



**REDUCING DOMESTIC VIOLENCE  
...WHAT WORKS?  
HEALTH SERVICES**

Crime Reduction Research Series  
*Leslie Davidson, Valerie King, Jo Garcia, Sally Marchant,*  
University of Oxford  
January 2000

**Introduction**

This briefing note reviews the impact of domestic violence on the health services and what is known about the effectiveness of interventions within health care aimed at improving the health, and decreasing adverse consequences, for women experiencing domestic violence. We have focused mainly on women as victims of violence because of the greater magnitude and impact of domestic violence for women, though we note the lack of research about men as victims. Issues for children whose mothers experience domestic violence are covered in another briefing note. Evidence for the effectiveness of primary prevention of violence itself is not addressed in this review.

**The role of the health services**

The British Medical Association, the Royal College of Obstetrics and Gynaecology (RCOG), the Royal College of Midwives and the Royal College of General Practitioners have all issued (or are in the process of issuing) guidelines. These make recommendations as to how health professionals can best identify and respond to domestic violence in order to reduce the adverse impact on the victim. The Department of Health is shortly to produce a synthesised version of these guidelines to help health care professionals in a range of settings and for use in the development of local multi-agency protocols.

Domestic violence is an important public health problem with multiple health effects including serious injury, long standing health problems, psychological difficulties and problems for children as well as the mother. It is very costly in terms of the health of women and children, and health service resources. Interventions, in any setting, that are shown to reduce domestic violence are likely to lead to substantial cost savings in health.

The health service has a dual role in domestic violence. Firstly, it is the source of care for many of the injuries

(albeit the more serious injuries) of victims of domestic violence. It has responsibility for providing both immediate and long-term care to decrease the pain and possible disability resulting from such injuries, whether physical and/or emotional.

Secondly, since there is near universal contact with the health service, the NHS provides a key route to identification, risk assessment and appropriate health and other support for victims of domestic violence. Almost all women who are pregnant receive health services, including women experiencing domestic violence. Almost all women have a general practitioner. Children bring many of the women at most risk of domestic violence into contact with health care workers.

**Key findings**

*The quality and coverage of the research evidence*

Research, both published and unpublished in the English language, has been systematically reviewed. There is some information relevant to the UK on the extent of domestic violence identified in health care settings and on its impact on the health of women and unborn children. Costs of domestic violence arising from increased health service use have been estimated but information is very limited in all countries. Screening for domestic violence and programmes to offer better care have been described in a large number of reports which come mainly from North America. Women's expectations and views of health care have been described and some studies of the attitudes of caregivers are also available. The evaluation of interventions is, however, extremely limited, with no randomised trials in health care identified so far in any country. There are serious limitations to our knowledge about what works in health care settings in decreasing the impact of domestic violence on women, and consequently what is

cost-effective. There is an urgent need for evaluative research to guide us in developing policy and practice in this area.

### *Gaps in our knowledge*

In the UK we need to know more about:

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

### *Barriers to effective care in the health service*

Surveys of women indicate that they see the health sector as an appropriate site for intervention. Often women do not understand the failure of health professionals to ask in more depth about possible causes of their injuries or health problems. Most women, including victims and non-victims do not mind being asked about their experiences of violence. They expect the health services to take an interest in understanding and acting on women's experiences of violence.

Although health care professionals see they have a role in identifying and referring women experiencing domestic violence, they have had little training in domestic violence and often feel they do not know enough to be effective. Women may feel stigmatised if staff attitudes are judgmental; and they may not be referred appropriately, or helped in other ways. Health providers often know little of the processes which fuel violence, and its relationship to drugs and alcohol. Women report that some health professionals act as if the victim is an equal partner in provoking the violent encounter.

Care settings are often not appropriately structured to allow the privacy and time needed to explore the woman's problems. Women experiencing domestic violence often report, for example, being unable to have their needs met in a busy accident and emergency department. Furthermore, it is often difficult to see a woman without her partner and maternity care has more recently explicitly tried to involve partners in all aspects of care. The Department of Health's report on confidential enquiries into maternal deaths in the UK

(1994 – 96) restates the RCOG recommendation that all women are seen on their own at least once during their antenatal care. It also recommends the *routine* inclusion of enquiries about domestic violence when taking a social history for all pregnant women, and the provision of an interpreter if necessary. Asking women about domestic violence requires the prior development of local strategies for referral and a programme of education for the health professionals involved.

The availability of support services is limited in health care settings. Health care professionals are often isolated from other agencies with an active role in supporting victims of domestic violence. There is often little involvement from health services in the local authority domestic violence fora and similarly insufficient grass roots contact between professionals from different agencies.

## **Recommendations**

### *The effectiveness of interventions*

It is critical to test the effectiveness of a programme before adopting it. Though there is much that can be done now to improve care for women experiencing domestic violence, there is a great deal to study before we adopt new programmes. We have to be clear about what we know works and what needs to be tested. To date, many programmes in domestic violence have been adopted without appropriate evaluation.

The Scottish Needs Assessment Programme report on domestic violence (1997) sets out a list of the information that would be needed to address cost-effectiveness:

- 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.

### *Education and training*

Interventions involving education, training and policies for identifying women experiencing domestic violence generally show improvement in the short-term though the effect may decline over time. Education and training regarding domestic violence should be incorporated

into the curricula for all health professionals and into post-graduate education as well. Training should be made available for all NHS staff working with women, particularly in primary care, maternity services, paediatrics, psychiatry and emergency care.

Key recommendations from women for care-givers include:

- listening to women;
- providing enough time and privacy;
- asking directly about abuse;
- responding with sympathy and understanding;
- making clear that they condemn domestic violence;
- not blaming women or making a joke of the situation;
- taking care about confidentiality and safety;
- being well informed about abuse in general and local resources;
- referring women appropriately;
- not relying on medication as the response; and
- not being critical if a woman is unable to resolve the situation quickly.

#### *Identifying women experiencing domestic violence*

Research suggests that identifying women suffering domestic violence can best be done by universal screening rather than by selective screening based on risk factors. Training can increase screening and identification rates. Identifying women suffering domestic violence could be a crucial first step in reducing danger and providing women with important information and contacts in the community. Protocols have been shown in a limited number of studies to increase identification, abuse assessment, safety assessment and referral.

On the other hand, universal screening could do harm as well as good – care-givers could inadvertently increase the risks to women of further or more intense violence. We need to conduct a randomised controlled trial in health care settings of universal screening of women for domestic violence. This trial could determine the benefits including cost-effectiveness and estimate the possibility of increasing risk to the woman and the potential for harm.

#### *What happens after identification?*

Very few studies in health settings have either documented the next steps of treatment, support and referral to other agencies, or evaluated the impact of what is provided. One study provides some limited support for introducing advocacy within a health care setting. Many of the interventions will take place within other sectors (social services, voluntary, police and justice) and therefore studies of health interventions

should involve collaboration outside the health field, since the relevant outcomes, costs and benefits are in both the health and other sectors.

Studies have often taken a short-term perspective so far. The longer-term impact on women and children of any interventions should be assessed alongside the more immediate outcomes. Outcomes should include the impact on children in the family as well as on the woman.

## **Conclusions**

UK health policy has developed over the past few years to raise the profile of domestic violence, to advocate education and training for health care professionals and to encourage the development of local policies. More recently professional organisations have recommended the adoption of screening either for all women or those at high risk. Too little has been accomplished and not enough has been evaluated. There is an urgent need for implementing training and education initiatives to enable professionals to identify and support victims of domestic violence and for a substantive research programme to evaluate health service interventions to reduce the impact of domestic violence. The lack of comprehensive evidence on how the health service could effectively reduce the impact of domestic violence should not be an excuse for lack of action on what we know is a major cause of difficulty for women's health and their quality of life.

Initial changes that could improve the service offered to women include:

- ensuring health sector inclusion at a senior level in the local inter-agency domestic violence fora;
- reviewing provisions for confidentiality;
- providing private settings for discussion;
- ensuring time for the woman to talk with health care workers;
- providing links to child protection teams; and
- considering provision of services on nights and weekends when women experiencing domestic violence might need it most.

## **Further reading**

British Medical Association (1998) *Domestic Violence: A health care issue?* London: BMA.

Bewley, S., Friend, J. R. and Mezey, G. C. (eds.) (1997) *Violence Against Women*. London: RCOG Press.

Scottish Needs Assessment Programme (1997) *Domestic Violence*. Glasgow: Scottish Forum for Public Health Medicine.

