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Responding to domestic violence and abuse (DVA) in healthcare settings: considerations for health visitors

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Abstract

Domestic violence and abuse (DVA) exerts a significant impact on the lives, health and wellbeing of all of those who experience abuse and this includes children. Health care professionals in a variety of settings are well placed to identify potential DVA cases and respond appropriately to disclosure. Presenting the background and an overview of current policy this article considers the role of health visiting in responding to DVA.

Keywords

Domestic violence and abuse, intimate partner violence, health visitor's role, practice development

Introduction

Intimate partner violence (IPV) which is referred to in the United Kingdom (UK) as domestic violence and abuse (DVA) – these terms are used interchangeably in this article in recognition of UK and global terminology that can be found within the literature - is now widely recognised as a significant global public health and societal problem (World Health Organisation (WHO), 2017). Internationally, it has been reported that around 35% of women have experienced physical and/or sexual IPV or non-partner sexual violence (WHO, 2017). While in the UK, approximately 26% of women between the ages of 16 and 59 experience DVA (Office for National Statistics, 2017). It should also be noted that, for a number of reasons including for example, feelings of fear, shame and stigma or lack of formal recognition and/or absence of specialist services/support, these figures are likely to be an under representation of the actual number of women who experience DVA. Health visitors as an important segment of the health care system and the fact that they provide services to young children (and therefore are often well placed to recognise DVA by the nature of their position and contact with families) can play a very important role in recognising and supporting those who experience DVA (Department of Health, 2013).

This article aims to provide a brief overview of the issue of DVA, its impact on the survivor/victim and to consider the health care professionals' role with regards to DVA generally within the contemporary health climate. This article will also help health visitors broaden their understanding of DVA and its impact and their particular position in responding to those who have experienced abuse.

DVA is multi-faceted and the complexity surrounding abuse is has been recognised in the UK through the formal definition of DVA which has recently been revised as outlined (Box 1) below:

Please insert Box one here

It is important to acknowledge that DVA can happen in any community and is not defined for example by socio economic status or ethnic group. However, this does not mean that DVA occurs at similar rates across '*all walks of life'* and it has been suggested for example that '*rates are highest in disadvantaged communities, among low income families and single mothers with children'* (Stanley, Miller, & Richardson Foster, 2012, p. 192). There is also a clear body of evidence that DVA is also experienced in same sex relationships and that women can also perpetrate violence against their male partners. However, the number of women abused by their intimate partners and the severity of abuse experienced by women is greater overall (National Institute of Health Care Excellence, 2016; Peckover, 2003) and therefore, it is important to understand this issue as a gender related one.

Impact of DVA on health and wellbeing

DVA exerts a significant impact on the lives, health and wellbeing of those who experience abuse and those who witness it, for example children. The impact for those who have experienced DVA in term of physical ill-health may include for example, direct injury caused by physical violence or related physical health problems. While DVA may also significantly affect psychological health and wellbeing. This is further illustrated (Box 2) below where a number of potential indicators of DVA have been highlighted. It should also be noted however that this list while helpful is not exhaustive:

Please insert Box 2 here

The health consequences of DVA may be either immediate or longer term (McGarry, 2011 et al). They may also continue to exert an influence long after the abuse has ended. The most serious consequence of DVA is death and it has been highlighted that every year in the UK approximately 100,000 people are at risk of being seriously injured or killed as a result of DVA (SafeLives, 2015). DVA does not have to include physical or sexual violence as some abusers use tactics of coercive control to threaten and control the individual. Some abusers also deliberately weaken their partner physically by restricting their access to food, interfering with their sleep and ability to access health and social care, pressuring them to have children or to not have children against their wishes, pressuring them to use alcohol or drugs, or through other control tactics (Fontes, 2015). An individual may not even realise that they are being abused and may blame themselves for their experiences or that in some way it is their fault. As well as those who directly experience abuse, DVA also exerts a significant detrimental impact on other family members and especially children. This is the case irrespective of whether or not children directly witness DVA and as highlighted by Holt et al (2008)

> *Where previously children were thought to be tangential and disconnected to the violence between their parents, and commonly labelled 'silent witnesses', more recent qualitative research has disputed this opinion, finding children dynamic in their efforts to make sense of their experiences, while navigating their way around the complexity and terror intrinsic to domestic violence* (p798).

The role of 'front line' health care professionals in recognising and responding to DVA

Health care professionals across a range of settings are often a key point of contact for those who are or have experienced DVA for example, through presentation at the emergency department (ED) (McGarry & Nairn, 2015). A significant number of women however will access a range of primary care services (Feder et al., 2011) (National Institute of Health Care Excellence, 2016) with or without signs of physical abuse.

Acknowledgment of the significant impact of abuse on families and children has resulted in DVA now being '*constructed as a public health and safeguarding children issue'* (Peckover, 2014, p. 1771) and as such public health nurses including health visitors have the potential to play a key with regard to DVA in the healthcare setting (Bradbury-Jones, Appleton, & Watts, 2016) as they could be noticing or identifying manifestations of DVA when visiting babies or children for the provision of routine services.

A number of barriers have been identified which prevent healthcare professionals from recognising or responding to DVA and these include health care professional's knowledge and awareness and understanding of DVA, their attitudes towards DVA, attentiveness, empathy, level of comfort and confidence to ask questions related to DVA and understanding of their roles and responsibilities in providing care to DVA victims/ survivors (Ahmad, Ali, Rehman, Talpur, & Dhingra, 2017).While there is a significant body of research that has been conducted to identify factors affecting health care professionals' ability to identify and support those experiencing violence, research related to health visitors is relatively scarce. While factors affecting health visitor's ability to provide appropriate services to DVA victims may generally be similar, there is a need to specifically understand the perspective and experiences of health visitors with regards to identification and management of DVA victims. In addition to these and within the specific context of health visiting, another important factors include the *'fear of having what are termed as 'difficult conversations' about DVA'* largely based on their discomfort surrounding the subject area and of worry about causing offence' (Bradbury-Jones et al., 2016, p. 25). Conversely however, a number of studies have also identified that women would like to be asked about DVA even though they may not themselves initiate a conversation with health care professionals (Taylor, et al. 2013). A number of other barriers have also been highlighted within the literature with direct reference to health visitors for example, concerns regarding safety when carrying out home visits and a lack of training around DVA more generally (Peckover, 2003).

NICE (2014) have recently published explicit guidance to support a range of health and allied professionals in the development of strategies to identify and manage DVA effectively. In the guidance it is clear that education and training for all 'frontline staff in all services' (health visitors are explicitly listed in the guidance in this category) is central to recognising indictors of DVA and in developing skills to ask relevant questions and support individuals in disclosure of abuse (NICE, 2014) and as such to:

Ensure frontline staff in all services are trained to recognise the indicators of domestic violence and abuse and can ask relevant questions to help people disclose their past or current experiences of such violence or abuse (NICE, 2014)

In 2016, NICE introduced a Quality Standard for DVA (QS116) which was developed to provide clear guidance for a range of agencies and frontline staff and to offer key recommendations for healthcare professionals. The Quality Standard includes a number of quality statements that have been summarised in Box 3, presented below:

Please insert Box 3 here

Health visitors, as members of a wider multi-disciplinary team are in a key position to recognise and respond effectively to DVA within the practice setting. However, in order to do so there are a number of key factors that need to be considered and these include having the requisite education, training and support. There are a range of resources available to support professional development and training and some of the examples are suggested in Box 4. Health visitors as well as other health care professionals need to understand the presentation of DVA and the factors that may impact on individual victim/survivors' ability to disclose their experiences. This article has provided an overview of DVA generally and has provided the reader with an initial introduction in terms of its relevance to the role of health visitors.

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Box 1: UK definition of domestic violence and abuse

[DVA is defined as] Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass but is not limited to the following types of abuse: psychological, *physical*, *sexual*, *financial*, *emotional […]*

Controlling behaviour is: a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.

*Coercive behaviour is: an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim." **

**This definition, which is not a legal definition, includes so called 'honour' based violence, female genital mutilation (FGM) and forced marriage, and is clear that victims are not confined to one gender or ethnic group*

(Home Office, 2013).

Box 2: Indicators of DVA (NICE, 2014)

- symptoms of depression, anxiety, post-traumatic stress disorder, sleep disorders
- suicidal tendencies or self-harming
- alcohol or other substance misuse
- unexplained chronic gastrointestinal symptoms
- unexplained gynaecological symptoms, including pelvic pain and sexual dysfunction
- adverse reproductive outcomes, including multiple unintended pregnancies or terminations
- delayed pregnancy care, miscarriage, premature labour and stillbirth
- genitourinary symptoms, including frequent bladder or kidney infections
- vaginal bleeding or sexually transmitted infections
- chronic unexplained pain
- traumatic injury, particularly if repeated and with vague or implausible explanations
- problems with the central nervous system – headaches, cognitive problems, hearing loss
- repeated health consultations with no clear diagnosis
- intrusive 'other person' in consultations, including partner or spouse, parent, grandparent or an adult child (for elder abuse).

The National Institute for Health and Care Excellence (NICE, 2014) (adapted from Black et al. 2011) https://www.nice.org.uk/guidance/ph50/chapter/glossary#domestic-violence-and-abuse

Box 3: NICE Quality Standard (2016)

- People presenting to frontline staff with indicators of possible domestic violence or abuse are asked about their experiences in a private discussion: […] Services should ensure that that they can provide a safe and private environment in which people feel able to disclose that they are experiencing domestic violence and abuse […]
- People experiencing domestic violence and abuse receive a response from Level 1 or Level 2 (appropriately) trained staff: […] Training staff to respond to disclosure (level 1) and how to ask about domestic violence and abuse (level 2) is essential for safe enquiry about experiences of domestic violence and abuse and a consistent and appropriate response (…)
- People experiencing domestic violence or abuse are offered referral to specialist support services: (…) It is important that people who disclose that they are experiencing domestic violence and abuse can access appropriate support. This should include support for any children in their family who can be affected (…)

(…) abbreviated from the full version of the guidance

Box 4: Useful websites

Health Visiting and School Nursing Programmes: supporting implementation of the new service model
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/211018/9576-TSO-Health_Visiting_Domestic_Violence_A3_Posters_WEB.pdf **(accessed January 2018)**

Institute of Health Visiting

https://ihv.org.uk/for-health-visitors/resources/resource-library-a-z/domestic-violence/

(accessed January 2018)

DASH: http://www.dashriskchecklist.co.uk/

MARAC: http://www.standingtogether.org.uk/standingtogetherlocal/standingtogethermarac/

Independent Domestic Abuse Services: https://www.idas.org.uk/training/

Safe Lives: http://www.safelives.org.uk/