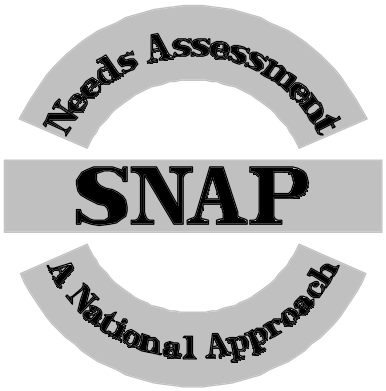
Scottish Needs Assessment Programme



DOMESTIC VIOLENCE

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Scottish Needs Assessment Programme

Women's Health Network

Domestic Violence

"Half of the women victims of homicide in Scotland are killed by their partners."

Hitting Home: a report on the police response to domestic violence.
HM Inspectorate of Constabularies for Scotland 1997.

Domestic Violence is a matter of public health. Violence debilitates women and girls physically, psychologically and socially, sometimes with lifelong results.

Bunch C. The intolerable status quo: violence against women and girls.
Progress of Nations. Unicef 1997.

"The 49th World Health Assembly in 1996 agreed that violence is a public health priority. Resolution WHA 49.25 endorses recommendations made at prior international conferences to tackle the problem of violence against women and girls, and to address its health consequences.

Violence against Women: a priority health issue.
Women's Health and Development, Family and Reproductive Health.
World Health Organisation, Geneva, 1997.

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Women's Health Network

Domestic Violence

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Executive Summary

The extent of domestic violence and its subsequent effect on the health and well-being of women makes it a significant public health issue with implications for health services.

Extrapolations from the range of available prevalence studies suggest that between 260,000 and 700,000 Scottish women may be experiencing domestic violence.

The definition of domestic violence used for this report is: psychological, emotional and economic, as well as physical and sexual abuse of women by male partners, or ex partners.

Women who experience domestic violence are more likely than those who do not to have poor health, chronic pain problems, depression, addictions, difficulties in pregnancy and to attempt suicide.

Domestic violence has serious effects on children. There is evidence to link perpetrators of domestic violence with physical and sexual abuse of children in the same family. A range of emotional difficulties have been identified amongst children in these families.

Women present to any of a range of health service settings with primary care as a key first contact point, either as a direct result of domestic violence or where it is a factor in the presenting problem.

The NHS is not in a position to solve the problem of domestic violence but needs to define its role clearly.

In order to make an informed assessment of the implications for the health service it is necessary to consider both why and how women use different health service settings as well as their experiences in using those services.

Research in different health service settings has shown that there are a number of prerequisites for improving service delivery to women who have experienced domestic violence. These are as follows:

- attitudes to and knowledge of domestic violence vary greatly affecting service delivery
- protocol introduction may overcome these variables but the support of senior management for training (which explores attitudes to domestic violence and current practice of operational staff) is required
- once agreement has been reached to introduce change, this needs to be communicated effectively to all staff members
- service providers need to consult on domestic violence with specialist services such as Women's Aid in order to set up appropriate training and to provide appropriate referral information to women.

Women with health problems related to domestic violence are potentially consuming large quantities of health service resources each year. **If health professionals and the health service as a whole could respond more systematically and effectively to women attending for health care, there is the potential to create either a better quality service for women or to release some resources for use in other equally beneficial activities.**

The NHS is part of society and an employer of large numbers of staff, the majority of whom are women. Therefore, it is likely that general prevalence rates for domestic violence will also be found within the workforce with consequent effects on the health of the individuals involved.

Maximising health gain at a local level requires a national framework for action on domestic violence to support

the activity of Health Boards and Trusts.

A multi-agency approach is considered essential to ensure an improvement in the health of women experiencing domestic violence and the health service could act as a catalyst to change with these other agencies. The health service, with a major role in providing health care, has a similarly important role in referring women to other agencies and in working with these agencies on a common plan for effective intervention and support in a community.

Summary of recommendations

The current levels of knowledge awareness are such that action around domestic violence in a health service context have led the SNAP group on domestic violence to make the following recommendations:

Domestic violence is adopted as a key health service issue, using the definitions and principles outlined in this report.

Addressing domestic violence as a health service issue is the responsibility of the Scottish Office, health boards, trusts and primary care based professionals.

The Scottish Office should be responsible for the development of a national framework for addressing domestic violence which makes clear the roles and responsibilities of local agencies.

Health boards should use their influence at national level to ensure national policy and guidance on the issue of domestic violence.

Ownership of the issue to be taken at senior level by all healthcare organisations and a lead officer identified to develop and co-ordinate planning. This should be matched in local agencies.

Locally-appropriate systems to be devised for involving women who have experienced domestic violence in service planning and delivery.

Pilot projects to be set up to establish a national recording and monitoring framework, and also to develop a methodology for needs assessment.

Health boards to facilitate, and trusts to cooperate in, the development of guidelines for each health service setting.

Training for all health service staff on domestic violence should be comprehensive and systematic.

Evaluation techniques to be developed which cover both process and outcome measures.

A resource centre to be established to support the work undertaken by Health Promotion Departments which can provide a comprehensive source of information and technical assistance in developing the work.

The health service to recognise it is one player in a multi-agency response to domestic violence and in the absence of the lead coming from elsewhere must initiate the development of multi-agency strategies.

1. INTRODUCTION

1.1 The need for a SNAP Report on Domestic Violence

Awareness of domestic violence and its consequences for women has grown in recent years as the issue has become more public. Some studies estimate that it occurs in as many as one third of all marriages or intimate relationships between women and men.[1] With this has come recognition of the effect of domestic violence on the health of women and the consequent impact on the use of health and other services.

Organisations such as Women's Aid have been raising the issue for over twenty years while providing refuge (safe temporary accommodation), and support for women and children who experience domestic violence. Their knowledge and understanding have subsequently been given even additional weight by a body of quantitative and qualitative research. This research has begun to identify the widespread nature of domestic violence and its impact, as well as systematically recording women's experiences. Campaigns such as Zero Tolerance[2] have helped to challenge public perceptions of domestic violence and to create a climate whereby women can declare their experience of violence and seek to remedy the situation if they wish to do so.

The physical, sexual and psychological nature of domestic violence means that it will affect health. Domestic violence can result in death, serious injury and chronic physical and mental health problems for all those affected, either directly or indirectly. Research indicates that women present to any of a range of health service settings either as a direct result of domestic violence or where it is a factor in the presenting problem[3 4 5 6]. Often women have found the service wanting[1 7]. This has profound implications for the health service and presents a considerable challenge to both health care commissioners/planners and providers in acute and primary care services.

This challenge is a complex one because it requires a health service response to a social issue around which there is much debate and misunderstanding. It involves:

creating a greater awareness amongst staff and policy makers of the issue
a response which is systematic across services and which is based on the experiences of women using health services
a joint approach which involves the NHS in overcoming the fragmentation of service provision.

The efforts to publicise and challenge domestic violence have been supported by public statements from the Home Office and the Scottish Office.

1.2 The role of the SNAP Group on Domestic Violence

Despite the apparent size of the problem and the obvious health implications, there appears to be a limited awareness of the issue and its link to health. As a consequence there has been little attempt by the health service to consider its role in relation to domestic violence. It is this deficiency that SNAP wishes to address by highlighting the significance of domestic violence as a public health issue.

The conventional role of SNAP groups is to link needs assessment in a range of medical and health issues to measurable improvements in health outcomes by producing reports which make recommendations for effective commissioning/planning. The SNAP group on Domestic Violence was convened with a similar intention but in order to increase the likelihood of the recommendations being implemented it also recognised the need to raise awareness of the importance of this issue prior to the publication of a report. This has been carried out by:

hosting the conference "Domestic Violence is a Health Service Issue" the report of which is available as Appendix 1.
linking with the Greater Glasgow Health Board Health Gain Commissioning Team and its research activities on Domestic Violence and
linking with the Multi-agency Domestic Violence Project and its Strategy in central Scotland.

This report is intended primarily for the commissioners/planners and the managers of all services used by women although it contains relevant information for practitioners. It will also be of interest to other statutory and voluntary agencies because it acknowledges the need for the health service to work in tandem with other agencies to provide an effective and comprehensive response which supports women.

1.3 Principles

The SNAP group acknowledges the need for guiding principles in creating an effective response to women who have experienced domestic violence. It has adopted the principles of the Multi-agency Domestic Violence Project in central Scotland[8], the aim of which has been to determine a common strategy for a range of public and voluntary organisations - Forth Valley Health Board, Central Scotland Police, Falkirk,

Stirling and Clackmannan councils and the Women's Aid groups in the same areas. The principles have been adopted by the range of agencies participating and are stated as follows:

the interests and safety of women and children are the prime consideration
action is taken to ensure prevention, provision and protection in relation to those affected by domestic violence
the needs of women who have experienced violence will determine the development of services
equity and access are ensured in the planning, development, delivery and availability of services in consultation with women and children
a common approach and community involvement are the means of achieving an effective response to domestic violence

1.4 Aims of SNAP Report

The **aims** of this report are :

To provide an understanding of the meaning and nature of domestic violence
To define domestic violence as a public health issue by assessing current information on prevalence, health implications and use of health services
To draw attention to women's perceptions of using health services
To determine the potential for health gain
To make recommendations for consideration by commissioners/planners and providers
To provide support materials to facilitate action

2. WHAT IS DOMESTIC VIOLENCE?

2.1 Definition

Clarification of what is actually meant by domestic violence is crucial in determining both the extent of the problem and the action required to respond effectively to it.

The definition of domestic violence used for this report is: **psychological, emotional and economic, as well as physical and sexual abuse of women by male partners, or ex partners.** [8]

The Declaration on the Elimination of Violence against Women passed by the United Nations General Assembly (Vienna Declaration 1993) states that:

"*Violence against women is a manifestation of historically unequal power relations between men and women...and that violence against women is one of the crucial social mechanisms by which women are forced into a subordinate position to men*" [9]

The use of the term "domestic violence" in this report cannot be seen as synonymous with violence towards men by women, elder abuse or other forms of intra-familial abuse, all of which deserve detailed consideration in further reports. Furthermore, despite the implied nature of the term "domestic", violence also occurs between men and women who have or have had an intimate relationship but who have never lived together.

This report recognises that violence against women is a violation of women's human rights and that

it is a product of the way that society views the position of women and the subsequent inequality that women face,
male violence against women is the result of an abuse of power created by this inequality
it is part of a range of related practices which include among others, sexual harassment, child sexual abuse, sexual assault and even pornography.

It also recognises that whilst it has only recently been named as a problem it is not new and that it has always had significant implications for the health and well-being of women.

2.2 The Nature of Domestic Violence

It is important to recognise the ways in which women are abused. The term 'domestic violence' covers a combination of physical, sexual, psychological and economic violence and has been reported by women to include:

psychological - verbal abuse, constant criticism, distorting women's sense of perspective, playing mind games, undermining self confidence, humiliation in front of others, monitoring women's movements,
economic - withholding of money, denial of opportunity to work, denial of economic independence
physical - punching, slapping, choking, hitting with objects or weapons, threatening with a knife or gun, stabbing, shooting, throwing out of cars, drowning
sexual - rape, sexual assault, penetration with instruments and unwanted sexual intimacy

Domestic violence is rarely an isolated, individual event but a continuum of behaviours. It usually starts early in a relationship and escalates in frequency and intensity over time. Dobash and Dobash reported that half of a sample of 108 women staying in refuge accommodation had been assaulted within the first year of living with their husband and in most cases the violence had emerged within the first three years of marriage[3 4]. Often different forms of abuse can be used together over the course of a relationship. Some episodes consist of a sustained attack with one form of violence repeated many times often combined with other tactics. Others comprise a single act. Episodes can last from a few minutes to several hours or days. Domestic violence carries a risk of death with 40-45% of female homicide victims in England and Wales having been killed by present or former partners. This compares with 6% of male homicide victims. [10]

"He trailed me round the house... and banged my head off everything. At this stage I was about three months pregnant. And he'd kicked me up and down the stairs and trailed me through the kitchen, and through the living room, using my head to open the doors and all. You know, just banged it off the doors. And he brought a Stanley knife and he said, " if you ever do that again (go to the police) *I'll mark you for life."* [7]

"I remember the tension of becoming aware that I had to notice what I was saying all the time, to make sure I didn't offend him...I had become afraid." [7]

Research has shown that conflicts which lead to violence have four interlinked sources [3]. These are:

men's possessiveness and jealousy,
men's expectations concerning women's domestic work,
men's sense of women as their property to be punished after a supposed wrongdoing,
the importance to men of maintaining authority.

2.3 Women who experience domestic violence

Women who experience domestic violence come from all backgrounds. Social class, family income, level of education, occupation, ethnicity or race, age or impairment make little difference to incidence or prevalence.[3 5 11] Contrary to popular perceptions, domestic violence occurs almost as frequently in affluent middle class communities as it does in poor communities. A study by Mooney showed that 25% of women came from a professional group, 29% from lower middle class and 30% from a working class background and that the type of violence varied for each group.[12] Other research also shows differences in the style and type of violence, being more covert and with a greater likelihood of psychological violence in middle class communities. [13]

A number of researchers have found that violence increases in severity and frequency during pregnancy and is directed both at the mother and at the foetus.[14 15] Other work has shown that women are more likely to report domestic violence at this time.[16] It is estimated that between 15-17% of women are assaulted during pregnancy and that 60% of these women experience repeated acts of violence.[14 15 17 18]

For some groups such as elderly women, disabled women and lesbians, violence is more hidden because of the barriers faced by women in these groups to disclosing or escaping violence. For black and ethnic minority women, language barriers, fear of racism, or absence of settled immigration status can compound the difficulties further.

2.4 Women's response to domestic violence

Surviving domestic violence can be extremely hard and requires courage and determination by women. As there is considerable stigma associated with domestic violence, disclosing it to friends, family or professionals similarly requires strength and when women do this they may be disbelieved or blamed. They may also have been threatened by their partner with further violence if they do tell. By the time a women has spoken about the violence she has experienced she will often have tried many strategies to cope with or minimise the violence. [3]

Women report that leaving a violent partner can be extremely difficult for many reasons - belief or hope of reform, fear of reprisals, effects on children, lack of accommodation or independent finance, loneliness and isolation.[1 3 4 7 19] If they do leave, women are often at greater risk with their partners seeking them out in safe spaces such as refuges and inflicting further violence. Another common pattern of behaviour is that when a woman leaves her partner he goes after her, apologises for hitting her, acknowledges the error of his ways, promises that it will not happen again, reaffirms his affection for her and pleads with her to return. Often permanent separation is preceded by many attempts by a woman to leave and throughout this process, she requires understanding and support.

Many women do successfully leave violent relationships and go on to lead new lives. Some women do not however wish to leave the relationship but want the violence to stop, a view that needs to be respected.

2.5 Perpetrators

The Home Office report on Domestic Violence[6] highlights that the historical roots of domestic violence are ancient and deep, correlating with the sanctioned subjugation of women. Nevertheless, there remains a persistent view that perpetrators are either deviant, mentally ill or become violent as the result of the stress of experiencing difficult circumstances. Dobash and Dobash[3] provide an historical and contemporary analysis which highlights the limitations of these perspectives.

" Seeking the causes and sources of violence and crime through an emphasis on pathological individuals or deviant relationships has been an important activity of those who would ignore the simple fact that violence is endemic to modern Western societies. The use of physical force against wives should be seen as an attempt by the husband to bring about a desired state of affairs. It is primarily purposeful behaviour and not the action of deviant or abhorrent individuals or the prerogative of deviant or unusual families...Although such factors [as alcoholism, drug abuse or lack of parental love] may be associated with the problem of violence against wives, they are not crucial to the explanation of that violence. Rather, men who assault their wives are actually living up to the cultural prescriptions that are cherished in Western society - aggressiveness, male dominance, and female subordination - and they are using physical force as a means to enforce that dominance."

The acceptance of domestic violence as a product of social norms has meant that it is only relatively recently that women have had protection under the law. It is only since 1981 that there has been some protection, for example under the Matrimonial Homes (Family Protection) Act (Scotland). Even now there is a gap between the law as stated and the law in action, with the woman often seen as having provoked the violence and justice is therefore not administered.[20] It does however appear that interventions aimed at bringing about change in the behaviour and beliefs of perpetrators have to be linked to the criminal justice system if they are to have any effect and not form part of a pre-court diversion scheme[21].

A recent evaluation of two programmes for violent men in Scotland compared the impact on violent behaviour of men's programmes through re-education with other criminal justice sanctions such as fines and probation.[21]

"The comparisons show that twelve months after the intervention, a significant proportion of the offenders who participated in the men's programme reduced their violence and associated controlling behaviour and their women partners reported significant improvement in their relationship with these men. By contrast, men experiencing other criminal justice sanctions (fined, admonished, placed on probation or sent to prison) were less likely to have reduced their violence and controlling behaviour and their partners were less likely to report an improvement in their quality of life or in the relationship"...."Changes were generally sustained twelve months after the completion of the programme, and those who failed usually did so within the first

three months after intervention".

"The evaluation found 'three stories of change':- 1) men who cannot or will not change despite the intervention, 2) men who engage in limited change maintained under the watchful eye of the enforcers of law and the threat of increasing sanctions, and 3) men who change their violent behaviour and supporting attitudes and become the regulators of their own behaviour".

2.6 Responsibility for change

Current thought indicates that changing society's attitudes and the abusive behaviour of individual men requires [6] :

abusive men to accept responsibility for their behaviour

everyone to consider their role in counteracting social and historical norms which condone male violence within relationships

responsibility of agencies to consider their role and the need to challenge male violence in their work, and that work with violent men should put the safety of women and children first and confront men about their abuse of women.

3. DOMESTIC VIOLENCE AS A PUBLIC HEALTH ISSUE

The extent of domestic violence and its subsequent effect on the health and well-being of women makes it a significant public health issue with implications for health services as part of a range of relevant support services in the statutory and voluntary sectors.

3.1 The extent of domestic violence

Domestic violence has been described as the biggest blind spot in official statistics.[6] A 1989 Home Office Report, "Domestic Violence: An overview of the literature" states that "domestic violence constitutes a pervasive problem" in Britain, the study of which has not received systematic attention in the academic world.[6] Any attempt to address this gap needs to recognise that women internalise blame, fear reprisal from the perpetrator and fear negative responses from a variety of agencies if they disclose domestic violence.

Despite limitations in the research, it is possible to build a composite picture of the extent of domestic violence from the information that is available and how apparent prevalence is changing over time as methods improve. In 1975, the House of Commons Select Committee on Marriage estimated that approximately 1% of married women experienced violence from their partner.[22] In 1979, Dobash and Dobash reported that violence to female partners constituted 25% of all assault reported to the police.[3] In 1983, another study estimated that between 1 in 5 and 1 in 3 of all married women experience violence from their partner.[23] In the 1992 British Crime Survey, 11% of women who had lived with a partner reported physical violence against them in their relationship.[10] In 1993, Mooney, in a study on women in North London, found that 12% of women surveyed had experienced physical violence, 8% had been injured by their partners and 12% had experienced mental cruelty, within the last 12 months. In addition, 27% of women reported that they had experienced physical injury and 37% mental cruelty at some point during their relationship with an intimate male partner.[12]

In March 1993 the House of Commons Home Affairs Committee [24] reported on domestic violence, stating that 'the extent of the problem....is perhaps only now beginning to be properly revealed'. Their report was concerned primarily with protection under the criminal and civil law and recommended an upgrade in the quality of national statistics on domestic violence which come to the criminal and civil justice system. They highlighted the need for all departments to tackle domestic violence effectively and for the Government to encourage local inter-agency co-operation on domestic violence.

3.2 Extent of domestic violence in Scotland

Extrapolations made from the studies presented above suggest that as many as 260,000 to 700,000 Scottish women may be experiencing domestic violence. These extrapolations are based on a Scottish female population of 2,169,930 women over 15 years of age and that there is such variation in the numbers illustrates the limitations of current prevalence studies

3.3 Health effects of domestic violence

Women who experience domestic violence are more likely to have poor health, chronic pain problems, depression, addictions, difficulties in pregnancy and to attempt suicide than women who do not.[26]

3.4 Physical health problems

Dobash and Dobash (1994) present data which indicate a broad range in the nature and severity of physical injuries. The most common form was bruising, often extensive, followed by cuts.[3] Ruddle and O'Connor (1992) showed that women suffered injuries which left them with permanent scars and disfigurement. Often these injuries are untreated. [27] Some women have been beaten into unconsciousness and may have had to be hospitalised as a result of the violence.[28] In the United States, over 80% of assaults on spouses or ex-spouses result in injuries, compared to 54% of cases in violence by strangers.[29]

The American Medical Association has suggested that there is an association with delayed physical effects, particularly arthritis, hypertension and heart disease.[30] This requires further investigation.

Campbell and Alford (1989) have shown that in one study 36% of women living in refuges reported 'vaginal stretching', 37% vaginal bleeding, 25% missed menstrual periods, 17% infertility and 6.5% sexually transmitted diseases which they attributed to sexual abuse by their partner.[31]

3.5 Emotional and mental health problems

The risk of attempted suicide is much higher amongst women who have experienced domestic violence, Amaro et al (1990) found that 17% of women who had experienced domestic violence had attempted suicide as compared to 5% of those who had not.[32] Other studies put the figure as high as 35-40% [33].

Psychosocial problems occur more frequently amongst women who have experienced domestic violence than those who have not. Walker (1985) documents high levels of anxiety, fears and panic attacks, depression and other clinical symptoms.[5] Jaffe et al (1986) similarly found that women who had experienced domestic violence had significantly higher levels of anxiety and depression than a comparable sample of women who had not.[34] 40% of the women in the study by Mooney indicated that they had trouble sleeping and 46% of them felt depressed and had lost confidence. [12]

There is also a link with use of substances. The connection between domestic violence and alcohol abuse was made in the late 1970s when nearly all the women on an alcohol rehabilitation programme disclosed domestic violence.[35] More recently, Stark and Flitcraft (1991) have also suggested that domestic violence is the most important cause identified for alcohol abuse amongst women rather than alcohol use contributing to domestic violence. They also indicate that there is nine times greater risk of women who have experienced domestic violence using other drugs.[36] The Aberlour Child Care Trust, a drug and alcohol project in Scotland have reported that 70% of women contacting their service have some experience of domestic violence and 87% have experienced sexual and physical abuse as children.[37]

3.6 The effect on children witnessing domestic violence

Domestic violence has serious effects on children. They will often witness or hear acts of violence being committed or observe the results whether as physical injuries or the emotional effects such as fear, hurt or anger. Some reports indicate that as many as 90% of children of women experiencing domestic violence are witness to it, often without the realisation of parents. [38] There is also evidence to link perpetrators of domestic violence with physical and sexual abuse of children in the same family, either as part of the violence directed at their mothers or on separate occasions or both.[39]

A range of emotional difficulties have been identified amongst children of mothers experiencing domestic

violence.[40] These include increased levels of anxiety, psychosomatic illness, depression, sadness, withdrawal, fear, lower rating in social competence and disruption to their education.

4. IMPLICATIONS FOR THE HEALTH SERVICE

In order to make an informed assessment of the implications for the health service it is necessary to consider both why and how women use different health service settings as well as their experiences in using those services.

4.1 Help seeking behaviour of women

Women are reluctant to report or disclose domestic violence for fear of their partner finding out, the stigma attached, the difficulties in raising the subject or the attitudes of service providers which may be unsympathetic or judgmental. Dobash and Dobash found that only 2% of the women who had experienced domestic violence had reported an assault to the police and that on average a woman is assaulted 35 times before seeking help from anyone[3]. In the United States, the FBI believes that domestic violence is the most unreported crime and estimates that it is probably ten times more unreported than rape.[41]

The medical profession is often the first formal agency that women do turn to for help. Dobash and Dobash have reported that in one study, 80% of the sample of women experiencing domestic violence had sought medical help for injury, chronic illness and pain at least once. 40% had sought help on at least five separate occasions.[3]

The nature of the health effects are such that women will inevitably be presenting at a range of different health service settings. **No routine data about domestic violence are collected by the NHS in Scotland.** There is only limited research about use of a few of these settings and much of this has been carried out in the United States.

4.2 Primary Health Care

There have been few studies that have looked at general practice in relation to domestic violence. Those that do exist have relied solely on doctors' perceptions of the frequency of consultation by women who have experienced domestic violence.

Borkowski et al (1983) interviewed 50 GPs in Britain who made rough estimates of the number of consultations by women experiencing domestic violence and the results suggest that they were consulted infrequently.[23] More recently, an exploratory study in Tayside found that out of the 29 GPs responding to a questionnaire sent to all in the Health Board area on domestic violence and workload, 23 estimated that it accounted for between 1-5% of their workload, 3 estimated between 6-10% and 3 indicated that it was over 11%.[19]

Non-random surveys of women who have experienced domestic violence have also provided estimates which vary widely. One 1979 study of 50 women living in a refuge revealed that 64% had consulted their GP at some time about the violence in their relationship.[3] This figure may vary between 50% and 80%. [3]

Very little is known about the role and responsibility of the wider primary health care team in this context. Binney et al showed that less than a quarter of the sample had contacted a health visitor whilst other work suggests that it forms just under 2% of health visitor workload. [42] The Tayside study suggested that it accounted for between 1-5% of current health visitor workload.[19]

4.3 Accident and Emergency Departments

Accident and Emergency Departments in Scotland do not routinely collect information on the use of their service by women experiencing domestic violence. Despite many limitations, literature from the United States offers some valuable information in the face of this local deficiency. These studies indicate that a large proportion of women experiencing domestic violence who turn to agencies for help will enter the health care system through an accident and emergency department [43] [44] This may be because of the nature of the injury or the relative anonymity and twenty-four hour access that accident and emergency departments provide.

In one American study, Stark et al, in a retrospective record review of 481 women attending a casualty department for treatment, categorised cases into definite, probable and negative for domestic violence. The results indicated that 1 in 12 women were categorised as definite or probable for domestic violence.[33]

In another A & E department, the percentage of women detected who had experienced domestic violence rose from 6% to 30 % after the introduction of staff training and protocols.[45] However, this percentage had fallen to 8% in a follow-up study and the authors concluded that ongoing advocacy for the issue was vital.[46]

A recent paper by Abbott et al (1995) is useful in distinguishing between the incidence of domestic violence presenting at an A & E department and the prevalence of attendances by women who have experienced domestic violence at any time in the past. The results demonstrate that 1 in 9 (12%) women with a male partner were seeking emergency care that day because of domestic violence. The prevalence rate was found to be 54%.[47]

Stark, Flitcraft and Frazier (1979) found that women who had experienced domestic violence who were seen in Accident and Emergency were three times more likely to be pregnant when injured.[33]

4.4 Gynaecology

An extensive literature search has found few reliable estimates of women seeking gynaecological services as a result of violence inflicted by a partner. However, chronic pain is the most commonly discussed gynaecological complaint and its possible link to domestic violence has been discussed by various authors. Haber (1983) examined the link by interviewing all women attending a pain clinic over an eight month period. The results showed that 53% of the women who presented had a history of physical and/or sexual abuse. This correlation does not however necessarily imply that domestic violence was the reason for the chronic pain and the figure is probably a prevalence rate.[48]

From the growing understanding of a link between domestic violence and gynaecological problems, especially chronic pelvic pain, it is likely/possible that women who have experience of it will receive treatment from a gynaecologist at some time in their lives. This may involve exploratory surgical procedures such as laparoscopy when in actual fact the real problem may be related to the psychological effects of abuse.

4.5 Obstetrics/Maternity

It is known that violence inflicted during pregnancy can result in injuries requiring medical attention. Examples of injuries include: placental separation, antepartum haemorrhage, foetal fractures, rupture of the uterus, liver or spleen.[49] Amaro et al (1990) found that 36% of women who had experienced domestic violence had seen a doctor for at least one violent incident during pregnancy and 10% were hospitalised overnight as a result of violence.[32] Webster et al (1994) noted a figure of 31% in their sample.[50] None of the authors however examined the potential for increased ante-natal admissions as a result of injury, or for social reasons.

4.6 Psychiatry

In common with other areas of health care utilisation, there are no reliable estimates about the use of psychiatric services by women in the United Kingdom who have experienced domestic violence despite the known links with psychological problems. Those studies that do exist are based on non-random samples of abused women.

Hilberman and Munsen (1978) found that 50% of women referred for psychiatric consultation were in abusive relationships, although only 7% of cases were previously identified.[35] Carmen et al (1984) reported that 43% of female inpatients studied had a history of abuse, 90% by family members.[51] Hillard (1985) found that women who had experienced domestic violence were significantly more likely than those who had not to have “problems with their nerves”, to visit their doctor due to “nerves”, to have medicine prescribed or to be hospitalised.[52]

More recently, Bergman and Brismar (1991) reported the results of a 5-year follow-up study of 117 women who had experienced domestic violence. Total use of psychiatric care was found to exceed widely that of

control subjects. **59% had been admitted to a psychiatric inpatient clinic compared to 1% in the control group.** 48% had attended a psychiatric outpatient clinic compared to less than 8% of controls. The spectrum of diagnoses covered substance use, attempted suicide, depression and psychoses.[53]

4.7 Other settings

The impact of domestic violence on all aspects of a women's health and well-being implies that women will be using other health service settings as a result. Some obvious examples are orthopaedics (due to injury), dental services (oral injury and trauma), family planning and well woman services (emergency contraception and advice on termination), children's health services and paediatrics. Nevertheless, no evidence can be found in the literature.

4.8 The NHS as a cross-section of society

The NHS is part of society and an employer of large numbers of staff, the majority of whom are women. There is, therefore, every reason to suppose that general prevalence rates for domestic violence will be also be found within the workforce with consequent effects on the health of the individuals involved. A proportion of the male workforce comparable with the rates amongst the general population will also be perpetrators.

There are therefore implications for both occupational health services and personnel departments.

4.9 The response of services - Women's experiences

Studies of women's experiences of the medical services indicate that they are receiving a very varied response. A survey of women in refuges showed that just over two fifths of those who had consulted a doctor had found them helpful although it is not known whether this was in a primary care setting or elsewhere.[54] However, another survey in 1992 of 1000 women who had experienced domestic violence indicated that they gave health care professionals the lowest effectiveness rating behind refuges, solicitors, social workers, police and clergy.[7]

It is likely that the general practitioner or a member of the primary health care team will be the first health professional that a woman will consult. The work on women's experiences with both general practitioners and health visitors generally indicates that women are dissatisfied with the response.[7 19] When they do disclose domestic violence they report that they are often prescribed tranquillisers. These can help a woman to cope but are often viewed as an inappropriate stop-gap measure or even dangerous because they may limit women's alertness leaving them more vulnerable to assault.[55] It is also easier to prescribe medication than to explore the issue.

Where women have not voluntarily disclosed the violence, the research shows that this is often because they found it difficult to raise the subject, they feared that partners may find out indirectly or that it might be raised with them if they both had the same general practitioner or that their actions would be judged.[1 3 7 19] Neither general practitioners nor health visitors appear to recognise signs and symptoms relating to domestic violence and this is mirrored by women's experiences in Accident and Emergency Departments where many have their injuries dealt with but the issue of the violence is not raised.

4.10 Helpfulness

Women who have used health services paint a very clear picture of what constitutes a helpful response.[7] The elements of this response are as follows:

Awareness of the possibility of domestic violence
Recognising signs and symptoms
Initiating discussion about domestic violence by asking direct questions in a sympathetic and non-judgmental way
Willingness to listen and make time
Give appropriate advice and information about available support services

McWilliams and McKiernan stress that:

" Interviews with the medical and health professionals showed how the violence could often be minimised and not diagnosed or identified... this is the process which results in a double victimisation of women, once by the perpetrator and once by the system to whom she turned for help.

Where women did get advice and information, they were often then enabled to take the next step. In the absence of information and advice, many of the women did not know what their rights were and could not therefore effect change in their own lives." [7]

The indication from women of the need for a systematic and uniform response suggests that it may be possible to learn from other, parallel systems (e.g. CAGE questions for use of alcohol) which indicate that it need not be difficult to approach all attendees at health care settings in a simple and objective manner. It is also important to note that the NHS is not in a position to solve the problem of domestic violence but needs to define its role clearly. (See section 6)

4.11 Implications for health service resource use

It is evident that women experiencing domestic violence attend for health care in a variety of settings and consequently are likely to use a large amount of health service resources. It is difficult to measure these resource quantities with any degree of accuracy since there are no local or national data recording systems for domestic violence in place in Scotland.

A recent economic analysis has however attempted to estimate the quantities of health service resources used by women experiencing domestic violence in Scotland.[56] It is based on a review of the literature which is only available for certain NHS settings - general practice, accident and emergency, gynaecology and psychiatry. The objective of the literature review was to estimate the likely proportion of total resource use by women each year. In the case of general practice, estimates were obtained from the literature about the percentage of women experiencing domestic violence who visit their GP at least once over a one year period.

Given the limitations of the literature, a range of resource use quantities has been estimated for Scotland for a one-year period and is detailed in Table 1. A more detailed analysis is provided in Appendix 7 and provides a tool for Health Boards to estimate their own resource implications.

Table 1: Estimated range of resource use for selected settings

Item of resource use	Quantity/year
General practitioner consultations	87,000 - 136,000
Accident and emergency outpatient attendances	58,000 - 145,000
Gynaecology outpatient attendances	28,000 - 69,000
Gynaecology daycare procedures	3,000 - 8,000
Gynaecology inpatient bed days	16,000 - 40,000
Psychiatry new outpatient attendances	5,000 - 9,000
Psychiatry return outpatient attendances	22,000 - 43,000
Psychiatry inpatient bed days	120,000 - 239,000

These figures strongly illustrate that domestic violence is indeed a health service issue. Women with health problems related to domestic violence are potentially consuming large quantities of scarce health service resources each year. **If health professionals and the health service as a whole could respond more systematically and effectively to women attending for health care, there is the potential to create either a better quality service for women or to free up some resources for use in other equally beneficial activities**.

It is important to note that these figures do not include all areas of resource use - previous sections point to the use of a much wider range of services including family planning, dental services, obstetrics, orthopaedics, general medical and general surgical facilities. In particular, in the case of dental services, recent research from Canada indicates substantial implications for both the use of health service resources and for women who have to pay for dental treatment [57]. However, it is not possible to estimate the quantities of resources

used in these settings given the dearth of reliable information. In addition, there will also be the costs of dispensing and pharmaceutical services but there is very little information about the patterns of medication use by women experiencing domestic violence. Consequently, the figures presented may underestimate the magnitude of the problem. A more accurate estimation of resource use will not be possible until routine data recording systems are developed in health service settings.

Women may take time off work to recover from injuries sustained during episodes of domestic violence. Therefore, there are also implications in terms of productivity losses for the health service as a major employer of women. The NHS in Scotland employs 106,646 women, which accounts for 77% of the total work force. Based on the available literature it is also estimated that as many as 45,000 work days are lost annually as a result of women taking time off from NHS workplaces to recover from injuries sustained through incidents of domestic violence. A detailed analysis is provided in Appendix 7.

5. ATTEMPTS TO IMPROVE SERVICE DELIVERY

There is a growing awareness of the need for health professionals and the health service to respond more systematically and effectively to women who have experienced domestic violence. Nevertheless, this has not yet led to a systematic response by the NHS in Scotland.

5.1 The Council on Ethical and Judicial Affairs of the American Medical Association[55] is instructive in its recommendations where it states that the principle of beneficence requires health care professionals to intervene in cases of domestic violence. It further argues that treating only for injury and symptoms of domestic violence can exacerbate the problem. Early recognition of domestic violence as an underlying cause of health care problems can lead to prevention of further violence and ill health. The Council also recommends that the principle of non maleficence (do no harm) also directs health care practitioners to address the violence because if it is missed then treatments are likely to be inappropriate, contra-indicated or even harmful.

5.2 The Home Office Report on Domestic Violence in 1989.[6] recommended a number of steps for development within the NHS following US examples. These were:

develop a standard protocol for identifying women who experience domestic violence
develop training programmes for health service staff
encourage staff to liaise with and refer to other agencies
develop data recording systems to estimate the extent of the problem and to ensure that details of visits and injuries are carefully recorded for prosecution purposes.

5.3 In 1989 in a leader in the British Medical Journal, McIlwaine[58] argued that domestic violence should be viewed as part of a more holistic approach to women's health and that doctors play a crucial part in helping women by "being aware that domestic violence occurs and by being prepared to ask key questions." More recently, there have been further editorials and letters in the BMJ calling for a systematic response to violence against women.[59 60] There have also been reports of attempts to introduce guidelines into service delivery.

5.4 Examples in Scotland of action to address the issue of domestic violence

As part of its implementation of the Women's Health Policy for Glasgow[61], Greater Glasgow Health Board has set up a Health Gain Commissioning Team on Domestic Violence in order to inform the commissioning/ planning process. The remit of this group is to review the response of a number of different health service settings to women experiencing domestic violence and to produce a series of recommendations for the contractual process based on the Home Office guidelines regarding the introduction of protocols. The audits were also designed to provide participating departments or services with possible methods for improving detection and their response to women. Research in two settings - Accident and Emergency and Family Planning and Well Woman - has been completed.

The audit process involved determining current detection rates, current practice and attitudes of staff, training for staff on protocol introduction, introduction of a protocol over a fixed time period and assessment of the impact. Considerable time was also spent in drawing up the protocols in line with both American reports and local prevailing service conditions. The protocol comprised five stages:

initial assessment of domestic violence
provision of a quiet and private environment
identification and naming the abuse: asking the question
clear documentation of the abuse
provision of information about options and resources

A full example can be found as Appendix 5.

In both cases, knowledge and attitudes of the staff were found to have changed but there was no significant difference in detection rates after the introduction of the protocol. However both services presented a number of logistical and organisational problems which resulted in alternative scenarios being developed. For example, difficulties in releasing staff in the selected Accident and Emergency department led to the development of a distance learning package which relied on staff motivation and release from duties for completion. The Health Gain Commissioning Team reached the following conclusions about the pre-requisites for improving service delivery to women who have experienced domestic violence:

attitudes to and knowledge of domestic violence vary greatly and this can affect service delivery
protocol introduction may overcome these variables but the support of senior management for training which explores attitudes to domestic violence and current practice of operational staff is required
once agreement has been reached to introduce change, this needs to be communicated to all staff members
service providers need to consult with outside specialists on domestic violence in order to set up appropriate training and to provide appropriate referral information to women.

Despite the difficulties in introducing significant change, the Health Gain Commissioning Team will be making recommendations on data collection and training for staff in two settings to the commissioning organisation for the 1997/98 year.

5.5 Health Education Board for Scotland Demonstration Project on an Interagency Approach to Domestic Violence

The Health Education Board for Scotland agreed in 1995 to fund a two year demonstration project on domestic violence in a specific community as part of its Safety Programme. The project has two main aims. The first, acknowledging the importance of the health service in the issue, is to research the current ways in which Castlemilk Health Centre provide a service to women who have experienced domestic violence. The second is to work with the health centre in conjunction with other agencies to improve the quality of service overall to women experiencing domestic violence in the community.

To date the research in the health centre has indicated a marked disparity between current detection rates by general practitioners and incidence of domestic violence amongst their patients as reported in a series of interviews with the researcher. Attempts to introduce monitoring in the other participating agencies as part of the subsequent development of an interagency strategy have highlighted similar difficulties in recording incidence.

5.6 The Multi-Agency Domestic Violence Strategy in central Scotland

The Multi-agency Domestic Violence Strategy developed in central Scotland[8] sets out a comprehensive policy and strategic objectives for addressing the issue of domestic violence. It recognises that women have complex needs and may require a range of services including Women's Aid or other voluntary organisations, the Health Service, Police, Housing, Social Work, Education and the Courts. A multi-agency approach is regarded as a means of providing a co-ordinated service which is relevant to women and their children.

The strategy was developed and agreed by a steering group representing Central Scotland Police, Central Regional Council, Stirling District Council, Falkirk District Council, Clackmannan District Council, Forth Valley Health Board and three Women's Aid groups in the areas represented. Its aims are to develop:

a common policy on domestic violence which is agreed by all agencies
a policy which addresses the needs of women and children and challenges the acceptance of male violence

to women

a structure to enable, achieve and sustain organisational and strategic change necessary for implementing the strategy

the means of developing a co-ordinated response

participation by women in the planning and development of services to enable agencies to meet their needs effectively.

It has been recognised that the implementation of the strategy has significant implications for health service practice, either through the contractual process with providers and through liaison with general practice. Ultimately, implementing the Strategy will involve a number of changes at many different levels in order to bring about recognisable improvement to the ways services are delivered to women. These are likely to include: the commissioning of new services by the Health Board; a cultural change, with a move to a more women-centred rather than a service based approach and a stronger focus on prevention of violence; organisational change, including the development of training, the management of services, a system for recording and monitoring assistance sought and given, coordinating work with other agencies and involving women in the planning process; evaluation of the effectiveness of provision.

6. IMPROVING THE HEALTH SERVICE RESPONSE

6.1 Health Gain

Current national strategies for improving health are built upon the concept of health gain. This has been identified as a measurable improvement in health status in an individual or population, attributable to earlier intervention.

Health gain from interventions for domestic violence depends on their ability to change the experience and future experience of domestic violence both for the individual and society. It is, however, much harder to link cause and effect in the provision of altered services for a social issue rather than a medical/clinical issue. The demonstration of health gain in this instance refers to any positive changes to quality of life or length of life. Good clinical practice requires understanding of the signs and symptoms indicative of domestic violence. Providing appropriate care also benefits the carer in the satisfaction gained from providing a good standard of care. Longer term health gain derives from empowering women and promoting their health and well-being.

This means that the impact of health service interventions on the health and well-being of women experiencing domestic violence cannot be assessed solely by quantitative medically based outcomes or those that are finance driven. Recognising that these have a place, attention needs also to focus on investing in tools for ‘measuring’ the quality of life that women experience, the quality of contact they have with health care workers and the quality of health care delivery. The health gain cycle comprises needs assessment, planning, implementation, evaluation and review, and commissioning needs to invest in all stages as they apply to domestic violence.

6.2 National framework

Maximising health gain at local level requires a national framework for action on domestic violence to support the activity of health boards and trusts. The National Agenda for Action in the U.K drawn up following the United Nations Fourth World Conference on Women in Beijing [62] similarly supports the need for a co-ordinated national strategy to tackle the issue of violence against women. A national taskgroup to identify research requirements on the issue, tools for monitoring and guidelines are essential. Existing national systems such as ISD also need to acknowledge the significance of domestic violence as a health service issue.

6.3 Prevention

Strategy development for the prevention of violence is at the centre of developing a woman-centred approach to domestic violence. It relates to the planning and delivery of services and also to changing the culture and acceptance of male violence to women. Strategies should be concerned with challenging prevailing attitudes to the social roles of women and men, the extent to which people can change and the identification by organisations of their specific role in prevention. There are a number of ways of intervening which play

a part in preventing violence. These include:

protection for women and children at home;
empowering women to choose a course of action for themselves and their children;
assisting women to move to secure accommodation;
assisting women to use the justice system more effectively;
crisis intervention;
development and evaluation of effective practice;
co-ordinating community response;
development of relevant health promotion programmes in schools, community, workplace and statutory and voluntary organisations;
educating men;
effective publicity campaigns linked to service development

6.4 Commissioning for domestic violence

In the current health service, the commissioning of services is the key to specifying standards of care, and also a major route to achieving change in service provision. All stages of the commissioning/planning cycle can be used to address domestic violence by:

aggregating information,
introducing a statement about the care required by women experiencing domestic violence into the service specifications
establishing effective monitoring systems
senior management taking ownership of the issue and identifying a lead officer.

To acknowledge that domestic violence is a health service issue, commissioning organisations should negotiate with providers to ensure the following:

data collection about the number of women and children seeking help for domestic violence for monitoring purposes
domestic violence included as part of case record keeping with the consent of the woman
measures which introduce staff to the responsibility of health organisations to respond to domestic violence
costed plan for auditing current practice and the barriers facing women in using services and action required to make improvements, with timescale
assessment of staff training needs
costed plan for staff training

6.4.1 The need for health alliances on domestic violence

The purpose of the NHS in Scotland is “to promote good health” [63] and this can only be achieved through the formation of alliances for health with other organisations. A multi-agency approach is essential to ensure an improvement in the health of women experiencing domestic violence. No one agency has either the resources or the requirement to deal in isolation with domestic violence. The health services, with a major role to play in providing health care for those affected by domestic violence have a similarly important role in referring women to other agencies and in working with other agencies on a common plan to provide effective intervention and support in the community.

This multi-agency way of working is not simply another way of defining interagency working which is the sharing of plans and communication in order to integrate action to minimise agencies working across each other. It involves a greater degree of commitment with common planning at the outset in order to produce a strategy agreed across all agencies, individual agencies therefore surrendering some of their autonomy in the interests of the issue and population group involved. Working together in a multi-agency approach to domestic violence can provide a co-ordinated service which is relevant to women and children and which can meet the range and type of services and support required. It offers the opportunity to overcome the fragmentation of services by combining the development of best practice, training, recording and information systems, guidance and protocols, publicity and information and monitoring and evaluation.

Both health boards and trusts will have a role in multi-agency working, requiring them to identify the

appropriate other agencies (statutory and voluntary) in their area with which to develop partnerships. This may involve funding specialist services such as Women's Aid to ensure sufficient local service provision.

6.4.2 Providing an appropriate women-sensitive service

The research with women outlined previously indicates that the elements of an appropriate response are as follows:

Awareness of the possibility of domestic violence
Recognising signs and symptoms
Initiating discussion about domestic violence by asking direct questions in a sympathetic and non-judgmental way
Willingness to listen and make time
Giving appropriate advice and information about available support services

In addition, recording both individual cases and the numbers of women and children attending services in relation to domestic violence is essential. It supports women as it helps them provide evidence if they choose to charge the perpetrator, provides local incidence data and aids the planning of a quality service.

Ensuring that services used by women acknowledge domestic violence is the responsibility of trust management, clinical managers and practitioners as well as general practitioners and the primary care team. The obvious points of entry into the health care system are attendance at general practice, accident & emergency departments or family planning (for emergency contraception) but women may be referred to other acute or psychiatric services and it is, therefore, essential that a corporate approach be taken.

Women may also be attending women-specific services such as well woman services, family planning and obstetrics and gynaecology for medical reasons unrelated to domestic violence. The prevalence of domestic violence is such that staff need to be aware that domestic violence may be a feature in the lives of women patients and also be alert to possible signs and symptoms.

6.4.3 Assessing need

There is no typical abused woman and survivors of violence should not be categorised but there are some typical responses such as tendency to self blame, feelings of helplessness or hopelessness and lack of confidence and self esteem. Whilst it is necessary to focus on the issues which women present, they need to be understood in terms of how violence is experienced. Some women would not define themselves as abused, many who experience violence will not seek help or may do so reluctantly, others will identify particular difficulties for which they require help from time to time. Many find it difficult to disclose violence. Health practitioners therefore have an important role to play in 'breaking the silence' by recognising the signs and symptoms of violence and offering information and assistance.

Assessment of need in relation to developing services around domestic violence differs significantly from assessment associated with other areas of health provision based on an epidemiological model and for which there are specific criteria for intervention and care. The concept of need for social health problems such as domestic violence requires an approach which involves women in defining the appropriate response in partnership with practitioners. Methodologies developed for community health needs assessment may be more appropriate.

6.4.4 Assessing cost effectiveness

The widespread introduction of programmes aimed at improving the detection and management of women presenting to the health service with problems related to domestic violence would, however, require some investment. It is recognised that resources are limited and their use in such programmes may mean that they are not available for use in other beneficial activities. However, when an investment in a health care programme is shown to be a cost-effective use of resources, the additional cost is justified by the additional benefit it brings. Ultimately, decision makers would still need to assess whether any additional benefit was worth the additional cost when compared to other competing alternatives.

It is difficult to calculate their likely cost-effectiveness given the limitations of the available data. The basic

economic evaluation would involve comparing the costs (i.e. the value of resources used) and benefits of programmes to improve the detection and management of women presenting to the health service with the costs and benefits of the current situation (i.e. in most cases the 'do nothing' alternative). Thus accurate data are required on a number of important indicators including:

basic epidemiological data about the prevalence of domestic violence;
detection costs;
costs of training and education;
health care use and treatment costs;
possible averted costs as a result of better management;
possible increased costs as a result of increased detection;
costs to women themselves;
appropriate summary outcome measures by which to assess effectiveness;
changes in health related quality of life; and
information about the timing of costs and benefits so that programmes with different cost-benefit profiles can be compared.

Careful consideration must be given to which outcome measures are used to assess the effectiveness of programmes involving domestic violence. Potential intermediate outcome measures might be number of cases detected, information and changes in staff attitudes. Final health outcome measures need to relate to women's well-being or to their final health status.

Given the dearth of information about the cost-effectiveness of such programmes this should form one issue for consideration by a national working party. Particular attention should be paid to the development of appropriate summary outcome measures.

6.4.5 Practice guidelines on domestic violence

A set of practice guidelines (systematically developed statements to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances) for responding to domestic violence is likely to be the best tool for introducing changes to service delivery. These need to encapsulate the findings of research into women's perceptions of a quality service. Guidelines currently being used or tested comprise the following components:

initial assessment of domestic violence
provision of quiet and private environment
identification and naming the violence
clear documentation of the abuse
provision of information about options and resources

An example is included as Appendix 5.

6.4.6 Training

Training underpins the development of good practice and this needs to be planned and co-ordinated both within specialities and corporately. Training should provide the opportunity for management as well as medical, nursing and, where appropriate, paramedical and reception staff to:

improve their awareness and understanding of domestic violence;
improve their awareness and understanding of agencies which provide support for women experiencing domestic violence
consider their attitudes to domestic violence
acquire the tools to implement practice guidelines effectively and systematically as applied to their own work setting

Experience of introducing training into different settings by the Health Gain Commissioning Team in Greater Glasgow Health Board has shown that there has to be planning to overcome a number of constraints to ensure a comprehensive, systematic programme for all staff. These particularly concern availability of staff time, locum costs and the costs of bringing in essential outside expertise from specialist

agencies. An accredited distance learning pack [64] has been developed involving the use of trained mentors but has not yet been evaluated.

Training to facilitate a multi-agency approach is also essential. The recommended content for a training programme can be found in Appendix 6.

6.5 Implications for Trusts

The onus however for introducing change does not just lie with commissioning organisations. Trusts have a responsibility for the different settings used by women who have experienced domestic violence as well as determining how they might take a corporate approach to the issue. The following checklist for Trusts mirrors that for commissioning organisations:

systems for recording and aggregating information about the numbers of women seeking help in relation to domestic violence
measures for introducing staff to the issue
evaluated protocols or guidelines for responding to women in a way that is appropriate to them
training programmes for staff
systematic liaison with specialist agencies
mechanisms for utilising the expertise of women in determining changes that are required

6.6 Implications for Primary Care

As women are likely to use primary care services as the first point of access to the health service, it is also important that primary health care considers its role in responding appropriately to domestic violence. Helping and hindering forces have been identified for general practitioners in moving from an inadequate to a more effective and enabling response. [65] These are summarised in table 2 (overleaf):-

Table 2: The role of the GP in the management of domestic violence

INADEQUATE GENERAL PRACTITIONER RESPONSE

Helping forces	**Hindering forces**
Desire to offer a high standard of service to all patients whatever their health need.	'Blindness'.
Long-term relationship of general practitioner and patient.	Unreconstructed social attitudes.
Accessibility, acceptability and lack of stigma of the general practice consultation.	Hidden presentation which offers the general practitioner the opportunity of collusion.
Increasing 'partnership of experts' within general practice allowing empowerment of the patient.	Fear of revealing a problem which is difficult and time-consuming to tackle.
Changing attitude towards domestic violence within society with lessening of stigma.	Sense of helplessness about being able to improve the situation combined with a fear of making things worse.
Services and information offered by Women's Aid.	Relationship between the general practitioner and the extended family.
Increasing availability of information about local services which can offer appropriate help.	Difficulty of asking the question.
Increasing presence of policy domestic violence units.	Inadequate record-keeping.
Heightened awareness of the prevalence of domestic violence.	Lack of availability of information at the moment of need in the consultation.
Increased understanding that domestic violence causes other health problems.	.

EFFECTIVE AND ENABLING GENERAL PRACTITIONER RESPONSE

6.7 The role of Public Health

Three of the strategies for achieving health outlined in the Ottawa Charter for Health Promotion[66] have particular significance with respect to the issues outlined in this report: building "healthy" public policy, re-orienting health services, and strengthening community action. Action on these strategies at a national and local level could help to reduce the prevalence of domestic violence in Scotland and require a lead from Public Health.

Building Healthy Public Policy

Healthy public policy to reduce domestic violence requires policy reform in all sectors at a national and local level. Domestic violence should be identified as a major health issue. While it is seen as vital that policies are introduced in the health sector, the involvement of all other sectors in society is also critical. There is a need for domestic violence to be given priority to enable health boards and others to develop an effective approach, to raise professional awareness of domestic violence by providing education and training and for action on domestic violence to be integrated into health promotion work and hospital, community and primary care services.

Re-orienting Health Services

There is a need for a shift in the orientation of the health services in relation to domestic violence, from a curative, professionally driven service to a preventative community based approach. Within this approach violence can be more readily identified as a major health issue and one that is influenced by the broad determinants of health. The response to domestic violence would focus on the health and social needs of women and children rather than a medical response which may ignore the link between violence and the social context. This approach is central to the tasks required by the health service and other agencies of screening, identifying, documenting, supporting and appropriately referring women who are being abused by their intimate partners. Central to the concept of reorienting services is the health alliance approach to supporting women and preventing violence.

Strengthening Community Action

The achievement of domestic violence prevention requires a pro-active approach which originates in the community. The basis of this process is enabling community members to set priorities, make decisions and plan and implement strategies to address violence. Those strategies should include creating public awareness; school, community and professional education; community programmes aimed at supporting women and children and preventing male violence; and challenging the acceptance of violence at every level. Community action must ensure the full participation of community members including those who have experienced violence.

6.8 The role of Health Promotion

In the context of the role of Public Health, making progress will also be facilitated by a systematic approach by Health Promotion departments. The table below summarises the relevant action that can be taken, once the guiding principles outlined in this report have been adopted.

Table 3

Function or Activities	**Generic Examples**
awareness raising & campaign work how DV reported; destigmatising issue.	mass media campaigns on DV; media work re: impact/effects of
2. training knowledge, attitudes, skills with specific target groups.	organising/facilitating training on issues associated with DV on
3. networking/health alliances/liaison centred approach (user led services); joint and individual organisations strategic planning; information production and dissemination; policy/protocol development; partnership with voluntary sector, especially Women's Aid.	facilitating the development of: multi-agency approach; women
4. organisational development and service providers via health promoting establishment context; plus development roles as described in 3	advice and consultancy to specific organisations as employers
5. research/needs assessment and how to do it; advocate women centred approach; audit of current provisions; identifying gaps.	advocating/highlighting need for local health needs assessment
6. resources development + provision leaflets; directory developments. background reading.	info and advice leaflets; rights leaflets; service availability

7. community development advocacy role for women - enabling women's voices/needs/ issues to be heard; resourcing grass roots work + supporting local action.

6.9 Conclusion

In Canada and the United States, domestic violence has been recognised as much a public health issue as a civil or criminal justice one, as evidenced by the following statement from the Canadian Public Health Association [67]:

> "A thorough understanding of domestic violence requires information on its epidemiology, the social value underlying human relationships and effective strategies used to prevent violence and reduce its effects."

It is time that Scotland took such an approach.

7. SUMMARY OF RECOMMENDATIONS

The current levels of knowledge awareness are such that action around domestic violence in a health service context have led the SNAP group on domestic violence to make the following recommendations:

Domestic violence is adopted as a key health service issue, using the definitions and principles outlined in this report.

Addressing domestic violence as a health service issue is the responsibility of the Scottish Office, health boards, trusts and general practitioners.

The Scottish Office should be responsible for the development of a national framework for addressing domestic violence which makes clear the roles and responsibilities of local agencies.

Health boards should use their influence at national level to ensure national policy and guidance on the issue of domestic violence.

Ownership of the issue to be taken at senior level by all healthcare organisations and a lead officer identified to develop and co-ordinate planning. This should be matched in local agencies.

Locally appropriate systems to be devised for involving women who have experienced domestic violence in service planning and delivery.

Pilot projects to be set up to establish a national recording and monitoring framework, and also to develop a methodology for needs assessment.

Health boards to facilitate, and trusts to cooperate in, the development of guidelines for each health service setting.

Training for all health service staff on domestic violence should be comprehensive and systematic.

Evaluation techniques to be developed which cover both process and outcome measures.

Establishment of a resource centre to support the work undertaken by Health Promotion Departments which can provide a comprehensive source of information and technical assistance in developing the work.

The health service to recognise it is one player in a multi-agency response to domestic violence and in the absence of the lead coming from elsewhere must initiate the development of multi-agency strategies.

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