

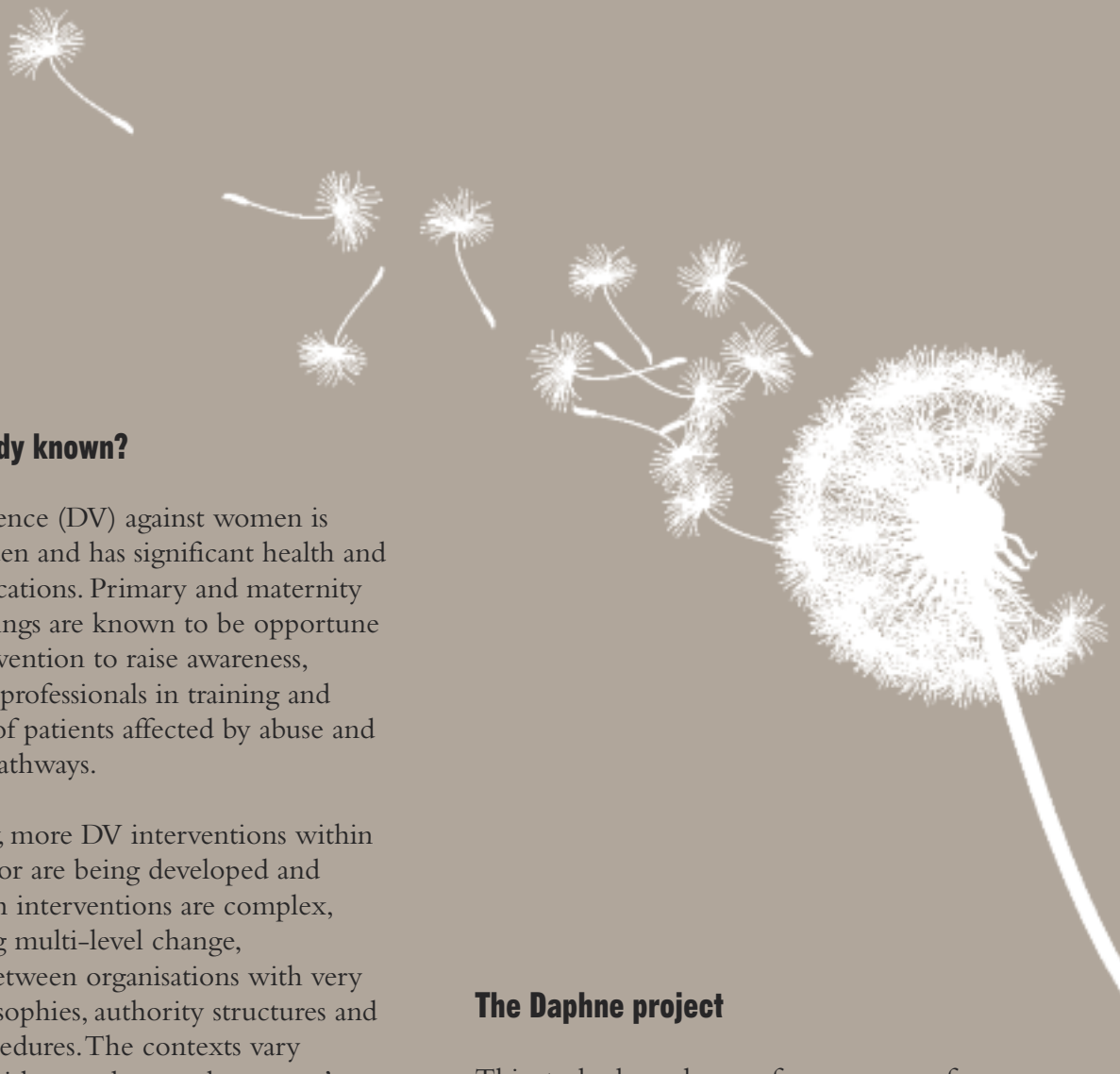


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Health Sector Responses to Domestic Violence: Promising Intervention Models in Primary and Maternity Health Care Settings in Europe





What is already known?

Domestic violence (DV) against women is common, hidden and has significant health and resource implications. Primary and maternity healthcare settings are known to be opportune points of intervention to raise awareness, involve health professionals in training and identification of patients affected by abuse and develop care pathways.

Internationally, more DV interventions within the health sector are being developed and evaluated. Such interventions are complex, often involving multi-level change, partnerships between organisations with very different philosophies, authority structures and operating procedures. The contexts vary considerably with regards to each country's legal frameworks and policy agendas; the organisation and delivery of health care; the presence and power of survivor movements; the availability of community resources and specialist DV organisations; as well as the inherent cultural differences.

Where are the gaps?

There is scant literature on service implementation and few studies make explicit the underlying programme theories.

Policy makers, funders and health system decision makers need to understand not only whether an intervention works, but when, why and how it works. The contextual characteristics can help to explain the success or failure of interventions.

The Daphne project

This study draws lessons from a range of promising intervention models in seven European countries: United Kingdom, Finland, the Netherlands, Spain, Germany, Belgium and Serbia. The key findings are based on: (i) data from 82 mapping surveys relating to 81 interventions in these countries covering wide geographical areas, multiple clinics and health professional disciplines; (ii) case studies involving interviews with 37 key personnel from interventions in 6 countries; (iii) and a two-day workshop with all country partners.

Exemplar intervention models in Europe



United Kingdom

MOZAIC Women's Well Being Project is a partnership between the maternity and sexual health services of Guy's & St. Thomas' NHS Foundation Hospital Trust and the 170 Community Project, a non-governmental organisation in South East London. The project uses an 'in-reach' approach whereby Independent DV Advocates (IDVA) based in the hospital provide direct support to women, training to health professionals, and policy level advocacy to strengthen links between the local community and the hospital.



Finland

As part of a national initiative funded by the Ministry of Health and Social Affairs, public health nurses in maternity and child health clinics received DV training, which included routine enquiry using a screening form. Care pathways involve referral to other health professionals in the health centres (e.g. therapists, social workers and GPs) as well as community DV organisations. Guidelines for health professionals in maternity and child health care were published in 2004 with the latest version published in 2011. The Regional State Administrative Agency of Southern Finland has developed a standardised form, which is also available in electronic format, for reviewing patients admitted to health centres and hospitals for physical injuries resulting from abuse (PAKE).



Netherlands

MeMoSA (Mentor Mothers for Support and Advice) is based in general practice settings in Rotterdam and Nijmegen. GPs receive DV training through an established training pool. An in-reach approach is also utilised where women experiencing DV are referred to mentor mothers, semi-volunteers who are trained to support mothers with children 18 years or under living at home. This early stage, time limited intervention focuses on four areas: cessation/reduction of violence; children who witness violence; management of depressive complaints; and improving women's social networks and reducing isolation. In Nijmegen, the mentors receive training and weekly coaching from HERA, the largest specialist DV organisation in the province which also runs a network of refugees.



Spain

Under Spain's Organic Law 1/2004, the governments of all 17 autonomous communities are obliged to address gender violence within the health care system. In the community of Castile and León, a top-down and bottom-up approach to implementation of the Common Protocol for a Healthcare Response to Gender Violence has been adopted. Management teams in Primary Care and Hospitals were initially targeted for awareness raising activities. A multi-disciplinary training team of 35 professionals was trained to cascade training first to Primary Care Teams, emergency services, obstetrics services and reception staff. Health professionals use their established networks with social workers, the police, refugees and other health professionals to support women affected by DV. Autonomous communities are also required to record disclosures of DV, as well as other data, in the health care information system. The data is submitted to the Ministry of Health and Social Policy to publish annual epidemiological surveillance on gender violence and follow-up of interventions.



Germany

Among many initiatives in Germany addressing DV in primary health care, the study focused on the national pilot project MIGG (Medical Intervention Against Violence) funded by the Federal Ministry of Family, Senior Citizens, Women and Youth (2008-2011). MIGG is the first systematic project to improve health care for patients affected by domestic violence in primary care. It was developed and evaluated in 5 cities. Partners in MIGG include the Institute of Forensic Medicine University of Düsseldorf, SIGNAL e.V. and Gesine (a network for health interventions against DV). Both SIGNAL e.V. and Gesine are non-governmental organisations that work closely with primary care health professionals. They provide a DV intervention program, DV training, develop supporting materials such as posters, leaflets and abuse documentation forms. Post-training reinforcement and support activities include multi-professional meetings, annual conferences, GPs quality circles and twice yearly 'train the trainer' meetings. These provide a forum for exchange of good practice and research, case discussion and further training. Attention, Recognition, Action is a domestic violence training intervention based in the Department of Psychotherapy and Psychosomatics at University Hospital Dresden. Training is delivered to staff in the hospital and primary care professionals. Referrals pathways include other health professionals and domestic violence organisations.



Belgium

A number of innovative initiatives in Belgium (Flanders) were considered. Domus Medica, a professional organisation for Flemish GPs, delivers basic and advanced DV training to GPs sponsored by the Federal Ministry of Health and Security of the Food Chain. It co-trains with social workers from the Centres for General Wellbeing (also known as CAW). CAW provide first line social care and under an initiative by the Flemish Ministry of Welfare, 13 of 26 CAWs were funded to develop DV policy and training. The intervention promotes referral to social care, but also has aspects of creating a supportive multi-professional network for GPs. The Child and Family Service (Kind en Gezin) provides DV training to public health nurses who work with children up to 3 years of age. The MOM (Difficult Moments and Feelings) randomised controlled trial will compare referral information for pregnant women affected by DV with standard care. The study is recruiting at different sites in Flanders and coordinated by Ghent University Hospital.



Serbia

The Women's Health Promotion Centre (WHPC) is a non-governmental organization established in 1993 working on the health consequences of gender-based violence. WHPC design and deliver basic and advanced DV educational programmes for health care professionals and government and non-government organisations. They also conduct local and international research, produce health information resources, and organise a range of advocacy and outreach initiatives for survivors. WHPC was one of the authors on the national protocol on the protection of female survivors of gender based violence and in 2008 developed the only existing manual for health providers on recognising and treating female survivors of gender based violence. In 2011, WHPC developed a computer software package for health professionals to document domestic violence and its health consequences, and facilitate rigorous monitoring of intervention activities. After pilot testing, the system will be part of the electronic information system for medical issues.

Key findings about what works well

Committed leadership and organic growth from the bottom up are essential to creating and maintaining a 'DV aware' system. Committed senior clinicians sensitise colleagues to their role in identifying and supporting patients affected by DV and can challenge resistance within the organisation. They also have an important networking function with local organisations, multi-agency fora and help facilitate ownership and sustainability of the intervention as it evolves.

Lead roles: Funded and/or formally recognised lead roles were reported in some case studies. In the UK **MOZAIC Women's Well Being Project**, the Hospital Trust has appointed a **Matron for DV and adult safeguarding**. In Belgium, **Centres for General Wellbeing** received **Community Government** funding to develop a lead social work role for DV. In Germany, as part of the **SIGNAL** intervention, nurses from departments in **Charité Hospitals** formed a **DV working group with support from the Director of Nursing**. **Informal clinical leads and peer support** were reported in the case studies in the **Netherlands (GPs)** and **Finland (public health nurses and clinic managers)**. In **Serbia**, round table discussions were held with the management teams of health centres to gain their cooperation in implementing the **Special Protocol on the Protection of Women Exposed to Gender Based Violence**. In **Spain**, a state commission was established with representatives from all regions for monitoring health policies and interventions for gender based violence.

Regular training with feedback mechanisms helps to create a continuous learning culture. After initial training, health professionals need to practice their skills, reflect and receive feedback on their experiences of dealing with women affected by DV. Across all countries, reinforcement and support post-training was an important theme.

Feedback and learning: Health professionals have a formalised partnership and direct referral pathway to advocates and mentor mothers who provide feedback on individual cases (UK, MOZAIC and the Netherlands, MeMoSA). **MOZAIC advocates also have limited access to women's electronic maternity notes and can alert midwives and doctors to the fact that**

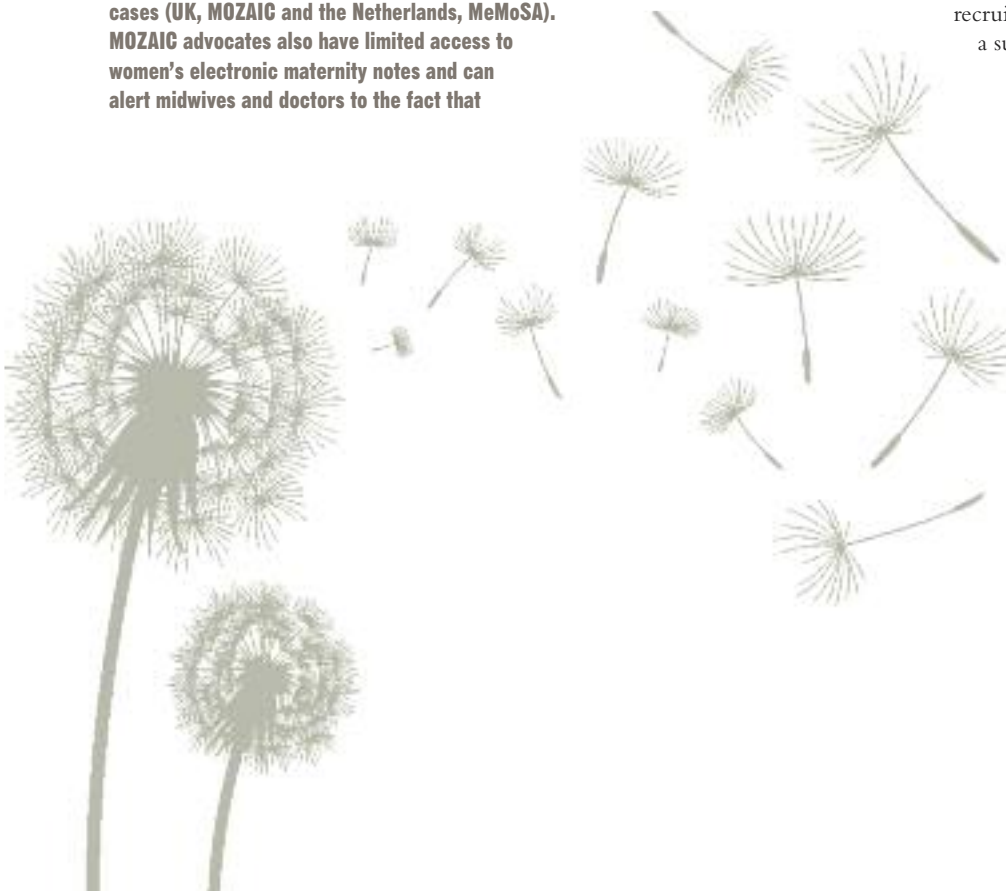
the woman is receiving help from them and that it may not be safe to discharge her from the postnatal or antenatal ward. The **MOZAIC** trainer utilises the evaluation data and best practice capture in the training sessions. In Belgium, **Domus Medica & CAW** run **intervention groups** and in Germany (**SIGNAL e.V. & Gesine**) health professionals are invited to meet each other and representatives from local organisations at **annual conferences and quality circles**. These are used to share research, experiences of dealing with complex cases, establish links with community organisations and obtain additional training. In Spain and Belgium, networks of trainers receive funding from local or federal bodies to support health care professionals by sharing tools and training resources. They are coordinated at the state level to decide on the quality of the training and evaluation.

Incentive schemes and flexible training programmes are needed to motivate health professionals to attend training, particularly in contexts where health professionals work in single-handed practices and/or on a fee for service basis.

Mandating/motivating training: In Belgium and Germany, where GPs tend to work single-handed, training is provided out of office hours (i.e. evenings and weekends). In the Netherlands, GPs are largely shifting from single-handed to group practices. GPs need **40 Continuing Medical Education** points yearly to maintain their registration and can accrue points through DV training. Similarly, in **Serbia**, primary care providers are required to obtain **24 points** a year to maintain their medical licence and receive **6 points** for DV training. In **Spain**, health professionals who wish to attend train the trainer courses are freed from their work and paid expenses. In the **UK**, midwives are required to attend a set number of study days each year to maintain their registration. In the **MOZAIC** intervention, DV is offered as a study day.

Creating a pool of local trainers which includes health professionals is one method for ensuring sustainability of the intervention. However, the courses need to recruit on a regular basis in order to maintain a sufficient number of trainers.

Sustaining training: In Belgium, Domus Medica organise meetings for GPs and **CAW** social workers who have undertaken the train the trainer course. In Germany, **SIGNAL e.V.** has funding to host yearly meetings with their train the trainer pool. In the Netherlands, the **MeMoSA** intervention in Nijmegen has created a training pool to ensure continuity of training. In Spain, in the autonomous community of **Castile and León**, a multi-disciplinary training team of **35** professionals provided training to health professionals. Of the **81** interventions described in the mapping surveys, **37** reported a train the trainer component.



Developing clear referral pathways and multi-agency work are necessary steps in any DV intervention. Health professionals must know how to refer to organisations that support women and children affected by DV. Interventions must be developed in a multi-agency context in order to develop a consensus about issues such as roles and responsibilities, information sharing, confidentiality and dealing with high risk cases.

Safe referral pathways: In some countries, such as the UK and Germany, multi-agency work is well established and formalised. However, the use of Multi Agency Risk Assessment Conferences for dealing with high risk cases was only described in the UK case study and surveys. In the UK (MOZAIC), the Netherlands (MeMoSA) and Belgium (Domus Medica/CAW) the advocates, mentor mothers and CAW social workers provide the link to liaison with community organisations. Care pathways are increasingly harmonised between sectors. In Spain, Finland and some of the interventions in Germany, health professionals work closely with each other and community organisations to support women.

Survivor input and accountability should be part of the intervention's initial development and continue as the intervention evolves. Although this was not common there were some examples of good practice within the case study interventions.

Listening to survivors: In the UK, a survivor's group called MOZAIC VOICES was launched at the House of Commons in 2011. The Chair and membership consist solely of current and former clients. As a registered charity, the group engages in fund raising and awareness raising activities and are consulted about decisions relating to the service and research plans. In the Netherlands, all women referred to MeMoSA have an exit interview providing insights that are fed back into the intervention. Interventions should be tailored to women's needs.

Documenting the implementation process of the intervention, through formal evaluation is necessary for understanding the influence of contextual factors, as well as identifying practices that work well, problems that occur, solutions tested and changes made to the model. A mechanism for feeding back this evidence to health professionals is required. **Impact evaluation** is also needed for demonstrating the benefits and potential harms of the intervention. Outcomes should reflect the underlying programme theory since early stage interventions may have qualitatively different outcomes to those that involve intense ongoing advocacy and risk assessment. Without any evaluation or monitoring, it is extremely difficult to convince funders to invest in the intervention.

Evaluation and monitoring: Just under half of the 81 interventions in the mapping surveys reported the inclusion of formal research or rigorous monitoring activities. All the case study interventions included a research component.



Common Challenges

Despite the diverse contexts of the case study interventions, participants all described similar ongoing challenges including: difficulties in motivating health professionals to attend training, particularly where GPs work single-handed and/or on a fee-for-service basis; a lack of funded and supported leadership roles within the health care setting which are essential to implementing and sustaining the intervention; the need for coordinated and funded multi-agency working groups; a lack of funding for training and reinforcement activities; a lack of funding for research and evaluation; and the reluctance of some health professionals to identify DV.

Best practice recommendations

- Clinical leadership roles are needed at all stages from initiating change, gaining organisational support and sustaining the intervention. This should be formalised through task description of their roles and responsibilities, supported by health management and funded on an ongoing basis to avoid intervention atrophy.
- DV training should be part of all health professionals' undergraduate and postgraduate curricula and continuing professional development. Training needs to be delivered on a regular basis to ensure all new health professionals are included.
- Reinforcement training, feedback mechanisms and support for health professionals post training are needed to maintain a 'DV aware' culture and to support sustained changes in practice.
- A mix of incentive schemes is needed to motivate health professionals to engage in training activities, such as accreditation, contribution of points to medical license, reimbursement of expenses, and offering training during or outside of working hours according to needs.
- Practical and communication skills training in the identification of DV should continue after the initial session. Health professionals need to practice their skills in real clinical situations and obtain feedback and support.
- Funding must be provided for NGOs who take a lead role in designing and delivering training programmes, coordinating post-training support and providing direct support to women.
- Opportunities for developing multi-agency partnerships can be achieved by including community organisations in the training of health professionals and enables all those involved to develop a greater understanding of each other's roles in supporting families affected by DV.
- Interventions should be tailored to women's individual needs. Some women will require intense advocacy support and/or counselling whilst others will benefit from early interventions which assist them in developing a supportive network, reducing isolation and increasing their safety behaviours.
- Research and evaluation are essential for demonstrating the process, impact and cost effectiveness of the intervention. Interventions should include mechanisms for feeding back the evidence to health professionals in order to motivate, create ownership and ensure sustainability.
- Future intervention studies should consider how to measure outcomes for victims and their children. The relationship between the nature of the intervention and the outcome of interest should be made explicit. Vulnerable groups that should be included in future research are older women, those with physical disabilities, visual or hearing impairments, without speech, mental health disorders, intellectual disabilities, refugee and asylum seekers, prisoners, trafficked women, and women with drug and/or alcohol abuse problems. Health care settings in which DV intervention research is lacking include: mental health, accident and emergency, reproductive and sexual health (including abortion) and social services.

Acknowledgements

Supported with a grant from the European Union under the Daphne III Programme 2007-2013 and co-funding from the Finnish Ministry of Social Affairs and Health.

Thank you to project partners for their commitment to making this a success and to the translators and interpreters for all their hard work. Special thanks are due to participants of the mapping survey and case study interviews who gave generously of their time to share their insights based on years of expertise in the field of DV and health.

Web link to the full report can be found on the project website **DIVERHSE (Domestic & Interpersonal Violence: Effecting Responses in the Health Sector in Europe)**

<http://diverhse.eu>
<http://diverhse.org>

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