 – wallet sized card providing information on local supports for abused women. Intervention 2 - 20 minute Nurse Case Management session. Providing supportive care, anticipatory guidance (advising women what to expect if contacting supports or reporting abuse), safety advice, information on dynamics of abuse and guided referrals.	Randomised clinical trial. Country: USA Sample of women attending primary care who reported physical or sexual abuse from a partner in the preceding 12 months. Intervention 1- 180 women Intervention 2 – 180 women (Ideal sample size achieved.)	Use of community resources and ongoing experience of abuse. Measures used: • Safety Behaviour Checklist • Severity of VAW • Community resources checklist • Danger assessment scale • Employment harassment questionnaire • Abuse assessment scale Data gathered at 6, 12, 18 and 24 months post intervention.	Both groups: Increased safety behaviours, reduced community resource use and reduced experience of abuse over time. Authors suggest that enquiry about abuse and provision of information on resources may be sufficient to support engagement with services.	No difference in control and intervention group findings.

Reference: Tiwari, A., Leung, W.C., Leung, T.W., Humphreys, J., Parker , B. & Ho, P.C. 2005. A randomised control trial of empowerment training for Chinese abused pregnant women in Hong Kong. *BJOG*, 112 p1249-1256				
Intervention	Study design	Outcome measures (incl timescale follow up)	Findings	Demonstrate an effective intervention?
An empowerment intervention based on McFarlane & Parker (1994). Developed to be culturally sensitive by including concerns about gambling and adapting some wording.

Intervention group - A single 30 minute interview between nurse and abused woman and provision of a brochure with information on safety, choice making and problem solving.

Control group – brief written information on support services. | Randomised control trial

Country: Hong Kong

110 pregnant Chinese women with history of domestic abuse in preceding 12 months.

55 women in intervention group and 55 in comparison group. | • Conflict tactics scale
• Health related quality of life (SF-36)
• Edinburgh post natal depression scale

Data collected 6 weeks post delivery by telephone. | Intervention group:
• Lower post natal depression scores
• Reduced limited functioning – physical and emotional
• Reduced psychological (but not sexual) and minor (but not major) abuse
• Increased physical pain.

There were no adverse consequences reported from participating. | Yes. Intervention group had significantly improved outcomes for mental and physical health and less severe abuse. |

Reference: Katz, K.S., Blake, S.M., Milligan, R.A., Sharps, P.W., White, D.B., Rodan, M.F., Rossi, M. & Murray, K.B. 2008. The design, implementation and acceptability of an integrated intervention to address multiple behavioural and psychosocial risk factors among pregnant African American women. *BMC Pregnancy and Childbirth*, 8 (22)				
Intervention	Study design	Outcome measures (incl timescale follow up)	Findings	Demonstrate an effective intervention?
This intervention was designed to address four pregnancy risk factors: 1. Maternal cigarette smoking 2. Environmental exposure to cigarette smoke 3. Domestic abuse 4. Depression McFarlane & Parker (1994) was used to respond to domestic abuse. The intervention was delivered concurrently with pre natal care over 10 sessions (at least 4 sessions as a minimum).	Randomised control trial. Country: USA Total sample 1044 pregnant African American women, before 28 weeks gestation, with at least one of the 4 risk factors. (A third of sample reported experience of domestic abuse.)	Outcomes related to feasibility of delivering intervention e.g. delivery of intervention as prescribed at assessment. Acceptability of intervention to service users. Measured by engagement and service user views.	Multiple risk behavioural interventions can be implemented in practice. 54% of women in the intervention group attended 4 or more sessions.	Feasible, acceptable intervention.

Reference: Joseph, J. G., El-Mohandes, A.A.E., Kiely, M., El-Khorazaty, M.N., Gantz, M.G., Johnson, A.A., Katz, K.S., Blake, S.M., Rossi, M.W. & Subramanian, S. 2009. Reducing Psychological and Behavioural Pregnancy Risk Factors: Results of a randomized clinical trial among high risk pregnant African American women. *American Journal of Public Health*, 99 (6) p1053-61				
Intervention	Study design	Outcome measures (incl timescale follow up)	Findings	Demonstrate an effective intervention?
NOTE – Same study as Katz et al (2008). This paper reports on effectiveness of intervention.	As above Follow up data collected for 850 of 1044 participants.	- Conflict Tactics Scale - Maternal smoking - Exposure to smoke at home, in car or in same room. - Beck Depression Inventory Data gathered by telephone during 2nd and 3rd trimester of pregnancy.	The majority of participants had multiple risk factors (60%). Findings indicate that this approach can support women to reduce risk however, the impact on domestic abuse is not explored individually. Overall, more women in the intervention group resolved risk factors than those in the control group but the impact on abused women as a group is not clear.	Not clear if domestic abuse response was effective.

Reference: Curry, M.A., Durham, L., Bullock, L., Bloom, T. & Davis, J. 2006. Nurse Case Management for Pregnant Women Experiencing or at Risk for Abuse. *Journal of Obstetrics, Gynaecology and Neonatal Nursing,* 35 (2) p181 - 192				
Intervention	Study design	Outcome measures (incl timescale follow up)	Findings	Demonstrate an effective intervention?
Aimed to reduce incidence of low birth weight babies by reducing ante natal stress for women experiencing or at risk of abuse. Intervention group - Nurse Care management support. Women offered video "Faces of Abuse" and follow up support by nurse care manager 24/7 and received individualised care management throughout pregnancy. Control group – Brief written information on specialist support services.	Randomised Control Trial Country: USA Sample: Ante natal women attending clinic between 13 and 23 weeks gestation. 106 intervention group, 101 to control	• Abuse Assessment Screen (AAS), • Pre Natal Psychosocial Profile (PPP) • Danger Assessment if disclosure. Baseline data collected before 23 weeks gestation. Repeated between 32 weeks gestation and delivery.	Support was most commonly provided by telephone contact. On average women in intervention group had 22 contacts and 3.92 hours support per week. Women identify their own support needs. Only 30% women offered video viewed it. Stress reduced for both groups. Greater in the intervention group but not statistically significant. Social inequalities limit effectiveness of intervention.	No. Greater improvement in intervention group but not statistically significant. Not reported specifically for domestic abuse.

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Reference: Joyner, K. & Mash, R.J. 2012. The Value of Intervening for Intimate Partner Violence in South African Primary Care: Project evaluation. *BMJ Open*				
Intervention	Study design	Outcome measures (incl timescale follow up)	Findings	Demonstrate an effective intervention?
Assessment and management protocol delivered by a study practice nurse. Management included: • Record history of abuse experienced • Medicolegal history including accessing legal services and STD / HIV screening. If required women were assisted to access legal protection or have health screening conducted. • Mental health assessment and referral to specialist services if required. • Safety assessment.	Action research evaluation. Country: South Africa A sample of women (168) attending primary care who reported experience of domestic abuse in the preceding 24 months.	• Worker adherence to management plan • Women's views of the service Follow up 1 month after intervention.	75% of women reported the service was helpful. Adherence to action plan ranged from 40% (syphilis testing) to 100% (obtaining protection orders). Identifies role for health professionals to support access to legal advice and protection.	Yes. Women who received intervention reported positive outcomes and received screening.

Appendix 4.1 – Focus Group Schedule and Revisions

Original	Revisions following initial focus group
<u>Introduction</u> (Read by researcher prior to focus group commencing.) I'm Clare McFeely. I am working on a study which aims to improve how health services respond to domestic abuse. There are 3 parts to this study. The first is to look at the current literature. This tells us that there is a wide variation in knowledge, skills and attitudes towards domestic abuse amongst health care workers and few women tell workers about the abuse. Because of your role, Health Visitors are uniquely placed to find out about abuse and to respond to this. The second part of the study is to gather the views of practicing health visitors about working with domestic abuse and any challenges or barriers that you have experienced. That's why I'm here today. This is one of at least 4 focus groups that will take place across Scotland. Finally, we'll use the findings from the literature and the focus groups to develop an intervention for community nurses and test it	<u>Introduction</u> Overview of National GBV & Health programme and explanation that this requires a change in practice in asking about abuse. Then information about this study. It is research and at the moment we are exploring how things currently work. Then as original

Original	Revisions following initial focus group
out. I am working on this as part of my work as the Research Manager for the National Gender-Based Violence & Health Programme at Scottish Government. I am also studying part time for a PhD and would like to use the findings as part of this work as well. My contact details are on the written information you have and I will be here after the focus group if there is anything you would like to ask about. Today I'm going to ask you about working with women who have experienced domestic abuse – Does it affect how you work, what limits your responses and what would be helpful for you as health visitors? I'd like to record our discussion today. This is for my records only. The discussion will be typed up and all names removed during typing. Are you all happy for me to record this?	
Current practice	Current practice The Scottish Government defines domestic abuse as abuse by a partner or ex partner and can include physical, sexual, emotional and psychological abuse. What do you think of that definition? Domestic abuse is predominantly perpetrated by men and experienced by women and children. So I often refer to "women" when I am asking about people who have

Original	Revisions following initial focus group
To get us started I'd like to find out about how domestic abuse affects your work. Have you worked with women who have experienced domestic abuse currently or in the past? (What is the extent of this in your practice?)	experienced abuse. This is not to say that men do not experience abuse. Today I want to find out about your experiences as health visitors in working with people who have experienced abuse and if you have supported men it would be interesting to hear about that.

Then as original |
| Identifying abuse

Do you currently ask women about domestic abuse? (How / what / when?)

If you know about abuse from other sources (e.g. referrals) what do you do with that information?

(If you suspect abuse - What makes you suspect? What do you do?) | Identifying abuse

Spontaneous disclosure

Do you currently ask women about domestic abuse? (How / what / when?)

Do you receive notification from the police?

If yes, how often do you receive this?

How do you respond?

Are there patterns of notifications (notified about the same people repeatedly)?

If you suspect abuse how do you respond? |
| Responding to abuse

When women disclose abuse:

What is the health visitors' role? (What defines the health visitors' role? Why do you think that?) | Responding to abuse

When you aware of domestic abuse:

How do you respond?

Is there a standard requirement / response?

What supports do women request?

What options are available to women? |

Original	Revisions following initial focus group
	What options do you present to them? What information do you give? If perpetrators are present, how do you respond? Then as original
In your experiences to date have you been able to fulfil this role? What were the difficulties in responding to women? What supported you to respond? If not raised by participants ask specifically about: 1) Options available for women 2) Risk assessment and safety planning 3) Protection 4) Presenting options for women 5) Frequency of visits / planning follow up.	
Men	Men If the issue of men as perpetrators or victims are raised by participants: Do men experiencing abuse ask health visitors for support? If yes, how often and how do you respond? Do perpetrators ask health visitors for support? If yes, how often and how do you

Original	Revisions following initial focus group
	respond? Are they aware of resources for perpetrators? What do they think would be useful / effective resources for perpetrators? (Could lead to exploring their understanding of causes of domestic abuse.)
<u>Supporting Health Visitors</u> We have talked about the health visitor role and challenges / supports in responding. Ideally, what response would you like to be able to provide to women experiencing domestic abuse? How could we achieve that? Or How could we improve the response to women experiencing domestic abuse? (Recap on barriers / supports identified in previous question.) Are there specific supports that would help you as health visitors? (If training suggested ask on specific aspects – dynamics of abuse / safety planning / risk assessment / protection orders.) If not raised by the group ask about: Mentoring / advisor support for health visitors. Is there anything else that you would like to say?	<u>Supporting Health Visitors</u> As original
<u>Ending</u> Thanks very much for your time today. My contact details are on the written information. I will be producing a summary	<u>Supporting Health Visitors</u> As original

Original	Revisions following initial focus group
report of my findings and circulating them to the areas that have taken part.	

Appendix 4.2 – Semi Structured Interview Guide

Face to face interviews

NOTE: interviews will be adapted to accommodate women's disclosure of her experience. Italics indicate note to reader.

<u>Introduction to the researcher</u>

The initial conversation will ascertain that it is safe to proceed with the interview.

Shall I tell you a bit about myself and my work to start us off? I work at the University of Glasgow. I started there in June 2012. Before that I worked in the health service, originally as a midwife and then in research posts. My work has been in public health, looking at how we can improve health. My particular field is abuse issues, specifically looking at how services respond to people affected by domestic abuse.

Health visitors are now made aware of any police reported domestic abuse incidents and we'd like to find out more about how they can respond to that information. In 2011 I did some research with health visitors about what they currently do and now I would like to gather the views of women who have used the service.

There are 3 parts to the interview today. In the first we will look at the short story about a domestic abuse incident and I will ask you questions about the characters in the story. In the second, I'd like to find out more about your experiences, the response from the health visitor and other agencies and if you think things could be done differently. The final section will ask how you felt about taking part in the interview today.

You may stop the interview at any time or if there are questions that you prefer not to answer, simply say "next" and we can move on.   This should take an hour to an hour and a half is that OK with you?

Is there anything that you would like to ask before we begin?

Written Informed Consent obtained reading through each section with participant. Explain process for anonymity, data storage. Then state "If during the interview you tell me anything which makes me concerned that you or someone else may be at risk of harm I do

have a responsibility to share that information. In that case, I would speak to you about it first and tell you what concerns me.*"*

<u>Vignette – Introduction</u>
The participant will be given a pictorial visual aid indicating the main characters and their names. The vignette will be read to the participant.

Maggie has been working as a health visitor for 4 years. On Tuesday morning when she arrives at work a social worker calls to say that one of the women in her area, Lisa Taylor had been involved in a domestic abuse incident that the police attended. The incident happened on Saturday evening. The police reported that no one needed to go to hospital.

Lisa lives with her partner Steven and their two children. A boy called Ryan who is 4 and a girl called Emma who is 18 months. Maggie, the health visitor last saw the family when Emma was 9 months old at which time the baby and family appeared to be doing well.

What do you think Maggie, the Health Visitor will do?

Maggie calls Lisa and arranges to go and visit the following day. When she arrives Lisa is at home alone with the children. She looks anxious. When Maggie asks her how things are Lisa says "fine".

Maggie asks about the incident on Saturday Lisa says they had both been drinking and had an argument.

How do you think Lisa feels?
What do you think Lisa is thinking?
How should Maggie respond to what Lisa said?

Maggie asks if this has happened before and Lisa says that they do fight when Steven or both of them have been drinking. It's just the way things are.

How should Maggie respond to this?

Maggie tells Lisa that couples fighting can have a negative effect on their children whether the children are present or not. During the visit Maggie sees both the children and they appear well.

How do you think Lisa feels now?
How does Lisa respond?

Maggie tells Lisa that if it is more than fighting, if she is afraid of Steven, there are groups that can offer her help and support, for example, Women's Aid. Maggie also says that she might be able to help. Then Maggie asks if there is anything that she can do to help at the moment.

How does Lisa respond?
How do you think Lisa feels now?
What kind of support do you think is available for Lisa?
> **If recommend any responses ask why recommended and if the respondent has personal experience of that.**
Do you think Lisa needs support? (Why?) What kind of supports?
What should Maggie do now?

Depending on how women describe the incident, introduce some variables after reading through vignette. Would it make a difference:
- *If there was violence / no violence?*
- *No alcohol involved?*
- *Who called the police?*
- *If children were in the house / not in the house?*
- *If the woman said she had been experiencing abuse?*
- *If there is one child or older children?*
- *If the woman has separated or still lives with her partner?*

Providing context on domestic abuse

In Scotland, around 1 in 4 women will experience domestic abuse at some point in their life. Domestic abuse, can be from a partner or ex-partner and can include physical abuse (assault and physical attack involving a range of behaviour), sexual abuse (acts performed against women's wishes for example, rape or making them do sexual things that they don't

feel comfortable with) and mental and emotional abuse (such as threats, verbal abuse, racial abuse, withholding money and other types of controlling behaviour such as isolation from family or friends).

Abuse can be more common in younger women and during the childbearing years and can result in poor physical and mental health. In the past women did not call the police until they had experienced abuse on a number of occasions. Recently police reports tell us that more than half of the women involved in police incidents have experienced abuse on a previous occasion.

Women who have experienced abuse tell us that it can be difficult to get support, they want to be asked about abuse and think that it is appropriate for health workers to ask about this.

Health visitors seem to be well placed to see when abuse is happening and to offer support to women because they work with all women with young children.

In practice, the current response is similar to the situation that we just discussed. Health visitors tell us that often when they visit women after a police incident, the women say that they do wish any further support.

Why do you think women may find it difficult to get support?
Do you think anything can be done about that?

Asking about the participant's experience of abuse
Questions in this section are dependent on information shared when discussing the vignette but specifically aim to identify if the woman has experienced abuse (current or previous), views of the current service response and potential to improve responses.

You have already told me a bit about your own experiences while we were talking about the situation with Maggie and Lisa. I would like to ask you a bit more about that and if there is anything you think services could do for you or other women in the same position.

OR

I would like to ask about your experiences and if there is anything that you think services could do for you. Was any of this scenario familiar to your experience? If yes how? If no, how does your situation differ?

If requiring further prompting:

Could you tell me what happened the night the police were called?

Have you ever been afraid of a partner?

Was this with your current partner?

Have you ever been hurt by a partner?

Was this with your current partner?

Have you ever been made to have sex or do sexual things that you didn't want or feel comfortable with?

Who was this with?

Asking about participants experience of services

Did you contact the police? (Why?)

> What did you want the police to do?
>
> Was the police response helpful?
>
> Was there anything else that the police could have done?

How did your health visitor get in touch after the incident?

- o Did they ask about the incident?
- o How did you respond? (Why?)
- o How did they respond?
- o Was this useful?
- o What response would you have liked?
- o Is there anything that you would like support with now?
- o Do you know how to get help?

Have any agencies or professionals contacted you since the incident?

- o Who?
- o Did they ask about the incident?
- o How did you respond? (Why?)
- o How did they respond?
- o Was this useful?

- o What response would you have liked?
- o Is there anything that you would like support with now?
- o Do you know how to get help?

<u>Reactions to Research Participation Questionnaire</u>

<u>Consent for follow up</u>

I will be interviewing women until November 2013. I will then work with health visitors to try to integrate suggestions and ideas from interviews into practice. It would be useful to have women like you informing the process and sharing your ideas. You could do this on the phone, by email or by coming to meetings. Would you be interested in taking part?

Finally, a lot of research is carried out like this, in one interview. Situations can change over time and it would be really useful if we could contact some women who have participated in the future to find out if they have different ideas or different needs. At the moment, it is likely that any future interviews will take place in 18 months to 2 years from now but it could be as much as 3 years.

When we contact women in the future we would do this by letter or telephone stating that I work at the University and would like to do a follow up interview. Today we have talked about domestic abuse but for safety, we say that the research relates to women's health and health service responses.

It is entirely up to you at the time to decide if you would like to take part again or not. Would it be acceptable to contact you in the future?

If yes: Often women who have young families will move before the follow up interview. To help us stay in touch we ask for the name of a friend or relative that you would be happy for us to use to get in touch with you. Again, we would tell them that the research is about women's health and the health service responses. Is there a name and contact that you could give us?

Thank you very much for taking part today. *Advise that can contact health visitor at any time for advice or support and ensure they have contact details. Leave information on support services if appropriate.*

Telephone Interview Guide

1) **Check woman is free to speak – privacy.**

2) **Introduce myself:**

Researcher and I teach student nurses. I used to work as a midwife for the last 12 years have been a researcher with a special interest in how well health services care for people who have experienced abuse.

A few years ago, I did some work with health visitors and they said that women who are involved in police reported domestic incidents have a wide range of backgrounds and circumstances. I'm trying to find out a bit more about that and to see if the current way of working suits all the women using the service and if we can make it better.

3) **The study**

Whatever you tell me today will be anonymised, that means you're name will not be linked to anything you say and if you mention the names of children or other people, health visitors or doctors, these will all be removed as well. I don't report back to Assist, health visitors or any other workers on you as an individual but when I have results from the whole sample I will share these. E.g "woman 1 said… or ¾ women were worried about…."

If you tell me about something today which makes me very concerned about you or your children, I will tell you that I am worried and what about. I would encourage you to tell someone else and get help. I have a responsibility to share information if I think that you and / or your children may be at greater risk than services already think you are. Beyond that, anything you say will remain confidential.

Is there anything you would like to ask before we begin?

Is it OK to go ahead? If you want to stop the interview at any time just say so. If you would prefer not to answer any of the questions please just say "next question" and I will move on.

I'd like to record our conversation for my notes. It will be typed up but your name will be removed as this happens. Is it OK for me to start recording?

You may also hear me scribbling as I'll keep some notes in case the recording is deleted or to remind me to ask you about something.

4) **Questions – Experience of abuse:**

How old are you? How old are your children?

You were involved in a police reported incident a wee while ago – was it June?

Was this the first time the police had been involved?

Can you tell me a bit about the time around the incident?

Did you call the police?

Why did you call them / why did the neighbour call them? What did you want the police to do? Did they?

Were you afraid? Had you been hurt?

Had you been hurt / afraid before?

You have a child, were they around at the time?

Do you think they were affected by the incident?

5) **Health Visitors**

Did your health visitor get in touch after the incident?
- How did they make contact?
- Have you seen them since then?
- Did they ask about the incident?
- How did you respond? (Why?)
- How did they respond?
- Was this useful?
- How did you feel about the health visitor response?

- What response would you have liked?
- Is there anything that you would like support with now?
- Do you know how to get help?
- <u>If women not wishing any response</u> – Health visitors have a duty of care to people who may be at risk of abuse. We know that many women who are involved in police incidents have experienced abuse. <u>Given this, how do you think they could best respond?</u>

- Research with women who have experienced domestic abuse tells us that they want to be asked about abuse and they want support from health visitors. In practice, health visitors tell us that women often deny that they are experiencing abuse and often say they do not wish any support. <u>Why do you think this happens?</u>
- What about your children? Is there anything that they need? (Custody, is partner the father?)

- Is there anything that you need to help you look after your children?

6) Other agency responses

Have any agencies or professionals contacted you since the incident?

- Who?
- Did they ask about the incident?
- How did you respond? (Why?)
- How did they respond?
- Was this useful?
- What response would you have liked?
- Is there anything that you would like support with now?
- Do you know how to get help?
- How did you feel about this response?

7) Anything else

Is there anything you would like to add?

8) **We are nearly finished**. This might sound a bit odd but I'd like to ask you some questions about taking part in the study today. All the work I do has been approved by an ethics committee but these questions help to show if the questions I am asking are acceptable and reasonable. There are about 20 statements and some of them may feel like I'm repeating questions. Is it Ok to carry on?

9) **Thank you voucher**

Thank you for your time today, I really appreciate it. To thank you, I would like to send you a voucher for £20. I have them for Tesco, Asda and Boots. Do you have a preference?

How can I get this to you? I will send it off today as before, it will be called women's health research study.

Appendix 4.3 – Response to Research Participation

A.1 Introduction

The Response to Research Participation Questionnaire (RRPQ) was used in phase three of the current research to assess the costs and benefits of interview participation for health visitor service users who had been involved in a domestic incident which came to the attention of the police. The RRPQ, developed by Newman et al (1999), was introduced in section 4.7.3 of this thesis and the key findings discussed in section 7.7.4. As the RRPQ was introduced in parallel with the research described in this thesis, the RRPQ, rationale for inclusion, method of application in the current research and findings are presented in this appendix.

A.2 Costs and benefits of research participation

The concepts of autonomy, beneficence, non-maleficence and justice are fundamental considerations in any research study (Beauchamp & Childress 2012) and were discussed in section 4.8 of this thesis. Researchers have a responsibility to minimise the risk of harm from research participation, including discomfort and emotional distress and to ensure that the research provides benefits for participants or the wider group they represent (WMA 2013). If risk from participation outweighs the potential benefits the research should not proceed (WMA 2013). Frequently institutional review boards are tasked with deciding on whether or not it is ethical for research to proceed. Whilst principles of beneficence and non-maleficence are applied to any research involving human subjects, greater scrutiny is often applied to research proposals which propose inclusion of survivors of abuse (Becker-Blease & Freyd 2006, Newman et al 2001).

Both Becker-Blease & Freyd (2006) and Newman (2008), state that decisions on risks of participation of survivors of abuse are most often subjective as there is little evidence to support this. Therefore the vulnerability of some groups can be overestimated due to assumptions about the ability of survivors of abuse to make decisions about research participation (Newman 2008,Becker-Blease & Freyd 2006). Whilst there is little evidence to suggest that harm does occur from survivor participation in domestic abuse research, there is little research which demonstrates that harm does not occur. This is likely to result in review boards erring on the side of caution and declining approval of such studies. Whilst the intent is to protect individuals, Newman (2008) argues, that preventing such research has negative consequences for survivors by denying them a voice in service development and in identifying their support needs. Further, obstruction of research in

this area has been criticised as part of a wider societal collusion in the secrecy required for domestic abuse to be perpetrated and perpetuated (Ellsberg & Heisse 2005).

The limited evidence available suggests that a minority of survivors of abuse are distressed as a result of participation and when it did occur the distress was not "overwhelming" (Becker-Blease & Freyd 2006). Rather survivors frequently report that participation was beneficial as it provided opportunities to reflect on their own experience and to help others (Becker-Blease & Freyd 2006). Dr Elana Newman (2008) and colleagues identified a need for empirical research to enable researchers and review boards to make an informed decision about research in this area.

A.3 Response to Research Participation Questionnaire (RRPQ)

Newman and colleagues (2008, 2001, 1999) developed a quantitative data collection tool, the RRPQ, to generate valid data on the cost and benefits of participation in research on sensitive issues. The RRPQ is a 23 point questionnaire developed from an original study reported in 2001 (Newman, Willard, Sinclair & Kaloupek 2001). The researchers conducted both an exploratory factor analysis and confirmatory factor analysis to determine internal validity and reliability of the tool and refine the fields.

The first question relates to motivation for participation. A range of responses are provided (I was curious, to help others, to help myself, I don't know, thought it might improve my access to health care, felt I had to, for the voucher, I didn't want to say no) and the opportunity to enter free text for reasons not covered by the options. The following questions are divided into five domains: Participation; Personal benefit; Emotional reactions; Perceived drawbacks and Global evaluation and are answered using a five point Likert scale with response options of strongly agree, agree, neither agree nor disagree, disagree or strongly disagree.

Questions from the RRPQ have been incorporated in studies which explored a wide range of experiences including domestic abuse (Johnson & Benight 2003); dating violence (Shorey et al 2010) and trauma following a road traffic accident or assault (Ruzek & Zatnick 2000).

Johnson & Benight (2003) included three questions from the RRPQ into their research survey with survivors of domestic abuse as part of a self-completion questionnaire which

also included fields enquiring about mental health, ability to cope and experience of trauma and abuse. RRPQ statements included I gained something positive from filling out this survey; completing this survey upset me more than I expected; had I known in advance what completing this survey would be like for me, I would still have agreed. In common with the findings of Newman (2008), Johnson & Benight (2003) found almost half (45%) of the 55 participants reported personal positive gain from participation. A minority (6%) expressed regret for taking part and a quarter of participants stated they had been more upset by participation than they had expected.

The RRPQ was incorporated into phase three of this research to indicate if participants experienced harm through participation and to contribute to the wider evidence base on acceptability of research on sensitive topics but also served a practical purpose in bringing interviews to a close.

A.4 Method

Participants were asked to complete the RRPQ at the end of interviews. In face to face interviews participants (n=11) self-completed a hard copy of the RRPQ. Assistance in reading or responding to questions was offered by the researcher. To reduce responder bias women were advised that the questionnaire was anonymous and completed questionnaires were placed by women in envelopes which they sealed.

Women who participated in telephone interviews (n=6) were asked to complete the RRPQ at the end of the interview. The researcher provided the response options, read out all 23 questions and recorded the participants' answers. Telephone interviews were considerably shorter than face to face interviews (approximately 15 minutes compared to 60 to 90 minutes in face to face interview). Women shared personal information and described difficult experiences during telephone interviews but the researcher perceived less interpersonal engagement between researcher and participant compared to face to face interviews. This may reduce the potential for responder bias as participants will feel less pressure to provide the response they anticipated the researcher wished to hear. An additional attempt was made to reduce responder bias by explaining the purpose of the questionnaire, stating that the women's opinions were highly valued and encouraging them to answer as accurately as possible to enable the researcher to learn and make changes to the study as required.

As the RRPQ was completed by a small, non-probability sample a simple descriptive analysis was conducted. Where a wide range of responses was noted further analysis was conducted. Responses were re-categorised from five variables (Strongly agree, agree, neutral, disagree, strongly disagree) to three variables "positive" which collated agree and strongly disagree, "neutral" (as before) and "negative" which collated disagree and strongly disagree. These dependant variables were then analysed in relation to the dependant variable of face to face interview or telephone interview.

A.5 Findings

All 17 participants completed the questionnaire. For the first question, which enquired about motivation for participation, participants could select more than one response from the list. The majority of respondents (n=14) stated that they had taken part to help others; seven stated they were curious about the research, five that they wanted to help themselves and two thought it might improve their access to health care.

There was consensus amongst respondents in three of the domains: Participation, perceived drawbacks and global evaluation (Figures A.1, A.2 and A.3). All participants either agreed, or strongly agreed, that they were pleased to have been asked to participate, participated freely and with knowledge of what participation involved would take part again if invited. None of the participants agreed with the statements that taking part had been inconvenient, had taken too long or had been a boring experience. In the global evaluation participants agreed or strongly agreed that they had been treated with dignity, believed their responses would be kept private and that the research was for a good cause.

Only 11 of 17 participants responded to the statement "I understood the consent form" as written consent was provided for face to face interviews only. In telephone interviews verbal consent was obtained prior to interviews commencing.
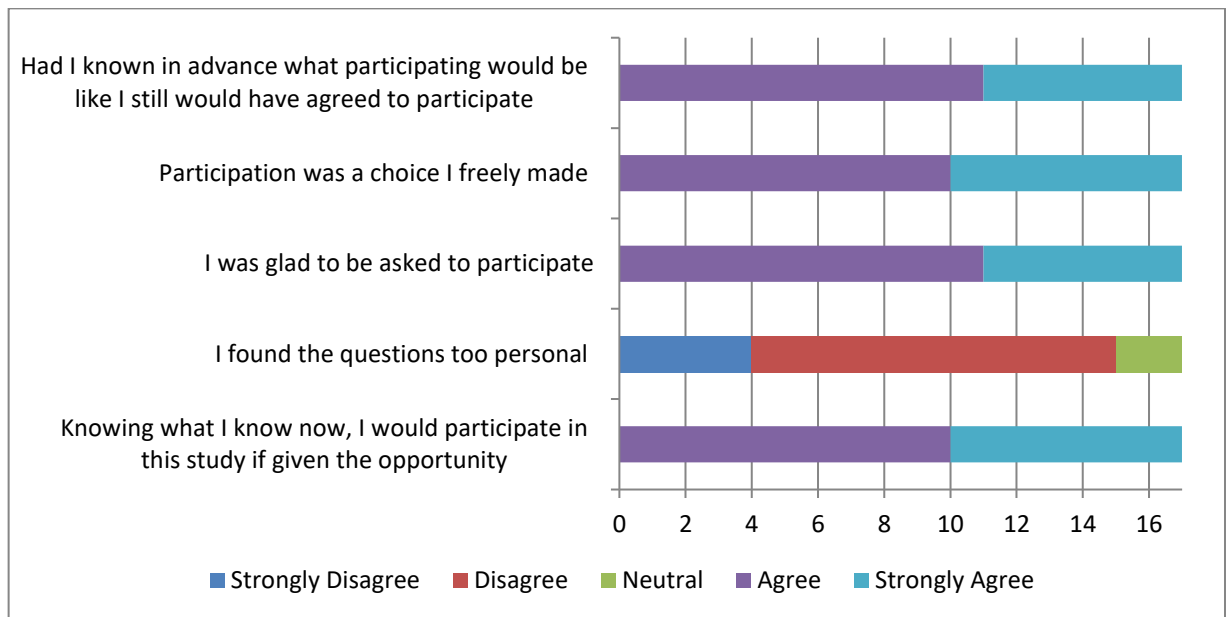
Figure A.1 Participation Domain Statements and Response
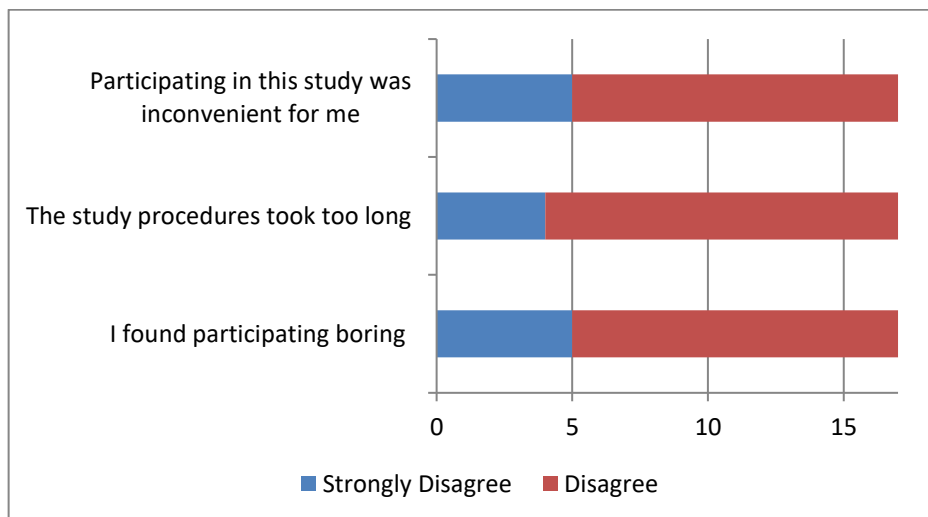
Figure A.2 Perceived Drawback Domain Statements and Response
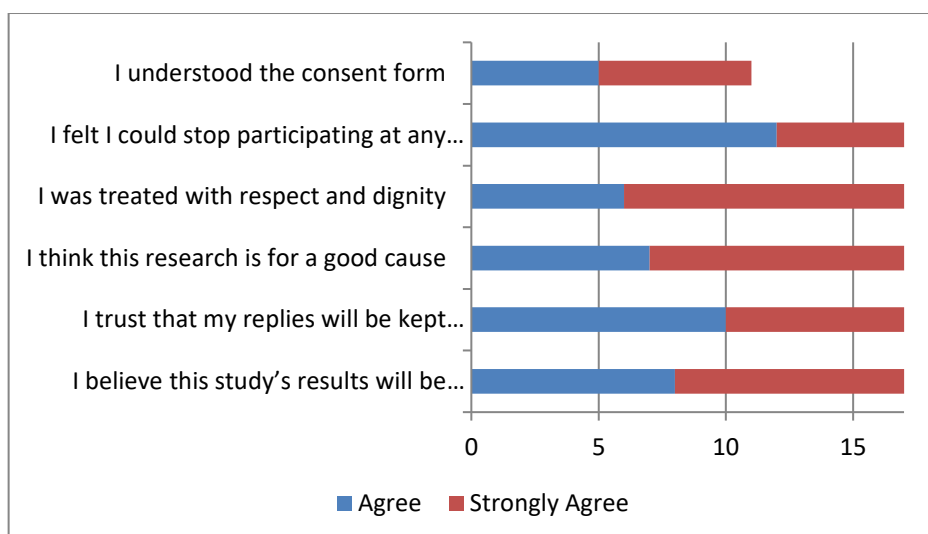
Figure A.3 Global Evaluation Domain Statements and Response

In the remaining domains of personal benefit and emotional reaction there was consensus in a number of fields but variation (from agree to disagree) was noted in others (Figures A.4 and A.5).

The vast majority of respondents agreed with statements that they gained something positive from participation (n=15) and two respondents neither agreed nor disagreed with the statement. Fifteen respondents stated they liked the idea they had contributed to science and 13 agreed that participation was beneficial to them. Fewer respondents agreed that participation had been "personally meaningful" (n=12), two giving a neutral response and a further three disagreeing with this statement.
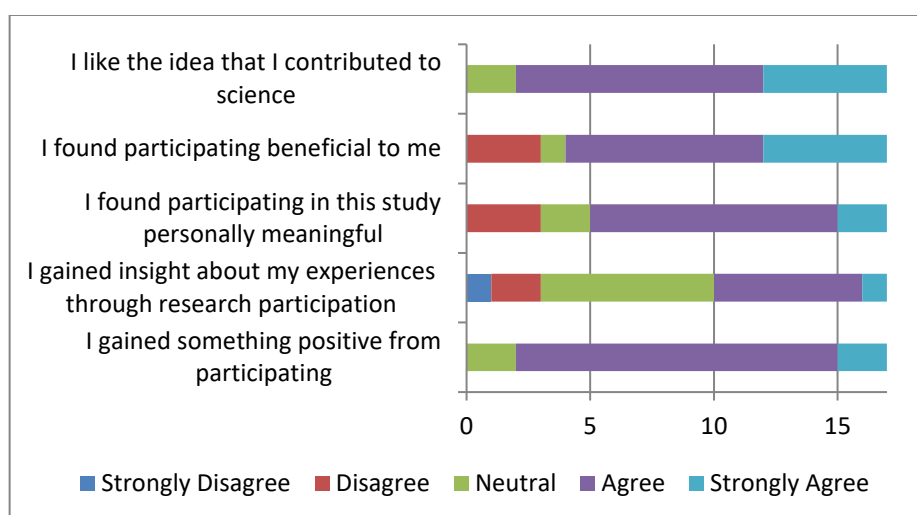
Figure A.6 Personal Benefit Domain Statements and Response

Greater variation was also observed in response to statements relating to emotional response to participation. Most respondents stated that they were not emotional during the research (n=9) but three participants agreed that they had been emotional. Around half of the participants (n=8) did not agree with the statement that they experienced "intense" emotions during the research. However, three women agreed that they had experienced intense emotions and, surprisingly given the term "intense emotion", six respondents neither agreed nor disagreed that they had experienced this.

Of the three women who agreed they had experienced intense emotions, all also agreed that they gained personal benefit and insight from participation and would participate again in the future, indicating that this was not unduly distressing for them. During interview the

researcher did not observe the participants becoming upset or distressed and all appeared to willingly engage with the interviewer throughout.

A further five respondents agreed that participation made them think about things they did not want to. All five also stated that they had not been emotional during the research and in the global evaluation questions stated that they felt they could stop the interview at any time and would participate again given the opportunity. Therefore it does not appear that they were co-erced into thinking about these things or that this experience resulted in unmanageable distress or harm for them.
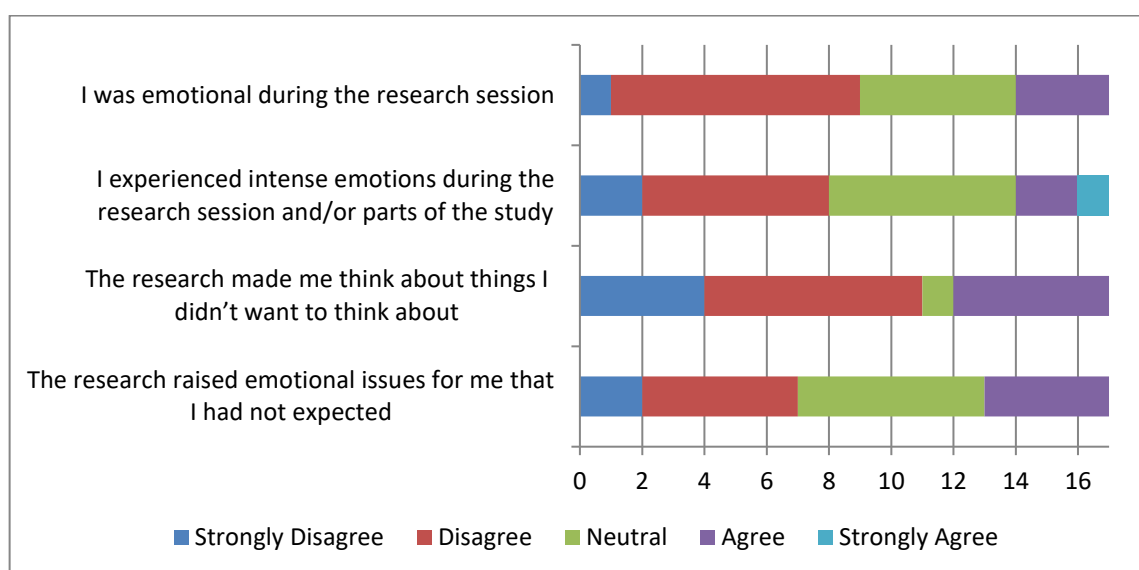
Figure A.7 Emotional Response Domain Statements and Response

A number of factors can contribute to the variation in responses including the method of administration of the RRPQ. Research suggests that self-completion of questionnaires can increase disclosure (Walby & Allen 2004) and so further investigation was conducted by interview type.

Table A.1 displays data disaggregated by interview type where responses ranged from positive (agree or strongly agree) to negative (disagree or strongly disagree). Percentages were rounded to whole numbers and do not always total 100.

There is some indication that participation in face to face research was more likely to provide insight to personal experience and also to make the participant think about things they did not wish to think about. Telephone participants appear less likely to experience

emotion but also more likely to agree with the statement that participation had raised unexpected emotional issues.

Events and issues in participants' personal lives, for example recent abusive incidents or the presence of children in home during interview may impact the participants' experience but these details were not routinely recorded in interviews. Even if recorded, generalisability from this small, non-probability sample would be limited.

Question	Interview Type	Positive Response (%)	Neutral Response (%)	Negative Response (%)
I gained something positive from participating	Telephone	4 (67)	0	2 (33)
	Face to Face	9 (81)	1 (9)	1 (9)
I found participating in this study personally meaningful to me	Telephone	5 (83)	0	1 (17)
	Face to Face	7 (64)	2 (18)	2 (18)
I gained insight about my experiences through participation	Telephone	1 (17)	3 (50)	2 (33)
	Face to Face	6 (55)	4 (36)	1 (9)
I was emotional during the research	Telephone	1 (17)	1(17)	4 (67)
	Face to Face	2 (18)	4 (36)	5 (45)
I experienced intense emotions during the research sessions	Telephone	1 (17)	1 (17)	4 (67)
	Face to Face	2 (18)	5 (45)	4 (36)
The research made me think about things I did not want to	Telephone	3 (50)	1 (17)	2 (33)
	Face to Face	2 (19)	0	9 (81)
The research raised emotional issues for me that I had not expected	Telephone	1 (17)	1 (17)	4 (67)
	Face to Face	3 (27)	5 (45)	3 (27)

Table A.1 Responses by Interview Type

A.6 Conclusion

Use of the RRPQ in phase three of the current research provided data to support the study design and ethical conduct of the study. In the current research RRPQ data suggests that there were no immediate negative consequences as a result of participating in the study and most participants (88%) agreed that they had gained personal benefit from participation. All participants stated that, with hindsight, they would participate in the study.

Women disclosed experiences of their own abuse, impact on their children and for some, experiences of other forms of gender based violence but did not report any negative consequences of sharing these experiences. This provides important evidence of "no

harm" from research participation. From a feminist research perspective, the use of the RRPQ provides a valuable contribution to supporting future research which raises awareness of the experiences of survivors of abuse.

Three women agreed with the statement that they had experienced "intense" emotions but this was not evident to the researcher during interviews. For example women spoke freely and openly about their experiences, they did not cry or appear reluctant to respond to any questions. However, during the interviews several women described concealing emotion and so these findings suggest the RRPQ provided an important insight to the interview experience unobserved by the researcher. In addition, these findings indicate that experiencing emotions is not necessarily a negative experience and identifies the strength of survivors in managing emotion.

The participant experience, as described through RRPQ responses, indicate that the interview structure and questions in phase three were appropriate for and acceptable to participants and confirmed the approach taken in this research. The findings indicate that the interview experience may differ for participants in telephone interviews and participants in face to face interviews however, there is insufficient data to explore further in the current research.

The RRPQ took little time to administer and provided immediate confirmation for the study design and conduct. In addition, the data provides a contribution to the existing evidence base, such as the work of Newman and colleagues (2009, 2006, 2001) and demonstrates, as argued by Becker-Blease & Freyd (2006), that research on sensitive issues can be conducted in a way which is both beneficent and non-maleficent.

Appendix 4.4 - General Health Questionnaire

Q1. I'd like to start by asking you some questions about your health. How would you describe your health?

Very Good, Good, Fair, Bad, Very Bad, Don't Know

Q2. Are you affected by any of the following conditions?

Coronary heart disease	
Stroke	
Arthritis; rheumatism; painful joints	
Osteoporosis	
Chronic pain	
Clinical depression	
Diabetes	
Cancer	
Asthma, bronchitis, or persistent cough	
Epilepsy	
Acquired brain injury	
Stress related conditions, e.g. difficulty sleeping or concentrating	
Severe hearing problems	
Severe eyesight problems	
Accident / injury	
Gastro-intestinal problems, e.g. peptic ulcer disease, irritable bowel syndrome	
High blood pressure	
Drug or alcohol related conditions	
Sexually transmitted infections, e.g. gonorrhoea, syphilis, chlamydia	
None	
Refused	
Other	

Q3. Thinking about the past year and your own health and your use of the GP surgery how many times have you:

Seen a GP?	
Seen a nurse/midwife from your surgery?	
Seen a health visitor?	
Seen physiotherapist /chiropodist /dietician /occupational therapist/clinical psychologist from your surgery?	
Seen someone else from your surgery e.g. health care assistant?	

Q4. Do you know how to contact your health visitor?

Now I would like to ask you some questions about your lifestyle.

Q5. How often are you in places where there is smoke from other people smoking tobacco?

Most of the time	
Some of the time	
Seldom	
Never	
Don't know	

Q6. Which of the following statements best describes you at present?

I have never smoked tobacco	
I have only tried smoking once or twice	
I have given up smoking	
I smoke some days	
I smoke every day	

Q7. Now I'd like to ask you some questions about the food you eat. On average, how many portions of fruit do you eat EACH DAY? Examples of a portion are one apple, one tomato, 2 tablespoons canned fruit, one small glass of fruit juice

Q8. On average, how many portions of vegetables or salad (not counting potatoes) do you eat EACH DAY? A portion of vegetables is 2 tablespoons

Q9. How often PER DAY do you usually eat items such as cakes, pastries, chocolate, biscuits and crisps?

Q10. In the past week, on how many days have you done a total of 30 minutes or more of physical activity, which was enough to raise your breathing rate? This does not include housework or things that you do everyday as part of your job.

Q11. Are there any aspects of your health that you would like your health visitor to support you with?

[If yes, ask permission to advise health visitor].

Thank you for your time today.

Appendix 4.5 Written Information for Health Visitors

University of Glasgow

**College of Medical,
Veterinary
& Life Sciences
Nursing & Health
Care School**

[NHS Board logo]

Strengthening the Health Visitor Response to Families Affected by
Domestic Abuse

What is the study about?

Recorded crime statistics indicate that health visitors will regularly care for women and children who have experienced abuse but research suggests that often, these services fail to meet the needs of abused service users.   The findings of a recent study conducted with Scottish health visitors disputes the extent and consequences of domestic abuse amongst their service users and highlights areas of conflict between theory and practice in responding to this issue.

This study seeks to explore the nature and extent of domestic abuse experienced by health visitor service users and to identify an effective and realistic response to these women.

Who is conducting this study?

The study is led by the Nursing and Healthcare School at the University of Glasgow and is funded by the Burdett Nursing Trust.

Why health visitors?

Health visitors are uniquely placed to identify and respond to those affected by abuse. Health visitors regularly encounter women for whom abuse has started or escalated in their pregnancy and who are now dealing with the consequences of their own experiences and risk to their children. Mechanisms are now in place to help health visitors to identify abuse including information sharing from maternity, social work and police services and some health visitors routinely ask about domestic abuse as part of their assessment.

How will the study be carried out?

This is a 5 stage mixed methods study. The stages include:

1. Review of current literature on health visiting and domestic abuse.
2. Analysis of police and health service data relating to domestic abuse.
3. Interviews with women involved in police reported domestic incidents.
4. Development of health visitor response model in collaboration with health visitors and service users
5. A feasibility study of the response model

How can I get involved?

The support of practicing health visitors is essential for the success of the study. At this stage of the research we would appreciate health visitor support in identifying service users who may take part in interviews. Following discussion with practicing health visitors it is anticipated that this can be incorporated into everyday practice.

What support is available for health visitors who do participate?

Clare McFeely, Research Nurse Associate, is the lead researcher for this study.
Nursing & Health Care School, School of Medicine, College of Medical, Veterinary & Life Sciences University of Glasgow, 59 Oakfield Avenue, Glasgow. Tel 0141 330 5645 or email: clare.mcfeely@glasgow.ac.uk

Health visitors have told us that for many of them responding to domestic abuse is part of everyday practice but occasionally complex or challenging situations can arise and they would appreciate specialist support in managing these cases. IN NHSGGC this support is available through the Gender-Based Violence Resource Unit.

If you have a complaint or concern about the study please contact
Margaret Sneddon, Head of School, Nursing & Healthcare, University of Glasgow, 57-61 Oakfield Avenue, Glasgow, G12 8LL
.

When will this study take place?

The study commenced in June 2012 and will conclude in May 2014. Service user interviews will be conducted between January and June 2013.

Appendix 4.6 Consent Form for Health Visitors

NHS SCOTLAND

University of Glasgow

Health Visitor Responses to Domestic Abuse – Exploratory Study

Consent Form – Participation in Focus Group

One copy each for participant and researcher

Please tick the appropriate boxes and the sign the form below.

I understand the purpose of this study	
I have been given the opportunity to ask questions	
I agree that this session may be recorded for use by the researcher alone	
Procedures for confidentiality and anonymity of data have been explained to me (Ensuring that my personal details are not linked with my responses or shared with anyone.)	
I voluntarily agree to participate	
I understand that I can withdraw from the study at any time	

Participant Signature:	Date:
Researcher Signature:	Date:

Thank you for taking part in this study.

Appendix 4.7 – Written Information for Service User Participants

University of Glasgow

College of Medical,
Veterinary
& Life Sciences
Nursing & Health
Care School

Burdett Trust for Nursing

[NHS Board logo]

Health Visitor Service User Research Study – Information for Participants

What is the study about?

We are trying to find out more about the health risks and support needs of women using the health visitor service.

Who is doing the study?

This study is being conducted by the Nursing & Healthcare School at the University of Glasgow, sponsored by NHS greater Glasgow & Clyde. The study is funded by the Burdett Trust for Nursing.

How can I take part?

Taking part is entirely voluntary and the care that you receive from health services will not be affected whether you decide take part or not.

If you would like to take part this involves one interview with a researcher from the University. Interviews will last between one hour and an hour and half and will be arranged a time and place that suits you.

If required we can arrange transport or reimburse travelling expenses.

Why am I being invited to take part?

Health visitors are asking every woman they visit after referral to take part.

What happens to the information collected?

If you agree, interviews will be recorded and typed up after the interview by the researcher. If you would prefer not to have the interview recorded, the researcher will take notes. The information will be stored in either locked cupboards or in password protected computer

files. Your personal details will not be stored with the information you share. The researcher will take care to ensure that participants cannot be identified by their responses.

We will be collecting data until the winter 2013. We will use the information that we gather to work with health visitors to improve the service we provide.

Further information

If you would like more information about the study please contact:

Clare McFeely, Research Nurse Associate, Nursing & Healthcare School, University of Glasgow, 57-61 Oakfield Avenue, Glasgow, G12 8QQ. Telephone 0141 330 5645

If you have any complaints about the study please contact:

Margaret Sneddon, Head of School, Nursing & Healthcare, University of Glasgow, 57-61 Oakfield Avenue, Glasgow, G12 8LL

Appendix 4.8 - Consent for Interview Form (Service Users)

University of Glasgow

College of Medical, Veterinary & Life Sciences Nursing & Health Care School

Burdett Trust *for Nursing*

NHS Greater Glasgow and Clyde

Consent Form
One copy each for participant and researcher

	Please Initial
I have received and understood the information about this study	
I have been given the opportunity to ask questions	
Procedures for confidentiality and anonymity of data has been explained to me	
I voluntarily agree to participate	
I understand that I can withdraw from the study at any time	
I agree that this interview can be recorded	

Participant Signature:	Date:
Researcher Signature:	Date:

Thank you for taking part in this study.

Consent to Participate in Future Research (Researcher copy)
Today we talked about how health visitors responded to you and to the characters in the story. The next stage of this research will use the ideas from interviews to develop the health visitor response.

We would like to get the views of service users on each stage of the development. Would you be happy for us to contact you in the future about this?

I agree that the research team may contact me in the future to discuss service development.	
Participant Signature	Researcher Signature
Date	Date

Situations can change over time and it would be really useful if we could contact some women who have participated in the future to find out if they have different ideas or different needs. We hope to do more research in the next 3 years. Could we contact you again in the future for further research?

I agree that the research team may contact me in the future to discuss service development.	
Participant Signature	Researcher Signature
Date	Date

How can we contact you? Please provide details:

Name	
Home Address	
Telephone (Landline)	
Telephone (Mobile)	
Email	

Is there a friend or relative that we could use get in touch with you if you move on from this address?

Name	
Relationship to you	
Home Address	
Telephone (Landline)	
Telephone (Mobile)	
Email	

Appendix 4.9 West of Scotland Research Ethics Service Approval for Phase One

WoSRES
West of Scotland Research Ethics Service

West of Scotland REC 5
Ground Floor – The Tennent Institute
Western Infirmary
38 Church Street
Glasgow G11 6NT
www.nhsggc.org.uk

Ms Clare W McFeely	Date	23rd November 2010
Research Manager	Your Ref	
National GBV & Health Programme	Our Ref	
NHS Greater Glasgow & Clyde	Direct line	0141 211 2123
4th Floor, Beacon Building	Fax	0141 211 1847
176 St Vincent St	E-mail	Liz.Jamieson@ggc.scot.nhs.uk
Glasgow G2 5SJ		

Dear Ms McFeely

Study Title: **Health Visitor Response to Domestic Abuse -
                   Exploratory Study**
REC reference number: **10/S1001/64**

The Research Ethics Committee reviewed the above application at the meeting
held on 17 November 2010. Thank you for attending to discuss the study.

Ethical opinion

The members of the Committee present gave a favourable ethical opinion of the
above research on the basis described in the application form, protocol and
supporting documentation, subject to the conditions specified below.

Ethical review of research sites

The favourable opinion applies to all NHS sites taking part in the study, subject to
management permission being obtained from the NHS/HSC R&D office prior to
the start of the study (see "Conditions of the favourable opinion" below).

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the
start of the study.

Management permission or approval must be obtained from each host
organisation prior to the start of the study at the site concerned.

For NHS research sites only, management permission for research ("R&D approval") should be obtained from the relevant care organisation(s) in accordance with NHS research governance arrangements. Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at http://www.rdforum.nhs.uk.

Sponsors are not required to notify the Committee of approvals from host organisations.

- The Committee noted that the interviews would be audio recorded but this was not included in the Consent Form. A revised Consent Form is therefore required.

- The Committee commented that there should be a statement in the Participant Information Sheet making clear that should something untoward be revealed during the study then the Researcher would have a duty of care to report such a disclosure to the appropriate agencies.

The Committee asked the Investigator whether the study would also include men as there was evidence to support that there was an increase in domestic abuse against men. You advised that the study would focus on woman with pre-school age children. The Committee noted this response.

It is responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

You should notify the REC in writing once all conditions have been met (except for site approvals from host organisations) and provide copies of any revised documentation with updated version numbers.

Approved documents

The documents reviewed and approved at the meeting were:

Document	Version	Date	
Investigator CV		21 October 2010	
Interview Schedules/Topic Guides	1	21 October 2010	
Academic Supervisor CV - to follow			
Participant Information Sheet: Health Visitor	1	21 October 2010	
Covering Letter		22 October 2010	
REC application		11 October 2010	
Participant Consent Form: Participant	1	21 October 2010	
Participant Consent Form: Researcher	1	21 October 2010	
Protocol	1	21 October 2010	

Membership of the Committee

The members of the Ethics Committee who were present at the meeting are listed on the attached sheet.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Now that you have completed the application process please visit the National Research Ethics Service website > After Review
You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.
The attached document "After ethical review – guidance for researchers" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.
We would also like to inform you that we consult regularly with stakeholders to improve our service. If you would like to join our Reference Group please email referencegroup@nres.npsa.nhs.uk.

10/S1001/64	Please quote this number on all correspondence

With the Committee's best wishes for the success of this project

Yours sincerely

Liz Jamieson
Committee Co-ordinator
On behalf of Dr Gregory Ofili, Chair

Enclosures: List of names and professions of members who were present at the meeting and those who submitted written comments
"After ethical review – guidance for researchers"

West of Scotland REC 5

Attendance at Committee meeting on 17 November 2010

Committee Members:

Name	Profession	Present	Notes	
Dr Wael Agur	Consultant Gynaecologist & Obstetrician	No		
Professor Pauline Banks	Reader (Older Persons' Health)	Yes		
Dr Stewart Campbell	Consultant Physician & Gastroenterologist	Yes		
Dr Rebecca Carleton	Consultant Psychiatrist	Yes		
Dr James Curran	GP	Yes		
Dr Angie Docherty	Lecturer	No		
Dr Darryl Gunson	Lecturer	Yes		
Dr Gillian Harold	Consultant Radiologist	Yes		
Mrs Christine Hogg	Semi-retired Psychotherapist	Yes		
Miss Margaret MacCallum	Nurse Advisor	Yes		
Professor Eddie McKenzie	Statistician	Yes		
Mr Sandy Morton	Retired (Teacher)	Yes		
Dr Gregory Ofili	Consultant Gynaecologist (CHAIR)	Yes		
Dr Akhtar Rasul	Retired (Engineer)	Yes		
Dr Bill Smith	Consultant Physician	Yes		
Mrs Liz Tregonning	Retired (Special Needs Teacher)	Yes		

Also in attendance:

Name	Position (or reason for attending)	
Dr Judith Godden	Scientific Officer/Manager	
Mrs Liz Jamieson	Committee Co-ordinator	

Appendix 4.10 – Communication Regarding Phase Two

From: Linda Haggerstone
Sent: 31 August 2012 12:09
To: Clare Mcfeely
Cc: Stuart Morrison
Subject: RE: Requirement for Ethics Approval

Hello, Clare.
I've confirmed for you that, because this project uses a secondary analysis on a sample of already anonymised data, ethical approval is not required.
Best wishes,
Linda

Linda Haggerstone
Administrative Assistant
MVLS College Research Office
Wolfson Medical Building
University of Glasgow
Phone: 0141 330 5356
E-mail: Linda.Haggerstone@glasgow.ac.uk

From: Clare Mcfeely
Sent: 30 August 2012 14:00
To: Linda Haggerstone
Cc: Stuart Morrison
Subject: FW: Requirement for Ethics Approval
Dear Linda

I am looking for some advice on the requirement for ethics committee approval for a proposed piece of work.

I would like to conduct a secondary analysis on a sample of anonymised data from Strathclyde Police.
The sample will consist of up to 500 anonymised records of women with children who have been involved in a police reported domestic incidence from Strathclyde Police Vulnerable Person's Database.
I aim to conduct a simple descriptive analysis of the nature and extent of abuse within the incident and to identify how many incidents were known to be repeat victimisation.
I am currently in discussions with a Senior Police Analyst and the Detective Chief Inspector of the Domestic Abuse Task Force in Strathclyde on the feasibility of obtaining the data. If feasible, I plan to submit my request through these contacts and understand that agreement for access will be considered by the Police Legal Team in the first instance.

Findings will be used in my current research project funded by the Burdett Nursing Trust and in my part time PhD studies.
I do not believe that University of Glasgow ethics approval is required for this work but would appreciate if your department could confirm or advise otherwise.

Kind regards
Clare
Clare McFeely
Research Nurse Associate
Nursing & Health Care School

Appendix 4.11 - West of Scotland Research Ethics Service Approval for Phase Three

West of Scotland Research Ethics Service

West of Scotland REC 5
Ground Floor - Tennent Building
Western Infirmary
38 Church Street
Glasgow
G11 6NT
Date   18 October 2012
Direct line 0141 211 2102 Fax   0141 211 1847
E-mail   sharon.macgregor@ggc.scot.nhs.uk

Dear Ms McFeely

Study title: Health Visitor response to Domestic Abuse - Service
     User Interviews REC reference: 12/WS/0254

The Research Ethics Committee reviewed the above application at the meeting held on 17 October 2012. Thank you for attending to discuss the study.
Ethical opinion

To summarise your discussion with the Committee, the following points were raised with you.
There were concerns for participant's safety if the Participant Information sheet is seen by their partner as it contained "police" and "domestic abuse". You agreed to remove the word police and advised that the headings are only for the REC submission and would be removed before giving to participants.
It was noted that criminal disclosure will be reported but it is not clear how this would be done. You advised that she will report any incidences back to the Health Visitor.
There could be confidentiality issues if the participant will be asked to give another contact in case they move away. However, you advised that you would only tell the contact that she wanted to get in touch with the participant about general women's health.

The Committee stressed that the vignette was definitely not discussed in front of any children as even younger children could pick up words. You would prefer that children are not present. You would judge in each case but would err on the side of caution and would do the general health questionnaire and reschedule the interview.
It was not clear whether women who did not call the police themselves would also be included (ie reported by a neighbour). You advised that this group would be included and that the questionnaire will be changed to take this situation into account.
There were concerns with your safety when you will be visiting the women's homes and the potential risk of the partner being there. You advised that you are very comfortable with working alone and that you follow the lone worker policy. You will use your judgement and check who is in the home when you first arrived.

<u>The members of the Committee present gave a favourable ethical opinion of the above research on the basis described in the application form, protocol and supporting documentation, subject to the conditions specified below.</u>

Ethical review of research sites

NHS Sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).
Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission ("R&D approval") should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements.

Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at http://www.rdforum.nhs.uk.

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of approvals from host organisations

The word "police" should be removed from paragraph 6 of the Participant Information sheet.

It is responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

You should notify the REC in writing once all conditions have been met (except for site approvals from host organisations) and provide copies of any revised documentation with updated version numbers. Confirmation should also be provided to host organisations together with relevant documentation

Approved documents
The documents reviewed and approved at the meeting were:

Document	Version	Date
Covering Letter		21 September 2012
Interview Schedules/Topic Guides	1	21 September 2012
Investigator CV		14 September 2012
Other: Reactions to Research Participation Questionnaire Revised	1	21 September 2012
Other: Supervisor's CV: L Paul		25 October 2011
Other: Supervisor's CV: M Burman		
Participant Consent Form		21 September 2012
Participant Information Sheet	1	21 September 2012
Protocol	1	04 September 2012
Questionnaire: General Health	1	21 September 2012
REC application		21 September 2012

Membership of the Committee
The members of the Ethics Committee who were present at the meeting are listed on the attached sheet.

Statement of compliance
The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.
After ethical review
Reporting requirements
The attached document "After ethical review - guidance for researchers" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:
•   Notifying substantial amendments
•   Adding new sites and investigators
•   Notification of serious breaches of the protocol
•   Progress and safety reports
•   Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.
Feedback

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.
Further information is available at National Research Ethics Service website > After Review
12/WS/0254 _____ Please quote this number on all correspondence

With the Committee's best wishes for the success of this project Yours sincerely

SMacgregor

for
Dr Gregory Ofili Chair
Enclosures:
List of names and professions of members who were present at the
meeting and those who submitted written comments "After ethical review - guidance for
researchers"
Copy to:
Ms Joanne McGarry, NHS Greater Glasgow and Clyde
West of Scotland REC 5 Attendance at Committee meeting on 17 October 2012
Committee Members:

Name	Profession	Present	Notes
Professor Pauline Banks	Reader (Older Persons' Health)	Yes	
Dr Stewart Campbell	Consultant Physician & Gastroenterologist	No	
Dr James Curran	GP	No	
Dr Darryl Gunson	Lecturer	No	
Dr Gillian Harold	Consultant Radiologist	Yes	
Dr Angela Jenkins	Anaesthetic Registrar	Yes	
Dr Ahmed Khan	Consultant Psychiatrist	Yes	
Professor Eddie McKenzie	Statistician	Yes	
Canon Matt McManus	Parish Priest	Yes	
Mr Sandy Morton	Retired (Teacher)	Yes	
Dr Gregory Ofili	Consultant Gynaecologist (CHAIR)	No	
Dr Akhtar Rasul	Retired (Engineer)	Yes	
Mrs June Russell	Retired (Research Chemist)	Yes	
Dr Bill Smith	Consultant Physician	Yes	Chairing
Mrs Liz Tregonning	Retired (Special Needs Teacher)	Yes	

Also in attendance:

Name	Position (or reason for attending)
Dr Judith Godden	Scientific Officer/Manager
Mrs Sharon Macgregor	Co-ordinator

Appendix 4.12 – Request for Police Data

57-61 Oakfield Ave
Glasgow
G12 8LL

10/10/12

Re: Health Visitor Response to Domestic Abuse Study - Request for Anonymised Vulnerable Persons Data

Dear Ms Ward

Following our discussions, please find below my request for an anonymised sample of Vulnerable Persons data following our discussions.

I have been advised by the University Ethics Service that committee approval is not required for this study. Data will be stored electronically on a password protected desk top computer. Back up data will be stored on a data stick in a locked cabinet which only I and my study supervisor can access.

A simple descriptive analysis of the data will be conducted and the results will be shared with you. Results will be reported in the final project report, PhD thesis and will be considered for publication in peer reviewed journal.

For information, DCI Yvonne Scott and DI Craig Willison from the Domestic Abuse task force are advisors to this study.

If you require clarification or further information on my research project, data request or plans for storage and management of data, please do not hesitate to contact me.
Thank you for your help in processing this request.

Yours Sincerely

Clare McFeely

Research Nurse Associate
Telephone: 0141 330 4053
Email: clare.mcfeely@glasgow.ac.uk

Health Visitor Response to Domestic Abuse Study - Request for Anonymised Vulnerable Persons Data

Analysis of the following data aims to describe the nature of abuse experienced by health visitor service users involved in police reported domestic abuse incidents.

Data from the Vulnerable Persons Form fields listed below are requested for a sample of 100 anonymised records for women with children under 5 years old, involved in Domestic Abuse Incident.

Please advise on whether it is possible to randomly select reports from a time period or use consecutive reports.

(Q indicates question number on Vulnerable Persons Form, data type also indicated in brackets)

- Type of incident (tick box physical / sexual / non physical
- Police division
- Q2 Date reported (date parameter on advice of police analysts)
- Please state the relationship between the victim, suspect and also all persons in this incident (free text)
- Q3 Locus of incident (free text) and type (tick box) e.g. at home, in street, other
- Q4 Any weapons or physical contact used? (tick box)
- Q5 If a crime or offence was committed, please specify (tick box)
- Q6 Has victim or suspect been involved in previous incidents? (tick box)
- Q8 Are they special risk as defined under SPECC system? (tick box))
- Q9 Interpreter required? (tick box)
- Q10 Has victim been referred to any Support Agencies? (tick box)
- Q13 Subject status (tick box)
- Q 14 Was the suspect under influence of alcohol or drugs and were they injured (tick box)
- Q22 Was victim under influence of alcohol or drugs and were they injured? (tick box)
- Q31 Please state the relationship between the victim, suspect and also all persons in this incident. (free text) e.g partner, ex partner
- Q32 Reporters' role in the incident (tick box)
- Q36 Reason for non submission of case if applicable (tick box)
- Q37 Other police action taken (includes referral to children's reporter / victim taken to safe place) (tick box)
- Q38 Does either party have children whether resident or not? Were children present at time of the incident? (tick box)
- Q41 Initial incident summary - known history of victim and suspect, specifically have either been involved in previous domestic abuse(free text)

In addition, the following information on all reports within a 12 month period would provide useful contextual information:

In a 12 month period
- How many victims / perpetrators had children?
- In how many incidents were children present in the home?
- How many incidents involved a current partner and how many involved an ex partner in incident?
- Total incidents reported by type of domestic incident (physical violence / sexual abuse / non physical / no crime).

Appendix 5.1 – Coding Framework

Code	Description
Understanding of Abuse	HVs demonstrating an understanding of dynamics and consequences of abuse
Identifying abuse	How HVs identify / recognise / describe domestic abuse
Identifying abuse - risk	Risk assessment from notifications of abuse before engaging with women.
Identifying abuse – women	Women not recognising / acknowledging abuse in their lives
Disclosure	Disclosures of domestic abuse
Disclosure of abuse – SES	Links between disclosure and socio-economic status
Disclosure of abuse – rural	Disclosure in rural communities
Disclosure – trust / relationship	Developing trust before women disclose abuse
Police notification	HV notification of domestic incident by police
Police notification – one off	Only incident to have happened. Not considered domestic abuse by HVs.
Impact	Overall impact of DA on HV work
Impact – men	Impact **of** abuse of men on the HV role
Impact - perpetrators	Impact of male perpetrators' needs on the HV role
Men	Men who experience domestic abuse
Men – Perpetrators	Men who abuse their partners
Involving men	HV role to involve fathers in the family and to work with the family
Responding	Responding to disclosure of abuse / notification of domestic incident
Experience of responses	HV experiences of actions in responding to women so far
Responding - Intervention pro-active	In response to depression, sounds structured, like there is an approach
Responding – accessing women	Creating opportunities to talk to women about abuse and offer support
Responding – RA	Responding risk assessment
Responding – SP	Responding safety planning
Responding – Options	Information / presenting options to women
Responding – legal	Information / knowledge of legal supports
Responding - HV safety	HVs managing and assessing their own safety
Responding - individual	No prescribed / minimum response. Each planned on needs of specific woman / child.

Responding - empower	Describing an empowerment approach
Responding – emotional	Emotional support to women
Responding - visits	Assessing needs for visit. Planning follow up visits.
Responding - recording	Recording disclosures / notifications of abuse
Responding – other agencies	Engaging with agencies other than social work.
Responding - children	Responses specific to children / parenting
Social work or HVSW	In addition to working with other agencies, more about role definitions / clarity / responsibility between social workers and health visitors
Advice exit	Advising / encouraging to exit (mostly acknowledging that this cannot happen) however, HVs feel only option.)
Outcome focused	Requirements of intervention to be needs led but outcome focused. Some difficulty in identifying safety and protection of women of women as a need or improving this as an outcome
Women / Needs led	Can only respond to specific requests of women?
Women's response	Women responding to HVs discussing notification and / or disclosure of abuse with them
Women response – abuse	Examples of women's responses to the abuse e.g. returning to partner
Challenge	Challenge for HVs to ask about or respond to DA with women
Challenge - ??	Challenge with other agencies
Dynamics of abuse / relationship	Exploring relationships and power with women. Is this the same as identifying abuse for both HVs and women?
Child protection	Relating to child protection concern, assessment or procedures
Safety	Safety of women and children
HV supports	What supports are available to health visitors / what supports would they like?
Children	Child centred / focused / led
Limitations of HV service	Restrictions / limitations / constraints of HV service.
Dedicated team	A dedicated health visitor team to work with women experiencing domestic abuse.

Appendix 7.1 - ASSIST Recruitment Protocol

1. Study overview

What?

Through interviews this study will gather the views of health visitor service users who have been involved in a police reported domestic abuse incident on the following areas:

- Their experiences of domestic abuse
- The response that they received from the health visitor service
- The response they would like to receive from health visitors

Where?

Interviews can be conducted in the service users' home or by telephone. If women prefer interviews could take place at the university or other area (e.g doctors surgery). Transport can be provided if necessary.

How?

Interviews will use vignettes and open questions to gather the women's views and will conclude with a structured questionnaire on participation in this research study. Interviews will last between 30 and 60 minutes. Women will be given a £20 voucher to thank them for participation.

Safety

The following actions will be taken to limit risk to women:

- Assessment of circumstances by ASSIST staff prior to initial contact
- The researcher will advise women of the purpose of the study in the first call and advise that in future calls it will be referred to as a "Women's Health Study".
- At the beginning of each telephone call / home visit the researcher will ensure the woman can speak in private. If this is not the case or the interview is interrupted the researcher will conduct a general health questionnaire.
- At the beginning of interviews the limits of confidentiality will be explained to women. If any issues arise during interview which concern the researcher this will be discussed with the woman and shared with ASSIST in the first instance.
- Written information will not contain references to domestic abuse.
- If all communication takes place on the telephone the researcher will advise women that they can raise complaints or queries through the University of Glasgow.

2. Proposed process for recruitment

a) Assist workers will volunteer to support the study.

b) Clare McFeely will make contact with each of the volunteer workers to describe the study in full and expectations of participants.

c) Assist volunteers will scan the records of potential participants identified by Clare. Unless otherwise indicated an ASSIST worker will make telephone contact with the woman.

d) Two attempts to make contact will be made and if unsuccessful, no further attempts will be made.

e) If contact is made the ASSIST worker will explain the following:

- ASSIST are supporting a study at the University of Glasgow.

- The study is looking at how health visitors respond when women have been involved in police reported domestic abuse incidents. (NOTE: Women who state this is an isolated incident are important to this study too.)

- The study involves an interview, on the phone or in person, with a researcher from the University. The interview will ask the women about the circumstances of the police report, the response she received from her health visitor (if any) and how this could be changed or improved.

- Participation is entirely voluntary and will not affect the service that they receive from any organisation.

- Before taking part in the study Clare, the researcher will make contact to tell them more about the study and if you wish, can arrange a time for interview. This first conversation doesn't mean they have agreed to take part in the study. If they do agree they can change their mind at any time.

f) Then ask

- Would you be willing to speak to the researcher, Clare, about taking part in this study?

g) If women agree:

- Advise the woman that on initial contact Clare will refer to the study as a "women's health study" until it is established that she can speak in private.

- Pass woman's name, telephone number and any advice on when best to contact her

Clare will then contact women directly and advise them of the purpose and expectations of the study, obtain informed consent and arrange a time and place for interview. As Clare

will not retain any of the women's personal details, when interviews take place on the phone, Clare will forward the gift voucher in a stamped envelope to ASSIST administrative staff to post to women.

3. Contact

Clare McFeely, Research Nurse Associate

Nursing & Health Care

University of Glasgow

57-61 Oakfield Ave

Glasgow

G12 8LL

Email: clare.mcfeely@glasgow.ac.uk or Tel: 0141 330 4053

11 References

Ackerly, B. & True, J., 2010. *Doing Feminist Research in Political & Social Science*. UK: Palgrave MacMillan.

Al Natur, A., Gillespie, G.L., Felblinger, D., Wang, L.L., 2014. Jordanian Nurses' Barriers to Screening for Intimate Partner Violence. *Violence Against Women*. Ch.23. pp. 1-6.

Bacchus, L., Mezey, G. and Haworth, A., 2003. Experiences of seeking help from health professionals in a sample of women who experienced domestic violence. *Health and Social Care in the Community*. 11(1). pp10–18.

Bacchus, L., Mezey, G., Bewley, S., and Haworth, A., 2004. Prevalence of domestic violence when midwives routinely enquire in pregnancy. *BJOG: An International Journal of Obstetrics & Gynaecology.* Ch. 111(5), pp. 441-5.

Bacchus, L., Bewley, S., Fernandez, C., Hellbernd, H., Lo Fo Wong, S., Otasevic, S., Pas, L., Perttu, S. and Savola, T., 2012. *Health sector responses to domestic violence in Europe: A comparison of promising intervention models in maternity and primary care settings*. London School of Hygiene & Tropical Medicine: London.

Bailey, B.A., and Daugherty, R. A., 2007. Intimate Partner Violence During Pregnancy: Incidence and Associated Health Behaviors in a Rural Population. *Maternal Child Health Journal*, (11) pp.495-503.

Bair Merrit, M.H., Feudtner, C., Localio, R., Feinstein, J.A., Rubin, D. and Holmes, W.C., 2008. Health care use of children whose female caregivers have intimate partner violence histories. *Archives Pediatric and Adolescent Medicine,* 162 (2) pp.134-139.

Barnett, C.,2005. Exploring midwives' attitudes to domestic violence screening. *British Journal of Midwifery,* 13 (11) pp.702-705.

Barter, C., McCarry, M., Berridge, D., and Evans, K., 2009. *Partner exploitation and violence in teenage intimate relationships*. NSPCC London.

Barter, C. and Renold, E., 1999. *The Use of Vignettes in Qualitative Research. Social Research Update Summer*. University of Surrey.

Bateman, W., and Whitehead, K., 2004. Health Visitors Domestic Violence Routine Questioning Tool: An exploration of women's experience, effectiveness and acceptability. *International Journal of Health promotion and education*, pp.14-22 & 42.

Beck, J.G., Clapp, J.D., Lentz, J., McNitt, J., Avery, M. and Olsen, S.A., 2014. The Association of Mental Health Conditions with Employment, Interpersonal and Subjective Functions After Intimate Partner Violence. *Violence Against Women* 20(11) pp.1321-1337.

Becker-Blease, K.A. and Freyd, J.J., 2006. Research Participants Telling the Truth About Their Lives. The Ethics of Asking and Not Asking About Abuse. *American Psychologist* 61(3), pp218-226.

Beauchamp, T.L. and Childress, J.F., 2013. *Prinicples of Biomedical Ethics*. 7th Edition Oxford University Press.

Berman, H., Hardesty, J.L., Lewis O'Connor, A. and Humphreys, J., 2011. Childhood Exposure to Intimate Partner violence. In: Humphreys, J. and Campbell, J.C., eds. 2011 *Family Violence and Nursing Practice* 2nd edition. Springer, USA

Bland, M. and Ariel, B., 2015. Targeting Escalation in Reported Domestic Abuse: Evidence From 36,000 Callouts. *International Criminal Justice Review,* 25(1), pp30-53.

Bloor, M., Frankland, J., Thomas, M. and Robson, K., 2001. *Focus Groups in Social Research*. Sage.

BMA 2007. Domestic Abuse. A report from the BMA Board of Science. *BMA*

Bourassa, D. and Berube, J., 2007. The Prevalence of Intimate Partner Violence Among Women and Teenagers Seeking Abortion Compared With Those Continuing Pregnancy. *Journal of Obstetrics & Gynecology Canada* 29(5) pp415-423.

Bourgeault, I., Dingwall, R., De Vries, R., 2010. Introduction to Bourgeault I, Dingwall R, De Vries R (eds) *The SAGE Handbook of Qualitative Methods in Health Research*. Sage

Bradbury-Jones, C., Taylor, J., Kroll, T., and Duncan, F. 2013. Domestic abuse awareness and recognition among primary healthcare professionals and abused women: a qualitative investigation. *Journal of Clinical Nursing* 23 pp.3057-3068.

Brocklehurst, N., 2004. The New Health Visiting: Thriving at the edge of chaos. *Community Practitioner*. 77(4), pp.135-139.

Brooks, O. and Kyle, D., 2014. *SIPR Research Report 23: Dual Reports of Domestic Abuse Made to the Police in Scotland: A Summary of Findings From a Pilot Research Study*. The Scottish Institute for Policing Research.

Bruce, N., Pope, D. and Stanistreet, D., 2008. *Quantitative Methods for Health Research: A practical and interactive guide to statistics and epidemiology*. UK: John Wiley & Sons.

Bryman, A., 2004. *Social Sciences Research Methods*. 2nd Edition. Oxford.

Bryman, A., 2006. Integrating Qualitative and Quantitative Research. How is it done? *Qualitative Research* 6(1) pp97-113.

Bryman, A. 2007. Barriers to Integrating Qualitative and Quantitative Research. *Journal of Mixed Methods Research*, 1 (1) pp8-22

Burnard, P., Gill, P., Stewart, K., Treasure, E. and Chadwick, B., 2008. Analysing an Presenting Qualitative Data. *British Dental Journal* 204, pp429-432.

Burman, M. and Johnstone, J., 2015. High Hopes? The Gender Equality Duty and It's Impact on Responses to Gender Based Violence. *Policy & Politics*. pp45-60.

Butchart, A., Mikton, C. and Krug, E., 2014. Governments must do more to address interpersonal violence. *The Lancet* 384 Dec 20/27,pp2183 – 2184.

Campbell, J.C., 2004. Helping abused women understand their risk in situations of IPV. *Journal of Interpersonal Violence*.

Campbell, J.C., Webster, D. and Glass. N., 2009. The Danger Assessment. Validation of a Lethality Risk Assessment Instrument for Intimate Partner Femicide. *Journal of Interpersonal Violence* 250, pp.14-19.

Carlson, J.A., 2010. Avoiding Traps in Member Checking. *The Qualitative Report* 15 (5) pp.1102-1113.

Cavanagh, M.R., Read, J. and New, B., 2004. Sexual Abuse Inquiry & Response: A New Zealand Training Programme. *New Zealand Journal of Psychology*. 33(3).
CEDAR 2015. *CEDAR* http://www.cedarnetwork.org.uk/about/ [Accessed on 15/05/15].

Centre for Maternal and Child Enquiries (CMACE) 2011. Saving Mothers' Lives: Reviewing maternal deaths to motherhood safer 2006-2008. The 8th Report for CEMD in the UK. *British Journal of Obstatrics & Gynaecology*, 118, Supp 1, pp.1-205.

Chang, J.C., Cluss, P.A., Ranieri, L., Hawker, L., Buranosky, R., Dado, D., McNeil, M. and Schoelle, S.M., 2005. Health Care Interventions for Intimate Partner Violence: What women want. *Women's Health Issues*. 15 pp. 21-30.
Chief Scientist's Office. 2012. *Research Governance*
http://www.cso.scot.nhs.uk/nrs/research-governance/ Accessed 26/02/15].

Cluss, P.A., Chang, J.C., Hawker, L., Hudson Schoelle, S., Dado, D., Buranosky, R. and Goldstrohm, S., 2006. The Process of Change for Victims of Intimate Partner Violence: Support for a psychosocial readiness model. *Women's Health Issues.* 16 pp.262–274.

Coggins, M. and Bullock, L.F.C., 2003. The Wavering Line in the Sand: The Effects of Domestic Violence and Sexual Coercion. *Issues in Mental Health Nursing* 24(6-7) pp.723-738.

Coker, A.L., Eggleston, K.S., Meyer, T.E., Luchok, K., Prabhu Das, I., 2007. What predicts adherence to follow-up recommendations for abnormal Pap tests? *Gynecologic Oncology* 105(1) pp.74-80.

Coker, A.L., Hopenhayn, C., DeSimone, C.P., Bush, H.M., Crofford, L., 2009. Violence against women increases cervical cancer rates. *Journal of Women's Health* 18 pp.1179-85.

Coker, A.L., Smith, P.H., Bethea, L., King, M.R. and McKeown, R.E., 2000. Physical health consequences of physical and psychological intimate partner violence. *Archives of Family Medicine* 9(5) pp451-457.

Coker, A.L., Smith, P.H., Thompson, M.P., 2002. Social Support Protects Against the Negative Effects of Partner Violence on Mental Health. *Journal of Women's Health and Gender-Based Medicine*. 11(5) pp465-475.

Cominsky, C. and Dempsey, O., 2013. Analysing Data From Small and Large Samples and non-normal and normal distributions. In: Curtis, E.A. and Drennan, J., eds. *Quantitative Health Research. Issues and Methods*. McGraw Hill Education.

Constantino, R., Yookyung, K. and Crane, P.A., 2005. Effects of a Social Support Intervention on Health Outcomes in Residents of A Domestic Violence Shelter: A Pilot Study. *Issues in Mental Health Nursing*, 26 pp. 575-590.

Corrigan, S., 2013. Understanding Probability in Curtis EA & Drennan J (2013) *Quantitative Health Research. Issues and Methods*. New York: McGraw Hill Education.

Covington, S.S., 2008. Women and Addiction: A Trauma-Informed Approach. *Journal of Psychoactive Drugs*, 40:sup5, pp.377-385.

Cresswell, J.W., 2014. *Research Design*. 4th Edition. London : Sage.
Crown Office, 2005. *In Partnership, Challenging Domestic Abuse: Joint Protocol Between Association of Chief Police Officers in Scotland (ACPOS) and Crown Office and Procurator Fiscal Service (COPFS).* Available at:
http://www.crownoffice.gov.uk/Resource/Doc/13545/0000143.pdf [Accessed 24/03/16]

Curry, M.A., Durham, L., Bullock, L., Bloom, T.and Davis, J., 2006. Nurse care management for pregnant women exposed or at risk for abuse. *JOGNN* 35(2), pp181- 192.

Cusack, K., 2004. Trauma history screening in community mental health centre. *Psychiatric Services.* Feb, 55 (2), pp.157.

Davies, C.,1988. The Health Visitor as Mother's Friend: A woman's place is in public health, 1900-14. *The Society for the Social History of Medicine*. 1 (1) pp39-59

Davies, L., Ford-Gilboe, M., Willson. A., Varcoe, C., Wuest, J., Campbell. J. and Scott-Storey, K., 2015. Patterns of Cumulative Abuse Among Female Survivors of Intimate Partner Violence: Links to women's health and socioeconomic status. *Violence Against Women*, 21(1) pp. 38-40.

De Boer, M., Kothari, C., Koestner, A., Rohs, T., 2013. What are the barriersto nurses screening for intimate partner violence? *Journal of Trauma Nursing* 20(3) pp.131-168.

de Bocanegra, H.T., Rostovtseva, D.P., Khera, S. and Godhwani, N., 2010. Birth Control Sabotage and Forced Sex: Experiences Reported by Women in Domestic Violence Shelters. *Violence Against Women* 16(5) pp.601-612.

Decker, M.R., Seage, G.R., Hemenway, D., Raj, A., Saggurti, N., Balaiah, D. and Silverman, J.G., 2009. Intimate partner violence functions as both a risk marker and risk factor for women's HIV infection: findings from Indian husband-wife dyads. *Journal of Acquired Immune Deficiency Syndrome*, 15(51) pp593-600.

Debbonaire, T., 2011. *Research: assessing risk in domestic violence cases.* Community Care 30 Available at: http://www.communitycare.co.uk/2011/09/30/research-assessing-risk-in-domestic-violence-cases/ [Accessed 01/06/16]

Dempsey, B.,2013. *Men's Experience of Domestic Abuse in Scotland: What we know and how we can know more.* School of Law, University of Dundee.
Denov, M.S., 2004. *Perspectives on Female Offending. A culture of denial.* Ashgate, UK

Department of Health (2005) *Responding to Domestic Abuse: A Handbook For Health Professionals. Available at:*
http://www.domesticviolencelondon.nhs.uk/uploads/downloads/DH_4126619.pdf

Department of Health (2010) Responding to Violence Against Women and Children – the role of the NHS. Department of Health, England.

Dillon, M., 2010. *Introduction to Sociological Theory. Theorists, concepts and their applicability to the twenty-first century.* UK: Wiley-Blackwell.

Dobash, R.E. and Dobash, R.P.,1979. *Violence Against Wives*. New York: The Free Press.

Dolev & Associates , 2008. *No Boundaries. The Tayside Domestic Abuse and Substance Misuse Project. Final Research Report.* NHS Tayside

Domestic Abuse Intervention Programs (No date) *Program Evaluation Activities at Domestic Abuse Intervention Programs.* Avaialable at: www.theduluthmodel.org [Accessed 07/07/15]

Donovan, C., Hester, M., Holmes, J. and McCarry, M., 2006. *Comparing Domestic Abuse in Same Sex and Heterosexual Relationships.* Economic & Social Research Council

Douglas, H. and Walsh, T., 2010. Mothers, Domestic Violence and Child Protection. *Violence Against Women.* 16(5) pp489-508.

Dutton, M., 1992. *Empowering and Healing the Battered Woman. A model for assessment and intervention.* USA:Springer Publishing.

Eckenrode, J., Ganxel. B., Henderson, C.R., Smith, E., Olds, D.L., Powers, J., Cole, R., Kitzman, H. and Sidara, K., 2000. *Preventing Child Abuse and Neglect With a Program of Nurse Home Visitation. The Limiting Effects of Domestic Violence*. JAMA 284(11) pp.1385-1391.

Edleson JL (1999) The Overlap Between Child Maltreatment and Domestic Violence. *Violence Against Women* 5 (2) p134-154

Elliot, L., Crombie, I. K., Irvine, L., Cantrell, J.and Taylor, J., 2004. *Nursing for Health. The Effectiveness of Public Health Nursing: A Review of Systematic Reviews*. Edinburgh: Scottish Executive.

Ellsberg, M. and Heise, L., 2005. *Researching Violence Against Women. A Practical Guide for Researchers and Activists*. USA: PATH.

Feder, G., Ramsay, J., Dunne, D., Rose, M., Arsene, C., Norman, R., Kuntze, S., Spenser, A., Bacchus, L., Hague, G., Taket, A. and Warburton, A., 2009. *How far does screening women for domestic (partner) violence in different health care settings meet the UK. National Screening Committee criteria for a screening programme in terms of condition, screening method and intervention? Systematic reviews of nine UK national screening committee criteria.* Health Technology Assessment. 13 (16)

Feder, G.S., Hutson, M., Ramsay, J. and Taket, A.R., 2006. Women exposed to Intimate Partner Violence. Expectations and Experiences When they Encounter Health care Professionals: A Meta Analysis of Qualitative Studies. *Archives of Internal Medicine*. 166 pp.22-37.

Felitti, V.J., 2009. Adverse Childhood Experiences and Adult Health. *American Pediatrics*. 9 pp.131-133.

Finch, J., 1987. The Vignette Technique in Survey research. *Sociology*, 21 pp.105 – 114.

Foster, J., 2014. *Alcohol, Domestic Abuse and Sexual Assault.* Institute of Alcohol Studies.

Foran, H. and O'Leary, K.D., 2008. Alcohol and intimate partner violence: A meta-analytic review. *Clinical Psychology Review*. 28 pp.1222-1234.

Ford-Gilboe, M., Wuest, J., Varcoe ,C., Davies, D., Merritt-Gray, M., Campbell, J. and Wilk, P., 2009. Modelling the effects of intimate partner violence and access to resources on women's health in the early years after leaving an abusive partner. *Social Science Medicine,* 68 (6) pp.1021-1029.

FRA (2014) *Violence Against Women: an EU-wide survey*. European Union Agency for Fundamental Rights, Austria
Frasier, P.Y., Slatt, L., Kolowitz, V. and Glowa, P.T., 2001. Using the Stages of Change Model to Counsel Victims of Intimate Partner Violence. *Patient Education & Counseling,* 43 pp211-217.

Frost, M., 1999. Health Visitors' Perceptions of Domestic Violence: the private nature of the problem. *Journal of Advanced Nursing,* 30(3) pp.589-599.

Furniss, K., McCaffrey, M., Parnell, V. and Rovi, S., 2007. Nurses and barriers to screening for intimate partner violence. *MCN American Journal of Maternal and Child Nursing*. 32(4) pp238-243.

Galvani, S., 2005. Grasping the Nettle. *AQUIRE Quartley Information and Research Bulletin*. Winter

Galvani, S., 2006. Safety first? The impact of domestic abuse on women's treatment experience. *Journal of Substance Abuse,* Dec, 11(6) pp.395-407.

Galvani, S., 2004. *Responsible Disinhibition: Alcohol, men and violence to women. Addiction Research & Theory*, 12(4) pp.357-371.

Gannon, T.A. and Cortoni, E., 2010. *Female Sex Offenders, Theory, Assessment and Treatment*. Oxford: Wiley Blackwell.

Garcia, E. and Lila, M., 2015. *Attitudes Towards Violence Against Women in the EU.* European Commission.

Gazmararian, J. A., Adams, M. M., Saltzman, L. E., Johnson, C. H., Bruce, F. C., Marks, J. S., Zahniser, C., & the PRAMS Working Group, 1995. The relationship between pregnancy intendedness and physical violence in mothers of newborns. *Obstetrics & Gynecology*, 85(6), pp.1031–1038.

Geilen, A,C., O'Campo, P.J., Faden, R.R., Kass, N.E.and Xue, X., 1994. Interpersonal conflict and physical violence during the childbearing year. *Social Science Medicine,* 39(6), pp.781 – 787.

Gelling, L., 2010. Gaining Access to the Research Site. In: Gerrish, K. and Lacey, A., eds. 2010. *The Research Process in Nursing*. 6th Edition Wiley Blackwell.

Gerrish, K. and Lacey, A., eds. 2010. *The Research Process in Nursing*. 6th Edition Wiley Blackwell

Gilbert, N., 1993. Research, Theory & Method. In: Gilbert, N., ed. *Researching Social Life*. Sage

Gilchrist, E., Johnson, R., Takriti, R., Weston, S., Beech, A. and Kebbell, M., 2003. *Domestic violence offenders: characteristics and offending related needs*. Findings 217. London: Home Office.

Glander, S.S., Moore, M.L.; Michielutte, R. and Parsons, L., 1998. The Prevalence of Domestic Violence Among Women Seeking Abortion. *Obstetrics & Gynaecology* 91(6).

Glowa, P.T., Frasier, P.Y., Wang, L., Eaker, K. and Osterling, W.L., 2003. What Happens After We Identify Intimate Partner Violence? The Family Physician's Perspective *Family Medicine* 35(10) pp730-736.

Golding, J.M. 1999. intimate Partner Violence as a Risk Factor for Mentla Disorders: A Meta-Analysis. *Journal of Family Violence,* 14(2) pp99-132

Gottleib, A.S., 2008. Intimate partner violence: a clinical review of screening and intervention. *Women's Health,* 4(5) pp529-539.

Gould, D., 1996. Using Vignettes to Collect Data for Nursing Research Studies: how valid are the findings? *Journal of Clinical Nursing,* 5 pp.207-212.

Graham-Kevan, N. and Archer, J., 2009. Control tactics and partner violence in heterosexual relationships. *Evolution and Human Behavior,* 30 pp.445–452.

Green, J. and Thorogood, N., 2014. *Qualitative Methods for Health Research*. Los Angeles: Sage Publications

Griffen, M.G., Resnick, P.A., Waldrop, A.E. and Mechanic, M.B., 2003. Participation in Trauma Research: is there evidence of harm? *Journal of Traumatic Stress* 16(6) pp.567-571.

Griffiths, F., 2009. *Research Methods for Health Care Practice*. London: Sage.

Guest, G., Bunce, A. and Johnson, L., 2006. How Many Interviews are Enough? An Experiment with Data Saturation and Variability. *Field Methods* ,18(1) pp.59-82 .

Haggblom, A.M.E., Hallberg, L.R.M. and Moller, A.R., 2005. Nurses' Attitudes and Practices Towards Abused Women. *Nursing and Health Sciences,* 7 pp.235-242.

Hall, D., 1996. *Health for All Children*. Third Edition. Oxford University Press.

Hall, D. and Elliman, D., 2004. *Health for All Children*. Revised Fourth Edition. Oxford University Press.

Hallam, J., 2000. *Nursing the Image. Media, Culture and Professional Identity*. UK: Routeledge.

Hamberger, L.K. and Phelan, M.B., 2006. Changing the Way the Health Care System Responds to Intimate Partner Violence. *Prevention of Intimate Partner Violence,* pp.61-69.

Hammersley, M., 1996. The Relationship Between Qualitative and Quantitative Research: Paradigm loyalty versus methodological eclecticism in Richardson, J.T.E. ed. *Handbook of Research Methods for Psychology and the Social Sciences*. Leicester: BPS Books.

Hansen, E.C., 2006. *Successful Qualitative Health Research. A practical introduction*. Open University Press
Harrison, L.A. and Willis Esqueda, C., 2000. *Effects of Race and Victim Drinking on Domestic Violence Attributions. Sex Roles,* 42 pp.1042-1050.

Hathaway, J.E., Zimmer, B., Willis, G. and Silverman, J.G., 2008. Perceived Changes in Health and Safety Following Participation in a Health Care – Based Domestic Violence Program. *Journal of Midwifery & Women's Health* 53(6) pp.547 – 555.

Heise, L., 1998. Violence Against Women. An Integrated Ecological Framework. *Violence Against Women,*4 pp.262 .

Heise, L., Ellesberg and Gottmoeller, M., 2002. A global overview of gender-based violence. *International Journal of Gynaecology & Obstetrics,* 78 supp (5) ppS5-S14.
Herman, J., 1992. *Trauma and Recovery*. New York: Basic books.

Hester, M., 2000. Chapter 6: Child Protection and Domestic Abuse: findings from a Rowantree / NSPCC study. In Hanmer, J. and Itzin, C. 2000. *Home Truths About Domestic Violence*: *Feminist influences on policy and practice a reader*. London: Routeledge.

Hester, M., 2004. Future Trends and Developments: Violence Against Women in Europe and East Asia. *Violence Against Women,* 10(12) pp.1431-1448.

Hester, M. and Westmarland, N., 2005. *Tackling Domestic Violence: Effective Interventions and Approaches. Home Office Research Study 290*. London: Home Office.

Hester, M., 2009. *Who Does What to Whom? Gender and domestic violence perpetrators*. Northern Rock Foundation.

Holloway, I. and Wheeler, S., 2010. *Qualitative Research in Nursing & Healthcare*. Wiley Blackwell.

Holt, S., Buckley, H. and Whelan, S., 2008. The impact of exposure to domestic violence on children and young people: A review of the literature. *Child Abuse & Neglect*, 32 pp. 797–810.

Home Office, 2009. *Findings of the British Crime Survey 2008-2009*. London: Home Office.

Home Office, 2010. *Together We Can End Violence Against Women and Girls: A Strategy.* London: Home Office.

Home Office (2013) *Guidance Domestic Violence and Abuse.* Accessed at https://www.gov.uk/domestic-violence-and-abuse#domestic-violence-and-abuse-new-definition [Accessed on 1/6/15]

Hoyle, C., 2008. Will she be safe? A critical analysis of risk assessment in domestic violence cases. *Children & Youth Services Review,* 30 pp.323-337.

Hughes, R. and Huby, M., 2002. The application of vignettes in social and nursing research. *Journal of Advanced Nursing,* 37(4) pp.382-386.

Hughes, R. and Huby, M., 2004. The construction and interpretation of vignettes in social research. *Social Work and Social Sciences Review,* 11(1) pp36-51.

Humphreys, C., 2010. Crossing the Great Divide: Response to Douglas and Walsh *Violence Against Women,* 16 pp.509-515.

Humphreys, C. and Thiara, R., 2003. Mental Health & Domestic Violence: I call it symptoms of abuse. *British Journal of Social Work,* 33 pp.209-226.

Humphreys, C., 2007. A Health Inequalities Perspective on Violence Against Women. Health and Social Care in the Community 15 (2) pp120-127

Humphreys, C., Houghton, C . and Ellis, J., 2008a. *Literature Review: Better Outcomes for Children and Young People Experiencing Domestic Abuse – Directions for Good Practice.* Edinburgh: The Scottish Government.

Humphreys, C., Mullender, A., Thiara, R. and Skamballis, A., 2008b. Talking to my mum: Developing Communication Between Mothers and Children in the Aftermath of Domestic Violence. *Journal of Social Work*, 6(1) pp.53-63.

Humphreys, C., Regan, L., River, D. and Thiara, R.V., 2005. Domestic violence and substance use: Tackling complexity. *British Journal of Social Work,* 35 pp.1303-1320.

Humphreys, C., Ravi, R.K. and Skamballis, A., 2010. Readiness to Change: Mother–Child Relationship and Domestic Violence Intervention. *British Journal of Social Work,* pp 1–19.

Jacoby, M., Gorenflo, D., Black, E., Wunderlich, C. and Eyler, A.E., 1999. Rapid repeat pregnancy and experiences of interpersonal violence among low-income adolescents. *American Journal of Preventive Medicine* 16(4) pp.318-321.
Jaffe, P. and Burris, C.A., 1984. *An Integrated Response to Wife Assault: A Community Model.* Ottawa: The Solicitor General of Canada.

Jeffereys, S., 1997. *The Idea of Prostitution.*Australia: Spinifex Press Pty Ltd.
Jenkins, N., Bloor, M., Fischer, J., Berney, L. and Neale, J., 2010. Putting it in context: the use of vignettes in qualitative interviewing. *Qualitative research,* 10,pp.175.

Joanna Briggs Institute (JBI), 2014. *Joanna Briggs Institute Reviewers' Manual: 2014* edition. Adelaide, Australia.

Johnson, L.E. and Benight, C.C., 2003. Effects of Trauma-Focussed Research on Recent Domestic Violence Survivors. *Journal of Traumatic Stress*, 16(6), pp.567-571.

Johnson, M.P., 2008. *A Typology of Domestic Violence. Intimate terrorism, violent resistance and situational couple violence.*USA: Northeastern University Press.

Johnson, P. and Hellerstadt, W., 2002. Current or past physical or sexual abuse as a risk marker for sexually transmitted disease in pregnant women. *Perspectives on Sexual and Reproductive Health,* 34,pp.62–67.

Johnson, R.B. and Onwuegbuzie, A.J., 2004. Mixed Methods Research: A research paradigm Whose Time Has Come. *Educational Researcher* 33(7) pp.14-26.

Jones, A.S., Dienemann, J., Schollenberger, J., Kub, J., O'Campo, P., Gielen, A.C. and Campbell, J., 2006. Long-term costs of intimate partner violence in a sample of female HMO enrolees. *Women's Health Issues,* 16(5) pp.252-261 .

Joseph, J. G., El-Mohandes. A.A.E., Kiely, M., El-Khorazaty, M.N., Gantz, M.G., Johnson, A.A., Katz, K.S., Blake, S.M., Rossi, M.W. and Subramanian, S.,2009. Reducing Psychological and Behavioural Pregnancy Risk Factors: Results of a randomized clinical trial among high risk pregnant African American women. *American Journal of Public Health,* 99 6) pp.1053-1061.

Joyner, K. and Mash, R.J., 2012. The Value of Intervening for Intimate Partner Violence in South African Primary Care: Project evaluation. *BMJ* Open.

Kalmuss, D., 2004. Non-volitional sex and sexual health. *Archives of Sexual Behavior,* 33 (3) pp197-209

Katz, K.S., Blake, S.M., Milligan, R.A., Sharps, P.W., White, D.B., Rodan, M.F., Rossi, M. and Murray, K.B., 2008. The design, implementation and acceptability of an integrated intervention to address multiple behavioural and psychosocial risk factors among pregnant African American women. *BMC Pregnancy and Childbirth*, 8 (22).

Keeling, J. and Birch, L., 2004. The prevalence rates of domestic abuse in women attending a family planning clinic. *Journal of Family Planning and Reproductive Health Care*, 30, pp.113-114.

Keeling, J. and Fisher, C., 2015. Health Professionals' Responses to Women's Disclosure of Domestic Violence. *Journal of Interpersonal Violence,* 30(13) pp.2363-2378.

Kelly, L., Hagemann-White, C. and Meysen, T., 2011. *Realising Rights. Case studies on state responses to violence against women and children in Europe.* The European Commission Daphne III Programme

Kelly, L., 1999. *Domestic Violence Matters: an evaluation of a development project Home Office Research Study 193*. London, Home Office

Kelly, L., 1988. *Surviving Sexual Violence (Feminist Perspectives)*. UK: Polity Press. Khan, K.S., Kunz, R., Kleijnen, J. and Antes, G., 2011. *Systematic Reviews to Support Evidence-based Medicine*. London: RSM Books.

King, E., 1996. The Use of Self in Qualitative Research in Richardson JTE (Ed) (1996) *The Handbook of Qualitative Research Methods for Psychology and the Social Sciences*. The British Psychological Association.

Kitzinger, J., 2005. Focus Group Research: using group dynamics to explore perceptions, experiences and understanding. In Holloway I, ed. *Qualitative Research in Health Care*. Open University Press.

Klevens, J. and Salzman, L.E., 2009. The Controversy on Screening for Intimate Partner Violence: A Question of Semantics? *Journal of Women's Health,* 18(2), pp. 143-145.

Kralik, D., 2005. Engaging Feminist Thought in Research; a participatory approach. In Holloway I ,ed. *Qualitative Research in Health Care*. Open University Press.
Kralik, D. and Van Loon, A.M., 2005. Feminist Research In Holloway I, ed. *Qualitative Research in Health Care*. Open University Press.

Krueger, R.A. and Casey, M.A., 2000. *Focus Groups: A practical guide for applied research*. 3rd ed. London, Sage Publications.

Krug, E.G., Dahlberg, L.L., Mercy, J.A., Zwi, A.B. and Rafael, L., 2002. *The world report on violence and health*. Geneva: WHO.

Lacey, A., 2010. The Research Process. In: Gerrish, K. and Lacey, A., eds. *The Research Process in Nursing*. 6th Edition. Wiley Blackwell.

Lathlean, J., 2010. Qualitative Analysis. In: Gerrish, K. and Lacey, A., eds. *The Research Process in Nursing*. 6th Edition Wiley Blackwell

Lazenbatt, A., Thompson-Cree, L., McMurray, F., 2005. The use of exploratory factor analysis in evaluating midwives' attitudes and stereotypical myths related to the identification and management of domestic violence in practice. *Midwifery*, 21, pp.322-334.

Lazenbatt, A. and Thompson-Cree, L., 2009. Recognizing the co-occurrence of domestic and child abuse: a comparison of community and hospital-based midwives. *Health & Social Care in the Community*, 17, pp.358–370.

Lee, R.M., 1993. *Doing Research on Sensitive Topics*. London: Sage.

Leibshultz, J., Battaglia, T., Finley, E. and Averbuch, T., 2009. Disclosing Intimate Partner Violence to Health Care Clinicians – What a difference the setting makes. A qualitative study. *BMC Public Health,* 8,(229).

Leonard, K., 2001. Domestic violence and alcohol: what is known and what do we need to know to encourage environmental interventions*? Journal of Substance Use,* 6(4), pp.235-247.

Lincoln, Y.S. and Guba, E.G., 1985. *Naturalistic inquiry*. Newbury Park: Sage Publications.

Litosseliti, L., 2003. *Using Focus Groups in Research*. London: Continuum.

Littleton, H.L., Breitkopf, C.R., Berenson, A., 2007. Sexual and physical abuse history and adult sexual risk behaviors: relationships among women and potential mediators. *Child Abuse & Neglect,* 31(7), pp757-68.

Loke, W.C.L, Torres, C., Bacchus, L., Fox ,E., 2009. Domestic violence in a genitourinary medicine setting--an anonymous prevalence study in women. *International Journal of STD and AIDs*, 19(11), pp.747-51.

Lorza, J., 2010. Child Custody Practices in the Family Courts in Cases Involving Domestic Violence in Hannah, M.T. & Goldstein, B.eds. *Domestic Violence, Abuse and Child Custody. Legal Strategies and Policy Issues.* Kingston NJ.

Lothian & Read , 2002. Asking about abuse during mental health assessments: Clients' views and experiences. *New Zealand Journal of Psychology,* 31(2), pp.98.

Luft, J.; Ingham, H.,1955. *The Johari window, a graphic model of interpersonal awareness. Proceedings of the western training laboratory in group development*. Los Angeles, University of California.

Loxton, D., Powers, J., Schofield, M., Hussain, R. and Hosking, S.,2009. Inadequate cervical cancer screening among mid-aged Australian women who have experienced partner violence. *Preventative Medicine* ,48(2), pp.184 – 188.

Lutenbacher, M., Cohen, A. and Mitzel, J., 2003. Do we really help? Perspectives of abused women. *Public Health Nursing,* 20(1), pp.56-64.

MacKenzie, M. and Lawson, L., 2004. *Evaluation of the Domestic Abuse Link Midwife Project*. University of Glasgow

MacLeod, P. and Page, L., 2010. *2009/10 Scottish Crime and Justice Survey: Partner Abuse*. Edinburgh: Scottish Government.

MacMillan, H.L., Wathen, C.N., Barlow, J., Fergusson, D.M., Leventhal, J.M. and Taussig, H.N.,2009. Interventions to Prevent Child Maltreatment and Associated Impairment. *The Lancet,* 373(9569), pp.250.

MacQueen, S., 2013. *Scottish Institute for Policing Research Annual Report*. Scottish Institute for Policing Research.

Malterud, K., 2001. The Art and Science of Clinical Knowledge: evidence beyond measures and numbers. *The Lancet,* 358, pp.397-400.

Mason, M., 2010. Sample Size and Saturation in PhD Studies Using Qualitative Interviews. *Qualitative Social Research* ,11(3).

MacPherson, K.I., 1983. Feminist methods: a new paradigm for nursing research. *Advances in Nursing Science*, Jan, pp.17-25.

McCloskey, K. and Grigsby, N., 2005. The Ubiquitous Clinical Problem of Adult Intimate Partner Violence. The Need for Routine Assessment. *Professional Psychology: Research & Practice*, 36 93, pp.264-272.

McCloskey, L.A., Lichter, E., Williams, C., Gerber, N., Wittenberg, E. and Ganz, M., 2006. Assessing Intimate Partner Violence in Health Care Settings Leads to Women's Receipt of Interventions and Improved Health. *Public Health Reports,* 121 pp.435- 444.

McCloskey, L. A., Lichter, E., Ganz, M. L., Williams, C. M., Gerber, M. R., & Sege, R., 2005. Intimate Partner Violence and Patient Screening Across Medical Specialties. *Academic Emergency Medicine*, 12, pp.712-722.

McFarlane, J., Campbell, J.C., Sharps, P. and Watson, K., 2002. Abuse During pregnancy and Femicide: Urgent Implications for Women's Health. *American College of Obstetricians and Gynaecologists,* 100 (1).

McFarlane, J., Soeken, K., Reel, S., Parker, B. and Silva, C., 1997. Resource Use by Abused Women Following and Intervention Program: Associated severity of abuse and reports of abuse ending. *Public Health Nursing,* 14(4) pp.244-250.

McFarlane, J., Soeken, K. and Wiist, W., 2000. An Evaluation of Interventions to Decrease Intimate Partner Violence to Pregnant Women. *Public Health Nursing,* 17(6), pp.443-451.

McFarlane, J.M., Groff, J.Y., Obrien, J.A. and Watson, A.,2006. Secondary Prevention of Intimate Partner Violence: A randomized control trial. *Nursing research* 55(1), pp.52-60.

McFeely, C., 2007. *Evaluation of Pilot of Routine Enquiry – Domestic Abuse*. NHS Greater Glasgow & Clyde Maternity Services. NHS Greater Glasgow & Clyde.

McGarry, J., Westbury, M., Kench, S. and Furse, B., 2015. Responding to domestic abuse in acute hospital settings. *Nursing Standard,* 28(34), pp.47-50.

McGee, C., 2000a. Childhood Experiences of Domestic Violence. London, JKP.

McGee, C., 2000b. Children's and Mother's Experiences of Support and Protection Following Domestic Violence. In Hanmer, J. & Itzin, C., eds. *Home Truths About Domestic Violence. Feminist influences on policy and practice, a reader*. Routeledge.

McLaren, S., 2013. Planning and Conducting Surveys in Curtis, E.A. & Drennan, J. eds. *Quantitative Health Research. Issues and Methods.* London: McGraw Hill Education.

McNutt, L.A., Carlson, B.E., Rose, I.M., Robinson, D.A., 2002. Partner Violence Intervention in the Busy Primary Care Environment. *American Journal of Preventative Medicine,* 22(2) pp.84-91.

McPherson, C.J. and Addington-Hall, J.M., 2004. How do proxies' perceptions of patients' pain, anxiety and depression change during the bereavement period? *Journal of Palliative Care*, 20(1), pp.12-19.

Miller, E., McCauley, H.L.,Tancredi, D.J., Decker, M.R., Anderson, H. and Silverman, J.G., 2015. Recent reproductive coercion and unintended pregnancy among female family planning clients. *Contraception.* 89(2) pp.122-128.

Millward, L.M., Kelly, M.P. and Nutbeam, D., 2003. *Public Health Intervention Research – the evidence.* Health Development Agency, London.

Mitcheson, J. & Cowley S., 2002. Empowerment or Control? An analysis of the extent to which client participation is enabled during health visitor / client interactions using a structured health needs assessment tool. *International Journal of Nursing Studies* 40 pp413-426

Mongan, D., 2013. Secondary Data Analysis in Curtis, E.A. and Drennan J., Eds. *Quantitative Health Research. Issues and Methods* McGraw Hill Education

Morgan, D.L., 1998. *Planning Focus Groups. Focus Group Kit 2.* London: Sage.
Morgan, D.L., 2007. Paradigms Lost Pragmatism Regained. *Journal of Mixed Methods Research 1*, (1) pp.48-76.

Morse, J. M., 1994. Designing Funded Qualitative Research. In: Denzin, N.K. and Lincoln, Y., eds. *Handbook of Qualitative Research*. Sage

Mullender, A., 2004. Domestic Violence: providing support for children who have witnessed domestic violence. *Development and Practice Report 33*. London: Home Office.

Myhill, A., 2015. Measuring Coerceive Control: What can we learn from national population surveys? *Violence Against Women,* 21(3), pp.355-375.

National Institute for Health & Care Excellence (2014) *Domestic violence and abuse: multi agency working PH50.* London

Nelson, A., Dumville, J. and Torgerson, D., 2010. Experimental Research. In Gerrish, K. and Lacey, A., eds. *The Research Process in Nursing*. 6th Edition. Wiley Blackwell.

Newman, E.,2008. Assessing Trauma and its Effects Without Distress: A Guide to Working with IRBs. Observer:Association for Psychological Science. 21 (5) Available at http://www.psychologicalscience.org/index.php/publications/observer/2008/may-08/assessing-trauma-and-its-effects-without-distress-a-guide-to-working-with-irbs.html [Accessed 12th July 2016]

Newman, E., Walker, E.A. and Gefland, A., 1999. Assessing the ethical costs and benefits of trauma focused research. *General Hospital Psychiatry*, 21, pp.1-10.

Newman, E., Willard, T., Sinclair, R. and Kaloupek, D., 2001. Empiracally supported ethical research practice: The costs and benefits of research from the participants' view. *Accountability in Research: Polices and Quality Assurance* 8(4), pp. 309-329.

Newman, E., Risch, E., Kassam-Adams, N. (2006). Ethical issues in Trauma-Related Research: A Review. *Journal of Empirical Research on Human Research Ethics*, 1(3), pp.29-46.

Nicolaidis, C., Curry, M.A., Gerrity, M., 2005. Health Care Workers' Expectations and Empathy Toward Patients in Abusive Relationships. *JABFP* ,18(3) pp.159-165.

Nursing & Midwifery Council UK. (NMC), 2010. *Standards for Pre-Registration Nursing Education: Guidance for Nurses & Midwives*. NMC

Nursing & Midwifery Council UK. (NMC), 2014. *Standards for Competence for Registered Nurses*. NMC

Nursing & Midwifery Council UK. (NMC), 2015. *Raising Concerns: Guidance for Nurses & Midwives*. NMC

Novisky, M.A., and Peralta, R.L., 2015. When Women Tell Intimate Partner Violence and the Factors Related to Police Notification. *Violence Against Women,* 21(1) pp.65-86.

O'Cathain, A., Murphy, E. and Nicholl, J., 2007a. Why, and how, mixed methods research is undertaken in health services research in England: a mixed methods study. *BMC Health Services Research* 7(85).

O'Cathain, A., Murphy, E. and Nicholl, J. 2007b. Integration and Publications as Indicators of ''Yield'' From Mixed Methods Studies. *Journal of Mixed Methods Research,* 1 (2) pp147-163

Olds, D.L., 2006. The Nurse-Family Partnership: An evidence based intervention. *Infant Mental Health Journal* 27(1) pp.5-25.

Oleson, V., 1994. Feminist Qualitative Research in the Millenium's First Decade: Developments, Challenges, Prospects. In Denzin NK & Lincoln YS (Eds) *The Handbook of Qualitative Research.* Los Angeles: Sage Publications.

Office of National Statistics, 2015. *Violent Crime and Sexual Offences - Intimate Personal Violence and Serious Sexual Assault.* London

Oliver, D.G., Serovich, J.M. and Mason, T.L., 2005. Constraints and Opportunities with Interview Transcription:Towards Reflection in Qualitative Research. *Social Forces* 84(2) pp.1273–1289.

Onwuegbuzie, A.J. and Leech, N.L., 2007. Validity and Qualitative Research: An Oxymoron? *Quality & Quantity,* 41 pp.233-249.

Oram, J., Treville, K., Feder, G., and Howard, L.M. 2013. Prevalence of Experiences of Domestic Violence Amongst Psychiatric Patients: Systematic Review. *British Journal of Psychiatry,* 202 pp94-99

Orloff, L.E., 1996. Effective Advocacy for Domestic Violence Victims. Role of the Nurse-Midwife. *Journal of Nurse-Midwifery,* 41(6) pp.473-494.

Pain, R., 2012. *Everyday Terrorism: How fear works in domestic abuse.* Durham University and Scottish Women's Aid.

Parker, B., McFarlane, J., Soeken, K., Silva, C. and Reel, S., 1999. Testing an Intervention to Prevent Further Abuse in Pregnant Women. *Research in Nursing & Health Care,* 22, pp.59-66.

Peckover, S. and Trotter, F., 2015. Keeping the focus on children: the challenges of safeguarding children affected by domestic abuse. *Health and Social Care in the Community*, 23(4), pp.399-407.

Peckover, S., 2002. Focusing upon children and men in situations of domestic violence: an analysis of the gendered nature of British health visiting. *Health and Social Care in the Community,* 10(4) pp.254-261.

Peckover, S., 2003a. I could have done with just a little more help. An analysis of women's help seeking from health visitors in the context of domestic violence. *Health & Social Care in the Community,* 11(3) pp275-282.

Peckover, S., 2003b. Health Visitors' Understandings of Domestic Violence. *Issues and Innovations in Nursing Practice.* 44(2), pp.200-208.

Petersen, R., Moracco, K.E., Goldstein, K.M. and Andersen, C., 2003. Women's perspectives on Intimate Partner Violence Services: The Hope in Pandora's Box. *Journal of the American Medical Women's Association,* 58(3) pp.185-190.

Pikarinen, U., Saisto, T., Schei, B., Swahnberg, K. and Halmesmäki, E., 2007. Experiences of physical and sexual abuse and their implications for current health. *Obstetrics & Gynaecology,* 109(5), pp.1116-22.

Plano-Clark, V., Huddleston-Casas, C., Churchill, S., O'Neil Green, D. and Garrett, A., 2008. Mixed Methods Approaches in Family Science Research. *Educational Psychology Papers and Publications,* Paper 81.

Police Scotland (2013) *Domestic Abuse Standard Operating Procedure.*

Police Scotland (2013) *Joint Protocol Between Police Scotland and Crown Office and Procurator Fiscal Service In Partnership, Challenging Domestic Abuse.*

Polit, D.F. and Beck, C.T., 2012. *Nursing Research. Generating and Assessing Evidence for Nursing Practice.* Ninth Edition. Lippincott, Williams & Wilkins.

Polit, D.F. and Beck, C.T., 2014. *Essentials of Nursing Research. Appraising Evidence for Nursing Practice*. Edition 8. Lippincott, Williams & Wilkins.

Porcerelli, J.H., West, P.A., Binienda, J. and Cogan, R., 2006. Physical and Psychological Symptoms in Emotionally Abused and Non-abused Women. *Journal of the American Board of Family Medicine*, 19, pp.2201-2204.

Prochaska, J. O., & DiClemente, C. C., 1983. Stages and processes of self-change of smoking: Toward an integrative model of change. *Journal of Consulting and Clinical Psychology*, 51, pp.390-395.

Public Health England, 2015. *UK National Screening Committee (UK NSC) criteria for appraising the viability, effectiveness and appropriateness of a screening programme.*

Punch, K., 2003. *Introduction to Social Research*. London: Sage.
Rabin, R.F., Jennings, J.M., Campbell, J.C. and Bair-Merritt, M.H., 2009. Intimate Partner Violence Screening Tools. A systematic review. *American Journal of Preventative Medicine* 36(5), pp.439-445.

Radford, L. and Hester, M., 2006. *Mothering Through Domestic Violence*. London: JKP.

Radford, L., Corral, S., Bradley, C., Fisher, H., Bassett, C., Howat, N. and Collishaw, S., 2011. *Child abuse and neglect in the UK today*. London: NSPCC.

Raj, A., Reed, E., Miller, E., Decker, M.R., Rothman, E.F. and Silverman, J.G., 2007. Contexts of condom use and non-condom use among young adolescent male perpetrators of dating violence. *AIDS Care* , 19, pp. 970–973.

Ramsay, J., Rivas, C. and Feder, G., 2005. *Interventions to reduce violence and promote the physical and psychosocial well-being of women who experience partner abuse: a systematic review*. Barts and The London. Queen Mary's School of Medicine & Dentistry.

Read, J. and Fraser, A., 1998. Abuse histories of patients to ask or not to ask. *Psychiatric services* 49(3), pp.355.

Renker, P., 2007. Women's views of prenatal violence screening. *Obstetrics and Gynaecology,* 107(2 pt 1), pp.348-358.

Renker, P.R. and Tonkin, P., 2007. Post Partum Women's Evaluation of an Audio/Video Computer Assisted Perinatal Violence Screen. *Computers, Informatics, Nursing,* 25(3), pp.139-147.

Renzetti, C.M. and Lee, R.M., 1993. *Researching Sensitive Topics*. London: Sage Publications.

Richards, L., Letchford, S. and Stratton, S., 2008. *Policing Domestic Abuse*. Oxford University Press.

Richardson, J., Feder, G., Eldridge, S., Chung, W.S., Coid, J. and Moorey, S., 2001. Women who experience domestic violence and women survivors of childhood sexual abuse: a survey of health professionals' attitudes and clinical practice. *British Journal of General Practice*, June, pp.468-470.

Rivara, F.P.L., Anderson, M.L., Fishman, P., Bonomi, A.E., Reid, R.J., Carrell, D., Thompson, R.S., 2007. Intimate partner violence and health care costs and utilization for children living in the home. *Pediatrics*, 120(6), pp.1270-1277.

Robinson, J., 2004 Health Visitors or Health Police? *AIMS Journal* 16 (3)

Robinson, A. and Howarth, E., 2012. Judging Risk: Key Determinants in British Domestic Violence Cases. *Journal of Interpersonal Violence,* 27(8), pp.1489-1518.

Robson, C., 2002. *Real World Research*. Oxford: Blackwell Publishing.

Rodriguez, M.A., Bauer, H.M., Flores-Ortiz, Y. and Quiroga, S.S., 1996. Breaking the Silence: battered women's perspectives on medical care. *Archives of Family Medicine,* 5 pp.153-158.

Rofle, G., 2013. Philosophical Basis for Research. In Curtis EA & Drennan J. eds. *Quantitative Health Research: Issues and Methods*. McGraw Hill Education

Rose, D., Trevillion, K., Woodall, A., Morgan, C., Feder, G. and Howard, L., 2011. Barriers and facilitators of disclosures of domestic violence by mental health service users: qualityative study. *British Journal of Psychiatry*, 198(3) pp.189-194.

Ruzek, J.I. and Zatzick, D.F., 2000. Ethical considerations in research participation among acutely injured trauma survivors: An empirical investigation. *General Hospital Psychiatry,* 22, pp. 27-36.

Sandelowski, M., 1995. Triangles or Crystals: On the geometry of qualitative research. *Research in Nursing & Health*, 10, pp.569-574.

Sandelowski, M., 2000. Whatever Happened to Qualitative Description? *Research in Nursing & Health* 23(4) pp.334-340.

Sandelowski, M., 2010. What's in a Name? Qualitative description re-visited. *Research in Nursing & Health*, 33(1), pp.77-84.

Schoenberg, N.E. and Ravdal, H., 2000. Using vignettes in awareness and attitudinal research. *Social Research Methodology,* 3(1) pp.63-74.

Schwaeber, L., 2010. Recognising Domestic Violence: How to know it when you see it and How to provide appropriate representation. In Hannah, M.T. and Goldstein, B., eds. *Domestic Violence, Abuse and Child Custody. Legal Strategies and Policy Issues*. Kingston NJ.

Scott, M., 2008. *Older women and domestic abuse in Scotland. CRFR Briefing 39*. University of Edinburgh.

Simons, L. and Lathlean, J., 2010. Mixed Methodes in Gerrish, K. and Lacey, A., eds. *The Research Process in Nursing*. Sixth Edition. Wiley Blackwell.

Scottish Executive, 2000. *National Strategy to Address Domestic Abuse* Available at http://www.scotland.gov.uk/library3/law/stra-00.asp

Scottish Executive, 2001. *Nursing for Health. A review of the contribution of nurses, midwives and health visitors to improving the public's health in Scotland* Edinburgh

Scottish Executive, 2002. *Choices and challenges. The strategy for research and development in nursing and midwifery in Scotland.* NHS Scotland.

Scottish Executive, 2005. *Health for All Children 4: Guidance on Implementation in Scotland*. Getting it Right for Scotland's Children. Edinburgh

Scottish Executive, 2006. *Visible, Accessible and Integrated Care: Report of the review of nursing in the community in Scotland*. Edinburgh.

Scottish Government, 2007. *Criminal Justice Series. Homicide in Scotland 2006-2007. Statistical* bulletin CrJ/2007/13. Edinburgh.

Scottish Government, 2008a. *National Domestic Abuse Delivery Plan for Children and Young People.* Edinburgh

Scottish Government, 2008b. *Chief Executives Letter 41. Gender Based Violence Action Plans.*

Scottish Government, 2008c. *Early Years Framework.* Edinburgh

Scottish Government, 2009a. *Domestic Abuse. What Health Workers Need to Know About Gender Based Violence*. Edinburgh.

Scottish Government, 2009b. *Harmful Traditional Practices. What Health Workers Need to Know About Gender Based Violence*. Edinburgh.

Scottish Government, 2010a. *Getting it Right For Every Child (GIRFEC) A Guide to Implementing Getting it right for every child: Messages from pathfinders and learning partners.* Edinburgh.

Scottish Government, 2010b. *Getting it Right For Every Child (GIRFEC) Evaluation Themed Briefing: Briefing 4. Implementing Getting it Right Every Child through a single trigger. Domestic Abuse.* Edinburgh.

Scottish Government, 2011a. *Asking About Abuse. Routine enquiry of domestic abuse Training Pack for Sexual Health, A&E, Maternity, Community Nursing*.

Scottish Government, 2011b. *A New Look at HALL4. The Early Years, Good Health for Every Child*. Edinburgh.

Scottish Government, 2013. *Domestic Abuse Recorded by the Police in Scotland, 2012-13*. Edinburgh

Scottish Government 2013b, *Chief Executives Letter 13 Public Health Nursing Services – Future Focus.* Edinburgh

Scottish Government, 2014a. *Equally Safe. Scotland's strategy for preventing and eradicating violence against women and girls*. Edinburgh.

Scottish Government, 2014b. *Scottish Crime and Justice Survey 2012/13: Partner Abuse*. Edinburgh.

Scottish Government, 2014c. *Scottish Crime and Justice Survey 2012/13: Main Findings*. Edinburgh.

Scottish Government, 2015a. *Equally Safe: Reforming the Criminal Law to Address Domestic Abuse and Sexual Offences*. Scottish Government Consultation Paper.

Scottish Government, 2015b. *Universal Health Visiting Pathway in Scotland. Pre-birth to pre-school*. Scottish Government, Edinburgh

Scottish Women's Aid , 2011. *Changing Lives: Outcome evaluation of Women's Aid support services in Scotland.*

Seng, J.S., Sperlich, M. and Kane Low, L., 2008. Mental Health, Demographic and Risk Behaviour Profiles of Survivors of Childhood and Adult Abuse. *Journal of Midwifery & Women's Health*, 53(6), pp.512-521.

Sharps, P., Koziol-McLain, J., Campbell, J., McFarlane, J., Sachs, C. and Xu, X., 2001. Health Care Providers' Missed Opportunities for Preventing Femicide. *Preventative Medicine* 33, pp.373-380.

Sharps, P.W., Campbell, J.C., Baty, M.L., Walker, K.S. and Bair Merrit, M.H., 2008. Current Evidence on Home Visiting and Intimate Partner Violence. *JOGNN*, 37, pp.480-491.

Shorey, R.C., Cornelius, T.L. and Bell, K.M., 2010. Reactions to Participating in Dating Violence Research: Are our questions distressing participants? *Journal of Interpersonal Violence,* 26, pp.2890-2907.

Simons, L. and Lathlean, J., 2010. Mixed Methods. In: Gerrish, K. and Lacey, A., eds. *The Research Process in Nursing*. 6th Edition. Wiley Blackwell.

Silverman, D., 2001. *Interpreting Qualitative Data*. 2nd Edition. London: Sage.

Silverman, D., 2000. *Doing Qualitative Research. A Practical Handbook*. London: Sage.

Stanley, N., *2011. Children Experiencing Domestic Violence: A Literature Review.* Research in Practice, England.

Stark, E. and Flitcraft, A., 1996. *Women at Risk. Domestic Violence and Women's Health.* Sage Publications.

Stark, E., 2010. *Co-ercive control.* Oxford University Press.

Stenson, K., Sidenvall, B. and Heimer, G., 2005. Midwives' experiences of routine antenatal questioning relating to men's violence against women. *Midwifery*, 21(4), pp.311–321.

Stella Project, 2007. *Domestic Violence Drugs & Alcohol: Good practice guidelines.* London, AVA.

Strauss, M.A., 2007. Processes Explaining the Concealment and Distortion of Evidence on Gender Symmetry in Partner Violence. *European Journal of Criminology Policy Research,* 13 pp.227-232.

Strauss, M.A., Hamby, S.L., Boney-McCoy, S. and Sugarman, D.B., 1996. The Revised Conflict Tactics Scales (CTSZ). Development and Preliminary Psychometric Data. *Journal of Family Issues*, 17(3) pp.283-316.

Streubert, H.J. and Carpenter, D.R., 2011. *Qualitative Research in Nursing. Advancing the Humanistic Imperative.* Wolters Kluwer Health / Lippencott, Williams and Wilkins.

Sullivan, C.M. and Bybee, D.I., 1999. Reducing Violence by Using Community Based Advocacy for Women with Abusive Partners. *Journal of Counselling and Clinical Psychology*, 67(1), pp.43-53.

Sun, A., 2007. Relapse among substance abusing women: Components and processes. *Substance use and misuse,* 42, pp.1-21.

Taft, A. and Shakespeare, J., 2006. Managing the whole family when women are abused by intimate partners: challenges for health professionals. In: Roberts, G., Hegarty, K. and Feder, G., eds. Intimate Partner Abuse and Health Professionals. *New Approaches to Domestic Violence.* Italy, Churchill Livingstone Elsevier.

Taft, A.J., Watson, L.F. and Lee, C., 2004. Violence against young Australian women and association with reproductive events: a cross-sectional analysis of a national population sample. *Australia and New Zealand Journal of Public Health* , 28(4), pp.324-329.

Taylor, J., Bradbury-Jones, C., Kroll, T. and Duncan, F., 2013. Health professionals' beliefs about domestic abuse and the issue of disclosure: a critical incident technique study. *Health and Social Care in the Community,* 21(5), pp.489–499.

Taylor, J. and Lazenbatt, A., 2014. *Child Maltreatment and High Risk Families: Protecting children and young people.* Edinburgh: Dunedin Academic Press.

Taylor, M.C., 2005. Interviewing in Holloway I, ed. *Qualitative Research in Health Care.* Open University Press.

Thames Valley Partnership, 2005. *Risky Business: Report of a strategic conference to develop effective multi-agency risk management in domestic violence cases in the Thames Valley.*

Tiwari, A., Leung, W.C., Leung, T.W., Humphreys, J., Parker, B. and Ho, P.C., 2005. A randomised control trial of empowerment training for Chinese abused pregnant women in Hong Kong. *BJOG*, 112, pp.1249-1256.

Tod, A., 2010. Interviewing. In: Gerrish, K. and Lacey, A., eds. *The Research Process in Nursing*. 6th Edition Wiley Blackwell.

Topping, 2010. The Quantitative- Qualitative Contimuum. In: Gerrish, K. and Lacey, A., eds. *The Research Process in Nursing*. 6th Edition Wiley Blackwell.

Tower, M., 2007. Intimate Partner Violence and Health Care Response: A Post Modern Critique. *Health Care for Women International* , 28, pp.438–452.

Trabold, N., 2007. Screening for Intimate Partner Violence Within a Health Care Setting: A Systematic Review of the Literature. *Social Work in Health Care,* 45(1).

Turnock, B.J., 2009. *Public Health. What It is and How It Works*. 4th Edition. USA: Jones & Bartlett.

Ulrich, Y.C., Smith McKenna, L., King, C., Campbell, D.W., Ryan, J., Torres, S., Price-Lea, P., Medina, M. and Garza, M.A., 2006. Postpartum mothers disclosure of abuse, role and conflict. *Healthcare for Women International*, 27, pp.324-343.
United Nations, 1993. *Declaration on the Elimination of Violence Against Women.* Geneva

Vartanian, T.P., 2011. *Secondary Data Analysis*. USA: Oxford University Press.

Virkki, T., Husso, M., Notko, M., Holma, J., Laitila, A. and Mantyysaari, M., 2015. Possibilities for Intervention in Domestic Violence: Frame Analysis of Health Care Professionals' Attitudes. *Journal of Social Science Research,* 41(1), pp.6-24.

Walby, S., 2004. *The Cost of Domestic Violence*. Women and Equality Unit. London.

Walby, S., 2005. *Violence Against Women: a statistical overview, challenges and gaps in data collection and methodology and approaches for overcoming them.* UN Division of Advancement for Women, Geneva Switzerland

Walby S (2009) *The Cost of Domestic Violence – 2009 Update* Available at http://www.lancs.ac.uk/fass/doc_library/sociology/Cost_of_domestic_violence_update.doc

Walby, S. and Allen, J., 2004. *Home Office Research Study 276. Domestic Violence, Sexual Assault & Stalking: Findings from the British Crime Survey.* Home Office Research, Development and Statistics Directorate, London.

Walby, S. and Myhill, A., 2001. New Survey Methodologies in Researching Violence Against Women. *British Journal of Criminology,* 11, pp.502-522.

Walker, L., 1979. *The Battered Woman*. New York: Harper & Row.

Warshaw, C., Taft, A. and McCosker-Howard, H., 2006. Educating Health Professionals: Changing Attitudes and Overcoming Barriers. In: Roberts, G., Hegarty, K. and Feder, G., eds. *Intimate Partner Abuse and Health Professionals. New Approaches to Domestic Violence*. Italy: Chruchill Livingstone Elsevier.

Warshaw, C., 1996. *Domestic violence: changing theory, changing practice.*

Wathen, C.N. and MacMillan, H.L., 2003. Interventions for Violence Against Women. Scientific Review. *JAMA,* 289(5), pp.589 – 600.

Webb, C., 1993. Feminist Research: definitions, methodology, methods and evaluation. *Journal of Advanced Nursing,* 18, pp.416-423.

Webster, F., Bouck, M.S., Wright, B.L., Dietrich, P., 2006. Nursing the social wound: public health nurses' experiences of screening for woman abuse. *Canadian Journal of Nursing Research*, 38(4), pp.136-153.

Whiting, N., 2007. *A Gendered Analysis of Domestic Abuse in Same Sex Relationships. A Contradiction in Terms?* Scottish Women's Aid

WHO, 1948. *Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference. Official Records of the World Health Organization*, 2(100).

WHO, 1978. *Declaration of Alma-Ata International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September 1978*

WHO, 2001. Putting Women First. *Ethical and Safety Recommendations for Research on Domestic Violence Against Women*. Geneva, Switzerland: WHO.

WHO, 2005. *Multi country study on Women's Health and Domestic Violence Against Women.* Geneva, Switzerland: WHO.

WHO, 2012. *Understanding and Addressing Violence Against Women: Intimate Partner Violence.* Geneva, Switzerland: WHO.

WHO, 2013. *Responding to intimate partner violence and sexual violence against women. WHO clinical and policy guidelines.* Geneva, Switzerland: WHO.

WHO, 2014. *Intimate Partner and Sexual Violence Against Women. Factsheet No 239.* Geneva, Switzerland:WHO

WHO, UNOCC & UNDP , 2014. *Global Status Report on Violence Prevention.* Wilkinson, R. and Marmot, M., eds. 2003. *Social Determinants of Health: The Solid Facts*. WHO

Williams, G.B. and Brackley, M.H., 2009. Intimate Partner Violence, Pregnancy and the Decision for Abortion. *Issues in Mental Health Nursing,* 30(4), pp.272-278.

Williamson, E., 2010. Living in the World of the domestic violence perpetrator: negotiating the unreality of coercive control. *Violence Against Women,* 16, pp.1412-1423.

Wilson, K.S., Silberberg, M.R., Brown, A.J. and Yaggy, S.D., 2007. Health Needs and Barriers to Healthcare of Women Who Have Experienced Intimate Partner Violence. *Journal of Women's Health.* December, 16(10), pp.1485-1498.

Wokoma, T.T., Jampala, M., Bexhell, H., Guthrie, K. and Lindow, S., 2014. A comparative study of the prevalence of domestic violence in women requesting a termination of pregnancy and those attending the antenatal clinic. *British Journal of Obstetrics & Gynaecolog,y* 121(5), pp.627-633.

Women's National Commission, 2009. *Still We Rise: Report from WNC focus groups to inform cross government consultation "Together We Can End Violence Against Women and Girls."*

Wood, M., 2003. *Making Sense of Statistics. A Non Mathematical Approach*. London: Palgrave. pp.22.

World Bank, 1993. *World Bank Study: World Development Report: Investing in Health*. New York: Oxford University Press.

World Medical Association, 2013. World Medical Association Declaration of Helsinki Ethical Principles for Research with Human Subjects. *Journal of American Medical Association,* 310(20), pp.2191-2194.

Wykes, M. and Welsh, K., 2009. *Violence, Gender & Justice*. Sage

Young, M., Read, J., Barker-Collo, S. and Harrison, R., 2001. Evaluating and overcoming barriers to taking abuse histories. *Professional Psychology, Research & Practice*, 32(4), pp.407-414.