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An examination of the factors that inform Health Visitors' effective identification and support of women experiencing domestic violence and abuse

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DECLARATION

"I certify that the work contained in this thesis, or any part of it, has not been accepted in substance for any previous degree awarded to me, and is not concurrently being submitted for any degree other than that of Doctorate in Education (EdD) being studied at the University of Greenwich. I also declare that this work is the result of my own investigations, except where otherwise identified by references and that the contents are not the outcome of any form of research misconduct."

Signature (Student)…… Date……

Signature (Supervisor) …… Date……

Signature (Supervisor) …… Date…….

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ABSTRACT

This study sets out to identify and analyse the factors that might influence Health Visitors' ability to ask about domestic abuse during a home visit and the impact this might have on the support given to women who disclose abuse or are in situations where domestic abuse is identified.

The study employed a mixed method approach to examine how Health Visitors' understood their role based on past experiences. The study focused on a large Community NHS Trust in England and was carried out in three phases: i. electronic surveys completed by 27 Health Visitors; ii. semi-structured interviews held with 10 Health Visitors; and iii. an additional 11 semi-structure interviews with Health Visitors. Interview data were collated and thematically analysed using a data management tool-MAX QDA. Data from the survey and interviews were merged following analysis to present findings.

Findings from this study indicated that Health Visitors had developed a range of coping strategies that enabled them to deal with the challenges that they encountered at work. The importance of being able to communicate concerns about clients within a team environment was invaluable. However, new work practices were identified as inhibiting client contact, contact with team members, and the Health Visitors' ability to carry out their role. Further, Health Visitors highlighted a lack of confidence in asking male clients and those in same-sex relationships about domestic abuse as well as the cultural competence needed to support women of Black and Asian minority ethnic groups. The findings also showed that the confidentiality and the reliability of interpreter translations appeared to create a barrier for Health Visitors. The recommendations set out proposals for the education and training of both undergraduate and experienced Health Visitors.

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ABBREVIATIONS

ACE	Adverse childhood experience
BAME	Black & Asian Minority Ethic
BERA	British Educational Research Association
DA	Domestic Abuse
DH	Department of Health
DV	Domestic violence
GP	General Practitioner
HV	Health Visitor
IDVA	Independent Domestic Violence Advisor
MARAC	Multi Agency Risk Assessment Conference
NHS	National Health Service
NICE	National Institute for Health and Care Excellence
NMC	Nursing & Midwifery Council
UK	United Kingdom
WHO	World Health Organisation

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DEFINITION OF TERMS

The definition of domestic abuse covers controlling behaviour, coercive or threatening behaviour, violence, or abuse between those aged 16 years or over. It can include but is not limited to psychological, physical, financial, or emotional abuse (DH, 2013). It also considers abuse regardless of gender or sexuality if the relationship is with an intimate partner or a family member.

Within this study, the term 'domestic abuse' will be used to encompass domestic violence, spousal abuse, battering, family violence, intimate partner violence, partner abuse, and ethnic violence, which are terms often used interchangeably to describe violence within interpersonal relationships (Corvo & deLara, 2010). However, when referring to literature that specifies one or the other terms, this will be used to maintain the authenticity of the research.

The terms Health Visitor, Practitioners, Healthcare professionals, Health worker and Health professional, Healthcare workers, and Public health nurses will be used interchangeably to reflect research undertaken. However, the term 'Health Visitor' is used where research directly focuses on the Health Visitor.

The terms 'routine enquiry' and 'routine screening' refer to asking women about their experiences of domestic abuse regardless of obvious signs of abuse or whether domestic abuse is suspected. It is the direct questions asked when healthcare professionals provide an opportunity for clients to disclose. In this instance, the term 'screening' refers to asking a defined population about domestic abuse who may not necessarily perceive they are at risk or have experienced abuse.

The terms 'victim' and 'survivor' of domestic abuse are both used interchangeably to describe women or men who have experienced domestic abuse.

The terms 'husband' or 'partner' will be used interchangeably. The term 'perpetrator' refers to 'a person who carries out a harmful, illegal, or immoral act' (Oxford English Dictionary, 2017).

CHAPTER ONE: INTRODUCTION

1.1 INTRODUCTION

This study sets out to explore the Health Visitor's role when asking women about domestic abuse to determine whether there are factors that have an impact on their ability to enquire routinely about abuse and provide support to women.

The introductory chapter will begin by providing an overview of the author's professional and academic journey when considering the motivation for the study. The aim and objectives introduce the research questions of the study and continue into an introduction about the scoping study.

1.2 RESEARCHER'S PROFESSIONAL BACKGROUND AND PERSONAL INTEREST IN THE TOPIC.

I have been a registered Health Visitor for the last 20 years, and since 2013 have been a Senior Lecturer at a University with the responsibility of teaching pre-and post-registration nurses and Health Visiting students about a variety of topics, including domestic abuse. I first became interested in aspects of domestic abuse through my experience of teaching the topic within the University. Discussions with Local NHS Trust Managers identified that there might be issues with experienced Health Visitors routinely asking women about abuse. It appeared that although the NHS Trust policy and the National Institute for Health and Care Excellence [NICE] (2014) guidelines suggested that clients are asked about domestic abuse at each client contact if it is safe to do so, this might not be carried out consistently. If the process of asking women about domestic abuse is inconsistent, this could place them at an increased risk of harm.

With ongoing changes to the organisation of Health Visitors' workloads and service delivery, very little is known about the driving forces that might influence a practitioner's ability to ask about domestic abuse. In 2013, I attended the Institute of Health Visiting (ihv.org.uk) two-day education programme that focused on domestic abuse. Attending the sessions piqued my interest in this important subject and is part of the driving force that led me to undertake this research.

1.3 STATEMENT OF THE PROBLEM

The cross-government definition of domestic violence and abuse is:

Any incident or pattern of incidents of controlling, coercive, 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. The abuse can encompass, but is not limited to:

- *psychological*
- *physical*
- *sexual*
- *financial*
- *emotional*

(GOV.UK, 2013)

Domestic abuse is a significant public health issue that affects a considerable number of women both nationally and internationally (World Health Organization, 2005). It is considered by many as a gendered crime since a higher proportion of women experience the offence than men (Office for National Statistics [ONS], 2018). The Crime Survey for England and Wales (ONS, 2018) identified that domestic abuse could affect any woman regardless of age, class, race, or ethnicity, with women more likely to be seriously injured or murdered by current or former partners. Data from the Crime Survey indicated that adults aged 16-59 had experienced domestic abuse with an estimated 4.3 million female and 2.4 million male victims according to the year ending March 2017 (ONS, 2018). These figures signify that approximately 26% of women and 15% men have suffered domestic abuse.

A report published by Walby (2009) found that an estimated spend of £15.7 billion was due to domestic violence and abuse in the UK. This figure includes the 'human and emotional' cost of domestic abuse to the tune of £9.9 billion. 'Economic output' was £1.9 billion which indicates time taken off work due to injuries and 'loss of productivity' due to stress and reduced performance at work. Also, there was an estimated £3.9 billion cost to public services such as healthcare, social services, housing and refuges. Despite these high numbers, this is still an under-reported area as it only highlights hospital and GP services and does not include the impact on children.

1.4 AN OVERVIEW OF HEALTH VISITING SERVICES

Health Visitors work with families and children under the age of five and have a unique relationship with their clients (Department of Health, 2009). They are accustomed to communicating with families, starting with antenatal client contact and continuing until the child reaches the age of five years. Since October 2015, commissioning of Children's Public Health Services (0-5 years) was transferred from NHS England to Local Authorities. The expectation from the Department of Health (DH) was that Local Authorities would provide Health Visiting services to key areas *(Fig 1.1).*

Health Visitors are commissioned to assess, monitor, and support the health and development of children based on staged interventions of the five mandated health reviews *(Fig 1.1)* which are linked to the Healthy Child programme (DH, 2009). Through the mandated reviews emanates the four-levels of service model – Community, Universal, Universal Plus, and Universal Partnership Plus *(Fig 1.1).* This approach of health promotion activities is seen to reduce safeguarding risks such as domestic abuse with a targeted approach to the assessment of needs according to individual families (Public Health England, 2016). Delivering Universal services ensures that a minimum provision is available to everyone, while Universal Partnership Plus supports families with complex and long-term needs with the involvement of other health or social care services.

To safeguard children's health and their social, emotional, and psychological wellbeing, Health Visitors recognise the impact that domestic abuse can have on a child's growth and development (discussed further in chapter 2).

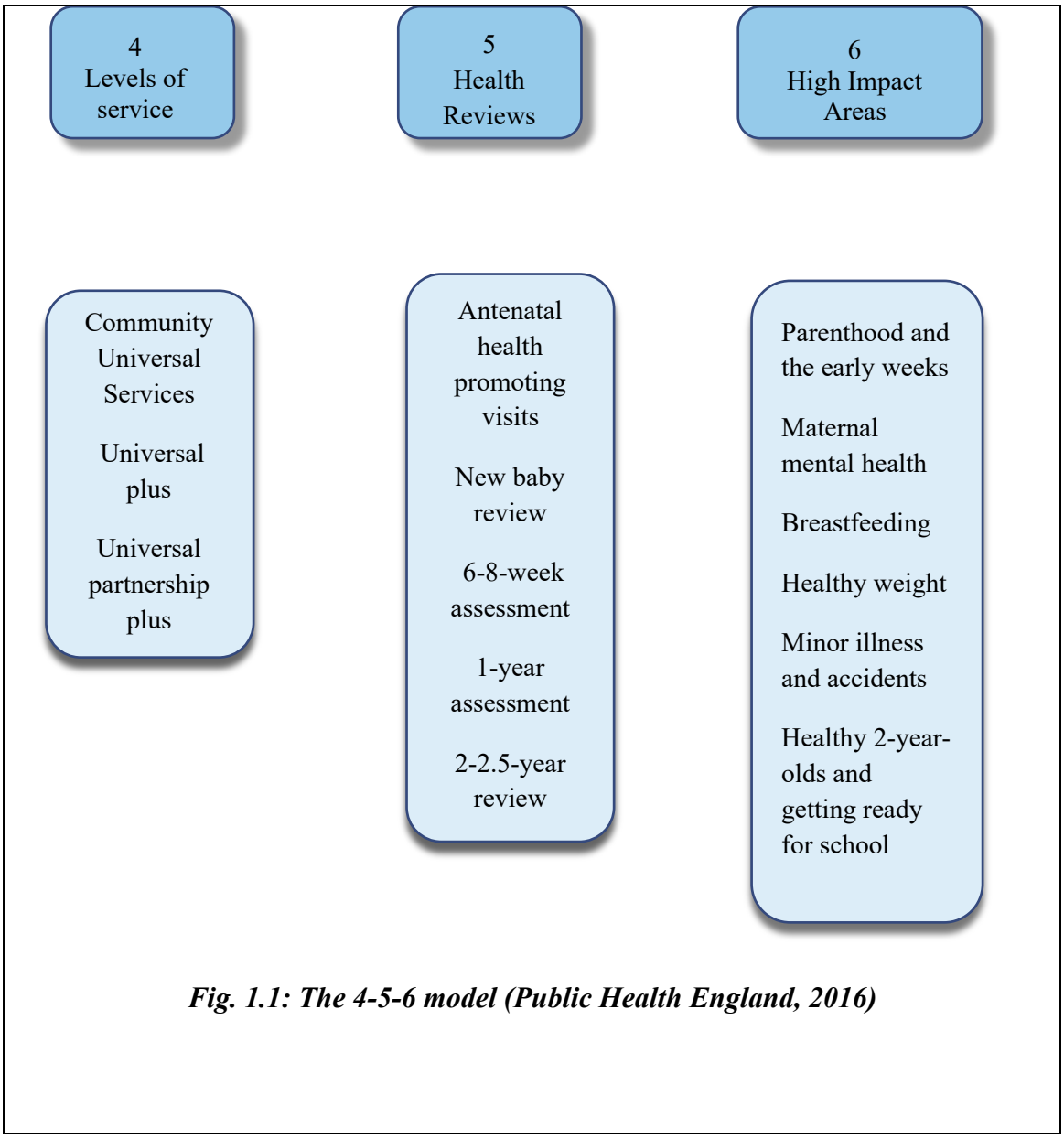

Fig. 1.1: The 4-5-6 model (Public Health England, 2016)

1.5 BACKGROUND TO EDUCATION AND TRAINING

In March 2011, the Government committed to develop education and training for Health Visitors to support families who were experiencing domestic abuse as the role was seen to be crucial to identify abuse and provide support. The aim was to embed domestic violence and abuse training in the Health Visiting education programme by 2015 (Home Office, 2011). The agenda was advanced significantly with a national rollout programme delivered by the Institute of Health Visiting in 2013 which trained 'Domestic Abuse Champions'

across the country to disseminate information, raise awareness, and educate Health Visitors about abuse within their organisations.

More recently the NICE (2016) guidelines and Local Trust policies have directed Health Visitors to ask about domestic abuse at each client contact if it is safe to do so. However, the assumption is that all Health Visitors follow the guidelines and policies, incorporating the practice of routinely asking women about abuse, which may not always be the case.

1.6 THE RELEVANT DISCUSSION

Domestic abuse is a serious, worldwide public health issue (World Health Organization, 2005) with one in four women suffering from domestic abuse in their lifetime (ONS, 2018). A primary concern of domestic abuse is that women are at increased risk of being subjected to physical and emotional abuse from their partners and sometimes from their communities which can include close family members (DH, 2005). Statistics show that on average two women are killed by their partner or ex-partner every week in England and Wales (ONS, 2018).

The issue of controlling crimes against women and children has received considerable critical attention whereby policy and practice need to be evident and developed. Over the years Government interest and public concern have fluctuated depending on what was seen to be of interest in the media. In recent years it has become more of a political issue when women are murdered, and domestic abuse was somewhere within the history of the crime (ONS, 2018). This issue has forced the government to acknowledge and recognise domestic abuse as no longer a private matter but a public concern with its effect on society requiring a collective response.

1.7 THE RESEARCH PROBLEM

In recent years, there has been increasing evidence indicating that although some women may not disclose domestic abuse, generally women want to be asked about abuse as a matter of course, so they do not feel targeted (Salmon, Baird, & White, 2018; Taket et al., 2003). The significance of asking women is that some may not be aware that they are being abused

and need someone to help them identify that this is the case (Murray *et al.*, 2015; DH, 2017).

As previously suggested, Health Visitors are well placed to ask women about abuse (Mcfeely, 2016). NICE (2016) require Health Visitors to ask about abuse at every client contact if it is safe to do so, and as a result, they are more likely to identify women living in abusive relationships. There is a substantial body of evidence that has focused on domestic abuse principally related to the victim, perpetrator, and children (Busch and Rosenberg, 2004; Spangaro, Zwi and Poulos, 2009; Keeling and Mason, 2010; Peckover and Trotter, 2015). Surprisingly, no single study has focused solely on Health Visitors and how they ask about domestic abuse while considering possible factors that may influence their ability to carry out this part of their role. There is a notable dearth of evidence giving focused attention to Health Visitors, domestic abuse and the issue of routine enquiry, suggesting this is an under-researched area, worthy of investigation.

1.8 AIM AND PURPOSE

The National Institute for Health and Care Excellence (2016) requires Health Visitors to understand that their role is to identify when domestic abuse is taking place, support women, and to signpost them to appropriate services. However, in order to be competent and confident in undertaking this part of their role, Health Visitors require the theoretical knowledge and practical experience to make sense out of the often complex issues of abuse and how it affects their clients (DH, 2017).

This study aims to explore factors that may influence Health Visitors' ability to ask about domestic abuse and provide support. This research will also provide an opportunity to understand what Health Visitors' think and feel about the routine enquiry while addressing issues around Health Visitors' confidence and competence.

The primary purpose of this study is to develop the education of Health Visitors around the subject of domestic abuse, contribute to the knowledgebase that underpins their experiences, and demonstrate the impact this can have on clinical practice. It is anticipated that the findings will provide insight and contribute to the development of specialised

courses for advanced practitioners around domestic abuse as well as present recommendations for clinical practice, health care policy, and future research.

1.9 CONTEXT AND SETTING TO THE STUDY

Previous studies have shown that the health care system may be the victim's first and only point of contact with professionals (Frost, 1999; Stöckl et al., 2013). Some survivors of abuse consider health professionals to be the most trusted with their disclosure of domestic violence (Battaglia, Finley, & Liebschutz, 2003). However, when a woman first discloses to a health professional and the response that she gets is unhelpful, disbelieving or blaming, the woman is unlikely to disclose again in the future. Therefore, when practitioners ask about domestic abuse, this must be conducted in a non-judgemental way with compassion and all consideration given to confidentiality (World Health Organization, 2014).

1.10 RESEARCH DESIGN

This mixed method study is based on an individual NHS Community Trust. The research seeks to hear the voices and experiences of Health Visitors and to explore factors that may influence the process of routine enquiry, including the impact this may have on the support offered to clients.

A survey was sent to 56 Health Visitors of whom 27 agreed to participate in the study. Data from the survey were analysed using Qualtrics, a web-based survey tool to identify key themes. Alongside the survey, 21 semi-structured interviews took place with Health Visitors in two phases. The interviews were audio-recorded then transcribed and data-analysed using MAX QDA, a qualitative data analysis programme that assisted with coding and identifying themes *(fig. 4.1)*.

1.11 THEORETICAL PERSPECTIVE UNDERPINNING THE STUDY

Social constructivism underpins this study, which examines the multiple realities of the Health Visitors in their role of routinely asking women about domestic abuse. Social constructivists consider personal experiences, culture, and environmental factors which influence how knowledge and meaning are constructed (Bourgeault, Dingwall, & De Vries,

2010). Kukla (2000) described how social constructivism was based on the development of human activity with Kim (2006) suggesting that assumptions about reality were the basis of this theoretical perspective. The constructivist approach can be seen throughout this study as the Health Visitors' views are sought to examine their practice around routine enquiry, and the possible influences that may affect their ability to identify domestic abuse and support women.

When considering social constructivism, Bandura's (2001) social cognitive theory is pertinent since it emphasises self-efficacy and agency. Self-efficacy influences how people think, feel, and act (Bandura, 2006). Having high self-efficacy is related to having a sense of agency and the belief that action can be taken to make a difference (Moore, 2016). With the confidence in their ability to make a difference in challenging environments, Health Visitors are expected to have the self-efficacy to adapt accordingly and cope with stressful situations to support women and keep families safe.

Health Visitors describe feelings of empathy and compassion towards the women's plight while others felt frustrated and silently criticise their decision to remain in the abusive relationship. The impact of practitioners who regulate or suppress their emotions, a behaviour that does not comply with the caring nature that is expected of them, may result in emotional dissonance and generate emotional labour for the practitioner (Sandi Mann, 2005).

Social identity theory underpins how professionals see themselves and how others perceive them (Stets & Burke, 2000). The ability to be adaptable and cope with the emotional labour of the Health Visiting role will be explored in this study together with conflicts between professional identity and changes that arise from shifting work patterns. Having a sense of personal and professional identity is an essential component for the development of resilience (Cameron & Brownie, 2010). Being resilient allows the Health Visitor to continue home visits even when they have concerns about their safety. These issues will be explored further within the following chapters.

1.12 ASSUMPTIONS AND LIMITATIONS

The Health Visitor plays an integral role in safeguarding children living in homes where there is domestic abuse (NHS Engand, 2014). Domestic abuse has a firm position within the remit of safeguarding; however, the focus of this study will not be on the issues of safeguarding. A detailed exploration of how domestic abuse affects children lies beyond the scope of this research. Also, this study will not engage with the in-depth issues surrounding the victim or survivor's thoughts and experiences of domestic abuse nor the possible reasons why perpetrators abuse others. Instead, the study will seek to explore the Health Visitors' experiences of asking about domestic abuse and the support given to women using data obtained from the survey and semi-structured interviews.

1.13 RESEARCH QUESTIONS

The research questions that frame this study comprise:

RQ1. *What are the influencing factors that affect the ability of Health Visitors to 'confidently' and 'competently' ask about the occurrence of domestic abuse as part of their routine enquiry?*

> ***SQ1a.*** *How do Health Visitors make a decision about an appropriate course of action to ensure the safety of the clients?*

RQ2. *Are Health Visitors able to identify the further training or educational requirements that they perceive as supporting their 'confidence' and 'competence' in working with clients?*

1.14 STRUCTURE OF THE STUDY

The study has six chapters and is organised as follows:

Chapter One: This chapter contextualises the research by providing background information about the study. An outline of the research focus, the motivation for the study, and the gaps in current research studies are highlighted. The research questions, aim, and objectives are identified to emphasise the issues that Health Visitors face when asking women about domestic abuse.

Chapter Two: The scoping study will present background to the research using a range of available literature with a focus on routine enquiry and the role of the Health Visitor. Since there is a dearth of evidence specific to Health Visitors, research from other health professionals is also utilised. This chapter will identify the gaps in previous research so that the significance of this current study is built on existing evidence to provide an original contribution to knowledge.

Chapter Three: This chapter describes an account of the researcher's philosophy, describing the ontological, epistemological and methodological standpoint for implementing a mixed method approach and to justifying the selection of methods and data collection. This chapter draws on how the data is collected and analysed following the survey and semi-structured interviews. The research questions, aims, and objectives are described, and ethical considerations concerning both the subject of the study and the researcher are addressed.

Chapters Four and Five: These two chapters provide a critical analysis of the empirical data and present findings following the survey and semi-structured interviews. The data that is gathered is analysed used to address each of the research questions in turn. The identification of important themes highlights significant issues drawn from the data. A discussion will take place following each identified theme to highlight similarities or to acknowledge gaps in current knowledge.

Chapter Six: The final chapter reflects on the extent to which this study has answered the research questions and includes a discussion that draws together the key findings. Recommendations for practice, education, and training will conclude the study with implications for future development and research.

CHAPTER TWO: THE SCOPING STUDY

2.1 INTRODUCTION

Levac, Colquhon & O'Brien (2010) advise that scoping studies are becoming increasingly popular to review health research evidence. Arksey and O'Malley (2005) suggests that the aim of scoping studies is to map the existing literature in a field and to review the volume, nature, and characteristics of the primary research study. There is extensive literature available that focuses on domestic abuse from a health professional's perspective, some include Health Visitors in the studies. Previous domestic abuse research studies and reports have centred around the victim, perpetrator, and children (Bacchus, Mezey and Bewley, 2002; Hamberger *et al.*, 2004; Keeling and Mason, 2010; Radford *et al.*, 2011). Some research has explored services and the range of professionals who support abused women (Gregory *et al*., 2010; Ramsay et al., 2012; Usta, Antoun, Ambuel, & Khawaja, 2012).

To position this current research within the existing evidence and to identify the gaps, a scoping study was conducted to map the literature and synthesise the research evidence most relevant to the research questions. The study focuses on an exploration of Health Visitors' experiences that may impact on their ability to enquire about abuse, escalate concerns, and support women routinely. The study also examines whether Health Visitors can identify the educational requirements that support their confidence and competence to carry out their role effectively.

It is anticipated that findings from the scoping study will specify what is known about the Health Visitors' role in asking and supporting their clients who are living in abusive relationships and identify the gaps in current research. Identifying the knowledge gaps will provide a rationale for the thesis and demonstrate the importance of carrying out the current study so that suggestions can be made for best practice and policy development and can inform future research.

To position the research study within the existing literature, the following stages are used to scope the literature:

- Application of an inclusion and exclusion criteria
- Identification of relevant studies
- Data extraction process

2.2 SEARCH STRATEGY

A systematic search strategy was carried out to provide the reader with an assurance that the review was an explicit representation of the literature while ensuring a transparent and replicable process (Aveyard, 2014). Systematically searching, appraising, and summarising all relevant studies allows a more objective assessment of the evidence and increases the reliability of conclusions (Neale, 2009).

A range of literature was searched using electronic databases, reference lists, public domain websites, government reports, and books used according to relevance. The literature was reviewed utilising various search engines; including EBSCO Host, Academic Premier, Cumulative Index of Nursing and Allied Health Literature (CINAHL), PsycInfo, Psych Articles, Medline, Psychology and Behavioural Science Collection. The electronic databases identified papers that were relevant to the research question and provided a broad scope of the literature. Activating Google Alerts provided further links to related articles allowing contemporary publications to be reviewed and incorporated into the thesis.

It was only in 1997 that the healthcare system first acknowledged it had a role to play in responding to domestic abuse, with the NHS first publishing guidelines making recommendations that routine enquiry should take place in healthcare settings. The routine enquiry was based on recommendations by the Royal College of Midwives (1997) and the British Medical Association (1998) following an enquiry into maternal deaths (CEMD) 1994-1996 (DH, 1998). Findings indicated that violence was a significant cause of death among pregnant women. Therefore, the scoping study included papers published between 1997 and 2018 that were related to the research question and provided context to the study.

Search terms used were *battery; domestic violence; family violence; interpersonal violence*; and *intimate partner violence.* Also, *battered wife / wives; spouse abuse; partner abuse / violence*, *ethnic violence and routine enquiry.*

As the title of Health Visitor is specific to the UK, the search terms *community nurse*, *health care practitioner*, *practitioner or health care professional*s were used to identify those who support young families in the community. Community nursing terms included *Health Visitor*; *community health nurse*, *practice nurse*, *community midwife, family nurse,* and *home visitor*. Truncated keywords were used to widen the scope of the search included *health visit*, community nurs*, family practi*, healthcare practi*,* and *home visit.*

Searches were carried out between 1997 and 2018 using a combination of Booleans operators 'AND' and 'OR' and 'NOT' were carried out by crossing several subject headings such as 'domestic violence, domestic abuse' for text words (abuse + domestic + women).

A search was also carried out on the 'grey literature' in the form of national and international policy documents including commissioned reports. Key national government and charitable organisation websites were accessed. Reference lists were hand searched from key journals, policy documents, and reports.

Papers were mapped against a set of inclusion and exclusion criteria as a final screening technique adding to the efficiency of the scoping study and helped to identify the relevance and accuracy of the search findings (Temple, 2006). The following criteria (2.1.1 and 2.1.2) were applied to ensure the literature addressed the research questions.

2.2.1 INCLUSION CRITERIA

The following inclusion criteria were used in answering the research question:

- Timeline for the search was between 1997 and 2018.
- English language research.
- Primary studies included those that explored the Health Visitor / healthcare professional / community nurse / healthcare practitioner / midwives and social workers in working with women who have experienced domestic
- Papers included peer-reviewed primary studies as well as various grey literature, in the form of government, health professional, local authority reports and policies.
- Included studies from national and international papers.

2.2.2 EXCLUSION CRITERIA

- Studies not written in English.
- Studies which pre-dated 1997 that focused on Health Visitors or health care professionals in aspects that did not include their experiences of working with women regarding the routine enquiry
- Unpublished material or articles that were not peer reviewed; however, reference lists were hand searched to seek other relevant papers.
- Studies that concentrated on substance misuse or abuse in general or if they were not primary sources of information or original research.

2.2.3 SEARCH RESULTS

Fig. 2.1 provides a PRISMA flow chart indicating the search strategy and results of the peer-reviewed journal articles. Initial searches showed 581 articles, while hand-searching identified 42 additional articles. Articles were examined initially to determine their fit and relevance to the study, initially removing all duplicates, then assessing titles and keywords, excluding those that did not meet the inclusion criteria. Further scrutiny was undertaken of the abstracts using the inclusion criteria to facilitate the selection (Levac *et al.* 2010). The electronic database search was used to download the full texts of 227 articles. Reviewing the remaining 152 papers allowed evaluation and consideration against the inclusion criteria with 57 identified as being relevant for the study.

The literature search generated both qualitative and quantitative studies published between 1997 and 2018. Of the papers, 57 focused on domestic abuse from the healthcare professional's perspective that comprised of nurses, midwives, general practitioners and social workers but were relatable to the practice of Health Visitors. Overall only three studies were identified that focused on the Health Visitors asking women about domestic abuse. In addition to the 57 articles, reports and grey literature also included can be seen in *Appendix 16.*

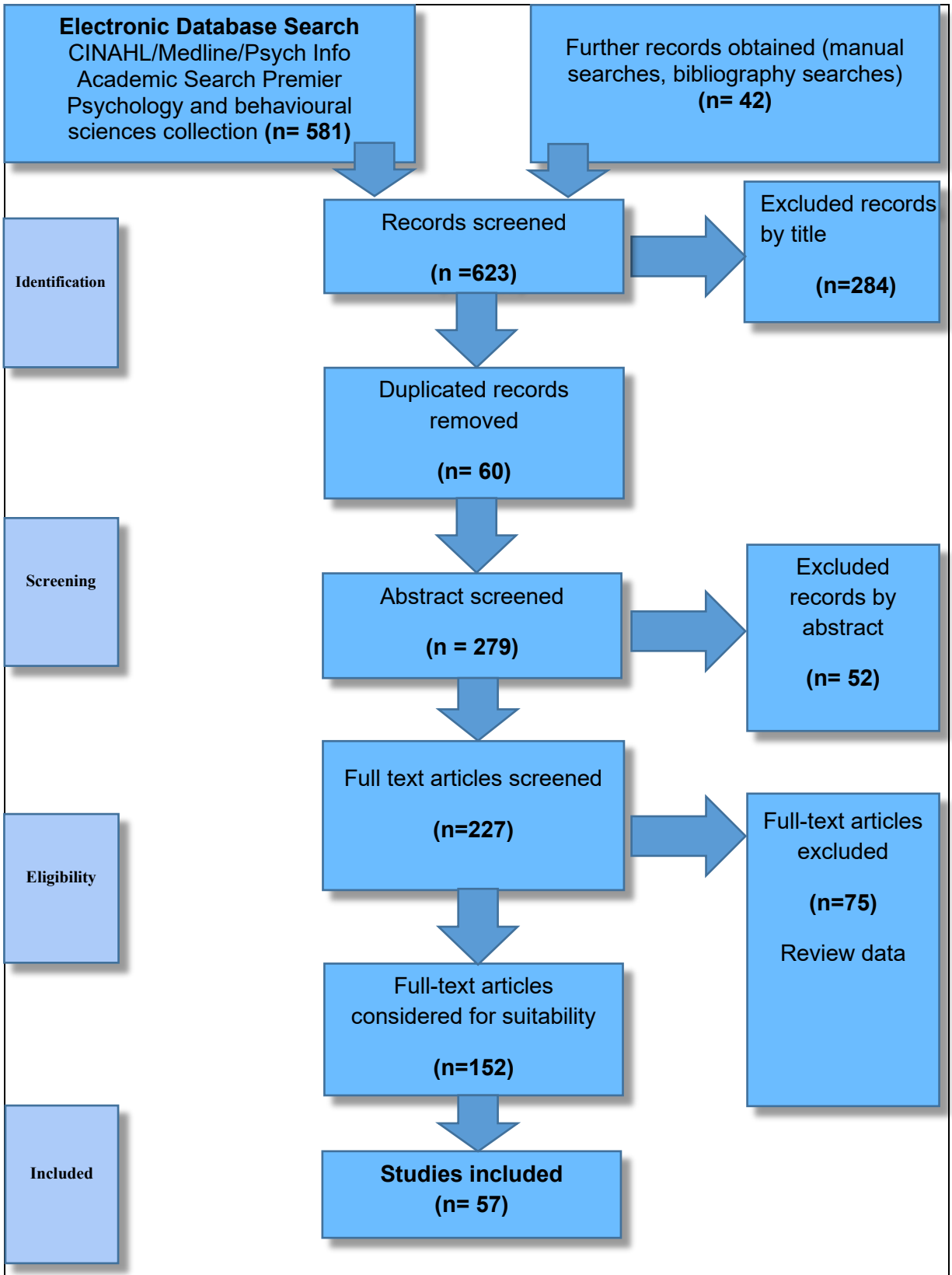

Fig 2.1: PRISMA flow chart indicating search strategy result (1997- 2018)

2.3 SCOPING STUDY OUTCOME

The 57 papers that were identified as meeting the inclusion criteria were analysed to identify key themes (refer to matrix *Appendix 17*). Three overarching themes emerged from the analysis related to the experiences that Health Visitors and healthcare professionals had with identifying and supporting women who experienced domestic abuse. They helped to establish the training required that may enhance their ability to work effectively. The three themes and fifteen sub-themes identified were placed into broad categories *(Table 2.1)* and have been used to structure the scoping study. An analysis of the findings was synthesised and used to develop themes. Patterns repeated across the data were used to relate findings to the research question.

Much of the literature reviewed focused primarily on the prevalence, causes, and consequences of domestic abuse. Evidence found on routine enquiry focused on the healthcare professionals including GPs, midwives and social workers. This scoping study identified significant gaps in the current knowledge base, with very little research focused entirely on routine enquiry from a Health Visitor perspective.

This review revealed that the experiences of Health Visitors in the identification and support of abused women is an area that has received little attention up until this point. There is a need for research studies that examine these issues and the impact that this could have on clinical practice.

Three key themes emerged from the analysis of literature comprising of: *The Health Visitors' role, professional practice and experience (2.4); The wider context of abuse (2.5); Learning, education and development (2.6)*. These are presented in Table *(2.1)* together with the accompanying sub-themes. Each of the themes will be discussed in turn in the sections that follow.

Table 2.1: Themes emerging from the search strategy

Section One	***Theme 1: The Health Visitors' role, professional practice and experience (2.4)***
2.4.1	The Health Visitors' role in recognising abuse
2.4.2	Health Visitors' understanding of the context and timing of the routine enquiry
2.4.3	Health Visitors' management of disclosure
2.4.4	Health Visitors' acknowledgement / concern of the safety of women and children
2.4.5	Multi-agency working
2.4.6	Health Visitors' approach to disclosure
2.4.7	Health Visitors' knowledge, competence and confidence
2.4.8	Health Visitors' personal experiences
2.4.9	Health Visitors' safety
2.4.10	Health Visitors' engagement with perpetrators

Section Two	***Theme 2: The wider context of abuse (2.5)***
2.5.1	Women who hide the abuse
2.5.2	Women who stay in abusive relationships
2.5.3	Black and Asian Minority Ethnic Groups (BAME)
2.5.4	Asylum seekers and insecure immigration

Section Three	***Theme 3: Learning, education and development (2.6)***
2.6.1	Education and training

2.4 SECTION ONE: THEME 1- THE HEALTH VISITOR'S ROLE, PROFESSIONAL PRACTICE AND EXPERIENCE

This section will identify findings from the literature published around the role of the Health Visitor / Healthcare practitioner and how they identify domestic abuse and elicit disclosure. The personal experiences, thoughts, and feelings that are described provide some indication of the influence this may have on a practitioner's ability to carry out their role effectively.

Further, this review identifies the range of clients who can experience abuse, and why they hide it and then decide to disclose. The impact of culture and how this influences a woman's ability to trust practitioners and to disclose the abuse will be explored.

2.4.1 THE HEALTH VISITOR'S ROLE IN RECOGNISING ABUSE

It is now well established from a variety of studies that the health care system is often 'the first port of call' for women experiencing domestic abuse, with evidence suggesting that healthcare professionals would be most trusted with a woman's disclosure of abuse (Usta *et al.*, 2012). A qualitative study by Bacchus, Mezey and Bewley (2002) conducted semi-structured interviews that included the perceptions and experiences of thirty-two women about domestic violence and found they wanted to be asked routinely about domestic abuse. Boyle and Jones (2006) interviewed 1,452 women from three general practice surgeries, and only 8.4% (n=122) indicated that they found routine enquiry by health professionals unacceptable.

In 2004 the Department of Health advised that throughout the UK, all women should be asked during the antenatal period about domestic abuse. 'Routine enquiry' has been the term used by the Department of Health since 2005 when asking women about abuse whether or not they saw signs of domestic abuse. A study by Rhodes *et al.* (2007) suggested that routine enquiry should be normalised and discussed at each contact with health professionals so clients become aware of the issue of domestic abuse. In a qualitative study undertaken by Bradbury-Jones *et al.* (2011) 17 women who had experienced domestic abuse were interviewed. The study found that in many of their cases abuse still went undetected even though they accessed services and despite the normalisation of routine enquiry. This finding demonstrates that routine enquiry is not a cure, but that it contributes to supporting and signposting women to services (Department of Health, 2005).

Despite routine enquiry, women speak about their feelings of shame and the stigma attached to being a victim of abuse which could lead to non-disclosure. Usta *et al.* (2012) conducted focus groups with healthcare professionals and 72 women routinely screened for domestic abuse. Findings showed that routine enquiry went some way in reducing the stigma that surrounded being asked about abuse, so women did not feel targeted. Routine enquiry appears to remove the feeling of isolation and shame because women become familiar with being asked about abuse as part of the routine assessment carried out by healthcare professionals (Baird *et al.,* 2013). However, a study by Bradbury-Jones *et al.* (2014), who conducted focus groups with 14 abused women, found they would still go to great lengths to conceal the abuse, feeling that it was easier to hide it than to disclose to health professionals.

Salmon *et al.* (2006: 9) suggested that non-disclosure may be unlikely; however, practitioners still need to ask about abuse with 'a non-judgemental positive approach to questioning'. Spangaro *et al.* (2010) explored ways practitioners could assist abused women who may be too frightened to disclose. Bacchus, Mezey and Bewley, (2003) concluded that practitioners must enquire about domestic abuse in a 'sensitive manner'. Rhodes *et al.* (2007: 8) determined that the way practitioners respond to disclosure – by being sensitive, empathetic and respectful – was 'just as important as asking the right questions.'

A report by the Department of Health (2017) recommended that healthcare professionals in partnership with women need to create the opportunity to have an open discussion and to 'name' the abuse. However, practitioners need to be aware that while some women may seek help and guidance in how to leave the abusive relationship, others may only want to talk about the abuse, seeking a non-judgemental response (Evans & Feder, 2016).

Baird, Salmon, & White (2013) and Bradbury-Jones *et al.* (2014) studies support the practice of midwives and other healthcare professionals asking about domestic abuse at every client contact if the environment is safe, and confidentiality is maintained when doing so. The fact that women are often comfortable being asked, supports the process of screening women routinely as an essential and beneficial intervention, even for those for those who wish to remain within the abusive relationship (Spangaro, Zwi and Poulos, 2011).

While previous studies have highlighted the benefits of routine enquiry into domestic abuse, only a limited number of research studies have focused on the impact associated with the Health Visitor's crucial role as part of their assessment of health needs and ongoing family support.

2.4.2 HEALTH VISITORS' UNDERSTANDING OF THE CONTEXT AND TIMING OF ROUTINE ENQUIRY

A fundamental component of the routine enquiry is Health Visitors' understanding the 'context' and being able to judge the timing of the discussion. Key contexts include pregnancy, women's readiness to disclose, women and children's safety, and the critical factor of building trust with the women.

The Department of Health (2005) described how domestic abuse often escalated when something 'changed' in the home such as the woman becoming pregnant. A study by Burch and Gordon (2004) involved screening 258 men convicted of domestic abuse. Findings revealed that one out of seven participants (n=33) admitted to committing an act of violence towards their partner when she was pregnant. Similarly, Stöckl *et al.* (2013) found the incidence of domestic abuse during the antenatal period was high. Out of 401 participants, 92% had experienced abuse during pregnancy. An escalation of abuse during pregnancy places the woman and unborn child at increased risk of maternal, foetal and infant morbidity, and mortality (Jahanfar, Howard, & Medley, 2014).

Salmon *et al.* (2006) found that pregnant women felt comfortable being asked about abuse when it came from a midwife. While Keeling and Mason (2010: 107) established that women who access early antenatal care were more likely to disclose experiences of domestic abuse as they often felt that they had 'nothing to lose' by the disclosure. Stöckl *et al.* (2013) confirmed that antenatal care provided the opportunity to ask women about abuse and to make the appropriate referral to support services with 56% of women agreeing with routine enquiry. Keeling and Mason's (2010) quantitative study of 221 self-administered questionnaires given to pregnant women suggested that although there were fears of ongoing abuse and possible escalation, these feelings were overshadowed once healthcare professionals were informed and took appropriate action. However, Salmon *et al.* (2006) revealed that women tried not to disclose even when the abuse was continuing

during pregnancy, often going to great lengths to hide it. A study conducted by Katiti *et al.* (2016) showed that only 23% of pregnant women abused during pregnancy disclosed, with the rest of them suffering in silence.

The risk of abuse during pregnancy was likely to continue following the birth of the baby, with women not disclosing, even though they were aware that the postnatal period placed them at a higher risk of the abuse escalating (Szilassy *et al.* 2013). A pregnant woman may see their antenatal booking as a 'fresh start' with the new baby possibly being the catalyst to 'sort out' the abusive relationship (Keeling and Mason, 2010). Keeling and Mason (2010) suggested midwives should build up a relationship of trust with women so that they are open to routine enquiry and more willing to disclose.

Previous research has focused on domestic abuse, routine enquiry, and pregnancy from a midwifery perspective. There are few studies that focus on Health Visitors who are now being commissioned to undertake early antenatal and postnatal client contacts as part of the five health reviews *(Fig 1.1)* and the role they play in asking women about abuse at this crucial time during and after pregnancy. Vanderburg *et al.* (2010: 351) echoed this stance by suggesting women could also be asked routinely during the postnatal home visit and that this was a 'feasible and worthwhile' activity for public health nurses to undertake.

This study will highlight how the Health Visitors are 'making every contact count' (Health Education England, 2012) and undertaking routine enquiry while working with changes to service delivery.

2.4.3 HEALTH VISITORS' MANAGEMENT OF DISCLOSURE

As already stated, women will often suffer in silence and are unlikely to talk about domestic abuse (WHO, 2010). This finding was echoed in a study by Othman, Goddard and Piterman (2014) who recognised that despite being asked about domestic abuse, some women may still not disclose. However, research findings by Bacchus *et al.* (2002) indicated that routine enquiry is likely to increase the frequency of disclosure. Salmon *et al.* (2006) suggested that non-disclosure by women should not dissuade professionals from asking them about abuse.

When routinely asking about domestic abuse, experience with managing disclosures is a crucial factor to prepare health professionals to feel ready to address issues and support women (Gutmanis *et al.* 2007). A study by Szilassy *et al.* (2013) found that practitioners were aware that asking women about domestic abuse was part of their role and that they had a responsibility to be alert and knowledgeable about the appropriate actions to take. To this end, Bradbury-Jones *et al.* (2014) criticised health professionals who did not ask women about domestic abuse, suggesting that women needed the opportunity to disclose when they were ready to do so.

It is important to remember that domestic abuse is not a one-off occurrence but is frequent and persistent with women often reluctant to disclose the abuse (Keeling & Mason, 2010; Taylor *et al.*, 2013). Therefore it is essential that Health Visitors be aware of the signs of abuse (DH, 2017; Peckover & Trotter, 2015). To identify abuse, Rose *et al.* (2011) found some health professionals concentrated solely on the physical symptoms of abuse rather than considering the holistic dimensions such as psychological or financial abuse. This focus was echoed by Husso *et al.* (2012) who determined that some health professionals ignored the origins of the symptoms and injuries. Practitioners who only ask about domestic abuse when there are visible injuries demonstrate a lack of knowledge and understanding by not considering the other modes of abuse which may not be as visible (DH, 2005).

Bradbury-Jones *et al.* (2014b: 3064) suggested that 'dual silence' can exist whereby practitioners or women do not broach the subject of domestic abuse. A study by Ramsay *et al.* (2012) was critical of practitioners' unwillingness to raise the issue of domestic abuse. A reluctance to start the conversation about abuse could discourage women from seeking help if responses such as blaming, disbelieving, and being judgmental were evident from the health professionals involved (Robbins, 2014).

The study by Bradbury-Jones *et al.* (2014) noted that health professionals and abused women might differ in how they developed awareness and recognised abuse. Bradbury-Jones *et al.* (2014: 3062) used the term 'closed area' when discussing situations where the woman does not recognise the abuse, but the health professional has identified it. On the other hand, this study also highlighted occasions when women were aware domestic abuse

was within the relationship, but for some reason, the health professional failed to recognise it.

Women will only disclose if they are not shamed in their disclosure, and will be safe from the perpetrator (Saberi *et al.,* 2017; Spangaro *et al.,* 2011). A qualitative study conducted by Othman, Goddard and Piterman (2014) found that semi-structured interviews conducted with ten women discovered a real fear of repercussions if the perpetrator found out about the disclosure. Katiti *et al.* (2016) suggested that women are likely to communicate with mothers, sisters, other relatives, and friends about the abuse. Disclosure to family or friends contrasts with a previous study by Hague & Malos (2009) that proposed that women would be unlikely to confide in and disclose the abuse to members of her family. Moe (2007) reported that when women disclosed to family members, it was the least helpful mode as women are often unfairly judged and likely to be met with a lack of empathy regarding the relationship and the decisions that they make.

A study by Thurston *et al.* (2013) suggested that abuse towards women could be perpetrated by other family members as well as her partner. Francis, Loxton and James (2016) noted that some families might put the women under pressure to remain with the violent partner. Evans and Feder (2016) summed this up by suggesting practitioners need to be mindful that even if women disclose to a family member, the risks remain high as this disclosure may not be followed up with appropriate support, guidance, or with the consideration of safety.

Spangaro, Zwi and Poulos (2011) emphasised the importance of facilitating disclosure. Non-identification of abuse was likely to be caused when women had difficulty establishing trusting relationships with healthcare professionals. The issue of trust was considered by Spangaro, Zwi and Poulos (2011) who found that women often viewed health services as a safe place to disclose domestic abuse and expected to receive support following disclosure. Practitioners need to establish a trusting relationship with clients and build respect around the professional relationship (Keeling and Mason, 2010). A study by Mauri *et al.* (2015) echoed the need to gain trust and confidence from women to elicit disclosure.

A Health Visitor should be a trusted person with whom the client can relate to and develop a relationship that is supportive and where open dialogue is promoted for discussions about domestic abuse (Bradbury-Jones *et al.*, 2014). The Department of Health's (2017) guidance

'Responding to domestic abuse: A resource for health professionals', supported this finding by proposing that Health Visitors need to establish a safe, trusting, professional relationship with clients to overcome women's fears and facilitate disclosure. Providing women with multiple opportunities to disclose through routine enquiry allows an exchange to form more naturally without the pressures associated with disclosure (Spangaro *et al*., 2011). Evans and Feder (2016) interviewed survivors of abuse and proposed that routine enquiry should be non-judgmental but also implemented with compassion and all consideration given to confidentiality. Ensuring confidentiality fosters a professional relationship built on trust.

The previous section has shown that much of the literature lacks focus on Health Visitors and whether they can identify the signs of domestic abuse or are willing to enquire routinely. Although previous studies have acknowledged the importance of assessing women's safety and gaining trust, there is limited knowledge around how much Health Visitors understand the fears of women who may want to disclose and how they carry out their assessment. This study will seek to explore these issues and to find out about Health Visitors' experiences with families when they suspect abuse, exploring their attitude towards the women when they are eliciting their trust. If disclosure is not managed in a supportive way, women are unlikely to identify the benefits of reporting the abuse (Spangaro, Zwi and Poulos, 2011).

The issue of trust is particularly challenging for Black, Asian, and Minority Ethnic (BAME) clients, particularly when English is not their first language, which is discussed later in this review.

2.4.4 HEALTH VISITORS' ACKNOWLEDGMENT / CONCERN FOR THE SAFETY OF WOMEN AND CHILDREN

The Adoption and Children Act (2002) clearly states that children are to be protected from 'seeing or hearing the ill-treatment of another'. Peckover (2002) recognised that practitioners may become concerned about the safety and welfare of the children within the home, with a previous study acknowledging that children are nearly always aware domestic abuse was occurring even when the adults thought they had kept it hidden (Stanley *et al.* 2012).

Domestic abuse affects the health and well-being of children living in an unpredictable environment where they may witness or get caught up in the violence and abuse (McCarthy *et al.*, 2017). Children can 'witness' abuse without directly observing it through overhearing arguments or observing cuts, bruises, and broken furniture (Cunningham & Baker, 2004). A report published by Radford *et al.* (2011) found that 15% of children had witnessed at least one form of domestic violence and abuse at some point during their childhood.

Children are the silent victims of domestic abuse which can interfere with their daily activities and have a detrimental effect on their physical and psychological health and wellbeing (McKinney *et al.* 2006). Adverse Childhood Experiences (ACEs) are traumatic and stress-related events such as domestic abuse that occur during childhood. ACEs can have an immediate effect on the child's health and wellbeing which can persist across the lifespan (Wiehn, Hornberg, & Fischer, 2018). Changes in a child's 'behaviour, presentation or engagement' are often one of the first signs that a child is living in an abusive environment (Peckover and Trotter, 2015: 402). These children are 'at risk of significant harm'(Children Act, 1989).

Safeguarding children and improving outcomes for families is an integral part of the Health Visiting role (Biggs *et al.*, 2014). Attention needs to be given to the effect of domestic abuse on children. This is emphasised by the Department of Health (2017) which reports that safeguarding children who are living in abusive environments is a public health concern for healthcare practitioners.

Mullender (2004) indicated that practitioners were aware of the importance of safeguarding children and need to keep their health and wellbeing at the centre of decisions made when identifying domestic abuse. While Chapin, Coleman, & Varner (2011) suggested that healthcare professionals must protect children from the neglect and harm that may result from living in abusive environments. To protect children, practitioners need to be able to elicit disclosure and to identify the signs that domestic abuse is occurring in a household

As indicated, previous research findings have been consistent to identify the harmful effects domestic abuse has on children living in abusive environments. In order to build on research conducted by Peckover (2003a, 2014); Peckover and Trotter (2015) this study will focus

on the Health Visitors' role to support women and protect children who are living in abusive homes. The research will explore how Health Visitors prioritise the health and safety of children and place them in the centre of their assessment when making decisions about when to escalate their concerns.

2.4.5 MULTI-AGENCY WORKING

Leaving a violent relationship does not happen overnight but is a process that requires careful planning (Ambuel *et al.*, 2013; DH, 2017). Peckover (2003) concluded that Health Visitors must recognise abuse by assessing the risk and participating in effective safety plans for women and children. Working with statutory agencies, police and voluntary agencies help to provide safe care for women and children. Once a victim of abuse has been identified, the practitioner is expected to make referrals to services and community agencies (NICE, 2016).

Safety planning conducted in partnership with other organisations are aimed to provide a seamless service and join other professionals (Robbins *et al.*, 2014). Factors that facilitate multiagency collaborations are when the different professionals understand and respect each other's roles and responsibilities. It is also essential to understand the different referral thresholds for services considering issues around confidentiality and information sharing (Stanley & Humphreys, 2014).

A study by Williamson (2000) found that practitioners do not have sufficient information about voluntary services, refuges, support groups and helplines as they did about the statutory services such as the police and social services. An Australian study of twelve women and twenty-five healthcare professionals found that women wanted sufficient information and support to help them plan for when they were ready to leave the abusive relationships (Francis *et al*., 2016). Information included local services that were both voluntary and statutory. Some would go further by suggesting that practitioners needed to provide women with written information in the way of leaflets and written protocols regardless of disclosure (Williamson, 2000; Cann *et al.*, 2001; Spangaro, Zwi and Poulos, 2011).

Information-sharing is an essential factor as some women expressed in a study by Spangaro *et al.* (2010). Women in the study indicated they 'didn't want direct help', by way of intervention but wanted information about the choices that were available (Spangaro *et al.* 2010: 50). It is not about taking over the situation and making decisions for women that they find the most helpful; it is about providing a supportive network around the victim and children involved (Keeling and Mason, 2010). Women want to be given information so that they can make an informed choice.

While the evidence suggests that working in partnership with other disciplines will enhance the support provided for families where domestic abuse is an issue, there is little evidence which suggests how successfully this is implemented. This study will explore how Health Visitors are working within multidisciplinary teams and the resources they have access to provide choice to their clients.

2.4.6 HEALTH VISITORS' APPROACH TO DISCLOSURE

Previous research has suggested women will not disclose abuse unless they know they will get a positive reaction and not be blamed for the abuse taking place (DH, 2005). Vanderburg *et al.* (2010), like others, emphasised that the practitioner's central role was to screen and identify women who have been or are experiencing abuse. This vital role is echoed by Robbins (2014) who suggested that women expect health professionals to provide support and guidance to help them to name the abuse (Bradbury-Jones *et al.*, 2014). While a study by Spangaro, Zwi and Poulos (2011: 158) highlighted that women value 'naming the experience as abuse', with the development of a therapeutic relationship with the practitioner going a long way to encourage this dialogue. Francis *et al.* (2016) emphasised the importance of practitioners who use a non-judgemental, flexible approach, tailored according to the needs of women are those who provide the most effective support. However, Cann *et al.* (2001) and Spangaro *et al.* (2010) found that practitioners may not respond appropriately to positive screening if the abuse was not recent or may not provide information regarding support services that are available to women.

Health Visitors must have the competence and confidence to support women effectively. Previous studies have not been able to determine whether Health Visitors are demonstrating

a non-judgemental attitude or if they can help women 'name' the abuse. The next section aims to explore the interactions between women from a Health Visitors' perspective.

2.4.7 HEALTH VISITORS' KNOWLEDGE, COMPETENCE AND CONFIDENCE

It is now well established that Health Visitors have a role in helping women to identify and name abuse, to provide support and keep them safe (Peckover, 2003b; DH, 2014; NICE, 2014). Practitioners need to have the knowledge, confidence and competence to carry out this role effectively. Allowing the client to discuss their experiences, checking that they are not in immediate danger, showing concern, and providing helpful options are important actions for practitioners to undertake.

The assumption that all practitioners agree with screening and routine enquiry may not be an accurate reflection of what is occurring in practice. Department of Health (2000: 20) highlighted some reasons practitioners did not ask about domestic abuse. Some practitioners felt the women deserved the abuse by deliberately choosing violent men (Department of Health, 2000). Others thought that it was a private issue or not a concern for healthcare practitioners. A recent study by Szilassy *et al.* (2017) identified that some practitioners lacked confidence and experience with discussing domestic abuse with clients and families. A qualitative study by Peckover (2003: 205) explored the understanding of twenty-four Health Visitors within the context of their work using a feminist poststructuralist approach. In the review, semi-structured interviews identified a 'hidden and private nature' where Health Visitors' identified a lack of knowledge or opportunities to openly discuss issues around domestic abuse. Peckover (2003) described how a lack of knowledge, confidence and competence could compel Health Visitors to avoid identification or naming of the abuse. In the same study, some participants used the term 'silence' when describing their knowledge and understanding of domestic abuse. Findings demonstrated that some Health Visitors were often reluctant to identify a situation as an abusive one and hesitated to name it as such (Peckover, 2003).

Peckover (2003: 206) proposed that Health Visitors need to address issues around confidence and competence by developing a 'more substantive knowledgebase about domestic abuse'. A study by Husso *et al.* (2012: 353) recommended to explain how practitioners 'made sense' of domestic abuse interventions. The research concluded that

when health professionals did not ask about abuse, this was often due to a lack of knowledge in how to start the conversation and intervene appropriately. Ramsay *et al.* (2012) concurred by suggesting that when a practitioner had insufficient confidence it could have an impact on their ability to identify and address issues around domestic abuse. In the same vein, Szilassy *et al.* (2013) found the development of confidence could increase the identification of abuse and is known to have an impact on a practitioner's ability to initiate discussions and when talking to children about domestic abuse.

Taylor *et al.* (2013), in examining health professionals' beliefs about domestic abuse, found that practitioners expressed frustration with women who decided to remain in abusive relationships or believed were complicit in their abuse. However, Lazenbatt *et al.* (2005) undertook a quantitative study of 488 midwives who completed a survey. With a 57% response rate, the research demonstrated that most midwives (82%) did not endorse stereotypical myths such as the victim being partially responsible for the abuse or that the women chose abusive partners and to remain in the abusive home.

A quantitative study by Cann *et al.* (2001) compared the knowledge, attitudes, responses and level of detection of domestic abuse among 685 practitioners. Findings demonstrated that 90% of practitioners agreed that domestic abuse was a significant health care issue. However, most practitioners did not agree with the routine questioning of large non-specific groups of patients, with 69% agreeing with targeted enquiry if injuries occurred in the home. Further findings by Cann *et al.* (2001) established that practitioners displayed confidence when discussing domestic abuse; however, some felt uncomfortable talking about it. These intense emotions towards women would mean practitioners had to suppress personal feelings in order to remain professional in their roles (Mann & Cowburn, 2005).

The Institute of Health Visiting published a report by Pettit and Stephen (2015) highlighting that Health Visitors should be aware of their attitudes and emotional reactions when encountering domestic abuse. A response such as blaming the victim or accepting theories around 'dysfunctional families' being the cause of domestic abuse rather than focusing on the behaviour of the perpetrator was not helpful (Williamson, 2000: 102). Research by Bradbury-Jones *et al.* (2014) went further in finding that some practitioners made assumptions about whether women were more or less likely to experience abuse whereby

making judgements based on stereotypical behaviour. D'Ardenne and Balakrishna (2001: 242) proposed that practitioners should be mindful of their 'personal attitudes, values and judgements' due to the impact this could have on their ability to support clients.

2.4.8 HEALTH VISITORS' PERSONAL EXPERIENCES

Szilassy *et al.* (2013) considered how personal exposure to domestic abuse may or may not influence a practitioner's ability to engage and address issues with clients. Gutmanis *et al.* (2007) found that 50% of practitioners had experienced abuse either personally or knew of relatives or friends who had been abused.

When considering the experiences of some practitioners, Bryant and Spencer's (2002) study of 118 nurse practitioners noted that those with a personal history of domestic abuse failed to identify victims or respond appropriately. However, when patient safety was at risk, these practitioners were more likely to report this to the police than practitioners who did not have personal experience of abuse (Bryant & Spencer, 2002).

A study by Christofides and Silo (2005) interviewed 212 nurses to find out whether their experiences of domestic violence influenced how they managed clients who were also suffering abuse. Findings showed that 40% of nurses had experienced either physical or emotional abuse; however, these experiences did not influence the quality of care that related to domestic violence. Of the nurses who had no personal experience of domestic violence, 20% were less likely to report the abuse. This study suggested that practitioners who had experienced abuse were well placed to understand that it took time for clients to feel comfortable and safe before disclosing (Bryant & Spencer, 2002).

An issue may arise where health professionals tolerate abusive behaviour within their private lives and may be less likely to understand why women want to leave the abusive relationship. Some health professionals had described their inability to understand why women would not disclose domestic abuse or why she stayed with an abusive partner endangering herself and her children (Baird, *et al*., 2017; Baird, Salmon, & White, 2011). Others indicated their frustration when women stayed with violent partners, while some practitioners still felt that domestic abuse was a personal issue.

When focusing on Health Visitors, previous studies have failed to explore whether there was a causal relationship between the personal experience of domestic abuse and the identification and reporting of abuse. This study aims to examine whether personal experiences impact a Health Visitor's ability to enquire routinely about domestic abuse and supporting women.

How Health Visitors maintain professional self-efficacy to carry out this challenging role and maintain their safety will be examined in the section that follows.

2.4.9 HEALTH VISITORS' SAFETY

The Department of Health (2017) suggests that practitioners consider the safety of the victim, children, and practitioner when asking about abuse. Peckover's (2002) research identified that home visits were often in the presence of men who were in the background. Findings showed that some Health Visitors were fearful for their safety and felt intimidated by the presence of the perpetrators. Although dated, a study by Shepard *et al.* (1999) highlighted the possible risk to the personal safety of practitioners who conducted home visits. The potential threat to their security may create a barrier to practitioners' intervening when domestic abuse has been identified (Shepard *et al.,* 1999).

Peckover's (2002: 258) study found that practitioners saw visiting homes where abuse was taking place as a 'potential threat, provoking anxiety about their safety'. Another dated but important study was undertaken by Humphreys (1999) who found that social workers identified that a lack of attention to worker safety could affect the quality of their practice and result in avoidance or minimising domestic abuse issues. When related to Health Visitors', concerns for their personal safety when routinely asking about domestic abuse, could restrict their ability to intervene appropriately.

The safety is emphasised within this research study as there is little evidence exploring this significant issue that could impact clinical practice around routine enquiry. The next section provides some insight into how practitioners overcome their apprehension to continue to identify abuse and support women despite concerns about the perpetrator remaining in the family home.

2.4.10 HEALTH VISITORS' ENGAGING WITH PERPETRATORS

Domestic abuse is a gendered crime with men often the perpetrators and with women and children the victims (Othman *et al*., 2014; Rai & Choi, 2018). However, perpetrators come from all parts of society as well as being service users. The Department of Health (2017) highlighted that practitioners might encounter perpetrators as a result of going to the family home where it is known, or where there is a suspicion of abuse.

Rhodes *et al.* (2007) acknowledged that if a third party were present, such as the perpetrator, this would limit the prospect of practitioners asking about abuse. A study by Rose *et al.* (2011) identified how some perpetrators prevented women from disclosing the abuse. Healthcare professionals may notice the controlling behaviour when the perpetrator tries to control the woman's version of events or does not allow her to be seen alone during the treatment period. The issue of control is the reason why the Department of Health (2005) guidelines advise healthcare professionals to see women alone at least once during their antenatal care to give her the opportunity to disclose any incidents of domestic abuse.

Practitioners need to also be aware of their role in case the perpetrator admits their abusive behaviour and asks for help to deal with the violence (DH, 2017). A study by Stanley, Miller and Foster (2012) identified that perpetrators often felt a sense of shame and embarrassment which was a barrier for women to disclose the abuse to family, friends and professionals. Stanley, Miller and Foster (2012) recognised how perpetrators wanted professionals to listen to their accounts in a non-judgemental way. However, practitioners should be aware that perpetrators tend to deny, lessen or excuse the abuse (Reisenhofer & Seibold, 2012).

Featherstone and Peckover (2007) considered the need to change the narrative around perpetrators and to focus on the needs of fathers in supporting women and children with an emphasis on the development of non-violent parenting. However, Stanley, Miller and Foster (2012) acknowledged the risks involved when the perpetrator was part of the equation and that engaging with perpetrators requires confident and competent practitioners who can focus on safeguarding the victim and children.

Studies by Featherstone and Peckover (2007) call our attention to challenges related to the professional relationship between Health Visitors and perpetrators and highlights the

difficulties faced by practitioners. Since there is little information available about the impact that perpetrators can have on a Health Visitor's ability to ask about abuse, this study will build upon previous research. The ways that Health Visitors relate to fathers who may be perpetrators and the level of confidence they feel to provide support to families when the abuser remains in the home will be explored further.

Practitioners have shown themselves to have a high level of self-efficacy to complete their role effectively despite concerns about engaging with fathers who may be perpetrators. The issue of self - efficacy and the impact this has on the Health Visitor's ability to carry out their role is discussed further in the next section.

2.5 SECTION TWO: THEME 2-THE WIDER CONTEXT OF ABUSE

2.5.1 WOMEN WHO HIDE THE ABUSE

Women have genuine concerns that prevent them from reporting abuse and becoming an expert in the patterns of their partner's anger because the fear of disclosure may result in an escalation of the abuse (Rose *et al.* 2011; Thurston *et al.* 2013). Research studies have suggested that many women remain silent about the abuse for many years before they finally tell someone (Ozçakar *et al.*, 2016). Women can be anxious, embarrassed, and fearful that they will not be believed and worry about what would happen to them following disclosure (Salmon *et al.*, 2006). Salmon *et al.* (2006) and Spangaro, Zwi and Poulos (2011) found that women fear disclosing abuse to professionals because of concern that child protection services would become involved and the impact this may have on the family. Women feel pressured to protect their children from the abuse and to avoid separation from their children (Stanley, Miller and Foster, 2012). As a result, they continue to hide the abuse (Bradbury-Jones *et al.*, 2014).

As previously discussed when women recognise that they are in an abusive relationship, they are still likely to conceal it from others (Bradbury-Jones *et al.* 2014). Naming the abuse is a step that women find very difficult to take, often feeling a sense of shame that prevents them from disclosing the abuse (Othman *et al*., 2014). In a more recent study, Katiti *et al.* (2016) found that 35% of women would not disclose or seek help by telling anyone about the abuse. Ten percent of women who eventually revealed still did not ask for support. For

many women, it is difficult to admit that there is a problem with the relationship. Embarrassment, guilt and shame are issues in women who have developed low self-esteem due to long periods of abuse are a barrier to disclosure (Stanley *et al.*, 2012).

Although studies suggest that women want healthcare professionals to ask about domestic abuse, women found it easier to hide the abuse from practitioners than to disclose it (Bradbury-Jones *et al.,* 2014). This fear not only reflects the mistrust some women feel about involving outside agencies but also a lack of knowledge about how organisations can help. In a community-based study of 1,325 pregnant women in Pakistan, Madhani *et al.* (2017) found 49.4% remained silent about the abuse for fear that the violence would escalate. Some women cited a lack of hope that any response to the violence would bring about change in their situation and they had no other option but to remain in the abusive relationship.

Previous studies have identified some of the reason's women do not disclose abuse. Reasons include feelings of shame and mistrust of professionals. This study will provide an exploration focused on Health Visitors' experiences and if this has an impact on the support given to women who choose to stay silent and remain in the relationship.

This review will now move to explore the knowledge Health Visitors have about why women may not leave abusive partners.

2.5.2 WOMEN WHO STAY IN ABUSIVE RELATIONSHIPS

Violence can range from physical abuse, sexual violence, coercive control, intimidation and control which are very physically, psychologically, and socially damaging (Taylor *et al.*, 2013; Rai and Choi, 2018). Physical violence can range from being raped, hit, kicked, bitten, burnt or strangled (Keeling and Mason, 2010; Ramsay *et al.*, 2012; World Health Organization, 2013). This list of abusive and violent behaviour is not exhaustive.

With the broad range of offensive actions directed towards women, some do not recognise physical, sexual or emotional abuse as domestic violence. Women often staying in abusive relationships because they are in denial (Francis, Loxton and James, 2016). Bradbury-Jones

et al. (2014) explained that women might not want to 'see' or express what is happening because this would be the first step to admitting what is going on in the relationship.

It takes women time to name what is happening to them as 'violent', so when they hide the abuse, this means their safety remains at risk when the abuse is not 'named' or recognised (Bradbury-Jones *et al.*, 2014). When women are unable to name the violence and abuse, this is a fundamental reason why so many do not seek help and support (Bradbury-Jones *et al.*, 2014; Spangaro, Zwi, & Poulos, 2009). Reisenhofer and Seibold (2012) conducted semi-structured interviews with women and found they were unwilling to report the abuse for a range of reasons with some minimising and normalising the violent incidents.

Some women are so reliant and dependent on the abuser that leaving is not an option. A reluctance to leave the perpetrator is probably true of women who rely on the financial income their partner brings to the household as disclosure may mean the partner refusing to support her or the children (Katiti *et al.*, 2016). Thurston *et al.* (2013) conducted a longitudinal study of immigrant women in Canada and identified housing as a significant barrier and a crucial determinant that made it difficult for women to leave the abusive relationships. Women may feel loyalty towards their partner or the extended family mainly if there are children involved (Reina, Lohman, & Maldonado, 2014). A qualitative study by Crowe and Murray (2015) interviewed and surveyed 231 professionals who helped survivors of domestic abuse and found some women just wanted the violence to stop rather than 'betray' their partner by informing the authorities.

A study by Stanley *et al.* (2012) had participants who suggested the victims of domestic abuse were more likely to express concern about the long-term effects of the abuse on the children. However, this concern outweighed the fear and stigma of becoming a single parent with no family support (Othman *et al*., 2014). It is evident that the reluctance to leave the family home is often due to many complex issues that victims need to consider before finally departing (Thurston *et al.*, 2013; Evans and Feder, 2016).

Patton (2003) found that women who are living in abusive relationships often contemplate leaving the abuser. Women may return to the family home several times before leaving permanently. Women need to recognise the abuse, as failure to do so places themselves and any children in the household at increased risk (DH, 2017). The significance of women

naming the abuse has been highlighted in previous studies. However, there is limited evidence that focuses on how Health Visitors identify and name the abuse by using their communication skills to build a rapport with women and secure a trusting professional relationship. This study aims to listen to the voices of the Health Visitors to explain how they engage women in naming the abuse and providing support.

The following sub-themes highlight how domestic abuse can be more challenging for specific client groups that require different considerations. Issues can be more complicated for women from Black and Asian Minority Ethnic groups (BAME) those who are asylum seekers with complex immigration issues. Additional challenges can also arise when identifying abuse within same-sex relationships. With the need for additional resources such as interpretation services, leaflets that are culturally specific, and community services such as refuges, these client groups are further disadvantaged making disclosure more unlikely and will be explored in more detail within the next four sub-themes.

2.5.3 BLACK AND ASIAN MINORITY ETHNIC GROUPS

Madhani *et al.* (2017) claim that some forms of domestic abuse are culturally specific, and others have a more significant impact on women when some BAME communities see domestic violence as a norm embedded within their culture. Klein (2006) suggested that in some hegemonic male-dominated cultures, women are expected to uphold the family honour, with rigid gender roles that firmly prescribe to women what their position is within the family. Katiti *et al.* (2016) found that women are expected to be submissive and subservient to their husbands, and the disclosure of abuse would be 'immoral' within the culture. Families socialise members into accepting beliefs regarding gender, social, economic, religious and cultural norms (Madhani *et al.*, 2017).

A report by the Women's National Commission (2009) found that children from BAME groups were more vulnerable to domestic abuse within the home. Furthermore, a study by Murray, Crowe, & Overstreet (2015) found that child abduction and forced marriage were more likely to occur in these homes as well as imprisonment, physical violence, threats and emotional abuse.

A Department of Health (2017) report identified that punishment could occur for bringing 'shame' on the family when victims do not comply with cultural rules. Incidents of honour-based violence can involve forced marriage, with strict views on inter-faith relationships often governing individuals on style of dress, makeup, marriage and divorce (WHO, 2005). Honour-based violence can result in the harm or killing of women or in forced suicide (Williams, Foster and Watts, 2013; WHO, 2013).

A report by Keen (2009) identified that multiple abusers could exist within one family. When considering multi-occupancy families living under the same roof, there may be cultural expectations that the head of the household also oversees the wife and children who are in the wider family unit. The wider family unit can consist of parents, grandparents, aunts and uncles all living under one roof. Women may experience physical and emotional abuse which could originate from her immediate family or the extended family.

Race and ethnicity can bring additional challenges for women who disclose and who want to leave the abusive relationship. This is because BAME women are more likely to experience threats of deportation, and abandonment and isolation from multiple perpetrators within the family and the broader community (DH, 2017). With this fear, BAME women are more reluctant to come forward and involve the police where there are issues of abuse. This reluctance could be due to cultural or societal norms which dictate that BAME groups remain silent (Madhani *et al.*, 2017).

Limited access to services may cause a cultural barrier that can discourage women from reporting abuse. It is essential for health professionals to understand the values and beliefs of the communities that they serve (Bent-Goodley, 2005). Although practitioners are aware of the additional challenges faced by different cultures, Peckover (2003) still found some Health Visitors who did not feel equipped to provide practical assistance and support for women from different races or ethnicities. Up to now, some studies have highlighted factors associated with ethnicity and culture and the additional impact this can have on domestic abuse. As noted by Peckover (2003a) Health Visitors appear to have a lack of understanding regarding the different cultural needs of their clients within the community and are ill-prepared to support them.

This research will build on previous studies by providing a more in-depth exploration that seeks to find out how Health Visitors address the challenges faced when supporting abused women from different cultural backgrounds and ethnicities. Being culturally competent will lead to appropriate support to address the additional challenges, particularly those faced by asylum seekers and women who have insecure immigration statuses. Issues regarding asylum seekers will be explored in the next section.

2.5.4 ASYLUM SEEKERS AND INSECURE IMMIGRATION

In the 1990s the campaigning group Southall Black Sisters and other organisations identified women who were immigrants to the country as being particularly vulnerable to domestic abuse (Rai & Choi, 2018). The World Health Organization (2014) reported that women were not likely to have information about support services and were intimidated by the fear of involving the police, particularly if they are undocumented migrants. Being undocumented prevents women from working unless they have permission from the Home Office which then limits their ability to sustain themselves as they will not have access to public funds such as social housing or welfare benefits (Fellas, 2008). These women are more likely to experience domestic abuse as they depend on their husbands for information regarding their legal status to remain in the country (Rai and Choi, 2018).

Women who are asylum seekers and refugees may be reluctant to contact the police because of the possible consequences of deportation from the country (Patton, 2003). The abuser will often use the woman's anxiety to control and keep them within the relationship by using threats of deportation and instilling fear of harm if they returned to their country of origin. There is the additional fear of losing custody of the children if they leave the abusive relationship.

Language is a barrier to the disclosure of abuse and prevents access to help from service providers (WHO, 2014) when these women are reliant on their families or interpreting services to relay information accurately. Jenner *et al.* (2016) suggest that if there is a lack of available translators to assist with communication, the voice of the abused immigrant woman is often left unheard.

Overall these studies illustrate some of the challenges faced by women who have an insecure immigration status and have no recourse to public funds. The additional issue of

women who have a language barrier means that disclosing abuse is less likely to occur. The Health Visitor's role in identifying and supporting clients who have an insecure immigration status and where English is not their first language, is an area that to-date has not been examined. This study will address this by exploring the challenges that Health Visitors face when supporting this client group. Another under-researched area is clients who are in same-sex relationships, which is the focus of the next section.

2.6 SECTION THREE: THEME 3- LEARNING, EDUCATION AND DEVELOPMENT

2.6.1 EDUCATION AND TRAINING

Gutmanis *et al.* (2007) called attention to practitioners' feelings of powerlessness and a sense of not being in control when they felt a lack of confidence. If practitioners felt a sense of helplessness, this could result in limited communication and the ability to relay concern and sympathy (Gutmanis *et al.* 2007). Radford and Hester (2006) maintain that education would allow a shift in knowledge, attitudes and practices from blaming the victim, to looking at empowering them while understanding the issues that may prevent some women from leaving the abusive relationship. Bryant and Spencer (2002) determined that health professionals require additional strategies to increase their knowledge and understanding about asking, supporting, and reporting clients who were suffering from domestic abuse. Rose *et al.* (2011) emphasised that education could improve the identification and referral for those experiencing domestic abuse. They recognised that a lack of training and concerns that practitioners had about offending their clients was a barrier to screening. Bacchus, Mezey and Bewley (2003) echoed this by suggesting that domestic violence training was a necessity for all healthcare professionals to provide enough information about resources available in the community such as women's aid, refuges, and access to legal services when they suspected abuse.

Peckover's (2003) research found that Health Visitors lacked training in domestic abuse. While Spangaro *et al.* (2010) proposed that healthcare workers require training to encourage them to be more sensitive and to respond more appropriately when clients chose not to disclose. Cann *et al.* (2001) found that when practitioners received education about domestic abuse, they were more likely to have a positive attitude towards this part of their

role. The effect of training was echoed further by Peckover (2003) who determined that health professionals must be educated on how to respond to domestic abuse, sensitively offer advice, and provide information about support services the services that are available to women. Strong organisational support combined with established practices builds a responsible approach to domestic abuse and helps practitioners to make appropriate decisions (Husso *et al.*, 2012).

Rhodes *et al.* (2007) pointed out that education should focus on improving communication skills and how healthcare professionals respond to disclosures. Gutmanis *et al.* (2007) maintained that education could enhance professionals' sensitivity and willingness to identify and empower women at risk. Minsky- Kelly *et al.* (2005) suggested training should be of a high standard but indicated that education alone was insufficient to significantly alter the behaviour of practitioners when screening, identifying, and helping victims within the healthcare setting. Instead, Minsky-Kelly *et al.* (2005: 1301) suggested 'periodic in-service training' to build up skills and to increase the comfort of practitioners who address domestic abuse. In contrast, Szilassy *et al.* (2013) discovered that practitioners who have been in service for five years or more did not attend training on domestic abuse. When there was a lack of training, it was often due to practitioners who did not feel it would be of benefit to them, which is an area of concern. Gutmanis *et al.* (2007) suggested that inadequately prepared healthcare professionals could be a barrier to routine enquiry.

Discussions should take place around the most appropriate way to undertake routine screening, and the types of questions asked during this process. Heffernan, Blythe and Nicolson (2014) suggested that knowledge gained from those who have experienced domestic abuse was most useful and should be involved in training and guide best practice. University-based courses should incorporate evidence-based techniques for working with abused women and children (Heffernan *et al*., 2014)., Minsky- Kelly *et al.* (2005), however, identified personal discomfort around the issue of domestic abuse, but indicated this could be addressed during training when discussing attitudes and behaviours.

Together, these studies have concluded that learning, education and training are vital to have a workforce of practitioners who can identify and support abused women. However, there is an indication that formerly trained practitioners may not value ongoing learning,

education and training. The issue around education and domestic abuse requires a more focused examination as there is limited research on this topic when related to Health Visitors. This study will examine what Health Visitors think and feel about ongoing domestic abuse training and discuss the impact that training has on the work that they do. Education and training must address the gaps in knowledge around domestic abuse and should include practical examples such as the needs of service users and the details of local services available for support.

2.7 SCOPING STUDY SUMMARY

To conclude this chapter, the scoping study indicated that women want to be asked about domestic abuse in a sensitive and non-judgemental way (Evans & Feder, 2016; Salmon *et al.* 2006). The evidence reviewed suggests that helping women to identify and name the abuse by overcoming their fear, is a significant part of the practitioner's role (DH, 2014; NICE, 2014; Vanderburg *et al.* 2010). While there is an extensive body of evidence related to women and domestic abuse, this review has highlighted the need for an exploration into the role of the Health Visitor when considering routine enquiry. Knowledge around aspects of domestic abuse has been seen to increase the confidence of practitioners and the identification of domestic abuse (Szilassy *et al.* 2013). However, there is a limited body of research that is focused explicitly around Health Visitors supporting women to identify and name the abuse. This study aims to address this by providing insight into this issue.

Some studies suggest that the practitioners' personal experiences of domestic abuse can influence their ability to identify domestic (Bryant and Spencer's, 2002). While others suggest the personal experience of abuse does not impact on practitioners' ability to escalate concerns (Christofides and Silo, 2005). This study will explore this issue.

Although research has examined why women may not disclose domestic abuse, this scoping study identified gaps in current research specifically Health Visitors' interventions and how these practitioners elicit disclosure. This study will address the issue of disclosure and the Health Visitor's role. Studies have highlighted the significant link between trust and disclosure (Keeling and Mason, 2010; Usta *et al.*, 2012). The ability of practitioners to engage with clients and build a rapport is a fundamental issue. Research findings demonstrated that practitioners who decide to escalate their concerns, ensuring the safety

of the children, have more confidence in helping women develop a safety plan, and refer women to services appropriately. Identifying the range of clients who can experience abuse provides incentive for further research into the Health Visitor's role mainly when men are victims or clients are in same-sex relationships. The impact of culture and how this influences a woman's ability to identify and disclose abuse was highlighted by practitioners who revealed a gap in their knowledge around cultural issues when supporting clients from different ethnic backgrounds. Concerns were raised in terms of clients who do not speak English and the use of interpreters during client interactions. The issue of interpreters will be explored further as there is a dearth of Health Visiting focused research that addresses this issue.

While previous research has focused on the self-efficacy of practitioners; this scoping study has provided some insight into how practitioners manage the difficulties encountered in their role. Being able to avoid 'compassion fatigue' and 'emotional labour' that may result from supporting abused women is a fundamental component in developing Health Visitors' resilience. However, much of the current literature ignores the impact that supporting abused clients may have on the Health Visitor's ability to carry out their role. Much of the current literature concentrates on the ongoing training for healthcare professionals who have contact with clients, with the promotion of ongoing education to support practitioners. It is essential to seek the opinion of Health Visitors to evaluate the effectiveness of education and training that builds confidence and competence. This study will seek the views of Health Visitors and consider whether there is value in ongoing learning, education and training around domestic abuse.

In conclusion, this scoping study has highlighted a need for more Health Visiting focused research studies. There is a clear indication that there is a limited range of research on this topic and strong evidence that further investigation is needed.

CHAPTER THREE: METHODOLOGY

3.1 INTRODUCTION

In the previous chapter, the scoping study provided an overview of emergent themes related to the ability of Health Visitors to ask women about domestic abuse and the processes involved to assess, make decisions, and provide support. Key areas for professional development were identified which focused on the educational needs of Health Visitors and how they impact the service Health Visitors provide.

This chapter presents the researcher's philosophical, ontological and epistemological perspective which informed the theoretical perspective, methodology, methods, analysis and findings of the study. The rationale is given for adopting the mixed method approach in the context of an epistemological and ontological discussion as well as its appropriateness within this field of research and in addressing the research questions.

This study aims to explore the experiences that may influence a Health Visitor's ability to ask about domestic abuse and provide support for women. It will also explore the learning and educational tools needed to support Health Visitors and improve their confidence and competence to carry out their role.

3.2 RESEARCH PARADIGMS

Philosophy means the use of abstract ideas and beliefs that inform our research (Creswell, 2013: 16). Kuhn (1970) used the term 'paradigm' to describe a set of beliefs consisting of ontology, epistemology, methodology and methods. This suggests that the paradigm provides a philosophical underpinning, a world view about the nature of knowledge and how it is created. In this study the researcher will explore the positivist, interpretivist and pragmatist paradigms as they are the most commonly used in healthcare (Harvey & Land, 2017).

The positivist paradigm views knowledge as based on cause, effect and objectivity (Grbich, 2003). Creswell (2009) echoes this stance by suggesting that positivist research seeks to identify and assess causes that influence outcomes.

A positivist ontological belief maintains objectivity by using a quantitative research strategy and a deductive approach based on careful observation and measurement of the objective reality (Creswell, 2009). This philosophical worldview has its advantages regarding the researcher's need to eliminate bias, and remain detached and uninvolved during the data collection process to enhance the validity of the research (Johnson & Onwuegbuzie, 2004). The use of a survey provides distance between the researcher and the participants and ensures practitioner anonymity. Therefore, despite the advantages of the positivist paradigm, it does not sufficiently accommodate the individuality of the Health Visitor's experiences which influence and potentially impact their role in clinical practice. Critics of positivism would agree that it is inappropriate when researching social life (Bryman, 2012; Silverman, 2011). The philosophy that drives the researcher's understanding of reality will not allow this study to be solely positivist. Therefore, the researcher reject's the positivist philosophy because it does not converge with the ontological and epistemological standpoints which will be discussed later in this chapter.

When considering the interpretivist paradigm, researchers aim to gain insight into how and why people behave the way they do, while focusing on subjective experiences, perceptions and language to understand intention and motivation that can explain behaviour (Parahoo, 2014: 37). Interpretivists believe the social world is constructed by human beings who are continuously making sense of and interpreting the social environment (Milburn, Fraser, Secker, & Pavis, 1995). The philosophical assumption is subjective in approach, using a qualitative research strategy and an inductive approach (Creswell, 2009). With many different interpretations, there is no universal truth because context, culture and values have an impact on an individual's experiences of how we live and how we interact with others (Witkin, 2017).

Findings from interpretivist research are context-related but may also have significance beyond the setting in which the study was carried out. The philosophy of the 'lived experiences' of participants is an important concept that the research seeks to explore (Creswell, 2009). Therefore, the interpretive philosophy would fit well with the current study where the Health Visitors are interviewed to explore their experiences, in relation to their professional practice.

With many ways of interpreting the world, the researcher accepts that understanding the different viewpoints of Health Visitors is important when considering the aim and objectives of this research study. Weber (1947) supports this stance by suggesting that knowledge is dependent on interpreting and understanding social actions in the context of culture and values. The Health Visitors in this study will have constructed different perspectives of domestic abuse due to individual experiences, which is likely to impact their understanding of this issue. Rubin and Rubin (2005) found that social reality cannot be external to social factors, but that it is constructed when people interact in response to different events.

The interpretive philosophy follows an open, flexible and unstructured approach to enquiry (Creswell & Clark, 2011). Data collection methods are used to understand people's lives and experiences by capturing the subjective meaning of social factors (Saks & Allsop, 2013). In this study, the Health Visitors were encouraged to share their views about routine enquiry, identification and support for women, which allowed for the collection of rich data that focuses on the description of experiences and perceptions. However, critics of interpretivism focus on possible researcher bias during the data collection process. Researcher bias was acknowledged in chapter one of this thesis, and all effort was made to minimise bias using a reflexive and transparent approach within the study as detailed in section *3.7*.

Having reflected on the positivist and interpretivist paradigm, the researcher was able to see the value in both (Carter and Little, 2007: 1321) whilst acknowledging that neither positivist or interpretivist worldviews were more superior than another but served a purpose depending on the way that the research question was stated. Considering the potential complexity, my judgement was towards the adoption of a pragmatic philosophy. Pragmatism has been described as eclectic, practical, logical, intuitive, dynamic and common sense (Doyle, Brady, & Byrne, 2009) rather than being restricted by a defined epistemological and ontological beliefs (Creswell, 2014).

Morgan (2007) presented pragmatism as an alternative to positivist and interpretivist philosophies. John Dewey (1959-1952), an American philosopher, was one of the first to consider the rigors of science, making it applicable to everyday events to resolve practical

problems. The philosophical stance of Dewy was to use techniques of observation and experimentation while being connected to practical human concerns that are firmly grounded in experience. Dewey placed great emphasis on experience as the means and end of inquiry, recognising the significance of all aspects of the human experience. Central to Dewey's work were the 'dualisms' between 'reason and emotion, thinking and doing, theory and practice' (Rylander, 2012: 15). Dewey proposed pragmatism as a theory of constructing meaning by recognising that there is a complex interchange between subjective feeling and objective demonstration. When considering pragmatism, Patton (2008) also suggested that it places great emphasis on human experiences built around sources of beliefs and the meaning that lies behind our actions. Pragmatism has increasingly become the philosophical choice in healthcare research and has been the 'middle way' between opposing paradigms of positivism and interpretivism (Doyle *et al*., 2009; Farrelly, 2013).

Having a pragmatic worldview subscribes to 'actions, situations, and consequences' (Creswell, 2009: 10). This philosophical belief is one that fits well with the researcher's previous and current roles as a Health Visitor and Senior Lecturer where theory and clinical practice all contribute to knowledge. Being outcome-oriented, pragmatists have an interest in finding out the meaning that lies behind issues (Johnson, Onwuegbuzie, & Turner, 2007). Exploring what lies behind the Health Visitors' ability to ask about domestic abuse and how they can make decisions about escalation within unpredictable environments lies within the research questions.

Pragmatists seek to bring together positivist and interpretivist positions to guide the choice of methodology, with the freedom to integrate multiple research methods that best meet the needs of the research study (Creswell, 2009). In making a choice, there are areas of convergence between the research question, aims and objectives that are influenced by the nature of the area of study. The choice of paradigm is also in line with Health Visiting as a discipline with a focus on experiences. Therefore, the researcher's philosophical choice of pragmatism is grounded within assumptions concerning the nature of truth. What is true in terms of a Health Visitor's experience when asking about abuse and supporting women is the focus of this study. Being able to hear Health Visitors' voices and to explore the

different context within practice that could influence their decision to identify and escalate abuse is an important factor in this study.

As a pragmatist researcher, each philosophical concept is deemed relevant and works to provide solutions that answer the research questions (Patton, 1990). Instead of being fully objective or wholly subjective, this study maintained an intermediate ontological position by accepting that both objective and subjective views are part of reality that would be of use in the research (Ansari *et al.*, 2016: 135).

3.3 JUSTIFICATION OF PARADAMATIC PREFERENCE

Denzin and Lincoln (1994) described ontology as the nature of reality with ontological assumptions about what constitutes 'reality'. When considering the positivist philosophy, there are advantages to undertaking quantitative research in terms of the importance of a ridged structure with an emphasis on the validity and reliability of findings from large sample sizes (Creswell & Clark, 2017). However, the researcher cannot agree that the quantitative approach alone can explore the depth, detail and context, which is a fundamental basis to the Health Visiting role and needs to be explored fully in this study. However, in order to inform policy, it was important to have a wide spread of participants to quantify how Health Visitors routinely enquire about domestic abuse in practice. Therefore, this study will have a small element of quantitative data that provides a rationale for a pragmatic philosophy and allows the flexibility required to answer the research questions.

Further justification for the pragmatic philosophy relates to the interpretivist component of the paradigm which is informed by the preferred theoretical framework. There also appears to be a natural convergence between pragmatism and social constructivism that focuses on the social context of behaviour and is further explored below. The convergence between the features of social constructivism, which is the theoretical framework that underpins this study, and the features of the interpretivist component of the researcher's pragmatic option provides sound justification for the choice.

3.4 THEORETICAL FRAMEWORK: CONSTRUCTIVISM

Social constructivism is strongly influenced by Vygotsky's (1978) work that suggested knowledge is first constructed in a social context, internalised and then used by the individual. Vygotsky (1978) believed that learning is a continual movement from the current intellectual level to a higher level referred to as the zone of proximal development. Social constructivism is a sociological theory of knowledge that focuses on how the individual constructs and applies knowledge in social contexts based on assumptions about reality, knowledge, and learning (Kukla, 2000).

Constructivism contrasts with those in the positivist paradigm but appears to converge with the pragmatic view with an assimilation of behaviourist and cognitive ideals; it acknowledges the learner's truth which is influenced by background, culture, and knowledge of the world. With an affinity between pragmatism and constructivism, Johnson & Onwuegbuzie (2007) agree that pragmatism is an attractive philosophy for integrating perspectives and approaches because it uses a combination of approaches to address the research question. Therefore, social constructivism as a belief system that influences how research questions are asked and answered and that concentrates on an individual's worldviews about the philosophy of knowledge is an appropriate choice for this research study (Lincoln & Guba, 1994).

The social constructivist framework will allow the researcher to provide an in-depth exploration of the Health Visitors' experiences. It is with the understanding that there will be multiple results drawn from individual practitioner experiences. Constructivism considers the social and historical constructs that may influence how the Health Visitors undertake their role and is a significant aspect of this study. Being able to understand the world in which Health Visitors live and work is fundamental to the constructivist approach. The constructivist framework allows the researcher to look for the complexity of views rather than narrowing meaning into categories or ideas (Creswell, 2009).

Crotty (1998) identified the need for social constructivists to use open-ended questions when interviewing participants. In order to reflect this need to allow participants the freedom to share their views, the survey questions were mainly open questions rather than closed-ended questions. However, it was only by interviewing Health Visitors that they

were able to provide context to their responses thereby providing more depth and meaning to their experiences.

The constructivist framework reflects how the Health Visitors need to be adaptable to the different families they encounter using their past experiences to navigate difficult conversations in variable settings when carrying out routine enquiry. Social constructivism is an appropriate theoretical framework in which to conduct this research study.

3.5 METHODOLOGY

Kaplan (1964: 18) defined methodology as 'the description, the explanation and the justification of methods, and not the methods themselves'. A mixed method design was adopted because it allowed both qualitative and quantitative approaches to the collection and analysis of data (Tashakkori & Creswell, 2007). This method reflects the pragmatic philosophical standpoint of the researcher by supporting an intermediate ontological position which accepts that both objective and subjective views of reality are useful in the study of social science (Ansari *et al.*, 2016).

This mixed method study focused on the fact that there may be different realities depending on the context and considered the subjective knowledge of the Health Visitors to build and construct understanding. This approach meant the researcher did not have to choose between qualitative and quantitative approaches but rather could draw on the strengths while reducing the impact of weaknesses found in both methods (Boswell, 2017; Harvey & Land, 2017).

The epistemology reflected in this mixed method study allowed researcher 'closeness' with the semi-structured interviews but also some distance between the researcher and the participants in the form of an electronic survey distribution. While semi-structured interviews were used to allow more depth of understanding and to hear the voices of the Health Visitors, the ability to use surveys as part of the study was an important option for Health Visitors who wanted to remain anonymous but still wanted to contribute to the research. This mixed method approach was an important factor for widening the scope of participants, resulting in a fuller understanding of the research problem by considering the 'story' in its entirety.

The choice of mixed methods is further justified by its effectiveness in previous studies in similar contexts. Similarities can be drawn from previous research to establish a justification for using this method. In these studies, explicit findings were informed by a combination of methods that the mixed method approach facilitates. For instance Heffernan, Blythe and Nicolson (2014) were able to demonstrate the ability of British social workers to recognise incidents of interpersonal violence and demonstrated how organisational policies and professional experiences impacted on their attitudes towards domestic abuse. A cross-sectional survey and follow-up of semi-structured interviews were used to gather the data. Similarly, Crowe and Murray (2015) used the combination of interviews and surveys to further establish the importance of professionals who helped survivors of domestic abuse. In addition, a study by Collins and Dressler (2008) used a mixed method approach to examine the cultural models of domestic violence among domestic violence workers that included nurses and a general population comparison group. Collins and Dressler (2008: 364) highlighted the advantages of using a mixed method approach in domestic violence research to capture an understanding of overall attitudes which would enable the researcher to build a more 'complete picture of experiences and better identify areas for improvement', further supporting the researcher's choice of this method.

This study focuses on a large community NHS Trust in the South of England. Patton (2002) also suggested that the interest is not in the generalisability but in the richness of the information generated, thus, the focus of this study is to explore and understand rather than to confirm and quantify in order to draw conclusions and provide insight into the larger group.

A mixed method approach of surveys and semi-structured interviews were used to gain an in-depth understanding of the Health Visitors' views by listening to their past experiences to create understanding and meaning. Using a mixed method approach allowed some distance between the researcher and the participants during the Phase 1 surveys. The electronic survey was distributed to reduce the possibility of researcher bias and to ensure anonymity. In Phase 2 and 3 of the study, the researcher interviewed participants. By using a qualitative research method, the focus was on eliminating bias by developing a relationship with the participants and seeking to understand the issue through their eyes.

This mixed method study converged with the researcher's philosophy of pragmatism as previously discussed. An overview of the research design is presented in fig. 3.1 and detailed in sections 3.14 and 3.17.

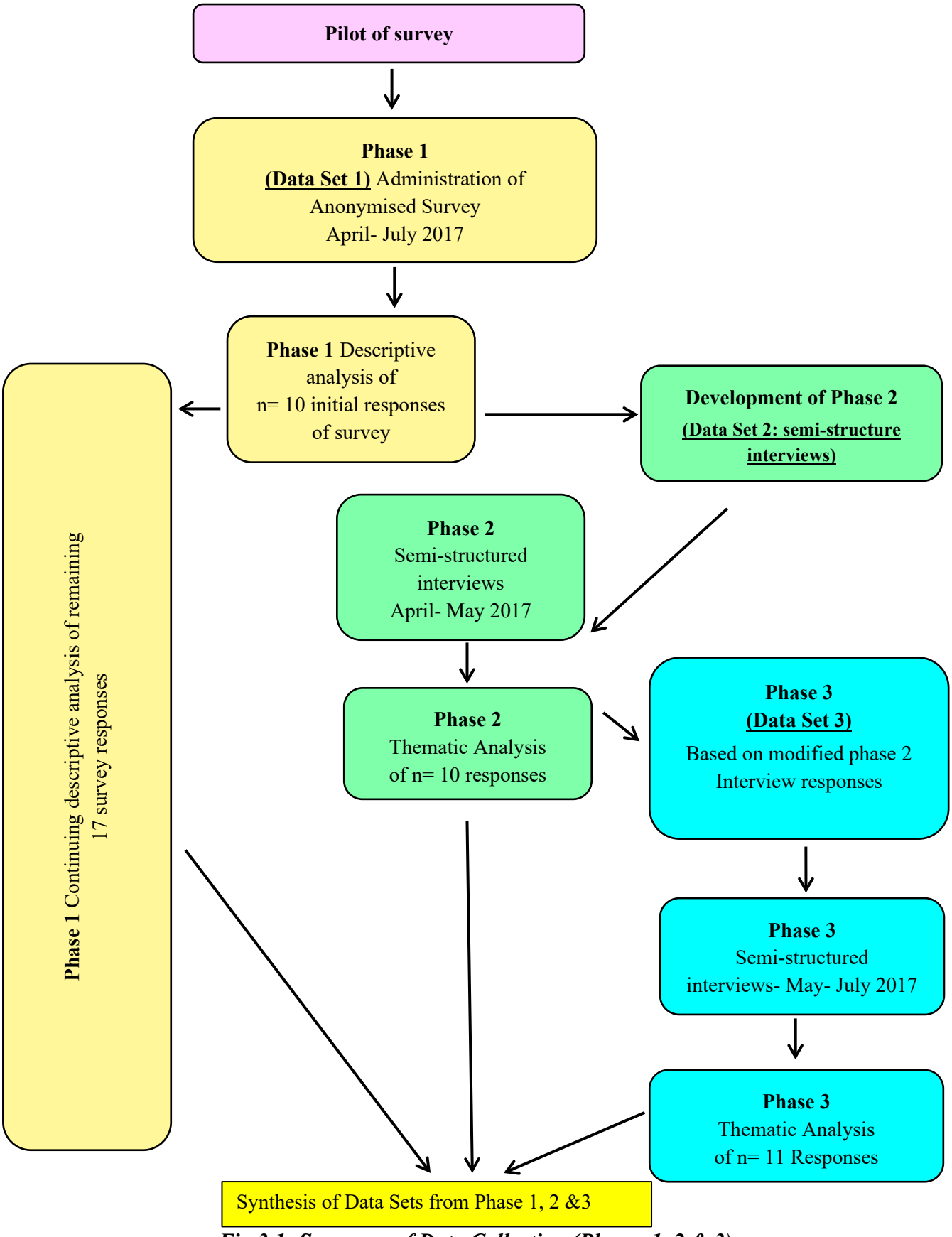

Fig.3.1: Sequence of Data Collection (Phases 1, 2 & 3)

3.6 INSIDER RESEARCHER

In this section I will refer to myself in the first person in order to discuss the issue of the insider researcher and to address potential issues of bias. To ensure that my approach to this study is transparent and to address potential issues of bias, it is important to identify the influence that my role may have on how the study data is generated and analysed.

Having worked in a management role in the NHS and line managed by the same Trust Manager who now manages some of the participants, it was impossible for the researcher to remain an 'outsider' researcher. This naturally raises the issue of reflexivity in research. Reflexivity is where the researcher 'positions themselves' in terms of background, work experience, or cultural experiences and how this may inform the interpretation of the study (Creswell, 2013). Being reflective allows the reader to understand how the researcher is linked to the topic being investigated and what the researcher may gain from undertaking the research (Creswell, 2013).

In response, I consciously made efforts to maintain neutrality, particularly in the collection and interpretation of data. For example, during *RQ2, Are Health Visitors' able to identify the further training or educational requirements that they perceive as supporting their 'confidence' and 'competence' in working with clients?* my experience as a Health Visitor and Lecturer was openly discussed. This allowed a form of commonality and understanding so that practitioners were aware that I understood their role and some of the challenges they were facing. The disclosure of my previous roles and experience promoted a level of openness that enabled participants to describe their experiences when being interviewed rather than viewing my presence as a barrier.

During the interview and the data analysis processes, a conscious decision was made to put my own preconceptions to one side to focus on the voices of the Health Visitors throughout the study. Creswell (2012b: 60) suggested that researchers must remain aware that to maintain neutrality they should be mindful of the multiple perspectives concerning the data collection, which had to speak for itself.

I recognise that my approach to this study would be through a 'singular interpretative lens' (Bourgeault, Dingwall & de Vries 2010: 357). As suggested by Pope & Mays (2006), I

maintained a diary throughout the research study that allowed me to identify the effects that my prior experience and relationships could have on the data collection and analysis process. Maintaining a diary also allowed assurance that I had not crossed boundaries and maintained my objectivity. Throughout the research, supervision-initiated discussions regarding my approach to the interview questions, data collection, coding and analysis, took place with my research supervisors. These discussions were particularly useful during the data analysis and interpretation phase of the study because they allowed for constructive criticism and deliberations over data interpretations and provided alternative views that needed to be considered. This allowed me to maintain my objectivity and widen my conceptualisation by consistently questioning the research process, findings, and interpretation of the data.

3.7 DATA COLLECTION METHODS

Mixed methods in social research is often advocated when considering human thought and behaviour (Teddlie and Tashakkori, (2009); Creswell and Clark (2011). Therefore, in this study a mixed method research design which was informed by the preferred pragmatic philosophy of the researcher. The methods included semi-structured interviews as well as surveys to provide a rich collection of data.

Creswell (2009: 8) suggested 'the more open-ended the questioning, the better'. The surveys (Phase 1) were circulated throughout a four-month period. Offering surveys as an option allowed participants who were not comfortable taking part in the semi-structured interviews to still contribute to the research and have their voices heard. However, one of the disadvantages of using surveys is that follow up or probing questions cannot be asked. Therefore, once ten of the surveys had been initially analysed, I was then able to shape the (Phase 2) semi-structured interview questions.

A conscious decision was made not to link participants across the different phases of the study. The goal was to ensure anonymity and ultimately to avoid bias. It was determined that tracking across the phases of the study would enable the researcher to specifically identify and associate comments to individuals which could lead to bias and prejudice the researcher's interpretation.

Creswell and Plano (2007);Creswell (2014) explains that mixed methods research involves the sequential or simultaneous use of both qualitative and quantitative data collection and / or data analysis techniques. A sequential mixed method design was used to collect data that merged Phases 1, 2 and 3 (*refer to fig. 3.1*) in the findings stage to provide an integrated analysis of the research (Creswell, 2013). The descriptive survey data was used to ask a different set of questions, but at the data analysis stage, findings of both studies were brought together to create a richer and more complex story (Hesse-Biber and Johnson, 2013).

The charts and graphs included in this study show the distributional patterns of the findings. However, the main concern was about the qualitative data collected with emphasis placed on the open boxes (qualitative) in the survey that allowed Health Visitors to write a descriptive narrative to share their experiences, reflecting the researcher pragmatic worldview. The convergence of data allowed for a more comprehensive understanding of the research questions, increasing the validity of the research when approaching the issues from different perspectives and standpoints.

Additional time and resources were required to collect two methods of data, analyse them, and report findings. This was one of the disadvantages of using a mixed method approach. Additional skills were required when creating the survey; understanding how to use the Qualtrics online system of survey distribution, using the MAX QDA qualitative data analysis tool, and having the skills to interview participants were examples of the challenges faced when using a mixed method approach. There was also the issue of generalizability, which may not be possible due to the small numbers of participants. However, the advantage of using a mixed method approach allowed a 'complete picture' of the issue (Kumar, 2014).

3.8 ETHICAL CONSIDERATIONS

It is the responsibility of the researcher to demonstrate that actions and decisions made during the research study are ethical (Fallon & Long, 2007). Creswell (2012b) also draws attention to the criticality of ethics at the beginning of a study, during the data collection

phase, data analysis, when reporting findings as well as within the publishing phase of the study.

An essential role of the ethics committee is to act as a protective barrier between the researcher and the participants (Saks & Allsop, 2013). Ethics panel's ensure the research design is appropriate and carried out systematically to reach sound conclusions (Department of Health, 2011). The Nuremberg Code (1949) first highlighted the importance of 'voluntary consent of the human subject' with the importance of informed consent and the ability in refusing to participate. The Declaration of Helsinki (2000) emphasised the role of the responsible researcher, placing the well-being of the 'human subject' above the interest of science and society. Based on this, Winter and Munn-Giddings (2001: 220) highlighted essential principles to guide researchers that comprised of the duty of care (which overrides mere personal interest); respect for the individual, irrespective of race, gender, age, disability; respect for cultural diversity; respect for individual dignity; and protection from harm. The researcher also has the responsibility to protect the participants' privacy, confidentiality, life and health (Green & Thorogood, 2014).

This study involved human participants, so an application was made to a formal research ethics committee to ensure their rights, dignity and safety. Indeed, Neale (2009) found that it was not unusual for a researcher to seek approval from more than one committee. In this instance, the researcher was required to seek permission from the University and the National Research Ethics Service (NRES). The researcher also contacted (online) the NHS Health Research Authority to determine which ethical authority was required. The online information guided the researcher to answer three questions to determine if the proposed research study required further scrutiny from the NHS Health Research Authority (Appendix 1). Results showed that the study did not meet the threshold of the NHS Health Research Authority Ethical Committee (Appendix 1) but would need to gain local approval of ethics.

Given the recommendations provided by the NHS Health Research Authority, the researcher contacted the NHS Trust Research and Knowledge Manager. Contact with the local NHS research department ensured that the researcher met the NHS Trusts

requirements of undertaking research (Appleton & Caan, 2004; Appleton *et al*., 2007). The researcher applied to the NHS Trust for local ethics approval (Appendix 2). Appendix 3 and 4 provides a copy of the Quality Project Approval Notification and accompanying email. The NHS Trust granted ethical approval for the study to take place.

As part of the University's process of approval, a detailed application was made to the Research Ethics Committee. One of the priorities of the ethics committee was to ensure that participants had written information and that consent would be given freely (Saks & Allsop, 2013). The research application included the relevant documentation to be circulated to participants about the potential risks associated with the study (Appendix 7). Evidence of the NHS Trust Ethics approval and NHS Health Research Authority documentation were presented at the University's committee. Approval for the research study to proceed was agreed.

Equally important are the research governance ethical codes of practice that are in place to guide researchers in the way they plan and carry out research (Neale, 2009). Consideration was given to address issues such as respect, justice, potential harm and possible benefits to the participants (Saks & Allsop, 2013). Adhering to the Ethical Guidelines for the British Educational Research Association (BERA, 2011) and the NMC (2015) Code of Professional Standards for Practice and Behaviour.

Following ethical approval, the researcher was provided with an honorary contract with the NHS Trust before any study-related activities could take place. The contract allowed the researcher to gain access to the Health Visitors and to enter NHS Trust premises. The Health Visitor Manager was allocated as the NHS Trust Research Supervisor and this person's role was to oversee and to be a point of contact from an NHS Trust perspective.

3.9 INFORMED CONSENT

The researcher attended the NHS Trust staff meetings to introduce the study. Attending the meeting allowed information to be shared and for the Health Visitors to consider whether to be involved in the study. Information about the study was also emailed to each Health Visitor in the Trust including a cover letter about the research (Appendix 6, 7, 8). Meeting

the Health Visitors and sending information provided them with an opportunity to ask any relevant questions or to raise concerns.

Lichtman (2013) highlighted issues around possible organisational vulnerability where people may feel that they are obligated to participate in the research based on their environment or setting. The Nuremberg Code (1949) and the Declaration of Helsinki (2000) focused on the responsibility to protect the well-being of the research subjects and detailed the importance of voluntary consent. Consent is where human subjects base their decisions on information that is provided to either give or withhold consent regarding the participation in a research study Declaration of Helsinki (2000).

An information sheet given to Health Visitors before participating in the study provided the right to opt out of Phases 1, 2 and 3 or at any point without any repercussions whereby giving informed consent (Boulton & Parker, 2007). Weis and Fine (2000) advised researchers to consider possible issues that may arise because of the study, and to be open and transparent with participants before obtaining consent (Appendix 9). Consideration was given to the power relations that may be implicit in research from an ethical perspective. The researcher addressed issues of 'power' through the voluntary participation of the participants by assuring they were free to withdraw from the study at any time without any repercussions (*Declaration of Helsinki 2000*; Department of Health, 2011).

In Phase 1 (survey), implied consent was assumed when participants returned the surveys electronically, while written consent was obtained before Phases 2 and 3. The researcher informed participants using the information sheet (Appendix 7) that the results of the study would be anonymised and made known to the University of Greenwich and the NHS Trust involved. Participants were informed that the work would also be made public in the future through publications, conference presentations, and policy developments. The NHS Trust would similarly have access to the results where the researcher would provide feedback regarding findings, which may influence future policy and practice development. Participants were willing to contribute to the development of the teaching and learning strategy around domestic abuse and the development of Health Visiting focused, evidence-based practice.

3.10 CONFIDENTIALITY

As highlighted in the scoping study, domestic abuse is a sensitive issue. In this respect, Hatch (2002) advised researchers to be responsive to vulnerable participants and to consider the likely risks and inconvenience they may face in participating in a study. Throughout the research study, the NMC (2015) Code of Professional Conduct and (BERA, 2011) Ethical Guidance for Researchers were adhered to for maintaining confidentiality, privacy and dignity of the participants. Green and Thorogood (2014), however, identified that conducting research 'close to home' made it more difficult to maintain confidentiality. Participants in this study had concerns about privacy due to the nature of the information they would be disclosing about their knowledge and professional practice. The anxiety that the data may be identifiable and available to their employers could be a real issue for some Health Visitors. A concern raised during a local staff meeting was that Health Visitors wanted to know that the information they shared would be confidential. The researcher assured participants who took part in the semi-structured interviews that their contact details would never be used for any purpose other than to email a copy of the transcription for verification once completed and for correspondence when arranging the interviews. This gave reassurance that the confidentiality of each participant would be guaranteed using pseudonyms and codes to preserve their anonymity while removing any identifying marks (Creswell, 2009).

With this and other issues around confidentiality in mind, giving assurance via staff meetings and on the participant information sheets confirmed the protection of their privacy and anonymity (Appendix 7). For this reason, the researcher gave participants the option to have their interviews at the University rather than within NHS Trust premises as it was seen to increase their protection of anonymity.

However, as Nursing and Midwifery Registrants, the Health Visitors and the researcher are by duty bound to report any safeguarding issues. Participants may disclose issues around safeguarding during the research study that related to clients or shared information that could compromise their safety or the safety of others. Adhering to the Trust policies and the NMC (2015) Code of Conduct, Health Visitors were informed by way of the

information sheet (Appendix 7) that any safeguarding issues raised would be reported accordingly to the NHS Trust Safeguarding Lead Nurse.

3.11 AMELIORATING RISK AND HARM

Kent *et al.* (2002) acknowledged research involves 'risk of harm' but could also provide benefits to the participants involved. Likewise, Green and Thorogood (2014: 74) highlighted the issues around the 'emotional consequences' of taking part in a research study. Being able to predict all possible incidence of when the participants may feel harm or distress was not a realistic goal; however, completion of the ethics application allowed the researcher to consider the management of potential problems and to develop a plan for minimising or preventing those issues (Saks & Allsop, 2013). Potential risks can involve the discussion of sensitive topics that may result in social or psychological harm of the participants (Renzetti & Lee, 1993).

The online survey (Phase 1) may not have appeared as intrusive as the semi-structured interviews (Phase 2 and Phase 3); however, participating in the study could bring up sensitive issues for the participants on a personal level. Evans *et al.* (2002) expressed concern about the impact that surveys could have on participants and the risk of harm when researching at a distance. In response to these concerns, as experienced practitioners, it was likely that the participants would have developed an element of resilience when discussing the sensitive issues around domestic abuse (Pettit *et al*., 2015). Hallowell, Lawton and Gregory (2005: 142) suggested that research 'is first and foremost a moral activity,' with the need to negotiate human relationships. This negotiation would hold during the semi-structured interviews where there may be a need to 'probe' for more in-depth answers.

The participants could disclose personal issues or recall traumatic memories that might cause them to become emotional. In anticipation of this, the researcher sensitively approached the study to minimise the incidence of possible distress to the participants. Being able to monitor the participant's reactions, particularly during the semi-structured interviews, was an essential part of the interaction (Neale, 2009). The researcher's experience in Health Visiting provided the appropriate knowledge and skills to carry out the research and ask about sensitive issues. Saks and Allsop (2013) highlighted that a

researcher's emotional involvement in a research study could mislead or cloud judgement but stressed the need not to be too detached and to maintain an empathetic stance in conducting ethical research that is humane.

Had any of the participants become distressed, the researcher would have used an empathetic, understanding and sensitive approach. Asking participants whether they would like the interview to stop or to exit from the research process from that point, would be options offered by the researcher. An information sheet that included helpline numbers and contact details of confidential support services were made available to each participant following the interview (Appendix 13). This information provided a balance of the potential 'harm and benefit' that guided the process ethically (Resnik, 2011).

3.12 RECRUITMENT STRATEGY

Access to professionals can be particularly challenging due to their increased workloads and limited time, so taking part in research was not always easy for practitioners (Green & Thorogood, 2014). Creswell (2013) emphasised the importance of finding individuals within an organisation who could provide access to the research site and facilitate data collection as an essential factor in the success of a research study.

Therefore, at the beginning of the study, contact was made with the NHS Trust Health Visiting manager. The aim of this was to discuss the purpose of the research and to establish the possibility of accessing the Health Visitors about completing the survey and participating in semi-structured interviews. The manager gave positive feedback and was keen for this study to take place as she felt it would inform the education and clinical practice of the Health Visitors within the Trust.

The researcher was invited to attend staff meetings to inform the Health Visitors about the study and to explain its relevance to practice. A flyer that contained the researcher's contact details and an information sheet was circulated (Appendix 5 & 7). The information sheet provided specifics regarding the interviews, survey, consent, confidentiality, anonymity, potential risks and benefits of the research, and contact details of the researcher and supervisors. The information sheet also presented details of what the participants of the

study were expected to do, and they were distributed electronically to all the Health Visitors who did not attend the information sharing meetings (Appendix 7).

Table 3.1: Inclusion and exclusion criteria

Inclusion Criteria	Exclusion Criteria
A qualified specialist community public health nurse (Health Visitor) or Registered Health Visitor qualification	Staff members who do not hold the specialist community public health nurse (Health Visitor) qualification or Registered Health Visitor qualification
Has had a caseload that includes clients living in abusive relationships within the last three years	Has not had a caseload that provides for clients living with domestic abuse within the previous three years
Working for an NHS Trust	Does not work for an NHS Trust
Currently in clinical practice	Not now in clinical practice
Aged between 21 and 65 years of age	Aged less than 21 or older than 65 years of age
Experience in handling domestic abuse cases	No experience of managing domestic abuse cases

Health Visitors were included based on their qualifications and experience of asking about domestic abuse and having clients within their caseload who were or had been living in abusive relationships (*fig 3.1).* There was a total of 67 Health Visitors in the Trust. The number of Health Visitors who met the inclusion criteria was 56. Those who gave consent by returning the survey determined the sample size which was twenty-seven. Semi-structured interviews were conducted with a total of twenty - one (Phase 2 n=10, Phase 3 n=11) Health Visitors until saturation had been reached (Kumar, 2014).

3.13 SAMPLING

This was a convenience sample in terms of the researcher choosing one NHS Trust to take part in the study. In convenience sampling the researcher recruits the most readily available participants who meet the criteria for inclusion (Casey & Devane, 2010). Robson, (2011) has suggested that convenience sampling is one of the weakest as there is a risk that the sample will not reflect the characteristics of the research population. In this case the researcher had a prior professional relationship with the manager within the chosen NHS Trust who welcomed the research to take place in her organisation. Although this study focused on one NHS Trust in the South East of England, it was decided that this would still provide some insight into identifying common themes and influencing factors expressed by Health Visitors, which could be transferred to other clinical settings in the country. This NHS Trust provided a representation of Health Visitors in the South East of England in terms of ethnicity but not necessarily nationwide (*Refer to appendix 15*).

A purposive sample of 21 (phase 2 and phase 3) Health Visitors participated in the semi-structured interviews, and 27 (phase 1) participated in the surveys. A purposeful sample is a non-random method of sampling which aimed to collect a group of people with specific characteristics and who had knowledge that would be valuable to the research study (Cresswell, 2013). This small number of participants could raise the issue of representativeness. While it has been established that the purpose of this study was not about generalisations, it was determined that the small sample was worthy of exploration to provide insight into issues around the Health Visitors' role in routinely enquiring about domestic abuse and would be a baseline for further investigations. Furthermore, since the purpose of this study was to develop knowledge and understanding, the number of participants became less significant as it would have been in other studies. Where the NHS Trust is concerned, the process can be replicated but not generalised in terms of findings.

The inclusion / exclusion criteria (*Table 3.1*) for the study was included in the information sheet so that only those who met the requirements completed the survey and participated in the semi-structured interviews.

Participants' demographic data

As indicated in table *3.2* (22%) of participants were aged between 22-40 and (77%) between 41- 60 years of age.

Table 3.2: Age group of participants

Age range	***22-30 yrs***	***31-40 yrs***	***41-50 yrs***	***51-60 yrs***
Number of participants	**1**	**5**	**14**	**7**

Out of 27 participants, 12 had qualified between 2-5 years ago:

Table 3.3: Qualification in years with (26%) recently qualified and the majority (44%) qualified between 2-5 years.

Years	***Less than 2 yrs***	***2-5***	***6-10***	***11-15***	***16-20***
Number of participants	*7*	*12*	*3*	*1*	*4*

Table.3.4: Ethnicity of Participants

Ethnicity	***Number of survey participants***
Mixed heritage	4
White British	13
Black African	4
Black British	1
Asian	1
Black Caribbean	1
Indian	1
White Irish	2
Total	**27**

Appendix 14 presents the demographic data for all the Health Visitors in the NHS Trust. Out of 27 Health Visitors who responded to the survey their ethnicities were described as White British, Black African, Mixed heritage, White Irish, Indian, Asian and Black British. Most participants were White British (48%) which is slightly above average for the NHS Trust which has a (43%) White British Health Visiting workforce. Out of a total of 27 participants, most (n= 17) had worked for the Trust for between 2-5 years.

3.13.1 SAMPLING BIAS

As previously discussed in chapter one, researcher bias could be introduced either in how the questions were framed; in how the researcher interpreted the responses, or in the reactions of the participants by positive or negative influences, sometimes referred to as the Hawthorne effect (Green & Thorogood, 2014). Bias was limited by sending participants who provided an email address with a copy of the interview transcription to verify the content and to provide feedback to the researcher. If the participant did not reply within two weeks, an assumption was made that they were satisfied with the level of accuracy.

It was also important to acknowledge the presence of 'power' in the research process (Saks & Allsop, 2013). Addressing the potential power imbalance within the semi-structured interviews were considered. Creswell (2012a) highlighted the building of trust and to avoid leading questions would help minimise some of the imbalance in the researcher / relationship. Creswell (2012a: 55) suggested 'giving back to address some of the 'time and effort' participants gave to the study by way of 'reciprocity'. As a goodwill gesture for their contribution to the research, all Health Visitors who participated in the semi-structured interviews were offered a small token of a £10 book voucher for use at the University bookshop to purchase resources that would contribute to their continuous professional development.

3.14 RESEARCH PROCESS

The following table provides an overview of the research process undertaken.

Table 3.5: Research process composition:

Phase	*Research Design*	*Detail*
Pilot Test	Questionnaire Semi-structured interview questions	Four participants from the field checked for clarity of questions/ potential bias
Phase 1:	Questionnaire (n=27)	Inclusion criteria
Phase 2:	Semi-structured interviews (n=10)	Initial participants interviewed
Phase 3:	Semi-structured interviews (n=11)	Participants interviewed with amended interview questions.

3.15 PILOT STUDY

Yin (2017) advised to carry out a pilot test to refine the collection of data and to ensure the relevance of questions. The survey and interview questions were pre-tested to check for clarity using the assistance of four Health Visitors not included in the primary study who did not meet the criteria for inclusion.

The pilot tested the wording within the survey and demonstrated how participants would understand the question and whether the participants would interpret the questions in the same way. The pilot participants were encouraged to identify issues around clarity and to ensure there was no ambiguity concerning the questions. This was an important exercise because if participants interpreted questions differently, this would affect the quality of the data.

The preliminary investigation allowed an overview of the participants' expected responses to the questions and gave the opportunity to troubleshoot issues regarding the questions before using them in the main study. Feedback given was regarding the length of the survey and the time it would take to complete. The pilot group highlighted that some of the wording was ambiguous. These issues were addressed by reducing the number of questions and rewording the survey for clarity. The pilot also gave the researcher an opportunity to test the web-links using the electronic 'Qualtrics' survey distribution and data collection system.

3.16 DATA PROTECTION

The survey was distributed electronically via Qualtrics (survey tool) which was password-protected and stored electronically online. The interviews were recorded using two digital recorders to capture the discussion. The recorders were placed on the table to be non-obtrusive to the conversation that took place, allowing the researcher to focus attention on asking questions and developing a rapport with the participants. The participants were informed when the tape recorder was switched on and off. At no point were the participants' names used. Their identities were anonymised using pseudonyms and codes to ensure confidentiality, and any identifying elements or remarks were removed.

Adhering to University policy, the research data would be stored securely for up to five years with consent forms kept in a locked cabinet that would be shredded following completion of the doctoral study.

3.17 DATA COLLECTION

Using a mixed method approach, the researcher distributed 56 electronic surveys to Health Visitors in Phase 1 of the study to address the quantitative aspect of the study. While the survey consisted of some 'closed' quantitative questions, the focus of the survey was on the use of 'open boxes' that encouraged qualitative responses. The survey was used to generate insight into relevant questions that were used to create the semi-structured interviews (phase 2) that took place soon after distributing the survey.

The advantage to using surveys was to give a voice to participants who may wish to maintain their anonymity when sharing sensitive information and they were less intrusive. Therefore, using surveys to collect data widened the scope to include more participants who may otherwise be unwilling to share their experiences. However, as Edwards *et al.* (2009) cautioned, response rates to surveys maybe low despite reminders. The researcher was required to remind Health Visitors through email and staff meetings to participate in the survey if they wished to do so. Another disadvantage of the survey method was that it would not be possible to interpret or clarify questions if unclear to participants (Wall, DeHaven, & Oeffinger, 2002). Despite these disadvantages, the researcher chose to use this method to ask some quantitative but mainly qualitative questions using comment boxes to give participants the opportunity to share their experiences since the benefits of using this method far outweighed the disadvantages.

To address the qualitative aspect of the data collection, the researcher considered undertaking focus groups as a method of data collection. A key strength of using focus groups is in the interaction within the group the ability of participants to compare and contrast ideas within an environment where there is social interaction (Morgan, 2010). Focus groups also provide a supportive environment for participants to discuss sensitive issues especially if the participants share an experience (Saks and Allsop, 2013). However, for the purpose of this study, the researcher wanted to hear the in-depth and detailed experiences of individual practitioners to explore their personal thoughts and feelings and, therefore, considered the use of semi-structured interviews to be more appropriate. Being able to probe and ask follow-up questions allowed the participants to provide in-depth and detailed information.

Semi-structured interviews took place in Phase 2 and Phase 3 of the research study (*Appendix 11 & 12*). This method of data collection allowed the freedom and flexibility to discuss participant attitudes, thoughts, feelings and experiences that would not be possible with using the survey method alone. The researcher was able to clarify and explain issues when asked by participants. It also allowed the researcher the use of both open and closed questions to 'probe' participants while having a list of pre-determined questions that provided structure to the interview (Parahoo, 2014).

The data from the surveys were analysed separately from the semi-structured interviews, proceeding to combine and interpret all the findings to answer the research questions (Creswell, 2013). Combining the findings allowed for more in-depth and broader understanding in the identification of convergences, divergences and contradictions when asking and supporting women who are in abusive relationships. A thematic approach was used to analyse the data to identify key themes selecting extracts from the surveys and semi-structured interviews that provided direct quotations of the participants' views.

3.17.1 PHASE 1- SURVEYS

The survey was compiled using 'Qualtrics' which is a web-based survey platform. Fifty-six surveys were circulated to the Health Visitors using a web link to complete 33 open and closed questions. The survey allowed participants the opportunity to elaborate on their thoughts and feelings with the open questions. The electronic surveys were sent to the Health Visitors with a covering letter detailing the purpose of the study, time of completion and highlighted issues of confidentiality and provided contact details of the researcher.

The web link was an inexpensive and convenient use of resources, allowing uniformity by collecting the same set of data from every participant in the study (Green & Thorogood, 2014). The survey offered flexibility as it could be completed at a convenient time (Parahoo, 2014) and place allowing more information from a broader range of participants than would be possible using semi-structured interviews alone.

The researcher was aware that a disadvantage of using a survey was the possible low response rate if participants failed to engage and complete the form (Saks & Allsop, 2013). To offset this issue, the researcher attended staff meetings to explain and justify the research methods with information leaflets and flyers, which helped to gain support from the groups. Health Visitors were assured of the anonymity of the online surveys, as there would be no face-to-face contact or interactions with the researcher.

Health Visitors had an initial period of four weeks to complete the survey. However, due to the low initial response rate, the timeframe was extended to a total of four months. Due to the challenges the Health Visitors were facing in their practice, setting aside time to

complete the survey was difficult. Emails were sent at monthly intervals reminding the Health Visitors to participate in the survey.

3.17.2 PHASE 2- SEMI-STRUCTURED INTERVIEWS

Interviews are a standard method of data collection when obtaining information from people. Nunkoosing (2005); Brinkmann and Kvale (2009) acknowledged that interviews set an equal partnership and power dynamic which was important in this instance. To facilitate feelings of safety and confidentiality, the Health Visitors had the option to have their interviews at either the NHS Trust or University premises whereby offering them a choice.

Semi-structured interviews were used to explore emergent themes arising from the Phase 1 survey responses and to formulate open-ended questions that went to the heart of the research study. The open questions allowed the participants the opportunity to discuss in their own words the issues around domestic abuse. The researcher considered the format, order, and content of the questions with indications of how to word the questions carefully to elicit an open response.

Semi-structured interviews allowed the exploration of complex and sensitive issues and provided scope for the researcher to prepare the participants for difficult questions (Creswell, 2014). Although the researcher wanted to allow the participants the freedom to talk openly, it was important to ask some specific questions during the interview that focused on the study and research questions. The researcher was flexible enough to listen to the responses given by the participants and to probe for more in-depth responses based on the information provided. The interview also gave the opportunity to add supplementary information based on responses gained from verbal and non-verbal body language. This flexibility had the advantage over using the survey method of data collection alone.

Regarding selection, the Health Visitors were offered an interview if they agreed to participate in the study and met the inclusion criteria. Appendix (*11 & 12*) gives examples of some of the questions asked during the interview. The researcher was conscious that the quality of the data would directly depend on the skill and ability of the interviewer, as the interviews allowed the researcher to identify subtle changes in the behaviour of the

participants that could indicate that there were issues that required probing for further details.

A possible disadvantage of using semi-structured interviews was that the interaction between the participant and the researcher could directly affect the outcome of the interview. Due to the sensitive nature of the questions asked, the researcher would be required to engage very quickly and to use communication skills to quickly build a rapport with the participants (Creswell, 2013). The researcher interviewed each participant personally as opposed to using multiple interviewers. Experience as a Health Visitor gave the researcher the ability to engage and build a rapport, which was a skill required in this instance. The researcher was conscious of building a rapport very quickly with the participants as the quality of the data depended on it (Green & Thorogood, 2014).

The attitudes and opinions of the participants were essential, so the researcher tried to engage in relaxing the participants using open body language and open questioning. The researcher was accustomed to having difficult conversations due to previous experiences as a Health Visitor and a current educationalist. Open questions were asked using verbal and non-verbal communication (nodding, eye contact) to engage and build a rapport with the participants. Ten Health Visitors agreed to participate in Phase two of semi-structured interviews. Each interview lasted up to 60 minutes.

3.17.3 PHASE 3- SEMI-STRUCTURED INTERVIEWS

Listening to responses following Phase 2 interviews (n=10) allowed the researcher to further develop the interview questions into ones that were able to probe more challenging, in-depth issues. In Phase 3, the revised interview questions were used with an additional 11 Health Visitors who met the inclusion criteria. Each interview lasted up to 60 minutes. Saturation had been reached once it appeared that no new information was forthcoming (Kumar, 2014: 248).

3.18 DATA ANALYSIS

The semi-structured interviews were conducted throughout a three-month period. The Phase 2 interviews were transcribed following each meeting with the participants, allowing familiarisation of the data. Following the transcription of ten interviews, the interview questions were amended (Phase 3) to include issues raised by some participants that the researcher had not listed. This included questions about same-sex- relationships, male victims, and interpreters.

The researcher transcribed several of the recordings *verbatim* to get a sense of the emerging data. A reputable and authorised audio typist familiar with reproducing confidential health data transcribed the remaining recordings. Once completed, the researcher uploaded all transcripts to the data analysis tool 'MAX QDA' which was password protected.

Thematic analysis was undertaken using Creswell's (2009) principles to guide the process (Appendix 15). Following the completion of each transcript they were read and re-read several times, so the researcher became familiar with the data and could identify important issues (Creswell, 2013). Preliminary notes were made alongside the data to increase the focus and to establish an initial understanding of the data from the perspective of the participant. Following this process, line by line coding progressed from descriptive coding through to a level of data-led interpretative coding (Creswell, 2013). Coding aimed to identify key themes, issues and meaning from within the data thoroughly and systematically (Creswell, 2013). The researcher was able to engage with the data and establish its meaning from the participants' perspectives, combining emergent themes and sub-themes. The researcher used an inductive approach so that the data 'spoke for itself'. Each question was considered individually during this process to identify question-specific elements, sub-themes and inter-relationships between the two research questions. A narrative approach was used to explain the concepts of each theme and sub-theme using the participant's words to tell the story of how they ask women about domestic abuse and the subsequent support provided. The participants were able to explore factors that influence their practice, decision-making, and support provided to clients. Additionally, participants were able to provide information about their education and training around domestic abuse and to suggest areas for further development.

The themes provided a summary of the data with the researcher initially choosing all the extracts from the data that answered the research questions. The researcher's assumptions and perspectives were put aside to allow the data to speak for itself to relay the viewpoint of the Health Visitors who participated in the interviews. A purposive sample of extracts relative to the theme was taken to ensure that participants' viewpoints contributed and made an impact. The researcher scrutinised each extract several times before making a final choice for presenting the theme or subtheme in the analysis and findings chapters.

CHAPTER FOUR: FINDINGS AND DISCUSSIONS *(RQ1)*

The analysis of the transcripts produced rich data concerning the Health Visitors' accounts of how they work with families. The findings and discussions of the survey and semi-structured interviews are presented in two chapters: chapters 4 and 5. Chapter 4 section one will address research question one (*RQ1),* chapter 4 section two will address the subsidiary question *(SQ1a)* and chapter 5 *(RQ2)* to enable a discussion of the interrelationship of the issues identified. The analysis of the two data sets that comprised the research is presented in each chapter.

4.1 CHAPTER FOUR: SECTION ONE

Chapter 4 section one addresses research question *(RQ1):*

RQ1: What are the influencing factors that affect the ability of Health Visitors' to 'confidently' and 'competently' ask about the occurrence of domestic abuse as part of their routine enquiry?

Chapter 4 section two addresses subsidiary question *(SQ1a):*

SQ1a: How do Health Visitors' make decisions about appropriate courses of action to ensure the safety of the clients?

In attempting to answer these questions, the researcher will draw on the survey data and the transcripts from Phases 2 and 3 (semi-structured interviews).

In addressing ***(RQ1)*** four key themes emerged with accompanying sub-themes and in ***(SQ1a)*** one key theme emerged ***(Table 4.1).*** These are examined in turn and illustrated with quotes in the sections that follow.

Table 4.1: Emergent Themes

Section One (RQ1)	
Theme 1: The opportunity to conduct routine enquiry (4.2)	
Sub-themes:	• The skill of engaging with women (4.2.1) • The ability to choose the right moment (4.2.2)
Theme 2: The identification of domestic abuse (4.3)	
Sub-themes:	• Explicit and subtle signs of domestic abuse (4.3.1) • Issues of disclosure and non-disclosure (4.3.2) • Why women stay: what choices do they have? (4.3.3)
Theme 3: Barriers to routine enquiry (4.4)	
Sub-themes:	• Cultural competence (4.4.1) • Lost in translation (4.4.2) • Policy induced limitations (4.4.3)
Theme 4: Health Visitors' silent views (4.5)	
Sub-themes:	• Personal experiences, values and beliefs (4.5.1) • Empathy, frustration and vicarious trauma (4.5.2) • Support mechanisms (4.5.3) • Health Visitors' views about safety (4.5.4)
Section Two (SQ1a)	
Theme 1: The escalation of concerns (4.6)	

4.2 THEME ONE: THE OPPORTUNITY TO CONDUCT ROUTINE ENQUIRY

RQ1 asks about the influencing factors that can affect the ability of Health Visitors to ask about the occurrence of domestic abuse. While there is a consensus about the importance of Health Visitor's ability to conduct routine enquiry, two sub-themes emerged.

The following discussions are drawn from Phase 1, 2 and 3 of the survey and semi – structured interviews and identified one theme and two sub-themes:

Table 4.2: Emergent Themes:

Theme 1: The opportunity to conduct routine enquiry (4.2)	
Sub-themes:	• The skill of engaging with women (4.2.1) • The ability to choose the right moment (4.2.2)

<u>Theme 1: The opportunity to conduct routine enquiry</u>

<u>Survey responses</u>

Survey responses comprised a combination of open and closed questions. Here it can be seen that participants viewed routine enquiry as part of their role. From the survey, 22 participants (81%) declared that they 'strongly agreed' and the remaining five 'agreed' with the NHS Trust policy of routine enquiry. Furthermore, most participants (92%) confirmed that they routinely enquired about abuse. This viewpoint reinforced the responses to the open component of the survey. Typifying this outlook, one participant noted:

> *Hearing the stories of survivors of DVA makes you realise how important it is that we ask about abuse and letting people know it is not their fault….it takes time for people to leave a controlling partner. P1: P2*

All 27 participants either agreed (n= 10) or strongly agreed (n= 17) that they felt confident in asking women about domestic abuse. Participants either agreed (n= 11) or strongly agreed (n= 16) that they felt competent in asking about domestic abuse. Findings

demonstrated that all participants had been asking women about domestic abuse, with a third of participants enquiring about domestic abuse for a period spanning 11- 20 years. Six participants explained that the frequency in which they routinely asked about abuse gave them confidence in carrying out this part of their role.

Out of 27 participants, 17 (62.9%) asked about relationships in general when introducing the question of domestic abuse. 14 (51.8%) participants talked directly about abuse, and in demonstrating their knowledge about domestic abuse, participants (n= 9) spoke about emotional abuse and (n= 6) about physical abuse:

> *'I am sorry if this doesn't apply to you, but as part of our routine questions, I need to ask if you have ever been a subject to domestic violence'... 'Domestic violence can be both physical or emotional, but there is help at hand, and your information is safe or is shared with us and other professionals who may be able to help in order to provide safety for you and your children'. P1: P5*

Out of the 27 survey participants, two mentioned financial abuse and the range of abusive behaviours that can be experienced by victims:

> *We ask all women that we are working with about their physical and emotional well-being, and if their partner is supportive and whether he has ever hurt her, is controlling or withholds money from her. P1: P6*

<u>*Findings from interviews*</u>

Participants gave accounts on how they lacked confidence in asking about domestic abuse when first qualified as Health Visitors.

> *When I first qualified [and] when I was a student, I used to fear asking the question P2: P4*

> *At first, I felt quite uncomfortable, but now I would ask the direct question. P2: P6*

However, with experience and frequency of routinely asking about domestic abuse, the fear and discomfort appeared to diminish:

> *I think just general life experience; it's given me the confidence you know and experience to be able to talk about sensitive subjects. P3: P11*

We are asking the question every time we see them; this is our normal work when we see them in the clinic or at home. P2: P3

Through experience, participants developed ways to routinely enquire about domestic abuse with confidence. Participants can be seen to ask general questions related to women's relationships, whilst others were more direct in their enquiry:

You adapt, I usually say something like 'how is your relationship, how long have you been together, how would you describe the relationship?' P2: P2

'How is your relationship with your partner?' and 'have you ever had any violent relationships with anybody?'. P3: P6

While I am there, I'll do some work on healthy relationships and then parts on domestic violence. P2: P2

I normally say, 'do you at any time feel threatened by anyone?' P2:10

In summary, participants agreed with the policy of asking clients about abuse at each contact if it was safe to do so. However, findings suggest that some participants lacked confidence when first qualifying as a Health Visitor and when enquiring about abuse. It appeared that with the frequency in which they asked questions about abuse, participants soon developed confidence and competence in carrying this out. Through experience, participants demonstrated their knowledge of physical, emotional and financial abuse. Experience was identified as a key factor, which then raised the question as to whether newly qualified Health Visitors are adequately prepared to undertake routine enquiry as part of their role?

Discussion

All of the Health Visitors in this study agreed that routine enquiry was an essential part of their role, reflecting guidance by the Department of Health (2017). However, one of the influencing factors that may affect Health Visitor's ability to enquire about domestic abuse routinely, was around their own confidence in raising this sensitive issue. The current study found that when Health Visitors were newly qualified, their inexperience resulted in a lack of confidence to ask about domestic abuse routinely. It is possible that these results do not represent the views of other newly qualified Health Visitors; however, the issue of

preparedness requires further consideration due to the impact this could have their ability to carry out routine enquiry and has implications for their initial training.

The results of this study support the idea that to develop confidence in routine enquiry; Health Visitors must be able to gain experience in asking about abuse frequently so that it becomes embedded in their routine work. These findings suggest that when introducing student Health Visitors to the concept of routine enquiry, they are given numerous opportunities to observe, practice and reflect on how they broach the subject with women in order to develop their skills in this area of work. This finding is consistent with that of Baird *et al.* (2017) who suggests that increased frequency in asking about abuse meant practitioners had more opportunity to build their confidence in this sensitive area of routine enquiry. The education and training of Health Visitors must ensure they are adequately prepared to undertake routine enquiry. Through education, the Health Visitors can develop their confidence and competence in the area of routine enquiry on qualifying as suggested by Gutmanis *et al.* (2007) and Beynon *et al.* (2012).

Experienced Health Visitors, in contrast showed that they were able to develop and adapt their practice in how they introduced the topic of abuse, with some cautiously asking clients about relationships in general, whilst others felt confident to ask more direct questions. Health Visitors in the study did not assume that women would be able to identify signs of abuse and understood the importance of providing information to clients. Confidence and experience were central themes. They perceived that being able to give detailed accounts of types of abuse would enable women to both have a better understanding, and to identify, if abuse was present in their relationships. However, Health Visitors will only be able to provide this level of detailed information if they are knowledgeable and can explain the different types of abuse by giving examples that clients may recognise as reflecting their own experience. The findings of this study suggest that Health Visitors must be allowed to refresh and extend their understanding in terms of the types of domestic abuse, and to practice their skills of routine enquiry. These findings support the idea of Coker et al. (2002), who suggested that through routine enquiry, health professionals can promote better outcomes for overall health and well-being. Regular updating then will allow

practitioners to reflect and update their knowledge which will then influence their confidence and future practice.

4.2.1 THE SKILL OF ENGAGING WITH WOMEN

It is recognised that Health Visitors having access to the family at home, allows for a more holistic assessment of the environment and interaction between the family members and that this can contribute to the early recognition of domestic abuse. The Health Visitor's role requires them to be intrusive, but in a non-threatening way that does not make the clients feel unduly questioned. Participants explained how they used their skills to build a rapport with mothers paving the way to ask about domestic abuse. When considering factors that could influence the Health Visitor's ability to ask about domestic abuse, consideration should be given to both the women's verbal responses but also their non-verbal cues. This sub-theme explores how Health Visitors use their intuition to enhance their assessment skills when identifying if women are suffering from domestic abuse.

Findings from interviews

The Health Visitor role is unique; they are invited into the home as 'professional guests' to offer a service to families with children under the age of 5 years:

> *I tend to go and introduce the Health Visiting service because some of them didn't get that antenatal visit, so they wouldn't know what we do. I sort of emphasise the fact that we are not just here for the baby but also for the family. P3: P2*

> *I don't suppose I've come across anyone that's not been willing to have a Health Visitor in the house……I suppose I've been quite lucky. P2: P9*

All participants were clear about their role and were quick to explain the boundaries that exist within their remit:

> *…. As I am going in, I'll be kind of like looking because I have no right to go into their rooms or anything. I'm not social care. P3: P5*

> *I mean you are a stranger in their home, regardless of what's going on you've been invited there, it's not your right to be there, so you have to build a healthy relationship so that the woman trusts you and feels able to talk to you. P2: P5*

Health Visiting is not statutory. If they don't want to take up the service, then they won't take up the service. P3: P4

You can't impose, you can only advise and do the best you can under the [NHS] Trust guidelines, so you're limited. P3: P3

'*The dance of engagement'* was a term used by some participants who identified this as the way they quickly developed a rapport with mothers. One participant spoke about a virtual 'dance' that appeared to take place between the Health Visitor and mother that kept them engaged in services.

Doing this dance with your client… making sure they continue to engage… P3: P4

It's like a dance! … you are sort of dancing with them but making sure they continue on [with] that dance… P3: P4

The participants explained how they made attractive offers to the mother by keeping them informed of what is available within the Trust that could benefit their baby. They also offered praise in terms of the mothers parenting skills to establish a rapport so that the mother would be relaxed during the client contact.

You offer things, you know [about] the service… 'we got the baby massage, would you want to come? Oh, it's really nice you know'. P3: P4

I'll try to be really positive and praise them for something…. about how amazing their children are or isn't it great the baby is doing well… P2: P2

One of the participants expressed her anxiety about the importance of keeping the mother engaged in the services. Knowing that the Health Visiting service is not statutory, meant that at any point the mothers could choose not to allow access to the family or the family home. This suggests that if Health Visitors can build a rapport with the women, they were more likely to allow access:

… I don't want someone to say, 'we're not taking up the Health Visiting service'. P3: P4

You don't want to make them stop using the service, so you want to make sure that they continue using the service because this is the only way you have access to that family, safeguarding the child... It can be very difficult; it's making it attractive for them to stay on… Not scaring them away. P3: P4

There was often a delicate balance between developing a trusting relationship, keeping the mother engaged, escalating concerns while keeping lines of communication open:

> *You do have to be careful because if you slip up on that road, you may never get back in the home. P2: P5*

> *Just keep those lines of communication open…I'm letting her know the options that she has so that when she feels ready to open up and tell me, she knows how to contact me. P2: P6*

Participants developed enhanced skills of engaging with women that were akin to '*walking on eggshells*' to try and keep the home accessible where they are invited in as 'professional' guests. Here participants described the different ways in which they kept the clients engaged with the service. In choosing their moment participants sometimes *'walked on eggshells'* to maintain the professional relationship:

> *You need to keep the relationship healthy, you don't want to push the mum away from you by being intrusive, but at the same time, you need to make sure that she's aware that it is an open-door policy and she can come to you if she needs to. P2: P5*

> *I suppose you can be curious as a professional and ask salient questions, but at the same time, you don't want to break that relationship down. P2: P5*

Participants were clear that their role was to support the women regardless of the decisions they made in terms of remaining in the abusive environment. Being non-judgmental appeared to be a key component in meeting the needs of the women. Also, a shoulder to lean on and someone to talk to was suggested by participants as an integral part of their role:

> *… I said, 'what do you want me to do for you, how can I support you?' P3: P6*

> *I want to help her as much as I can. I want to give her all the support, so she can have a really good life as well as her children…. P2: P3*

> *You have to be there to say to them 'you didn't know any better'… you have to support them… Because the majority of them do feel guilty as to why they have let themselves[get] into that type of relationship. P2: P3*

Participants supported women in a variety of ways. Here participants are seen making themselves available to their clients. Offering help in a variety of ways demonstrated the

important role they played by being available to clients who may not have support networks available to them:

> *I would leave my mobile number… and just say you can always contact me, text me if you need anything in general… we have to support you. Not only for the baby but for the mum and the family. P3: P2*

> *I think they are actually very grateful sometimes maybe it's the only lifeline that they have, and I think it's really important because I think they need to know that there is somebody that they can approach. P3: P10*

> *It's not just straightforward cases, the complex cases, those who need us most is the most important thing to me... Being able to be there for them is the most important thing. P3: P9*

In summary, the fact that Health Visitors are invited 'professional guests' into the family home makes this a unique role considering they do not have statutory rights to enter. Findings suggest that people are willing and prepared to take up the Health Visiting service with practitioners developing ways in which to build a rapport and to keep lines of communication open. Having a non-judgmental attitude and a supportive approach allows Health Visitors to offer a service to families. This raises the concern around Health Visitors who are less experienced and less able to use skills such as the 'dance of engagement' or 'walking on eggshells' whilst trying to maintain lines of communication. If so, how do they develop these skills?

Discussion

Donetto *et al.* (2013) and the Department of Health (2014) have highlighted the distinctive characteristics of the Health Visiting role is around the holistic support given to families. Entering the home was an opportunity to introduce the Health Visiting services and to highlight the health promotion and prevention focus of the role. However, Health Visitors were clear that they do not have statutory rights and were aware of their limitations regarding being a 'professional guest' in the family home. Health Visitors were aware of the importance of developing relationships with women before sensitively asking about abuse. Demonstrating their experience was by maintaining a professional relationship with a flexible approach to the clients' during home visits to offer advice and support. This study found that participants developed a rapport with women while holistically assessing the

family's needs. The skill was to gather information while not appearing too intrusive but still asking pertinent questions and building a rapport.

The ability to build a rapport cannot be over-emphasised as this allows the development of a professional relationship, one where the women are more likely to accept questions about domestic abuse when they feel a connection to the Health Visitor. These findings suggest that if Health Visitors are unable to build a rapport, this could influence their ability to routinely enquire about domestic abuse and effect how openly women will respond. As an essential component, practitioners must have the skill of building a rapport with women in a short period of time. Their inability to do this will impact on their ability to ask about domestic abuse. This is an issue to be raised during training sessions so that Health Visitors can share experiences in how they develop a rapport with one another thereby building their skills around this important quality.

Consistent with the literature, Health Visitors in this study were able to build a rapport with their clients and identified this as the basis of being able ask about domestic abuse, as suggested by McCarthy *et al*. (2017). This finding broadly supports the work of other studies in this area that links rapport-building with practitioners feeling comfortable in asking about domestic abuse (Stöckl *et al.*, 2013). If Health Visitors are not able to develop a rapport, this is likely to have an impact on their ability to routinely enquire with the likelihood that women are less open and honest in their responses. Building trust and rapport is particularly crucial for women to feel comfortable to disclose abuse within a relationship (Usta *et al*., 2012). It is essential to consider how Health Visitors develop and establish a rapport with their client group and there are clear implications for any education and training programmes. Health Visitors need to be allowed to have open discussions in how they build a rapport, engage with clients in order to build a trusting relationship. There are additional barriers in developing a rapport and building trust when women do not speak English; where an interpreter (as a third party) is present; or where the client is hostile towards the service or when there are cultural influences. Each of these issues will be examined further in sections *(4.4.1 and 4.4.2).*

Turning now to an interesting finding, in which the Health Visitors described how they 'walked on eggshells' to maintain their continued entry into the clients' homes. Previous

studies have not explored the issue of ‘walking on eggshells' in much detail, but these findings appear consistent with research by Entilli and Cipolletta (2017) who denoted the phrase ‘walking on eggshells’ in regards to victims who were always alert to the next abusive episode. In the same vein, research by Beynon *et al.* (2012) identified the term ‘walking on eggshells’ to health professionals who feared offending women when asking about domestic abuse. These findings explain how practitioners navigate through the process of asking about abuse whilst keeping women engaged with the service. It appears that Health Visitors may not always address the issue of routine enquiry or may avoid asking direct questions in order to maintain the relationship. Either way, Health Visitors must still address the question of domestic abuse so as not to offend women. Explaining that all women are now asked about domestic abuse and that it is a routine question that may go some way in avoiding offence while adhering to the Trust policies in asking about abuse.

Another intriguing finding was that some Health Visitors felt they almost had to create a ‘dance’ with some clients, whereby offering something of value from within the service that allowed practitioners, enabled continued entry to the family home. These results reflect those of Gerbert *et al.* (2000: 330) where a survivor of abuse spoke of how she and the healthcare professional ‘danced around the issue of abuse’ but validated the intervention when the practitioner displayed a non-judgemental and caring approach. Is this a skill that Health Visitors need to develop in carrying out their role? If this is an important skill, then Health Visitors need the opportunity to learn through observing and reflecting on practice with others who can ‘walk on eggshells’ or ‘dance’ around the issue of abuse while demonstrating some of the ways they engage women during client contacts. These findings suggest that education and training programmes should include a discussion around issues of trust and how to build a rapport that keeps clients engaged in the service.

Another important aspect is that Health Visitors highlighted the extent of the supportive aspect of their role. Findings from this study suggest that practitioners made themselves available to be contacted by clients who needed support and advice. In general terms, this placed greater pressure on the Health Visitors to make themselves accessible, and to understand the type of support women were likely to need, within the limitations of their

role. Therefore, Health Visitors must build on their knowledge-base and be aware of resources to signpost and support women.

4.2.2 THE ABILITY TO CHOOSE THE RIGHT MOMENT

Women need the opportunity to disclose abuse within a safe environment and without increasing the risk to their safety. NICE (2016) guidelines suggest that women must be alone when being asked about domestic abuse. Therefore, Health Visitors need to consider the ideal moment to enquire routinely. This sub-theme considers how Health Visitors decide on the right time to ask about domestic abuse within a safe environment.

Survey responses

A minority of the 27 participants (n= 2) said that they used their discretion as to whether they 'might or might not' ask, given the circumstances. From the survey data, 16 out of 27 (59.2%) participants found that asking about domestic abuse and implementing the policy was not difficult to carry out; they used their discretion citing possible reasons for not asking such as: the presence of the perpetrator, family members or visitors in the room. One survey participant suggested that they would not ask about abuse if the partner was present:

> *I would never ask the question in front of a partner. P1: P4*

Participants indicated that the presence of a partner made it challenging to find the right moment when the woman was alone to ask about abuse. Participants provided some insight into why routine enquiry may not be possible:

> *Asking at every contact is sometimes difficult to achieve. P1: P16*

> *It is difficult sometimes to ask appropriate questions when the client's partner is present. P1: P7*

Participants reiterated the notion of safety and the ability to ask questions. They highlighted the conscious decision only to ask questions when the partner was not present. One noted:

> *If it's not safe to ask the question, I can't ask it. P3: P4*

Another commented:

> *If he's there, I'm not asking. P2: P4*

This sub-theme shows that discretion is used to ensure the clients' safety. It provides insight into some of the thought processes participants go through when deciding on the right time to ask about domestic abuse. How do they choose the moment?

> *You introduce yourself, and you make sure the environment is conducive… the client is relaxed making sure when you are asking the question their partner or whoever may be the perpetrator is not around. P3: P9*

> *It's all a matter of using your judgement as to how the situation is…and if it feels right then you ask the question. P3: P3*

> *I wouldn't ask directly if the dad was there, I would just talk more about healthy relationships and relationships in the home rather than ask directly about domestic abuse. P2: P7*

> *[When] she is a bit more relaxed, and then I'll ask her about relationships…. P2: P2*

In summary, the findings highlighted here suggests that not only was routine enquiry a significant issue, but the timing of such enquiries balanced with judgements about issues of risk and safety, was crucial. A lingering question, therefore, is, when is it safe to make enquiries? Are Health Visitors then able to make enquiries at a time they consider risk free and safe?

Discussion

One issue emerging from these findings is the competence of Health Visitors. While the subject knowledge of their role is not in question, there is an additional dimension to the requirement for this role that needs further exploration, namely, the use of soft skills. Although Health Visitors know that they should ask the question in routine enquiry, why do they hesitate to do so? If the underlying reason is a lack confidence in their use of soft skills, one answer that seems rather obvious to Health Visitor educators is the need to develop and assess this skill-set during Health Visitors' training and development.

Another issue relates to timing. Findings highlight the importance of asking about abuse at

the ‘right time’ to make enquiries. There is an overwhelming view that the Health Visitors were aware that there were timing issues that required consideration before broaching the subject of domestic abuse during client contacts. The key question is; how do they negotiate for the right time so that the safety of the women is not compromised? Participants indicated that discretion and professional judgement plays a crucial role in Health Visitors’ decision and their attempt to ensure the safety of women. As such, they were mindful not to ask when a third party was present. This finding is consistent with that of Gerbert *et al.* (2000), who suggested that practitioners needed to develop individual practices when asking about abuse and with experience, and choose their moment when to ask.

As women are likely to conceal the abuse, finding the right time to enquire about domestic abuse supports the notion of routine enquiry. Finding the right time also demonstrates the importance of keeping the women safe by not asking in the presence of a partner. One interesting finding is that some Health Visitors used the opportunity to talk more broadly about a healthy relationship if the partner was in the room rather, than ignore the issue altogether. In this way, the couple were made aware that the Health Visitor could be approached in the future if there were concerns. Therefore, Health Visitors need to develop a professional relationship with their clients. Knowing that this could take more than one client contact, should enable the Health Visitors to use a variety of approaches to ensure they could speak to the women without a third party being present. However, this becomes problematic when there is a limit placed on the number of times that Health Visitors can conduct home visits which will be discussed further in section (*4.4.3*) where Trust policies restrict Health Visiting client contact.

An important point is that of timing, specifically, choosing the right time to enquire routinely about abuse. However how do newly qualified Health Visitors who may lack experience in deciding the right moment to ask about abuse, manage? The issue here is not a question of merely identifying the right time, but whether the practitioners are prepared adequately. The issue to address, therefore, is more of the level of preparedness rather than the ability to remember when to make enquiries. These findings suggest that education and training programmes must include issues around choosing the right moment to ask about domestic abuse, mainly when the partner or a third party is not present, and how to do this without compromising the woman’s safety.

4.3 THEME TWO: THE IDENTIFICATION OF DOMESTIC ABUSE

RQ1 asks about the influencing factors that can affect the ability of Health Visitors to ask about the occurrence of domestic abuse. When asking women about domestic abuse and choosing the right moment in which to do so, Health Visitors must be able to identify signs of abuse particularly if women are not willing to share this sensitive information.

The following discussions drawn from Phase 1, 2 and 3 of the survey and semi-structured interviews have identified one theme and six sub-themes:

Table 4.3: Emergent Themes

Theme 2: The identification of domestic abuse (4.3)	
Sub-themes:	• Explicit and subtle signs of domestic abuse (4.3.1) • Issues of disclosure and non - disclosure (4.3.2) • Why women stay: what choices do they have? (4.3.3)

4.3.1 EXPLICIT AND SUBTLE SIGNS OF DOMESTIC ABUSE

Health Visitors are expected to enquire about domestic abuse routinely. However, when women have been abused, it is recognised that the effect of this can present itself in different ways. Some signs of abuse are explicit and identified through direct observation; however, some women present subtler signs that Health Visitors must also identify.

Survey responses

The survey responses indicated that out of 27 participants, 14 (51.8%) participants could identify when the women were 'controlled' and 12 (44.4%) would note physical signs that would suggest a woman had experienced abuse:

> *Physical evidence, such as unexplained marks or bruising. P1: P21*

> *Unexplained injuries or stories that do not match the bruises or injuries shown. P1: P12*

While the physical signs may be more visible; participants also identified discrete signs such as a lack of eye contact or engagement, as possible indicators that abuse was taking place. Survey participants were able to identify the subtle signs as well as the more obvious signs of domestic abuse. Five participants suggested that when women looked frightened, they could see this in her body language. Seven participants noted that a lack of eye contact or when women were withdrawn indicated signs that made them suspect abuse was taking place. Here participants gave examples of some of the subtler signs of abuse:

> *Lack of eye contact when asking the questions [about abuse], sometimes they do not even realise that they are in an abusive relationship. P1: P21*
>
> *A lack of engagement in discussing domestic abuse… P1: P21*
>
> *… the perpetrator is present and does not let the woman speak. P1: P12*

Participants were able to elaborate and identify other signs that could indicate abuse, as shown in the following excerpts identified in the survey and interview responses:

> *Poor maternal mental health, low self-esteem, lack of confidence. Minimising, denying, isolated from family and friends. Incidents or pattern of incidents. Physical, sexual, financial or emotional abuse. P1: P28*

Findings from interviews

Participants detailed how perpetrators exhibited signs of financial abuse as well as controlling behaviour by limiting the victims' ability to make independent choices:

> *She has no access to the phone as he is controlling the phone. P3: P3*
>
> *He kind of commands and dictates you know… so she cannot do anything or buy anything for herself. P3: P5*
>
> *This husband hid the passport because he was abusing her. He used to lock her up in the house. P3: P3*

Even when in the presence of Health Visitors, the perpetrator can be seen to control the woman's ability to speak freely. One participant remarked:

I've been in to see a client and apparently, she speaks English but every time I speak to her, he would speak, or she would look at him as if to get the go-ahead to speak… I find that controlling. P3: P5

Being aware of the numerous ways that abuse can show itself in a relationship will enhance the Health Visitors' ability to identify it when seen. One participant reported that:

When you bump into them, you stop and chat so maybe you might see some physical signs. P3: P5

Participants demonstrated their knowledge and understanding about the different ways domestic abuse can be seen while also identifying how women may not be aware they were living in an abusive relationship, as shown in the following excerpts:

I did explain what domestic violence is and [that] domestic abuse is some sort of emotional abuse. But she doesn't see it is that. P3: P8

She said that 'actually he was quite good but apart from the fact that he is financially abusing me and stopping me from seeing my family. That was all it was; otherwise, he's a good husband'. P3: P6

If the man is doing a lot of the answering of questions on her behalf, or if you always see the woman and her partner is there, that can sometimes be a bit of a red flag, especially when you know they're working and deliberately made sure they are [both] at home. P2: P5

Participants described a 'sixth sense' or intuition to pick up non-verbal cues to identify domestic abuse:

Sometimes you have to look at the non-verbal communication between partners. P3: P8

This is based on just going in and having a feeling and doing an assessment. I mean I've been into places where I've felt there'd been an element of control. P3: P4

It all depends on what they're telling you, and it all depends on your instinct... because sometimes you have to make a judgement. P3: P8

If the perpetrator is there and you get a sense, you're like… something doesn't feel right, you know, and it's the vibes you pick up, like the aura around someone that you pick up. P2: P9

Further, participants attempt to articulate their ability to notice the subtle signs when 'something isn't right' but could not fully explain this concept:

I don't know whether it's because you see so many people, so many families that you're more in tune and you know when something is not quite right. P2: P10

You have 'some kind of inkling' you know...that gut feeling. P2: P10

It's kind of… your intuition or your… sixth sense. It's strange, isn't it because you can't always put it down on paper. Because on paper actually, everything could be okay. P3: P6

I suppose it comes with practice and experience of being with people, that you get a sense of happiness or not… there is something not quite right there that they're not telling you. P2: P9

In summary, this theme demonstrates that some participants identified the physical signs of abuse such as visible bruising and injuries, but participants also identified how they could sense when there was a controlling element within a client's relationship. A lack of engagement or eye contact required further exploration by the participants. It was found that the constant presence of a partner during the time of the home visit would influence the Health Visitor's ability to ask about abuse and to elicit disclosure.

Discussion

Health Visitors should inform women that all types of abuse are unacceptable as there is always the risk of escalation. However, less than half of the Health Visitors who completed the survey indicated they were able to identify when someone had been physically abused. This is an interesting finding since previous studies have not focused on Health Visitors' ability to identify the signs of abuse as highlighted in the scoping study *(pg 27)*. In contrast to the survey findings, interviewed participants were importantly, able to provide a context, indicating that they were able to detect both the physical and emotional signs of abuse. Therefore, a note of caution is due here, as it is possible that the survey findings may not accurately reflect Health Visitors' ability to identify physical abuse. It is proposed that further research is needed to gain a better understanding of the possible reasons for the non-detection of physical abuse and to ascertain whether this is a broader issue. It is essential to consider how Health Visitors identify women who may be in denial or do not recognise domestic abuse, especially if it involves emotional and financial abuse. Are Health Visitors trained to tactfully ask follow-up questions if they observe subtle signs of abuse rather than

visible bruises and injury? To be able to identify the subtler signs of abuse suggests that Health Visitors require regular updates to discuss the physical, emotional and psychological signs of domestic abuse. Being able to have discussions around experiences would allow Health Visitors to enhance their skills and make meaningful links when encountered in practice.

Health Visitors in the study shared experiences where they witnessed husbands controlling their wives by not allowing her to speak freely and being a constant presence during the client contact. Health Visitors have indicated that the constant presence of a partner would influence their ability to ask about abuse, and to elicit disclosure. Being able to speak to women alone is important as some did not always understand what it meant to be in an abusive relationship and sometimes downplayed the extent of abuse that they were experiencing. These findings are in alignment with those reported by Spangaro, Poulos and Zwi (2011) and Bradbury-Jones *et al.* (2014), who suggested that women needed help and support in identifying a relationship as abusive, as they did not always recognise this. It is essential to consider whether Health Visitors can decide when a partner is genuinely caring and supportive, as opposed to, one who is exerting coercive control during the client contact. Women need to be allowed to have a voice and often require more than one client contact to allow the Health Visitor to speak to the women alone and gain a clearer understanding about any issues in the relationship. However, being able to see clients alone on more than one occasion may be problematic as the NHS Trust policy currently limits the number of client contacts (as highlighted in section *4.4.3).* To meet the needs of individual clients, requires a service that is flexible, one where Health Visitors can make decisions based on their assessment.

Some Health Visitors who were able to identify the less visible signs of abuse, described how they made their initial assessments when meeting families through observing non-verbal cues and ‘reading a visit’. The ability to ‘read’ body language and to listen to their instincts emphasises the complexity of the Health Visitor’s role and how they make sense out of complex situations, as suggested by Ling and Luker (2000). Health Visitors described this instinct as a feeling, or an aura, and could sense when there was a controlling element within a client's relationships that required further investigation. Either consciously or

subconsciously Health Visitors often used this enhanced skill when carrying out a family assessment and described it as ‘having intuition’.

Although they found it difficult to articulate, Health Visitors did not ignore their instincts and often used this to make overall assessments of the home environment. Having a ‘gut feeling’ often led to more probing questions or follow-up visits to speak with women when they were alone. Being able to recognise when there was a possible mismatch between what had been verbalised, and non-verbal body language was a skill some Health Visitors appeared to develop with experience. Some would call it a ‘sixth sense’. Having this ability allowed practitioners to understand more than surface features when communicating with clients; describing it as an aura, an atmosphere, or a look in the women's eyes that could tell a story. A lack of eye contact, low self-esteem and depression are potential signs of domestic abuse that are not to be ignored. Ling and Luker (2000: 577) suggested Health Visitors referred to this as ‘intuitive awareness’. Picking up on non-verbal cues through ‘reading’ a client’s body language and that of her partner provided another level of assessment enabling the Health Visitor to verify their judgement.

The ability to make a quick and accurate assessment using ‘clinical intuition,’ is an essential skill, suggests Schacht *et al.* (2009: 55). The ability to listen and use their instincts can enhance Health Visitors decision-making and develop their ability to ‘read a visit’. Having an intuitive nature could be considered as an essential quality that is required of all Health Visitors as this enhances their ability to carry out ‘holistic’ assessments. However, how can this be developed, identified or even tracked? How can we be sure that Health Visitors have the required intuition? These findings suggest that if intuition is not developed early on in Health Visitors’ careers, this could leave their clients at increased risk of abuse. If intuition is an essential skill that all Health Visitors should have when routinely asking about abuse; what is the effect if the practitioner does not have this ability or is not able to ‘tune in’ when clients have issues with domestic abuse? It is proposed that being able to recognise the subtler signs of abuse and how to ask more probing questions of women during routine enquiry should be an essential component of education and training programmes. Currently, there is little research available that examines this interaction, and suggests that further studies are needed to explore the mechanisms and relationship of intuition in the identification of domestic abuse.

4.3.2 ISSUES OF DISCLOSURE AND NON- DISCLOSURE

When Health Visitors ask women about domestic abuse, the assumption cannot be that they will disclose if there is abuse within the relationship. The next section discusses how women hide abuse and examines some of the reasons for non-disclosure. However, what choice do they have when they are living with an abusive partner who is also controlling them? This sub-theme presents findings around how women decide to hide or disclose the abuse and some of the factors that women consider when making their decisions.

Survey responses

Survey data found that out of 27 participants, 24 (88.8%) indicated that women had disclosed domestic abuse. This finding indicates that if given the opportunity, women may disclose this issue to Health Visitors.

Table 4.4: Number of disclosures

Number of disclosures	**None**	**1-5**	**6-10**	**11-15**	**16-20**	**21-25**	**31 or more**
Number of participants	3	11	7	2	0	2	2

When asked about their initial thoughts when a client discloses domestic abuse; participants can be seen to empathise with the women while expressing concern about their safety and wanting to provide support. One practitioner appeared to understand how difficult it was for women to disclose the abuse by identifying them as 'brave':

> *Relief that she is might be willing to seek help. P1: P25*
>
> *Empathy and understanding, wanting to help in whatever way I can in a professional capacity. P1: P21*
>
> *The client is very brave to admit this. P1: P20*
>
> *I feel sad for the client. Worried about what may happen to the client and children while putting support in place. P1: P18*

Participants were asked 'in cases where you suspect domestic abuse is occurring in a relationship, but the woman does not disclose this information, how do you manage this?' The following excerpts are typical of the responses:

> *[I]Try my best to develop the relationship and hope she will feel comfortable and free to discuss domestic violence. P1: P30*
>
> *If the woman doesn't disclose the abuse, but I suspect it is happening, I accept what has been said but offer other opportunities to talk further. Assessing the immediate safety of the woman, child or children is paramount. P1: P27*
>
> *…building a good working relationship and providing her with as many opportunities as possible to disclose to me. P1: P21*
>
> *I would try to engage with the mother and family to build up a relationship, so she could feel able to disclose. P1: P12*

Findings from interviews

The NHS Trust policy and NICE (2016) guidelines suggest Health Visitors need to ask about domestic abuse at every client contact if it is safe to do so. However, participants were aware that women might require several opportunities before trusting the Health Visitor enough to disclose the abuse.:

> *They have been asked so many times before they will admit it… The chance of them actually telling you after knowing you for a short period of time is really remote P2: P5*
>
> *It's taken several visits before that trust has built up… P3: P10*

Carrying out routine enquiry at each client contact will alert the mother that Health Visitors are interested in their wellbeing and are professionals they can trust. Participants were aware that unless women trust the health professional, she is unlikely to disclose the abuse.

> *You have really got to try and build a foundation so that she feels comfortable to talk to you. P2: P5*
>
> *If they build a relationship with you, they may feel 'now I can open up to these people', and it's all through raising awareness as well. P3: P3*
>
> *Sometimes it may take a while, but they normally open up to you and accept your help. P2: P7*

The level of disclosure at client contacts was found to be variable. Interviewed participants reflected on their experiences, and some of the potential barriers that a woman faced that may prevent her from revealing domestic abuse:

> *I do not know if that man hit her again if she would ever divulge. P3: P4*

> *I arranged a follow-up home visit when he wasn't there... initially she did not want to disclose anything. P3: P3*

> *It's very difficult for them to disclose a lot within a home environment. Sometimes I will ask them 'can we meet in the clinic?' or 'can we meet at the children centre?' P3: P8*

> *When they're disclosing, it's more like, how could I explain…. it's more like anxious behaviour… they're actually saying, 'I'm frightened'. P2: P10*

Participants described how women ignored, minimised or retracted their disclosure by making excuses or denying the abuse:

> *I think she knows deep down that she is a victim of domestic violence, but she cannot acknowledge it, because if she acknowledges it, then she is going to have to do something about it and that I do understand. P2: P2*

> *They're not disclosing it… we know that violence is going on, but they are making excuses for what is going on. P3: P8*

> *She will disclose a bit and then she retracts it, and it's almost a bit like a cat and mouse sort of game. P2: P8*

Interviewed participants revealed that some women appeared to feel regret or guilt about disclosing the abuse, displaying anger and hostility when the abuse was identified; changing their admission and retracting the disclosure.

> *For me, the hardest to ask are the hostile ones. Hard to reach and hostile. P2: P2*

> *Mostly they're quite responsive but some of them are not, and they're quite angry. P2: P10*

> *I've got a couple of clients that are angry with me for disclosing it. P2: P8*

Participants demonstrated their understanding of how difficult it was for women to disclose but then highlighted limitations within their role in accessing the home and asking about abuse:

> *I just understand that people are different and she's not ready to disclose now. P3: P4*

> *It's really challenging when it's those kinds of situations because you can't just visit them indefinitely in the hope that one day, they will tell you. P2: P5*

In survey findings, very few of the women talked to family or friends in response to verbal and physical abuse. However, this contrasted with participant responses during the interviews that highlighted family and friends were often the first to identify when something was 'not right' within the relationship or recognised changes to the woman's demeanor and personality. When family and friends identify abuse, they are mainly seen to be protective and supportive of the women:

> *Families sometimes do phone anonymously and say, 'I've got a feeling she's been beaten up by the husband.' 'He is not nice to her, and there is financial abuse going on, which can lead to other forms of abuse'. P3: P3*

> *We have had a situation where somebody's sister actually did phone in and say, 'I'd like you to keep an eye on my younger sister because I've got a feeling she's been subjected to abuse, keep it anonymous but keep an eye on her'. P3: P3*

> *She came with a friend of hers who was supporting her and then it was her friend who disclosed… P3: P11*

In summary, women are not likely to disclose domestic abuse initially but must feel a sense of trust in the Health Visitor before they share their experiences. Although participants were aware of the different reasons' women may not want to disclose, they knew there was a limit to the number of home visits they could offer even though they suspected abuse could be taking place. Participants felt they had a professional responsibility to carry out their role in the identification of abuse despite the difficulties in eliciting disclosure.

Discussion

Health Visitors demonstrated that they understood why it often took many occasions before women felt they could trust and disclose the abuse. However, with women frightened of sharing information because of the possible consequences; a lack of trust was a barrier to women disclosing the abuse. Practitioners were aware that some women would never divulge the abuse and that victims of domestic abuse were likely to feel a sense of shame. With feelings of shame, self-blame and guilt, women often go to great lengths to hide the abuse and are reluctant to talk to Health Visitors about it (Peckover, 2003). Feelings of shame were echoed by Bradbury-Jones *et al.* (2011) as abused women felt a sense of self-blame and low self-esteem that ultimately affected their self-worth.

Overall findings suggest that women may disclose domestic abuse if given the opportunity to share this information when they are ready to do so (Bradbury-Jones *et al.*, 2014). Health Visitors demonstrated their empathy; understanding that often women are frightened due to the increased risk of harm and had real concerns about the safety of their children and the risk faced if the perpetrator found out about the disclosure. Health Visitors explained the difficult position they were in professionally when women disclosed the abuse but retracted the statement later. It is important to consider how Health Visitors are expected to support women when the abuse is minimised, or they choose to accept it exists. Practitioners explained how they responded to retracted admissions of abuse by focusing on building a rapport and keeping the women engaged with the service.

Concerning the first research question, findings demonstrated that women might disclose incidents of domestic abuse if given the opportunity to do so (Bradbury-Jones *et al.*, 2014). These results reflect those of Spangaro *et al.* (2011) who also found that when women felt they had a choice, and asked about abuse by a trusted person, they were more likely to disclose. However, the time frame associated with women's decision to disclose was found to be variable and dependant on a range of circumstances that might delay or prevent disclosure altogether. Health Visitors were aware that non-disclosure did not mean the abuse was not taking place or that women were content to remain in the relationship. Therefore, attention needed to be given to the individual circumstances for each client, with the Health Visitor providing numerous opportunities to discuss domestic abuse and to encourage disclosure. This finding confirms the association between routine enquiry and

disclosure, which allows women to break their silence surrounding domestic abuse and is consistent with a study by Baird *et al.* (2017) which highlights the benefits of routine enquiry. This finding therefore, emphasizes the continued role of Health Visitors and routine enquiry.

According to Mauri *et al*. (2015), women have indicated that continuity of care is the best way to build up a trusting relationship and were more likely to disclose abuse. Having the confidence to build trusting relationships when they first met the women was a skill that came with practitioners' experience (Rose *et al*., 2011). Participants emphasised the importance of building relationships and raising awareness of domestic abuse so that women had the information that they could use when ready to make decisions about leaving the abusive relationship. Building trust requires the confidence to form a connection with women and to develop a professional/client relationship.

This study confirms the value of routine enquiry; the suggestion is for the policy makers within the NHS Trust review the length of time it can take for women to disclose abuse and keep themselves safe. An evaluation of Trust policies should be undertaken in order to reappraise current arrangements in terms of the number of face-to-face individual client contacts based on a health needs assessment. The Health Visitors require the autonomy to carry out their assessment and decide on the number of visits required based on the needs of individual clients. These findings reflect those of Spangaro *et al.* (2011), who also found that providing women with multiple opportunities to disclose, increases the likelihood of a disclosure.

Being able to build the Health Visitor/client relationship is fundamental to eliciting disclosure. However, even when women disclose the abuse, some retract their statement when they become frightened about the potential consequences. Women who are controlled, fear an escalation of harm if the perpetrator becomes aware of the disclosure, and planning to leave the abusive relationship, can create real fear (Francis *et al*., 2016). Therefore, when women display behaviour that is hostile or angry; or when they retract statements of disclosure or minimise the abuse, the Health Visitor needs to consider the reasons behind this behaviour. NHS Trust policy needs to guide how Health Visitors should manage these situations without leaving themselves open to increasing the risk for women

in their care. There should be a procedure that Health Visitors can follow when women retract their disclosure. In this way; Health Visitors will have clear guidance in how to support women.

Study findings also showed that some women blamed themselves for the abuse and wanted to avoid upsetting their family if they chose to leave the abusive relationship. Health Visitors have a role to play in providing reassurance and support to women and where possible finding out if there are family members who could play a supportive role rather than an accusatory one. Family and friends are often the first to see the signs of abuse or be told about the abuse (Fortin *et al*., 2012). This study showed how family members could have relevant information regarding the abuse that has taken place. Where possible, Health Visitors need to harness the support of close family and friends when exploring ways to elicit disclosure. Consideration is given to family and friends with the support they could offer as another way of keeping the family safe. However, the Health Visitor needs to consider that families can also be involved in the abuse and need to be mindful that including the family has to be with the full consent of the women involved.

When building a rapport and gaining the trust of women, discussions around the role of friends and family members, it would be useful in finding out the support networks women may have, with the focus around keeping the victim safe from abuse. Evans and Feder (2016) suggested that families may be able to offer practical solutions such as financial support or care of the children while friends could provide more emotional support. These findings should help to raise the profile of the larger family unit and how they may assist in providing further support for the abused women and possibly, help in the disclosure of abuse. However, involving families carries risks if they take the side of the abuser. Family members may also encourage women to leave the relationship before being fully prepared and ready (Evans & Feder, 2016). Therefore, Health Visitors require training in how to harness the support of trusted friends and family in keeping the victim and children safe with the women's consent.

4.3.3 WHY WOMEN STAY: WHAT CHOICES DO THEY HAVE?

Women who have been abused but remain in the family home may appear to do so through choice, however when exploring this issue in more detail, there are complex issues underpinning the difficult decision of deciding to stay or leave the relationship. The observations by the Health Visitors showed that they were very aware of the underlying reasons and the issues that the women faced.

Survey responses

Participants appeared to understand women's reluctance to acknowledge the abuse, which would require them to make decisions about leaving the abusive relationship. Participants demonstrated insight into some of the reasons that women may not want to leave the abusive relationship, as indicated in the following excerpts:

> *Lack of financial support… the safety of the children. P1: P28*

> *They feel that it is their fault, wishing he will change, they do not want to split up the family unit and deprive their children of a father. Another big factor is money; many mums are unable to manage financially. P1: P21*

> *Fear of losing children... housing, financial and immigration constraints. Fear of upsetting her family and friends. Fear that her children will be upset with her. Fear that he will harm her further… control and manipulation. P1: P20*

> *Financial hardship, lack of confidence and self-esteem…loneliness. No friends or family support or despite having friends and family being ashamed to confess to domestic violence... P1: P5*

Findings from interviews

Participants described their understanding of why women may be resistant to leaving abusive relationships:

> *Women from all sorts of backgrounds, ethnicities, social class. We know that domestic violence goes across all the ages. Why some women decide to stay in that relationship… we may never know that? It could be financial reasons, it could be just the control, it could be cultural, it could be the sham of a marriage breaking down… a relationship breaking down. P3: P10*

At the end of the day, it's their choice. Having said that really, it's not their choice because there are a lot of factors involved. P3: P2

Participants were aware that the level of abuse could escalate when women were planning to leave the relationship. Participants expressed their concern and were careful in not directing the women to leave the relationship but to offer them support:

You obviously know that if you tell them 'you should be leaving' that puts them at the highest risk of something terrible happening, so it's got to be them. I can help them and assist them as much as I can, but I can't tell them what to do, it's got to come from them. P2: P6

The client is potentially ready to ask for help and leave the relationship. This places her and the children at their highest risk of harm. The next steps for the professional are crucial for her safety. P1: P20

Participants explained that women stayed in abusive relationships for a variety of reasons. The difficulty for women was often that they did not have anywhere else to go:

[women have said] 'I've got my passport, but the challenge is I don't have anywhere to go, I don't have any family around here'. P3: P3

When some women are brought into the UK, abusive husbands often keep them isolated from their communities. This places the women at increased risk as they are totally dependent on their husbands who may exert control over them:

Some of them [women] came [to the country] illegally, and they don't have any documents, so they are at the mercy of the man. P3: P1

Women who have no recourse to public funds may be at increased risk of domestic abuse. A lack of money meant that these women felt they had no option but to remain with an abusive partner:

A lot of 'no recourse' mums, they haven't got access to their own money… It's tricky. P2: P6

Despite having an insecure immigration status, women were unlikely to be aware of services they could access for advice and support:

There is access to public funds… People feel that maybe I can't go and report this to my GP or to whoever because not having papers or access to public funds kind of limits them. P3: P3

Participants gave examples of how some women who managed to leave the relationship, appeared compelled to return to the perpetrator:

> *You know they are separated, but you find them coming back all the time. P3: P9*

> *[Women] were compliant with it… this is what we do, and we're comfortable… a controlling man is a strong man, and I like that… P3: P4*

> *The mum is still saying she loves the perpetrator which is really worrying because it was very traumatic. He broke her ribs, he put her in hospital, and there's a four-year-old and a two-year-old. At the moment there's a [non]molestation order out against the gentleman. P3: P10*

> *The husband was put in jail for domestic violence against her… She goes 'I would [still] like him to come back home'. P3: P4*

> *He is out of prison, and he's back in the house. P3: P4*

Some women appeared attracted to abusive partners, entering new abusive relationships having left a former abusive relationship:

> *Quite often you will see they find similar partners. P2: P1*

> *… they will go and find somebody who is the same character as the person that they have left. It's like they're always attracted towards those sorts of people and I'm not sure why. P3: P5*

Despite the dangers posed to the victim and children in the household, without an income, accommodation or supportive networks, some women may feel that they have no choice but to remain in the family home:

> *You get some that are just financially dependent, they have got no idea where they would go or how they would survive. P2: P6*

> *On a professional level, you look at all the different reasons why she's gone back. She has no family, she has no other network, and it's just her, the partner and the children. P3:11*

Despite the need to keep the women safe, the decision to leave the abusive environment must come from the victim, with the Health Visitor being a key support once the decision is made. Here the participant demonstrates her understanding that victims of abuse make difficult choices and takes a non-judgemental approach when supporting the family:

I think knowing the family setup on a personal level; there will be lots of reasons why a woman may go back... I will not judge that woman I would just try and work with her with the support of other agencies. P3: P11

The findings suggest that women remain in the relationship for a variety of reasons. Further exploration shows that while making a judgement that women should leave the abusive relationship, often they do not have a choice other than to remain. With nowhere to go and financial difficulties, women remain tied to the relationship. The fear is that they will lose their children to the abusive partner, and so they remain silent. Women who have no recourse to public funds, face additional challenges fearing they have no alternative but to stay in the abusive relationship.

Discussion

Perpetrators who control their partners were a significant reason for why women remained in the relationship with fear that the abuse would escalate, as identified by Kishor and Johnson (2004); Sokoloff and Dupont (2005). Health Visitors in the study understood the difficulties women faced when deciding to disclose and leave the abusive relationship. Although on first glance it would appear that women could choose when to leave or when to stay in the family home; Health Visitors were aware that often women did not have a choice and appeared to understand their decision to remain in the relationship. Health Visitors understood that abused women might not feel they 'have a voice' and may lack the confidence to speak out, as suggested by Sokoloff and Dupont (2005); Moe (2007). The stigma surrounding domestic abuse was significant enough for women not to disclose and may partly explain why women stay silent, keeping it in the family and away from the neighbours (Usta *et al.*, 2012). Therefore, Health Visitors who offer women the opportunity to disclose by having a confidential conversation about domestic abuse may increase the likelihood of a disclosure.

Some women explained that they were likely to suffer financial difficulties by way of justifying their decision to remain in the abusive relationship, which was also found in a study by Burman *et al*. (2004). Concerns about income and not being able to maintain herself or the children, also appear to be a significant barrier to disclosure. The findings reported here suggest that Health Visitors must be informed and able to signpost women to advisory services to address financial concerns. In this way, more women may come

forward following routine enquiry and disclosed the abuse if they knew they would not face financial hardship.

Women also had concerns about either losing custody of their children, or the children blaming them at some point for breaking up the family (Peckover, 2003). Although women may feel a sense of guilt in separating the family if she decided to leave the abusive relationship; being informed of the impact domestic abuse can have on children may help to inform decisions that leaving is the best option under the circumstances. This study confirms that Health Visitors have a role to play in educating the victim of abuse in terms of the risks posed to children if she decides to remain or leave the family home.

Another significant aspect of women remaining in abusive relationships is when Health Visitors found that due to a lack of information, women often relied on their husbands' goodwill to keep them in the country if they had 'no recourse to public funds'. These women experienced barriers in finding safety and support, making it unlikely they would disclose abuse when dependent on their partners. Women with insecure immigration status have little choice but to stay in abusive relationships if they are to remain in the country and avoid deportation. Research by Reina, Lohman and Maldonado (2014) and Rose *et al.* (2011) echoed these findings, showing that dependency on their husbands was the main reason women did not disclose.

With regards to eliciting disclosure; the Health Visitor needs to have information about how to provide support without increasing women's risk of deportation; otherwise, disclosure would be unlikely to occur. If Health Visitors are not aware of the support services for women with 'no recourse to public funds' they will not be able to provide reassurance that if they disclose, they are supported. It appears there is a gap in Health Visitors' knowledge in how to support these women. There is a call then, for practitioners to be educated about the legal rights of women who have no recourse to public funds.

With fear of escalation and the anxiety that surrounds possible disclosure, women often minimised or did not acknowledge the abuse. Participants explained how they offered services and discussed options with women. The rationale for this approach was that if at any point, the client changed their mind, or the abuse escalated, they still could make an informed decision about the way forward. However, some women appear to be in a cycle

where they are attracted to abusive partners and return to the abusive relationship even after they have left (Ozçakar *et al.*, 2016). With Health Visitors having a duty to safeguard the children within the family, it is important to consider maintaining a professional approach when the victim remains in the relationship. For example, Health Visitors recounted stories where the cycle of abuse was evident when women re-connected with men imprisoned due to domestic violence. On release from prison, some women welcomed these men back into the family home. It is essential to review the current policy that governs the principal actions adopted by Health Visitors for when women return to abusive relationships in order to keep them, and their children safe.

Hornor (2005) suggested that health care professionals have a central role to play in breaking the cycle by providing early intervention and support, which reinforces the need for Health Visitors to ask about abuse. While studies by Goldblatt (2009) and Spangaro *et al*. (2011) emphasise that Health Visitors need to understand the difficulties women face and resist blaming them for not leaving or returning to the abusive relationship. This stance will have some implications for policymakers and trainers. Baird *et al.* (2017) argued that practitioners must be knowledgeable and skilled to ask women about their safety and to respond in a sensitive way to disclosures. How can it be guaranteed that these practitioners have the required skills? A typical response to this in the literature is the suggestion of Baird *et al.* (2017), who argued for a bespoke form of training for practitioners. Therefore, Health Visitors must be given the opportunity for critical discussion and debate around women remaining in the abusive relationship and this must be on the agenda during training updates.

4.4 THEME THREE: BARRIERS TO ROUTINE ENQUIRY

RQ1 asks about the influencing factors that can affect the ability of Health Visitors to ask about the occurrence of domestic abuse. While there is a consensus about the importance of Health Visitor's ability to conduct routine enquiry, there are significant barriers that may be present that prevents the Health Visitor asking about domestic abuse.

The following discussion is drawn from Phases 1, 2 and 3 that identified three sub-themes:

Table 4.5: Emergent Themes

Theme 3: Barriers to routine enquiry (4.4)	
Sub-themes:	• Cultural competence (4.4.1) • Lost in translation (4.4.2) • Policy-induced limitations (4.4.3)

4.4.1 CULTURAL COMPETENCE

When considering the cultural aspect of domestic abuse, participants reflected on how this influenced their ability to enquire about abuse routinely. Here participants explored how their understanding of the different cultures could affect their ability to ask about abuse and elicit disclosure.

Interview and survey responses

Survey participants observed that in some cultures, the women were expected to remain married to their husbands regardless of the abuse. Ill-treated women were expected to 'endure', and leaving the relationship was not an option to be considered as it went against cultural norms. This sub-theme highlighted the issue of domestic abuse, culture and stigma within communities:

> *There was this element that you just have to stay because you were married… society will shun you if you come out of that situation, you don't want to be the woman who left the husband. P3: P3*

> *Nobody can take care of you because you probably have three or four children, no one is interested, and it brings shame on the family, so you just have to stick it and suffer. P3: P3*

> *[There are] Cultural and religious reasons for some women, social reasons, shame to the family. P1: P28*

Six out of 24 (25%) survey participants wanted more frequent training around domestic abuse to include issues around culture. The interview participants also highlighted this gap in education and training:

I think we need regular updates on domestic violence training also about different cultures and how they perceive domestic violence. P1: P18

Findings from interviews

Participants supported families from a range of cultural backgrounds within their caseloads. Participants suggested that the issue of trust was challenging to overcome, mainly when women were not familiar with the role of the Health Visitor or English was not their first language. Participants are seen to share their knowledge about some of their clients' cultural norms and the expectations placed on women within that culture:

I suppose there's that cultural aspect, in some culture's women get abused don't they and it's kind of the norm…. that's what [their] husbands do 'you have to be submissive to your husband'. P3: P3

I think some cultures are more accepting of it [domestic abuse] I suppose. P2: P7

[There is a cultural belief] You just have to abide by what your husband says P3: P3

Participants spoke about the challenges they faced in asking women of different cultures about domestic abuse. Women were guarded, often 'shutting down' conversations about abuse or denying its existence in their culture:

When I ask an Indian family or Black African families about the domestic violence question they just come out with laughing, 'it doesn't happen in our culture' kind of thing. P2: P3

Sometimes I find when I bring the question to African women, they sort of quickly…. say 'no' and that's the end of the conversation… You can tell they don't want to explore it anymore. P3: P11

I think Asian backgrounds… have a very close family unit and sometimes you are not able to get her on her own to ask the question. P3: P6

Eastern Europeans... I think particularly the Albanian, Northern Albania… I've had extreme difficulty getting in there when I know domestic abuse is going on. P2: P8

Some participants can be seen to understand how some cultures view men with the patriarchal role, firmly established. The participants explain that within some cultures, the role of the women is to be subservient to their husbands. Here participants talk about how

domestic abuse is the norm and where it is considered as ‘no big deal', when women are abused within the marriage:

> *... in some cultures, it will just be the norm really, the wife gets beat up it’s no big deal. P3: P3*

> *... they bring their women in; they are like slaves to them. They do all the housework. Even when they have a new baby. P3: P1*

Here a participant gave an example of what clients have told her about the African culture and women's place within the home:

> *...well, you know the African men; you know they want to do things as they did back home. He expects me to look after the children, cook and clean… all he does is to go to work, [and come] home. He expects me to do everything. He doesn’t think that he [is] supposed to help me with the housework or help me with the children. P3: P5*

One of the participants who were from the same culture as her client provided details about how the payment of a dowry meant that their husbands owned the women. Having a Health Visitor with ‘insider’ knowledge about cultures could help others understand the issues women face when considering domestic abuse:

> *In the Nigerian system and the Asian system. Once you have paid that dowry-you belong to the man… P3: P1*

Participants highlighted their involvement with extended families and the strong influence they had on women in the home and their involvement in the abuse:

> *... in some cultures, the mothers-in-law are quite powerful, so it doesn’t matter what the women think..., P3: P2*

> *It was actually more of the sister of the father who was mistreating her… P3: P2*

> *You find that the wife-shakes like a jelly, she is frightened of the in-laws in the house. P3: P1*

Participants considered how they approached routine enquiry. They recounted incidents where they knew women were unlikely to disclose the abuse due to cultural influences:

I wouldn't have any problems asking or discussing it with them, but you notice their reaction is more like 'oh no, that would never happen', or they wouldn't acknowledge it as a problem. P2: P7

I know that we have quite a large community of Nepalese where there is domestic abuse going on, and they wouldn't disclose it. P3: P2

I think they are such a close community network ... P3: P2

Here a participant explains how women go to great lengths to hide the abuse. Even when there are apparent signs that abuse is taking place, the victim and perpetrator will deny it is happening:

The Arabs will never tell you anything. Even if you catch them 'red-handed', they will never tell you there is domestic violence… even if the police were involved. P3: P1

Women could feel additional pressure not to disclose the abuse to outside agencies. Participants provided some examples of their experiences in the following excepts:

It will go to social services and a lot of African and Asians feel stigmatised if anything goes to social services. P3: P1

…it is just the fear that when it goes to social services, it is serious. They don't want the neighbours to hear about it. They don't want anyone to hear about it. They don't want their other relations to hear that they are with social services. P3: P1

Due to cultural beliefs, women often feel they have no choice but to stay in the abusive relationship:

Everybody was involved. But she said that she wanted to stay with the man. Because of her parents… she can't leave the marriage. P3: P1

Culturally she should stay...Africans, Asians and Arabs will never tell you anything. P3: P1

Everything is cultural actually. It's all cultural. P3: P1

Here participants explain the importance placed on being 'culturally competent' and the importance of education in developing an understanding of the different cultures:

I understand the culture as I had a colleague who is an Asian. [She] explained everything. That is why I have had a good experience in the Asian culture. P3: P1

> *You need to study all those cultures. If you can study them, you will find that you will be able to understand why certain people react to domestic violence in a certain way. A lot of them do not understand they are being abused. P3: P1*

The findings have demonstrated that culture has a direct impact on the way communities view domestic abuse. Within some cultures, women are expected to be subservient to the needs of the men, and domestic abuse may not be considered as a cause for concern. The abuse may extend to family members who see it as the norm when abusing the women in the family. As a result of this, women can appear to be guarded and will never disclose the abuse to 'outsiders' with the belief that what happens within the family unit remains private. It is important to consider the merits of the Health Visitor asking about abuse if these women are guarded and will never disclose.

Discussion

Clients from BAME groups are less likely to disclose incidents of domestic abuse (Robinson & Howarth, 2012). The whole family may be stigmatised within their community if it is known that the father is abusing the mother. As identified in the scoping study, the abuse of women can be deeply embedded in some cultures (Madhani *et al*., 2017). One of the Health Visitors in the study characterised how one culture viewed domestic abuse as 'no big deal', to highlight how commonplace abuse was within that culture. Another Health Visitor gave an example of how even with apparent signs of physical abuse, which she described as being 'caught red-handed', the women would still not disclose. A disturbing finding was when another Health Visitor who was familiar with the culture, talked about how women 'were kept like slaves', demonstrating that Health Visitors had 'insider' knowledge of how some women from different cultures were mistreated. However, they appeared limited in what they could do to keep these women safe.

The absence of support networks means that women were more vulnerable and unable to leave the abusive relationship. Participants explained how communities encouraged women not to leave their violent husbands, as being divorced and alone with children, was stigmatised. Instead of bringing disgrace to the family, women were expected to remain in an abusive relationship (Keen, 2009). Therefore, domestic abuse may not be spoken about

outside of the family home or may remain a 'known secret'. Having outside agencies such as the involvement of social services was seen to bring shame to the family and was to be avoided.

Findings from the study indicated that Health Visitors were accustomed to having clients from different cultures within their caseloads and had a range of experiences working with them. Some Health Visitors explained how they did not feel confident or competent in addressing domestic abuse within the different cultures they encountered in practice. Burman, Smailes and Chantler (2004) revealed similar findings, where they discovered that some participants struggled with the cultural aspects of abuse and recognised a gap in their knowledge and skills. Health Visitors in this study understood that being able to recognise the differences in cultural approaches to domestic abuse within their communities, would enhance their ability to advise and support women. Being culturally competent supports practitioners to understand how women may or may not accept help, if living in an abusive relationship. The NMC's 2015-2020 corporate strategy (NMC, 2015) that focused on the equality, diversity and inclusion framework, supports the shift towards culturally-competent practitioners.

However, how can Health Visitors gain the knowledge to understand the needs of women from other cultures fully? How do they elicit disclosure from women of different cultures? Consideration needs to be given to how Health Visitors support these women where they know they were being oppressed and experiencing domestic abuse. It becomes more important to build a rapport to raise awareness and to challenge cultural beliefs which support the ill-treatment of women.

Understanding the different cultures would allow Health Visitors to circumvent any barriers that may be in place in providing support for women. When Health Visitors were from the same culture as their clients, they had 'insider' knowledge in terms of how the culture viewed domestic abuse. This 'insider' knowledge contrasts with the evident gap in awareness stemming from Health Visitors who were not of the same culture as their clients. These practitioners called for more education and training to understand this client group. Liang *et al.* (2005) highlighted that cultural competence was an important issue, suggesting

that education and training should be offered to promote an understanding in how women from different cultures perceived domestic abuse and responded to routine enquiry.

Being more culturally-competent would help in understanding the additional difficulties faced by women and equip Health Visitors to address their needs. The importance of education and training was echoed by Thurston *et al.* (2013) when participants called for more knowledge around the cultural influences within their client group to facilitate their support of women. Further education and training will open the debate in the management of these clients (Brown & Groscup, 2009). Bent-Goodley (2005) advised the inclusion of culturally-competent educational programmes around domestic abuse. Cultural training would allow Health Visitors to understand the nuances that could influence practice, and potential interventions when working with a variety of client groups (Mullender, 2004).

4.4.2 LOST IN TRANSLATION

Health Visitors are expected to enquire about domestic abuse routinely. However, when women do not speak English, this presents as a communication barrier when asking about domestic abuse. When using a professional interpreting service, participants raised concerns about the translation reported back to them, which they thought might not have been accurate. Participants identified that the interpreter might influence their ability to enquire about domestic abuse routinely, especially when sensitivity was called for.

Findings from interviews

When communicating with clients who did not speak or understand English, participants indicated that they followed the Trust policy and NICE (2016) guidelines by not using family members to interpret, particularly when asking about domestic abuse. Participants spoke about the good experiences they encountered when using the interpreting service:

> *We use professional interpreters. I wouldn't use a family member; it's a professional service. P2: P6*

> *Actually, they were really quite helpful a lot of these interpreters were really good. P3: P6*

However, in using the NHS Trust's interpreting services, some participants highlighted difficulties they had encountered during joint visits where interpreters appeared to create an additional barrier to routine enquiry:

> *That's going to be very hard because if you have an interpreter, it's going to make the barrier even more. P3: P10*

> *You're having to build a relationship through a third person, and that's really fragmented, so you're trying to get a trusting relationship going which isn't fluid… that can be difficult. P2: P5*

Women may not feel safe to discuss or disclose abuse particularly if the family through their community is known to the interpreter:

> *There have been some reports that some of the interpreters are kind of known in the community. … whoever is been subjected to the abuse may not want that interpreter to know about it. P3: P3*

Here access to the family is denied when the interpreter not allowed to enter the home:

> *I was going to bring an interpreter for our next visit 'I don't want an interpreter' [he said] 'the interpreters-they know our family. I said, 'all the interpreters?' 'yes' he said. They know all about our family I don't want our business out there. Do not bring an interpreter. P3: P4*

One participant demonstrated how she questions the interpreters to gain some assurance that the family does not know them.

> *…half the time you don't know whether that interpreter knows the family. So, you have to make sure that they don't know each other. P3: P6*

> *So now I'd asked the interpreter 'what area are you from?'. Just to make sure she didn't have any connections to the family… I'd be interrogating the interpreter sometimes asking them where they were from, although it was probably not the right thing to do, but I felt like in that instance it was probably the right thing to do to protect this woman. P3: P6*

As well as being known to the family, some of the participants raised concerns suggesting that some interpreters may not be accurately translating. One of the participants was concerned that the English language might not fully be interpreted in a different language and vice versa with some expressing a lack of confidence in the interpretation. There is a risk that the enquiry about domestic abuse could be 'lost in translation':

I'm going with my culture and my language. There are certain things in my language that doesn't translate. We can't translate into English, so it's difficult. P3: P4

You're relying on that person interpreting the question in the right way because I don't know how the interpreter is phrasing it, she might not be phrasing it correctly, I wouldn't know…. P2: P5

Participants continued to express their concerns about using interpreters when asking about domestic abuse. They questioned how much of the conversation that took place between the mother had been accurately explained:

One of my colleagues had a situation where it turns out that the interpreter…. would not relate everything as they should. P3: P3

I find sometimes with interpreters I really don't know what they are saying…. P3: P2

Is it a translation or interpretation? What are they saying? Has she gotten the message? P3: P4

Participants were concerned whether the interpreters' beliefs about domestic abuse, could have influenced their ability to interpret accurately:

Whether they're actually conveying their own ideas, especially if it's a different culture…. I'm not sure what they are actually saying. P3: P2

... we've come out of a house and the interpreter said… 'We don't have that [abuse] in our country'…. Well, it [abuse]can happen anywhere, so keep your opinions and just ask my questions and report back, don't put your slant on it! P2: P4

[One interpreter explained] 'Hungarians don't have abuse?' I said [Health Visitor], 'Okay we should all live in Hungary!' P2: P4

As well as the language barrier, participants highlighted concerns around not being able to 'read' the clients non - verbal cues. Not being able to assess women's responses fully, may place clients at increased risk:

Is the interpreter going to pick up on the subtleties in her response that I might pick up if she was speaking English? P2: P5

The body language cues… if she hesitates when she speaks… you want to pick those things up [but] if you don't speak the language, that's an issue. P2: P5

Here the participants appear to be satisfied when they had a male interpreter and were quite supportive of their role. Participants did not appear to consider that a male interpreter may dissuade women from discussing the issue of domestic abuse or might inhibit their disclosure:

> *Some of them were male interpreters which were really interesting. Because that is quite interesting from the Asian background… P3: P6*

> *… this interpreter was very calming in his sort of mannerisms… he was like, 'no don't worry; it's fine'. He'd sit down and be quite respectful. He wouldn't interject or say anything extra… It did actually work quite well. P3: P6*

The findings suggest that interpreters can impact on the ability of Health Visitors to communicate with women and further, create a barrier to building a rapport and relationship. Health Visitors identified the risks associated with not knowing what the interpreter was saying to the women. Also, Health Visitors demonstrated a lack of trust and suspicion when not knowing whether the interpreter was providing a direct translation or putting their own 'spin' on the conversation. This raised questions about the influence interpreters have on the Health Visitor's ability to ask about domestic abuse and also perceived confidentiality where the interpreter may be known to the family. Moreover, concerns were raised when the interpreter was male and whether this had an impact on women's ability to disclose the abuse.

Discussion

When Health Visitors were required to communicate with women who do not speak English, it placed a barrier to routine enquiry, in particular when their partners or family members were present. Gerbert *et al.* (2000) suggested that family members should never take the place of trained interpreters. However, Health Visitors described husbands who insisted on interpreting during client contacts, thereby silencing the women and placing them at risk of continued abuse (Keen, 2009). Men were often present when the Health Visitors wanted to ask the women about domestic abuse but were aware of the importance of not asking while in the company of others. A partner's presence created a barrier and a missed opportunity to ask questions about abuse. This missed opportunity meant that women were disadvantaged and at risk due to a lack of knowledge about access to support services (Liang *et al*., 2005). The National Institute for Health and Care Excellence (2016)

recommends use of professional interpreters who are impartial and who can maintain confidentiality, and also recommended following a study by Baird *et al*. (2013), and the Women's National Commission (2009).

Some Health Visitors in this study spoke positively and gave examples of their experiences when using professional interpreters recommended by the NHS Trust, which worked well. However, some were not always confident in how effectively they were communicating with the women when the interpreter was present. A disturbing finding was that several Health Visitors expressed their concerns and had doubts about the reliability of responses given by the interpreter. Health Visitors raised doubt that some interpreters might not have accurately explained the women's responses when asking about abuse and went further by recounting incidences where they doubted the accuracy of the translation. Practitioners spoke about 'reading' the women's body language (as highlighted in section *4.3.1*) which did not always appear to reflect the explanation provided by the interpreter.

A prior study by Bailey (2010) suggested that being able to translate correctly and capture the meaning of words from one language into the words of another may be impossible. Bailey (2010) went on to imply that during the translation process, cultural meaning and specific nuances could be lost. It has called into question how reliable Health Visitors felt about the responses relayed by the interpreter, with some unsure of how the questions about domestic abuse were explained to the women. This uncertainty cast doubt over the interpreters' ability to convey accurate information. Some Health Visitors felt the interpreter might have inserted his or her own 'personal spin' or biased view on answers given by women when responding to the domestic abuse questions.

This issue of unreliable interpretations first came into focus when some interpreters suggested domestic abuse was not a problem in their culture, or that it simply did not exist. To deny the existence of abuse could indicate that an interpreter's values, attitudes and beliefs could have an impact on women's ability to be asked about abuse and their answers accurately relayed. How do Health Visitors routinely enquire about domestic abuse while providing a safe space for women to disclose? This is an issue for policy makers to consider how women who do not speak English are given same opportunity as others to disclose.

Health Visitors also raised concerns about interpreters who were sourced locally and could be known to the family. Women are likely to lack confidence in the preservation of their privacy when in the presence of an interpreter. It can be assumed that issues of confidentiality would create a barrier to women being able to trust and disclose incidents of abuse in the presence of the interpreter (Baird *et al.,* 2013). The Department of Health (2005) advises that interpreters sign confidentiality agreements and should have attended education and training programmes about domestic abuse. However, findings from this study broadly support the work by Beynon *et al.* (2012), who identified a distinct lack of interpreters who could maintain confidentiality and were culturally sensitive. A potential lack of suitably trained interpreters is a significant concern and calls for further studies in order to establish the extent of this problem. It could be that this concern is local to this NHS Trust, or it could imply a broader issue where interpreters are influencing responses given by women during the routine enquiry. Furthermore, work is required to establish the education and training needs of the interpreters to include aspects of confidentiality, the importance of unbiased translation and the accuracy of the translation.

Another significant aspect is to consider whether a male interpreter is likely to have an impact on women's ability to feel free to disclose the abuse. While some Health Visitors did not find issues with having a male interpreter, this was not the case for all of them and was considered to be an additional barrier. The impact of having a male interpreter asking women about domestic abuse, is an area that requires further studies to identify whether women are being discouraged from disclosing the abuse. Bacchus, Mezey and Bewley (2002) supported the use of female-only interpreters while NHS England (2015) and advised that clients should be allowed to express a preference in the gender of the interpreter. Although desirable and sound practice, it raises concern about the availability of female interpreters. There is a need for a review of the policy and available resources which appears to place this group of women at a distinct disadvantage. In this context, there was an increased risk to the safety of women who did not speak English.

These findings suggest that a language barrier was a significant issue and may influence how participants are asked about domestic abuse and women's responses. A further study is required to establish whether interpreters' attitudes, values and beliefs could influence their ability to translate accurately, during the routine enquiry.

4.4.3 POLICY INDUCED LIMITATIONS

Practice shows that women need to be asked on numerous occasions before they disclose abuse. The NHS Trust recently implemented new ways of working in the delivery of the Healthy Child Programme, which has had an impact on the opportunities available for Health Visitors to ask about domestic abuse. Participants recognised limitations created by working practices that appeared to have generated a barrier to identifying domestic abuse. This theme highlights the challenges participants faced when carrying out their role.

Findings from interviews

Participants identified missed opportunities to speak to women and routinely enquire about domestic abuse due to new working practices. Here participants identified some of the changes in their working practices and how this limited their contact with clients:

> *We work under universal caseloads, universal plus, universal partnership plus. I think moving that way can have a detrimental effect because if you then take them off your caseload because they're not someone you're worried about, that you're not doing any active work with, you then don't go back and see them... Three or four months down the line it could change where something detrimental could be happening to the children or the lady or even the partner. P3: P6*

> *With the pathways changing and the whole new configuration of our service, we are not working so much with universal, we have universal plus or universal partnership plus families, so it's working with needy families all the time. P2: P10*

> *The mother will receive a letter now, through the service, saying if you have any concerns, contact us. But if she is unable to contact us, like this particular woman … she didn't have her phone… P3: P6*

The following excerpts described the limitations that participants faced due to the NHS Trust changes which had been found to reduce their scope of practice in providing a full service to families where domestic abuse may be a factor. Participants exhibited frustration in how changes to their role had reduced their ability to engage with the women and build a trusting relationship:

> *You can't keep going back, because the service won't allow it, because if she is saying there is no domestic abuse, that's it. Universal services… As we know it takes time to get that relationship before they would want to tell you…. P2: P4*

We all know that if you talk to the mother, they may not talk about it the first time… They may want to have that relationship and trust that we always have with parents, and obviously now with the way we are working we don't have that. P2: P10

It's different for universal plus because you'll see them more often, but it's the ones on universal that we don't [see]. P2: P10

Limited home visits appeared to reduce the Health Visitors' ability to use their professional judgement and potentially the opportunity to visit families where abuse is suspected. The underlying tension shown here is in the tone the participants used to describe the limitations posed by the NHS Trust:

Not happy, because it's not what you came in to do as a Health Visitor. The role of the Health Visitor is changing now because [there is] limited time and this is actually why I came away from the hospital because it's such a short time with your client's. P2: P10

It's quite difficult sometimes because there are a lot of cutbacks, you have to justify the reason why you are seeing some of these mums. You can't just be going because you suspect something. P3: P8

I know the cuts are going to get worse, so I suppose if that happens then it's going to have a massive knock-on effect if they get stricter and stricter with how many visits you can offer because it takes time for people to open up about things… P2: P7

The worries are that families won't be supported enough due to time constraints P1: P20

Participants explained how limited client contact could impact on their ability to use professional judgement according to the needs of the clients:

It's a shame that nowadays they cut all contact that you can't follow-up [clients] and all those things. P3: P9

…There is a structure now as to how many visits you can do… you set up a goal and your progress towards it… you can't just go in and out 'willy-nilly', there's got to be a specific goal. P2: P9

You've got to put in a lot of groundwork if you've got suspicions. P2: P5

It's almost like you've been set up to fail because there is no time. You know you're trying to have the time to ask this question… P3: P4

However, participants did not lose sight of their accountability and of being professionals despite changes to working practices:

> *But you are a professional in your own right… Whatever happens, during a visit is going to follow you. So, if I go in and I'm suspecting domestic violence, and the client is not opening up I will develop that relationship and do a follow-up [home visit]. P3: P9*

Some participants demonstrated ways in which they adapted and were working within the new system:

> *It doesn't seem a lot of work, but it is for each family that you have got to then put a big care plan in place just because you haven't asked them 'was there domestic abuse?' P2: P4*

> *As long as you can still do all the visits that you need to do, you just have to make sure, but you do a care plan, and sometimes you just make sure you pick a pathway to put them on a universal plus [as a reason to go back into the home to ask about abuse]. P2: P7*

This participant highlighted explained the need to be proactive in the prevention of health issues which required the allocation of appropriate resources:

> *If the government is spending a lot of money on treating all these problems, why not spend a lot of money preventing it from happening in the first place? P3: P8*

In summary, participants in this study identified how new NHS Trust working arrangements limited their client contacts and reduced their ability to build relationships. Health Visitors felt they were not able to use their professional judgement in deciding how often families required home visits. However, participants did not lose sight of their accountability and used different ways to continue visiting clients where they suspected that abuse was taking place.

Discussion

Universal Services supports a more proactive approach when asking all women about abuse and provides multiple opportunities for the Health Visitor to speak directly to women (Vanderburg *et al*., 2010). Bradbury-Jones *et al*. (2011) and Spangaro *et al*. (2011) agree that women are offered many opportunities to disclose abuse through routine enquiry.

However, the results of this study show that the new organisational changes were limiting home contacts and likely to affect Health Visitors ability to enquire about domestic abuse routinely. Health Visitors voiced their concerns that reduced client contacts could have an impact on their ability to engage with others and build a rapport as echoed in a study by Hooker *et al.* (2014). As a result, new working practices reduced the number of opportunities women were given to disclose and limited the opportunities for the Health Visitor who may suspect domestic abuse, to conduct further home visits to build trust. Therefore limiting services and accessibility to clients, is likely to influence practitioners' ability to ask about domestic abuse and to identify when women were unsafe as suggested by Bacchus *et al*. (2002).

In line with the findings of Bacchus, Mezey and Bewley (2002), Health Visitors confirmed that rushing to enquire about domestic abuse on the first contact due to a lack of time or opportunity, would give women the impression that the Health Visitor will not have the time to deal with their issues. Usta *et al.* (2012) also suggested that women wanted more time to develop a rapport with practitioners before being asked about abuse, as highlighted in section (*4.2.1*). Hogg *et al.* (2013) proposed that having a professional relationship with the family was a fundamental factor that encouraged disclosure. The importance of a professional connection was also suggested by Bacchus, Mezey and Bewley (2003) who indicated that women were likely to disclose domestic abuse when they felt confident and safe. The findings of this study suggest that Health Visitors should retain their ability to have direct contact with families so they can use their professional judgement to support and keep women safe (Whittaker *et al*., 2013).

Despite organisational changes, Health Visitors continued to work as autonomous practitioners while others felt elements of their autonomy was eroded due to new ways of working. If Health Visitors are to remain autonomous, it is essential that they feel able to contribute to service changes that have a direct impact on their role and the support delivered to their clients. A report by Whittaker *et al.* (2013: 70) advised that Health Visitors should be involved in service redesign to preserve their sense of 'professional control' over decisions that would affect their practice. Therefore, Policy makers within the NHS Trust need to consult with Health Visitors, to listen to their knowledge around domestic abuse, their assessment of the risk associated with limited client contacts and their

ability to routinely enquire about domestic abuse. In this way, practitioners will be able to influence service delivery by highlighting the impact reduced client contacts might have on those experiencing domestic abuse.

4.5 THEME FOUR: HEALTH VISITORS' SILENT VIEWS

RQ1 asks about the influencing factors that can affect the ability of Health Visitors to ask about the occurrence of domestic abuse. Health Visitors are not often asked about their opinion on this issue. The following section presents Health Visitors who were willing to share their personal and professional thoughts on what they think and feel about domestic abuse.

The following discussions are drawn from Phase 1, 2 and 3 of the survey and semi – structured interviews and identified one theme and three sub-themes:

Table 4.6: Emergent Themes

Theme 4: Health Visitors' silent views (4.5)	
Sub-themes:	• Personal experiences, values and beliefs (4.5.1) • Emotional ties: empathy, frustration and vicarious trauma (4.5.2) • Support mechanisms (4.5.3) • Health Visitors' views about safety (4.5.4)

4.5.1 PERSONAL EXPERIENCES, VALUES AND BELIEFS

Health Visitors are expected to routinely enquire about domestic abuse at each client contact if it is safe to do so, however personal experiences, values and beliefs may potentially, influence their ability to ask about domestic abuse. Health Visitors' personal experiences, values and beliefs were explored to find out whether these elements in fact influenced their ability to carry out their role and support women.

Survey responses

Out of 24 participants who completed the survey, nine (37.5%) thought their values and beliefs did not influence how they asked about domestic abuse. This meant that ten (54%) participants thought their personal values and beliefs influenced their practice. With two (8.3%) participants expressing that their personal values and beliefs had a great deal of influence, and seven (29%) participants feeling they were moderately influencing their practice. Two participants were undecided as to whether there was an influence.

Table 4.7: Do Health Visitors' personal values and beliefs influence how they ask about domestic abuse?

	A great deal	***A moderate amount***	***A little***	***Not at all***	***I don't know***
Number of participants	2	7	4	9	2

Seven participants provided more detail and explained how their values and beliefs did not influence how they asked about domestic abuse and spoke about the importance of working to NHS Trust policies. Two participants maintained that they treated clients as individuals and focused on their specific needs.

> *My personal beliefs and thoughts do not influence my practice, which must be evidenced based and safeguard the child whatever the circumstances. P1: P21*

> *Each client is unique therefore my personal beliefs may not be the same as theirs. Therefore, I have to look at each client individually and take their beliefs and culture into consideration when I am discussing domestic violence. P1: P18*

One participant stated that of course it was natural that their values and beliefs would influence how they undertook their role:

> *It is natural for us as humans to draw on personal values and beliefs a little as they are inherent in us. P1: P29*

Nine of the 24 participants (n=9) who completed the survey gave accounts of how their knowledge and professional experiences with managing cases of domestic abuse, influenced their practice:

> *Having experience in working with clients who are suffering from domestic abuse builds your communication skills when asking clients questions about their relationship and your observation skills when detecting whether a client may be suffering domestic abuse. P1: P18*

> *As a professional I cannot help but use my experiences to influence practice- this helps to inform my decisions. P1: P29*

> *My experience alters the way I ask further questions and how I frame them. P1: P23*

<u>*Findings from interviews*</u>

One interviewed participant acknowledged that her personal values and beliefs had a positive impact on her clinical practice:

> *It [values and beliefs] has a lot of impact on the way I support women. It is a positive thing in providing support. P3: P1*

However, other participants explained how their personal thoughts about domestic abuse did not impact on their professional behaviour. Participants' over-riding feelings were to understand the decisions women made although they did not necessarily agree with them:

> *At the end of the day… love is blind. Personally… I will not put up with abuse… but I will give all the necessary information if they choose to remain… P3: P9*

> *Professionally I have no right… I can advise them; I can support them as much as I can. Nobody has a right to tell anyone to leave anyone. P3: P8*

Participants considered how domestic abuse had affected them on a personal level. Some were able to recount incidents from previous relationships and others from childhood experiences:

> *I have gone through domestic abuse before. I have my own experience to relate to. In my own time, I was very ignorant just doing what your mother wants you to… But if you say you want to leave the relationship, they say you can't have your children with two men… it has to be one man, so you need to stay in the relationship. P3: P1*

Yes, it did happen to me in my previous marriage where there was some form of abuse. A one-off incident and yes that kind of opened my eyes a bit. It just goes to show you that nobody is immune to these things. It's kind of made me become more self-aware and in a better place to offer counselling and to be understanding and not judgmental. P3: P3

I cannot relate personally to domestic violence, but I have experienced domestic violence through other close people around me, and so in that way, I can relate. P3: P5

Participants identified with some of the women's cultural beliefs from a personal level. Here one participant explained that she understood the concept that once married, women were required to stay married which was part of the culture:

I think coming from my culture where men are expected to do certain things, I understand women. The fact that all marriages are like a 'crown' you don't want to be out of your marriage, you want to be in it. I see that. P3: P4

One participant explained that in her culture, women endured violent and dangerous *relationships* in order to remain married:

I lived in a country where the women were tortured every week with no money to feed the family, and they remained in the marriage. P3: P1

While another participant explained the positive shifts in attitudes within her country of origin to where the ill treatment of women, was no longer acceptable:

Back in Zimbabwe years ago, not now because… they don't 'joke' anymore; women used to get beaten up. P3: P3

Participants also shared early memories from childhood experiences of being aware of domestic abuse:

As a child growing up, I felt quite happy. But I can remember my mum helping a neighbour. I can remember the neighbour running into our house when I was a very young child about five or six and my mum phoned the police. P3: P10

My parents were very good at protecting me from outside things… people always say children can't hear and see things, but you can. When I was a child, I knew my uncle was domestically violent to his partner. P3: P6

In this context, the participants considered how their knowledge of domestic abuse could be seen to have an influence on their personal relationship and professional role:

The thing is I'm married and sometimes when he does things I'm thinking 'is that controlling?' [Laughs] 'Am I being controlled?'[Laughs] P3: P4

I am sure personal experience does have an impact. It depends if you want to turn it into something positive… or something negative. P3: P2

The survey responses suggested that most Health Visitors felt, to a greater or lesser degree, that their personal values and beliefs had an impact on their ability to ask about domestic abuse. However, this finding appears to be contradicted through the interviews where Health Visitors suggested they utilised their knowledge and experience to carry out routine enquiry rather than being influenced by personal values and beliefs. The findings reported here, suggest that the personal experiences of domestic abuse and cultural background of some Health Visitors, contributed to their understanding of women who had been abused.

Discussion

Health Visitors had a mixed response in terms of whether they felt their personal values and beliefs influenced their practice. While most Health Visitors who completed the survey suggested their personal values and beliefs influenced their practice others who were interviewed suggested otherwise, in that their knowledge and understanding of domestic abuse influenced their practice. These Health Visitors were able to set aside their attitudes, values and beliefs to display a non-judgemental approach when supporting the families; empathising with women and the difficult decisions that they had to make. This inconsistency in findings could be attributed to survey participants sharing a more open and transparent response as opposed to those who were interviewed, who may have taken a more guarded approach. Nevertheless, it is a concerning finding, that Health Visitors would allow their personal values and beliefs to influence their practice particularly if they were up not in line with current policy, since these may interfere with the key focus of keeping women safe from abuse. However, a note of caution is due here with a suggestion that further exploration is advised as these findings are merely a reflection from a small group of Health Visitors. The importance of this issue requires a more detailed study to explore whether in fact, personal values and beliefs influence routine enquiry.

In addition to some Health Visitors' personal values and beliefs influencing their practice, Goldblatt (2009) suggested that in supporting abused women, health care professionals

found their own attitudes and emotions were challenged, inducing feelings of anger and criticism about the women's decision to remain in the relationship. Understandably, Health Visitors in this study had personal views about women's decisions not to disclose or to remain in the abusive relationship, however, this did not appear to override their professional practice and did not influence their ability to ask about domestic abuse. When Health Visitors were of the same culture as the clients, they were able to relate and understand the cultural views of domestic abuse. The issue of culture and routine enquiry is explored fully in section *(4.4.1)*.

The findings suggest that in this sample of participants, having personal experience of abuse, appeared to increase Health Visitors' understanding of how women felt and were able to empathise with their clients. This finding reflects that of Bradbury-Jones *et al*. (2011) who acknowledged that the experience of having been in an abusive relationship developed an understanding and non-judgmental approach in terms of the decisions made by clients. However, one could argue that if a Health Visitor is living in an abusive relationship and feels unable to leave, this may have an impact on their ability to support clients. Although Health Visitors acknowledged that their professional experiences and knowledge influenced their practice as highlighted in section *(5.3)*. Further research is required to explore the issue from the personal perspective of Health Visitors in abusive relationships and the impact this may have on the support they offer to women. Despite this conflict between Health Visitors' silent views and the requirements expected of their role, they adopted a professional stance.

4.5.2 EMPATHY, FRUSTRATION AND VICARIOUS TRAUMA

When considering factors that may influence Health Visitors' ability to ask about domestic abuse; their emotional involvement should be considered in terms of the potential impact on their ability to routinely enquire. The expectation is that Health Visitors support women who have suffered abuse however, the extent of the support required may result in an unintended consequence of Health Visitors experiencing compassion fatigue.

Survey responses

Survey participants provided some insight into the emotional demands placed on participants when working with women in abusive relationships. The table indicates that

16 of the 23 participants (69.5%) found working with women who were in abusive relationships, emotionally demanding. Five participants (21.7%) felt it affected them a little while two (8.7%) did not feel affected by routinely asking about domestic abuse.

Table 4.8: Is routine enquiry emotionally demanding?

	Not at all	***A little***	***A moderate amount***	***A lot***	***A great deal***
Number of participants	2	5	9	5	2

Participants provided more information about how they found the Health Visiting role emotionally demanding as follows:

> *The nature and remit of a Health Visitors' role are always emotionally demanding… P1: P28*
>
> *Worries that abuse can escalate very quickly and each day the family are at risk of harm. P1: P20*
>
> *You need to be able to switch off for your own mental health. However, there are some cases that are harder to switch off, and you find yourself thinking of the families at night and at weekends. P1: P21*

<u>*Findings from interviews*</u>

In this theme, the participants acknowledged that they empathised with the women but also recognised their professional boundaries by offering information to the mother so that they could make informed choices:

> *I can't make the choices for her… I can give her the services and the support that she needs. P3: P6*
>
> *You've got to acknowledge that it has to be their decision. P2: P6*
>
> *I find it hard to leave… I need to work on those boundaries. P2: P2*

Having empathy and understanding was something that they considered as part of their role and without it, would have an impact on the women they supported:

> *I feel incredibly sorry for them. I'll do whatever I can to help them. P2: P6*
>
> *I think you have to put yourself, if you can, in their place. P2: P8*
>
> *I treat her with compassion, treat her respectfully, treat her non-judgementally. P2: P2*
>
> *I bear in mind that she's a human being who's feeling vulnerable, even if she is being hostile, there's a reason for the hostility, and I bear that in mind. P2: P2*
>
> *Personally, I understand to a certain extent. Especially if you have children… P3: P8*

Despite feelings of empathy and understanding, some participants spoke of their frustration when considering some women's responses to domestic abuse and their decision to remain in the abusive relationship. Some participants recognised that some women who left abusive relationships became involved in new relationships which were just as abusive as the old one. Feelings of frustration were displayed when participants supported families knowing that the women had returned to a violent relationship:

> *He is out of prison and is back in the house. What do I feel? Frustrated! I feel really, really frustrated! P3: P4*
>
> *The only concern I have got is that she is back in a relationship with him… P2: P2*
>
> *Personally, it makes me feel sort of angry… I wouldn't put up with some of these things. P3: P5*

Some participants held strong views about women who decided to remain in abusive relationships:

> *Personally, I think they're mad because you know that's a horrible way to live. P2: P9*
>
> *I always think 'well why are you are staying in that relationship?'… I wouldn't… I don't understand it. P3: P11*
>
> *It is their choice… I would definitely not put up with an abusive partner personally. P3: P9*

Participants explained their views regarding domestic abuse. This included decisions women made and the impact this had on the children:

> *Sometimes what they tell us might not be the whole story. Then you think of the children, and you think-my goodness they've been exposed to this domestic violence and from a parent who is supposed to be loving and kind…they're hearing all of this and watching whatever it is that the father has done to the mother. P2: P10*

> *Personally, if I had my way, I'd get them out. P3: P3*

One participant considering the enormity of the task they faced when reflecting on the scale of the domestic abuse issue:

> *I just get the feeling it's the tip of the iceberg. I think there's a lot more that goes on than people realise or that people are willing to disclose. P2: P6*

This sense of emotional involvement was apparent when some participants were managing very complex and challenging domestic abuse cases. Participants were continually looking to keep women safe. Some found it quite upsetting when listening to painful stories from women who felt forced to stay in the abusive relationship:

> *Sad, it makes you think that you want to try and help her get out of it or try and keep her safe. P2: P7*

> *That's the emotional side because you want to help don't you, that's what you do the job for. P2: P4*

> *I think it's not easy to go because there's loads of reasons why women stay, and I think our job is to empower them to leave, our job is to build them up before they can leave, and that can be a very slow process. P2: P8*

Health Visitors may suffer secondary trauma such as compassion fatigue due to being in close contact with abused women. Secondary trauma could have a negative effect on participants' ability to function both professionally and privately as indicated in the following excerpts:

> *I found the work was challenging and getting on top of me. I would speak to my manager and say, 'look I'm not coping very well. I need not to be allocated anything for a couple of weeks, so I can get my head straight, get all of this work done, support the families because it's really intense'. P2: P5*

Some of the cases that we come across in themselves can be emotionally draining. P3: P3

It can be emotionally demanding especially the ones that you know something is not right somewhere, but you can't back it up with any facts. P3: P8

In contrast, some participants explained how their role was not particularly demanding and appeared to effectively manage themselves and the challenging cases they encountered:

I personally haven't found it draining… yet. P3: P11

I don't know why maybe I've just got that resilience; it just doesn't drain me, it doesn't. It is, what it is… it's my job, and I am there to try and support people to get through it. P2: P9

In summary, participants expressed empathy when women were suffering domestic abuse and understood the difficult decisions, they had to make in deciding whether to stay or leave the abusive relationship. Participants appear to understand the concerns women expressed and the impact this could have on the children, if they left the family home. Although participants took a non-judgemental approach regardless of women's decision to stay or leave the relationship; they had silent views and were often frustrated that the women did not leave the perpetrator. These left participants supporting women despite silently disagreeing with their decisions which left Health Visitors at risk of compassion fatigue.

Discussion

Pettit, Stephen and Nettleton (2015) propose that the possible consequences of Health Visitors working with trauma victims should be considered. In this study Health Visitors expressed their understanding of the increased prevalence of domestic abuse and the difficult decisions women had to make when faced with whether to disclose and leave the abusive relationship. This study found that some Health Visitors expressed feelings of compassion satisfaction where they felt positive about providing support to families. Health Visitors can be seen to effectively cope with supporting women and children who are living in abusive homes by following NHS Trust policies and national guidelines, while demonstrating their resilience for the role.

Taylor *et al.* (2013) identified increased emotional stress when referring to the way practitioners regulate their emotions to comply with their professional role whereby suppressing personal feelings that may be negative. Some Health Visitors felt that managing women's disclosures and providing support, was emotionally demanding with everyday challenges putting a strain on them personally and professionally. Taylor *et al.* (2013) suggested that 'emotional labour' could be a consequence of health professionals supporting women who had been through domestic abuse. Ongoing exposure to women suffering from domestic abuse could lead to compassion fatigue when there are feelings of sympathy and sadness for women's suffering (Coetzee & Klopper, 2010). Burnout can affect practitioners ability to function both professionally and privately (Goldblatt, 2009). It was evident that having to display empathy and compassion towards women who were experiencing domestic abuse, took its toll. However, it has been shown that Health Visitors are able to regulate their emotions and develop resilience to comply with the professionalism expected of their role (Pettit & Stephen, 2015).

One interesting phenomenon probably not previously identified in research, is what the researcher refers to as the 'silent views' of Health Visitors. By silent views, the researcher is referring to the personal thoughts of the Health Visitors and how they view domestic abuse. Health Visitors appeared to struggle with their personal views even though they considered their professional need to be non-judgmental. Having silent views and having to suppress feelings and emotions about the decision's women may make, appeared to place more pressure on some of the practitioners. Health Visitors' silent views in this study revealed a conflict of emotions from empathy to feelings of frustration when they thought about the challenging environment in which the women were living. Health Visitors expressed hope that women might make different choices, to take themselves out of the relationship, and to keep themselves and their children safe. Although Health Visitors felt empathy and compassion towards women, some felt a sense of frustration when considering how women continued to live with the abuse (Madhani *et al.* 2017). While some shared feelings of anger or silent criticism towards women who chose not to leave their abusive partner, others had strong personal beliefs that opposed women living in abusive relationships and could not understand why they would stay. Having silent views which may oppose the decisions women make, may have possible implications on the practice of Health Visitors and the support offered to women. Bradbury-Jones *et al.* (2011);

Reisenhofer and Seibold (2012) suggested a detrimental effect on the women where health care professionals lacked empathy and were judgmental in their interactions.

Compassion fatigue is characterised by feelings of sympathy and sadness culminating in 'burnout' (Benoit, Veach, & LeRoy, 2007). Pettit & Stephen (2015) found that compassion fatigue was likely to be an issue with professionals who held opposing personal and professional views. However, Goldblatt (2009) suggested that supressing negative feelings and emotions such as anger and criticism, allowed practitioners to fulfil the expectations of their role. The findings of this study supports previous research that suggests emotional labour can be found when Health Visitors regulate their emotions and develop resilience to comply with the professionalism expected of their role (Pettit & Stephen, 2015).

Although having silent views, Health Visitors in this study, maintained professional boundaries and kept their personal views private. Much of the existing literature emphasises how compassion fatigue and emotional labour can impact on individuals (Hernández *et al.* 2010; Wallbank & Woods, 2012). However, prior studies have failed to explore these issues with a focus on Health Visitors and the potential impact on their ability to routinely enquire about abuse, elicit disclosure and support women.

Health Visitors talked about their personal experiences of domestic abuse from child and adulthood. One mentioned that she had been in an abusive marriage suggesting that "it could happen to anyone and no one is immune". While some Health Visitors explained they would not personally stay in an abusive relationship. Another was mindful and watched in case she (the Health Visitor) was being controlled and abuse 'leaked' into her relationship.

Despite their silent views, practitioners talked about being non-judgemental and were often worried and sad about the position women found themselves. In this study, Health Visitors did not appear to lose sight of their supportive role regardless of their silent views and did not judge why women might stay in the abusive relationship. Health Visitors explained how they put aside their personal opinions and focused on the child's welfare through their assessment and decision-making, even though the mother might choose to remain in the abusive relationship (Murray *et al.,* 2015). However, Notestine *et al.* (2017) called for an exploration into the personal beliefs and biases of practitioners and the impact this might have when working with victims of abuse.

In this study, Health Visitors appeared to put aside their personal opinions and focused on the child's welfare through their assessment and decision-making, even though the mother may choose to remain in the abusive relationship (Murray *et al.,* 2015). Despite strong personal beliefs which may have opposed women remaining in abusive relationships, Health Visitors consistently placed the welfare of the mother and child at the centre of their actions. Health Visitors acknowledged that telling a woman to leave was not the answer and were aware of the potential risks associated with leaving an abusive relationship.

4.5.3 SUPPORT MECHANISMS

This sub-theme explores mechanisms in place that support the Health Visitors in their role. Organisational support mechanisms and self-help appear to underpin the contribution of education and training and is identified by the participants as contributing to their confidence and competence as Health Visitors.

Survey responses

Participants reflected on the support they valued the most when carrying out their role and indicated that they wanted more time with the Specialist Health Visitor:

> *Joint visits from the Specialist Health Visitor in domestic violence and abuse... P1: P14*

A survey participant highlighted the value of good management support which was also reflected during the interviews:

> *Management [has an] open door policy for support. P1: P7*

One participant valued the time given to supervision within the Trust:

> *... one to one supervision (clinical and safeguarding). P1: P19*

Findings from interviews

Although the NHS Trust provided support services to participants there appeared to be an ambivalence to using the services on offer:

> *They have a counselling service. I have never used it before. I can't see myself going to a counsellor. P3: P1*

It's a counselling service-but sometimes I just think… is that really confidential? I doubt it very much P3: P5.

Wanting more time with the Specialist Health Visitor was also echoed by one of the interview participants:

I do feel I'm struggling a little bit… so, I would always go back to the Specialist Health Visitor in domestic abuse and violence and ask her. P3: P11

While a survey participant suggested that regular supervision was also valuable in providing advice and support which was also reflected by two of the interviewed participants:

I do feel that we have got good management… they do listen. [I'm] not saying they can always do something, but they will listen. P3: P10

We do like the groups of supervision; we do supervision every six weeks… I think they're quite good. P3: P6

Participants indicated that when dealing with challenging and often complex families, team support made the most difference to them as practitioners:

Where you go back and share with your colleagues, they offer you containment. So, it gives you the opportunity to talk to your colleagues and say… this is how you are feeling about it, perhaps somebody else could also be going through that, and then discuss how you can cope with that. P3: P3

They 'contain' me… so I talk it through with them. P2: P8

There is a lot of emotional containment going on in Health Visiting. P2: P2

I think the impact on me emotionally is buffered by my colleagues and [the] supervision we get. P2: P8

Despite the need to share experiences and gain support from colleagues; participants explained how new ways of working reduced the support from colleagues:

There're times that people come in and you can tell they want to tell you something… want to chat, but if you chat to them for twenty minutes, you know you're late… that's another half an hour of working late. P2: P2

… if they want us mobile working, you would hardly ever see anybody. So how do you get to that point when you sit down and speak to a colleague about how everything is going or what you think you should do next or if you're stuck on something. P3: P6

But there is no time for working lunches anymore. Before you could schedule an hour and work through… but there's no capacity for that kind of thing anymore. P2: P2

There were some participants who considered that team support may not be the best way to 'offload' or gain emotional support. Some participants considered if there were more appropriate ways of gaining support:

… that's not quite right … we're all offloading, so we're just passing our emotions all around. P2: P10

A drop-in lunch or something where you can just talk to a colleague, somewhere confidential, somewhere safe where you can just go 'ahh'[sigh]... P2: P2

Sometimes you need somebody who is off record just to sit there who is a professional in their own right just like yourself and do the same job. But sit down and just talk it through and just see if you feel happy with everything that's going on. P3: P6

Health Visitors described how they took responsibility for their health and wellbeing by adopting self - help strategies:

I suppose we've got the skills from all the workshops… which kind of equipped us with ideas on how to cope emotionally. P3: P3

I suppose you've got to take responsibility for your own mental health, don't you? You can't rely on work to cover everything; they must prioritise care for the families. P2: P5

I've learnt a lot about self-care, self-compassion, and self-efficacy and things like that and I continue to do a lot of reading and work on that. P2: P2

Journaling, mindfulness…. what works for me is making sure you have enough sleep, that your diet is right, and exercise at a proper level… that you do switch off from work and have social time. P2: P2

In summary, participants valued the opportunity for joint visits with the domestic abuse lead which they found to be very supportive. The NHS Trust arranged supervision sessions that participants found useful, additionally, the opportunity to share and engage with

colleagues and to discuss areas of concern involving their practice, was appreciated. However, mobile working resulted in fewer opportunities for informal team support due to limited time together in the office. Participants talked about containment in the management of their emotions and found that self-help was more useful to them, than the NHS Trust counselling service on offer.

Discussion

A lack of support from the NHS Trust could have an impact on Health Visitors' ability to identify and support women experiencing domestic abuse as suggested by (Baird *et al.*, 2017). Most of the Health Visitors felt able to reach out to their line manager to express how they were feeling and received appropriate support. This highlights the importance of accessible line management as an important factor that promotes feelings of well-being within the Health Visiting teams. Therefore, strong leadership is an important factor to uphold policies and provide support for Health Visitors working with families experiencing domestic abuse.

As a key support system, Health Visitors reported placing high value on having a good team around them to share experiences and concerns. Health Visitors also spoke about the importance of team support as a platform for sharing their concerns about families (Whittaker *et al*., 2013). Having a supportive Health Visiting team in which to reflect on practice and to discuss concerned families, appeared to be the most valuable support mechanism that influenced Health Visitors' ability to carry out their role. Practitioners were able to reflect, share and learn from experiences and challenging situations in practice, finding this a crucial factor in building resilience (Pettit *et al*., 2015). However, with increased mobile working, there were limited opportunities to speak to team members for daily support with many expressing their concerns about the new working practices. With such importance placed on team support, the question should be asked whether the NHS Trust should review its current policy, which as it stands, may not currently enhance the health and well-being of the Health Visitors. It is possible that the organisation is not aware of this informal support network, and rather than attending counselling sessions for support the Health Visiting team would much prefer opportunities for supportive networking teams.

Health Visitors must make their voices heard so that the policy makers within the NHS Trust are aware of their specific needs and the impact this will have on clinical practice.

Some Health Visitors were quite clear that they were already resilient and did not find the challenges of the job difficult to manage (Wallbank & Woods, 2012). Whilst others, were aware of the need to sustain themselves so they could continue supporting victims of abuse. Health Visitors took personal responsibility for their health and well-being instead of relying to on the NHS Trust to do this for them. Being aware that burnout and compassion fatigue could occur without appropriate support when carrying out their duties; Health Visitors understood that being resilient was a quality that allowed them to carry out their essential role effectively (Agllias, 2012; Pettit *et al*., 2015).

However, as Goldblatt (2009) reports, burnout could be an unwanted consequence if Health Visitors are not sustained and supported in carrying out their duties. With some Health Visitors finding the role draining, they highlighted how they looked for resources they could use to help build their resilience to cope with the challenges of the role. Health Visitors identified that self-care, self-compassion and emotional containment were essential factors in the management of their wellbeing. In this study, journaling and mindfulness were used to relax and take Health Visitors' minds off some of the challenges and stresses faced at work (Berger *et al*., 2015; Rosenfeld, 2014). Some Health Visitors pointed out that having a balanced diet and exercise regime was always a solid basis for building resilience and coping with stress. In order to facilitate Health Visitors ability to self-care, it would be prudent for the NHS Trust to provide some training in relaxation techniques for stress relief. This could be in the form of meditation, yoga or deep breathing exercises to reduce everyday stress and to improve mental and physical health. In this way all Health Visiting staff would have access to this service that supports their continued ability to work with families who are experiencing domestic abuse.

Supervision is a form of reflective practice that supports personal agency as it helps practitioners to review choices made in practice and supports actions taken (Bandura, 1989). The National Health Visiting Specifications (2014) advised that Health Visitors should have access to clinical supervision to support and maintain their competence in all aspects of safeguarding. The supervision framework has been found to be an essential

component in increasing compassion satisfaction, reducing stress and potential burnout (Wallbank & Woods, 2012).

It was a reassuring finding that Health Visitors welcomed supervision in practice, acknowledging the importance this played in building their competence. Supervision also safeguards clinical practice and the quality of care provided for families (Wallbank & Woods, 2012). Health Visitors gave a clear indication that supervision had an impact on their ability to fulfil the requirements of their role while improving practice, reducing stress and promoting the safety of clients (Greaves, Watson, & Keen, 2016). Therefore, the NHS Trust need to ensure they have a robust system of supervision in order to meet the needs of Health Visitors to safeguard their practice, and ultimately safeguarding the care provided to women experiencing domestic abuse. These echoed findings by Peckover *et al.* (2003) who suggested that clinical supervision is essential to the support of practitioners and has an impact on the development of their knowledge and skills.

4.5.4 HEALTH VISITORS' VIEWS ABOUT SAFETY

It is important to consider whether the issue of Health Visitors' safety had an impact on the support offered to women living in abusive relationships and if this affected the participants' ability to ask about domestic abuse.

Findings from interviews

Participants described their concerns regarding personal safety when going into homes where domestic abuse is suspected or has been identified. The concern highlighted by some participants was significant and had the potential to impact on service delivery if concerns about safety prevented Health Visitors from raising the issue of domestic abuse:

> *Frightening. I've been in situations I tell you! P3: P6*
>
> *You do worry about your own safety and your own health and well-being. P2: P3*
>
> *I know when going to a client's home, we're always aware, we're always looking, we're always making sure, if possible, we sit nearer the door. P2: P10.*

There can be so many different people in the house; we don't know who is in the house, so if anything happened… how do you know what is going to escalate? P2: P10

It still gives me goosebumps just thinking about it. But yeah, it was scary. P3: P6

Some participants highlighted the risks involved when conducting home visits while others did not consider this as an issue of concern:

I've never felt unsafe going in. P3: P4

Resistant yes but not hostile towards me. P3: P2

I haven't had anyone really rear up to me and be aggressive. P3: P10

Participants demonstrated a pro-active stance when considering how to increase safety when conducting client home visits. The following excerpts illustrate how participants developed strategies to maintain their safety:

When the partner is very loud … I can tell that this person is unpredictable… So, my next contact, if mum is not going to come to the health advice session, I'm going to do a home visit with someone else. P3: P3

If the environment is not right, you move the client. Come to see me in the children's centre. P3: P9

My colleagues will always know if I'm going somewhere. So, I'll say to somebody else… '[I am] really worried about this lady, I'm going to see her… if I don't get back within half an hour-just give me a bell'. P3: P6

In summary, some participants identified that they do have concerns about their personal safety and going into homes where the environment may be unpredictable. However, others had no concerns about safety as they have never encountered hostility when in clients' homes. Participants have explained that if they do have concerns they think ahead and either suggest clients meet at health centres or children's centres. The other alternative was to make sure there was someone within the team who knew their whereabouts.

Discussion

When conducting home visits, practitioners considered how safe they were within their environment (Gutmanis *et al.* 2007). Although some Health Visitors felt safe and comfortable in the family home and had not experienced any hostility during visits, others expressed concerns about their safety. These findings indicate that Health Visitors have concerns about their own safety when conducting home visits, describing a heightened sense of awareness and consciousness in what they felt was an unpredictable environment. Health Visitors talked about how they sometimes felt fearful before going into the client's home. Others felt a sense of unease and sometimes fear in going into the homes knowing they would be asking about domestic abuse. One Health Visitor explained that on most occasions she felt comfortable asking about domestic abuse however, there were one or two episodes when she had felt uneasy. When probed further the Health Visitor could not identify the reason for this unease, only to say that it was present.

Health Visitors also had concerns about how they would manage a situation if there was an escalation of violence in the home when they were present. Some practitioners spoke about being aware that in some family homes there was often only one way in and one way out of the building which may prevent a quick exit. Concerns about safety become particularly challenging when Health Visitors worked with families where the perpetrator had been identified, but remained in the family home (Peckover, 2002). Practitioners explained how they became hesitant when considering clients who might be unpredictable and knowing who was in the home was often problematic in multi-occupancy households, proved an additional concern when visiting clients.

Although not all Health Visitors identified safety as being an issue for them as an area for concern; those who highlighted their worries about safety were quite clear that their anxieties would not deter them from asking about domestic abuse. This finding highlights the professionalism of the Health Visitors who continue to deliver the service according to NHS Trust policies and national guidelines. What should be much-admired is that despite these fears, Health Visitors continue to carry out their role entering family homes and enquiring about domestic abuse.

However, it could be argued that being in a state of fear and anxiety will have an impact on the health and well-being of the practitioner and can lead to compassion fatigue. Tower (2006) cautioned that when healthcare professionals are anxious about their safety, this may have an impact on their ability to ask about domestic abuse routinely and may be a significant barrier to taking appropriate action. Early research by Shepard *et al.* (1999) and Sugg *et al.* (1999) suggested that the potential risk to personal safety could be a barrier to intervening when domestic abuse is either, suspected or confirmed. Salmon *et al.* (2006) echoed this stance by suggesting that the ability to ask about domestic abuse could be compromised if the Health Visitor did not feel safe.

Health Visitors in the study did not allow anxieties about their safety prevent them from carrying out their role effectively. However, the NHS Trust has a duty to ensure the safety of the Health Visiting workforce and need to acknowledge when practitioners voice their concerns about safety. It is important that Health Visitors are able to speak out and raise issues around safety so that policy is reviewed and in place to provide reassurance to the Health Visitor that their safety has been considered in order to support the work they do and to keep them safe in the process. Peckover (2002) and Salmon *et al.* (2006) agree that consideration should be given to staff when they expressed concerns about personal safety.

CHAPTER FOUR: SECTION TWO *(SQ1A)*

As families can be complex; the Health Visitor needs to use assessment skills to make a professional judgement about when to escalate their concerns. This chapter identifies some of the challenges that Health Visitors face when making decisions about when to escalate their concerns. What do they look for, how do they search for health needs, and what is the 'tipping point' that results in a referral to social services?

This section will address the subsidiary question ***(SQ1a).*** The question comprises:

SQ1a: How do Health Visitors' make decisions about appropriate courses of action to ensure the safety of the clients?

***SQ1*a** is answered, drawing on two data sets, which comprise:

i. Survey data from Phase 1

ii. Transcripts from Phases 2 and 3 (semi-structured interviews)

One key theme emerged and will be examined with illustration by quotes in the section that follows.

Table 4.9: Emergent Theme

Theme 1: The escalation of concerns (4.6)

4.6 THEME ONE: THE ESCALATION OF CONCERNS

Once domestic abuse is either suspected or established through disclosure, Health Visitors are expected to make decisions on the next course of action. This theme explores how Health Visitors assess the level of risk to women and children and how they make decisions in terms of escalation and when to make appropriate referrals.

Survey responses

Some participants considered their actions if a client disclosed domestic abuse, but indicated that they did not want to leave the abusive relationship:

> *I would focus on the safety aspect, assessing the immediate safety of the mother and children… Risk identification checklist and a safety plan would need to be looked at. P1: P28*

> *Seek further advice from a safeguarding nurse, the safety of the child is always the focus, and therefore if a parent is not able to safeguard themselves, it would be a social care referral. P1: P21*

> *I would discuss with safeguarding or social care if I was concerned there was a risk of significant harm. P1: P12*

Findings from interviews

However, if at any point the mother demonstrated that she was not able to keep the children safe, this became a safeguarding issue that participants escalated without hesitation:

> *… when the children are involved, it's my duty to tell her she needs to put the safety of her children first. I need to be sure she can safeguard the children. P2: P6*

If I feel the physical abuse is there, then I will make a referral straight away. P3: P8

If there is a risk of harm to this mum and her children, then she needs to be moved. She needs to be safe, and a safety plan needs to be put in place for her and her children's well-being. P3: P10

Is this child at risk of significant harm? P2: P2

All participants who were interviewed identified the primary factor that influenced their decision of when to escalate concerns about domestic abuse, was the presence of children in the home and their safety:

We recognise that it has an impact on children; therefore, it's something that we do address… P2: P1

The priority is the child or children and what can I do to make them safer. P2: P5

One participant provided a graphic description of when there was an escalation of violence in the home and a child suffered abuse:

He actually hit her daughter. He was actually sitting at the computer, [he] punched her daughter out cold and then went back on the computer while she was out cold, so he was very physically abusive. P2: P8

Another participant gave a frightening example of a perpetrator exhibiting control by threatening to cause significant harm to a baby:

It's not silly… he's threatening to throw your baby out of the window…. he's threatening to take your child abroad. P2: P4

As well as the physical signs of domestic abuse, participants indicated their knowledge of the long-term impact of abuse on children:

You know the children are seeing that, and it's not fair on them, and they're going to grow up being the same and accepting the same behaviour. P2: P9

Undoubtedly even if they're not witnessing the abuse, they are going to be picking it up in another way or mimicking that behaviour or normalising that behaviour. They will be affected in one way or another. P2: P5

The safeguarding of children central to participants' decision-making of whether to escalate concerns, and to initiate discussions with the safeguarding team and other agencies. Participants explained their thought processes in how they made their decisions:

> *Obviously, you've got the child, so you don't want any harm to come to that child…. he's going to get hurt if he's in the middle of all of it... P2: P4*

> *I've got to be very clear with them that whatever we discuss is confidential, but if there is safeguarding concerns, it's my duty to report it to social care because there are children involved. P2: P6*

> *As soon as you have safeguarding concerns, then you would have no choice but to report it. P2: P2*

The participants were able to identify how they worked effectively with outside agencies to provide additional resources to ensure the safety of women and children living in abusive environments:

> *If they still insist that everything is fine… maybe send them to the children centre, let them be visible… so that if there is anything [wrong], somebody can pick it up… P3: P9*

> *They will need to know how they can access the charities for everything they need. P3: P1.*

> *She was moved to a refuge after that. P3: P3*

Participants worked in partnership with social services. However, when referrals made by participants did not meet the 'threshold' for social services to take up the case, this raised significant issues for participants:

> *The threshold for social services is so high; hardly anything meets it… P2: P7*

> *All social services wanted to know was 'what had changed?' I remember telling them, 'look there's a new baby in that home, and this makes a big change'. P3: P4*

> *The reply was that the MARAC is only used for families that are in immediate danger… well to me that mother was in immediate danger… P2: P10*

In summary, participants demonstrated that their focus was around the safety of the children involved in the abuse. Participants understood that when children were living in abusive homes, the impact on them could be physical but also psychological and might have long

term effects. Signs of physical abuse resulted in an immediate escalation and referral to social services with participants mindful that a safety plan would need to be in place to minimise the risk to the family.

Discussion

This study set out to determine how Health Visitors decide when to escalate their concerns when domestic abuse was in a relationship. Health Visitors acknowledged that the well-being of the children was of paramount importance, as suggested by Mullender (2004) and Olive (2007). The welfare of children was a 'benchmark' and used in deciding when to escalate concerns. When a mother did not disclose domestic abuse, but the Health Visitors had reason to suspect abuse was occurring; they would often use the welfare of the children as a 'barometer' to override the needs of the mother. Consistent with the literature, Health Visitors used their judgement to carry out holistic assessments when considering if and when to escalate concerns (Biggs *et al.*, 2014). Keeping the focus around the welfare of the child, allowed the Health Visitors to remain objective while using their professional judgement when making assessments as suggested by Ramsay *et al.* (2012). Health Visitors placed the child central to any decisions they made by asking themselves, 'are the children at risk of significant harm?' This finding is consistent with a study by Pettit and Stephen (2015), who suggested asking questions about significant harm before making a judgement.

According to the study, Health Visitors considered the possible risks posed to children living in abusive homes as an essential benchmark when deciding to raise concerns, which was in line with research carried out by Mullender (2004). Children always know what is going on when there is abuse in the family home, and they often witness it (Sousa *et al*., 2011). Health Visitors in this study identified that it was often much later when women realised the impact abuse had on their children and that it affected them emotionally as well as physically, when there was domestic abuse at home (Holt, Buckley, & Whelan, 2008). Signs of physical violence and aggression, is an indication of a severe escalation in the abuse, which could result in death (Finn, 2016). Therefore, it is crucial for Health Visitors to identify the risks and consequences associated with children living in abusive homes, and the importance placed on safeguarding them. This study confirms that if there were indications that the child's safety was at risk of being compromised, Health Visitors were clear that they would escalate concerns without hesitation.

This study found that Health Visitors were able to articulate their knowledge of domestic abuse and were clear about their role. Health Visitors were there to support the family and felt the weight of responsibility by acknowledging that families with young children were particularly vulnerable with the need to safeguard children. NICE (2016) and the Local Government Association (2017) considered the safeguarding of children as an essential part of the Health Visitor's role. Practitioners in this study took this responsibility seriously and were willing to risk their professional relationship with the mother to maintain the safety of the children, acknowledging that the welfare of the child is of paramount importance.

Findings in this study broadly support the work of others in this area as children remained the focus for Health Visitors who expressed their awareness about the impact of abuse on the child (Peckover, 2002; Mullender, 2004). Health Visitors work on the premise that most mothers want the best for their children and wish to keep them safe and would not hesitate to escalate their concerns in maintaining the safety of children. Health Visitors were clear that their professional duty was to escalate concerns, seek advice and use sound judgement to do this. Utilising their knowledge of domestic abuse, helped them to identify women who needed support. Although they spoke about the visible signs of abuse, they were also aware of looking for other signs such as the emotional well-being of children.

Health Visitors in this study appeared to welcome partnership working and were proactive in bringing a wide range of outside agencies, both statutory and voluntary, together to support families (Mullender, 2004). However, Health Visitors spoke about the challenges they faced when making referrals to some agencies such as social services, expressing concerns about families who were not deemed to have reached 'the threshold' for a social service intervention. These are troubling findings and are consistent with that of Peckover's (2014) study where Health Visitors gave accounts of social workers who did not accept referrals when not sharing an understanding of risk-level within the family. How do Health Visitors support these families on an ongoing basis? How do they keep the children safe from harm?

The findings reported here suggest that Health Visitors need to be clear about the management of families who do not meet the threshold for social services but where there are ongoing concerns. In this study, Health Visitors sought advice from line managers and

the domestic abuse lead, to agree on a way forward in how to provide support on an ongoing basis, when concerns did not meet the threshold for the intervention of social service. Consideration needs to be given to asking whether there are alternative ways in which families can be supported when they do not reach the threshold for a referral. Due to organisational changes, Health Visitors were more limited in the number of home visits they could offer to families who required more long-term support, as discussed in sub-theme (*4.4.3*). The question arises as to whether there are alternative support mechanisms available to these families? In order to have a consistent approach, NHS Trusts need to review the local policy and how this can support Health Visitors working with families who do not meet the threshold for a social services referral and may need to involve more multi-agency working.

CHAPTER FIVE: FINDINGS AND DISCUSSIONS *(RQ2)*

Chapter 5 addresses research question ***(RQ2)***: ***Are Health Visitors able to identify the further training or educational requirements that they perceive as supporting their 'confidence' and 'competence' in working with clients?***

In attempt to answer this question, the researcher will draw on the survey data and the transcripts from Phases 2 and 3 (semi-structured interviews).

Health Visitors asked for ongoing education and training to maintain their confidence and competence in order to meet the needs of their clients. While addressing *RQ2,* two key themes emerged along with accompanying sub-themes listed below. These are examined in turn and illustrated by quotes in the sections that follow.

Table 5.1: Emergent Themes

Theme 1: The broader context: safeguarding others (5.2)	
Sub-themes:	• Safeguarding men who are victims of domestic abuse (5.2.1) • Safeguarding victims in a same-sex relationship (5.2.2)
Theme 2: Education and training needs (5.3)	

5.1 THEME ONE: THE BROADER CONTEXT: SAFEGUARDING OTHERS

RQ2 asks whether Health Visitors can identify education and training needs. Participants acknowledged a gap in their training, specifically when asking men and same-sex couples about domestic abuse. Participants expressed concern about their lack of confidence and competence to address the issue with this client group. There appears to be a gap in their education and training that needs to be addressed.

5.1.1 SAFEGUARDING MEN WHO ARE VICTIMS OF DOMESTIC ABUSE

When considering domestic abuse, Health Visitors take a holistic view of the family and the impact abuse may have on the victim and the children. During the semi-structured interviews, participants raised the issue of encountering men who were victims of domestic abuse within their caseloads. This issue was an unintended consequence as the focus of the research question was around routine enquiry and women. Health Visitors were clear that they lacked confidence to adequately support men who were victims and called for more education and training in this area.

Findings from interviews

Participants raised the issue of women who were perpetrators of abuse and gave examples of when women are the abuser:

> *She was apparently the perpetrator of the domestic violence. P3: P4*
>
> *He then said '...she picked up a knife the other day while she was in the kitchen'. P3: P4*
>
> *A lot of men are going through domestic abuse. P3: P1*

Participants explained how their role focused on asking the mother about the abuse. There was a sense of not knowing why only women were routinely asked about abuse when men could also be victims:

> *It is the voice of the women that are heard more the voice of the men sometimes. P3: P1*
>
> *Yes, obviously more women are affected, but obviously, men can be abused as well. P3: P11*
>
> *I would definitely ask the mother, and I don't know why, because fathers could be [abused] too, but why do we always ask mothers? P2: P10*

There was an indication of how ill-prepared participants felt to ask men about abuse, and they lacked confidence in how they would support fathers who were victims of abuse:

> *I know it's on the increase, isn't it? Men are going through it, but then how do you ask men? P3: P6*

I haven't been able to ask [men] the domestic violence questions and support them in that way. P3: P6

…I have never asked a dad or partner… P3: P11

Participants identified their lack of experience in managing cases where women were the perpetrators. One participant expressed their uncertainty of how to keep the child safe when the mother is the abuser:

…the female is doing it, how is she safe to be around the baby? P3: P6

If she's doing that [abusing the father] sort of thing…the child is seeing that. So how do you support that family? I don't know how we will tackle that. P3: P6

Participants identified their lack of confidence to ask men about abuse, deal with disclosure, and provide ongoing support, despite being in an ideal position to do so:

I haven't actually dealt with one directly, so I don't know. P3: P9

…that's something that I've always thought about. I've never known how to tackle that… P3: P6

I know it's on the increase, isn't it? Men are going through it, but then how do you ask men? P3: P6

It was acknowledged by participants that men could be victims of domestic abuse and that it would be difficult for them to disclose the abuse:

It's quite difficult because most of the time we tend to deal with mothers more than fathers and for a father to even disclose it is huge. P3: P8

The men are the victims. Even when you ask the men to talk… they are not ready to do it. P3: P1

Participants were able to identify that there was a lack of support for men who were victims. Although one participant acknowledged that she would offer the same support to the father as would be offered to the mother:

Support for the men out there? I'm not sure. P3: P9

I guess I'd support the father in the same way I'd support the mother. P3: P2

I've had a dad to come and ask me for emotional follow-up visits without his partner. P3: P6

There was a call for education and training on how to address the issue of men as victims. Asking about abuse and providing support to men appeared to be an area that the participants wanted to know more about:

Much of the training is about male-female relationships and men being the perpetrator… P3: P6

We are taught to ask the domestic violence question at every visit if it's safe to do so. But we only ask the mums… P3: P11

In summary, participants understood that while women were often the primary victims of domestic abuse, men could also be victims of abuse. However, asking men about abuse is not currently part of what Health Visitors include in their routine enquiry. Findings suggest that participants were not confident or competent in managing the issue of domestic abuse when men were victims, and women the perpetrators. It is important to consider how Health Visitors support families in this instance. Participants expressed that they felt ill-prepared to tackle the issue when men are victims and with managing their disclosure.

Discussion

This study set out to determine the possible influences on the Health Visitor's ability to carry out routine enquiry, the point at which to escalate concerns, and the identification of educational and training needs. NHS Trust guidance on domestic abuse has focused on the protection of women and children with evidence that suggests women are the primary victims of domestic abuse (Keeling and Mason 2010; Peterman *et al.* 2011). To date, Health Visiting services have not explicitly focused on the welfare of men, but instead the women and children. Identifying men as victims could be considered a missed opportunity to educate both parties within the relationship about domestic abuse in general. However, discussing issues about abuse with both parties' present could increase the risk to the victim and must be considered. How can Health Visitors navigate this challenging issue while keeping the victim who may be male or female safe within the relationship? The male voice has not been heard. This is important since it is known that men are less likely to disclose the abuse, as noted by Dempsey (2013). There is a need to review national and local policies

to explore whether the Health Visitor has a role to play that is inclusive of male victims of abuse, rather than exclusive to women.

Health Visitors in the study raised concerns about the notion that women could be perpetrators and that it is not only women who suffer domestic abuse. They also raised concerns about how to keep the children safe in the relationship when the abuse comes from the mother. Some Health Visitors hesitated and sometimes avoided asking men if they had been victims of domestic abuse, while expressing some discomfort and a lack of confidence in doing so. The Office for National Statistics (2018) estimated that there are 2.4 million male victims of domestic abuse. With the aim to keep children safe and safeguard the victim, surely the current working practices, policies, and procedures around routine enquiry do not address this concern. Health Visitors are appealing for more guidance around this issue of men as victims. The local policy must address how Health Visitors support men who are victims and respond when women are the perpetrators.

The study findings demonstrated that Health Visitors lacked confidence when women were perpetrators, broadly supporting the work of Bradbury-Jones (2016) who acknowledged that Health Visitors have a role to play, to address men who are victims of abuse, and to influence policy and practice. This study also supported evidence from Robinson & Spilsbury (2008) who found that asking male victims about their experiences of domestic abuse was an area that required further development because Health Visitors did not feel equipped to provide support. How are Health Visitors going to build their confidence and competence around this matter? It is proposed that during education and training programmes, Health Visitors should be allowed to explore and discuss this issue and how to manage this in their practice in more detail.

Health Visitors identified their limited knowledge and experience regarding their support of men who are victims of domestic abuse (Ayala, Kotary, & Hetz, 2015). Appealing for more guidance, Health Visitors want to develop their competence and confidence to address men who may be victims of abuse. Meeting the needs of men acknowledges their role as fathers within families and avoids missed opportunities to identify abuse and to keep the family safe. Several questions remain unanswered at present. Further work is needed to

identify how Health Visitors can be confident in their routine enquiry, to choose when to ask men about abuse, and provide support.

5.1.2 SAFEGUARDING VICTIMS IN SAME-SEX RELATIONSHIPS

During the semi-structured interviews, participants introduced another area that had not initially been anticipated by the researcher. The participants were concerned about how they would raise the issue of domestic abuse when couples were in same-sex relationships. This sub-theme explored the gap in knowledge identified by participants and how they wanted to know more about asking, supporting and safeguarding same-sex victims of domestic abuse.

Findings from interviews

One participant indicated that they had not encountered clients in same-sex relationships, but other colleagues had:

> *I've never had a domestic violence situation between same-sex couples. P3: P6*

> *Some of my colleagues have been in and have done new birth [visits with] same-sex couples or gone in to do visits on parents of same-sex couples that have adopted [a child]. P3: P11*

Here two participants appeared to ignore the possibility that domestic abuse could occur in the same-sex relationship, and explained that they did not ask either parent about domestic abuse:

> *I don't ask them to be honest with you. P3: P9*

> *To tell you the truth, I didn't [ask]. P2: P10*

However, one participant explained that she had asked about domestic abuse:

> *I have asked about domestic violence in a same-sex couple [relationships]. P3: P6*

Although participants were aware that domestic abuse should be discussed during the client contact, they were uncertain how they would go about this:

Sometimes you see it on the news where two men have been in a relationship, and one's been domestically violent, and the other one hasn't. You just kind of think… who do you ask? P3: P6

I've never had a couple which has [been] both been males, so that's a difficult one… who do you ask? Do you see what I mean, it's difficult, isn't it? P3: P6

Who do you ask….? It's interesting because you see more and more of it these days [with] men being parents on their own. P3: P6

Interestingly participants appeared to focus on who gave birth to the baby before deciding whom to ask about domestic abuse:

If it's a new birth visit, I usually ask mum. The person who has just had the baby. P3: P8

I will ask the one that seems to be the woman… P3: P5

One participant is seen to face a dilemma when both parties in the relationship were male. Trying to find out who was the 'mummy' and who the 'daddy' in the relationship, appeared the primary goal:

This is a problem because I have a male couple…I tried to find out who was the mummy and who was the daddy… P2: P10

Another participant focused on who was giving the most care to the child as an indication of whom they would ask about domestic abuse:

I guess whoever is the main carer for the child, you would ask them…P3: P2

However, some participants solved the issue by asking both partners in the relationship about abuse:

[Ask] Both of them, but then that's because they're both females. P3: P6

I think it's fair to ask both of them. P3: P3

Well, I asked both of them... P3: P5

When considering the right time to ask about domestic abuse, there was a lack of clarity and consistency when couples were in same-sex relationships:

… I ask anyway but then, do you ask them together, do you ask them separately? How does that work? I don't know, that's a difficult one. P3: P6

I would ask when they are both there. P3: P5

Depending on my instinct I may decide to probably ask the question separately. P3: P3

… I would use my discretion as a professional as to whether I asked them separately. P3: P3

Participants asked for clear guidance on how to ask and support victims of domestic abuse regardless of gender:

What would be really good if we had training on how to…you know, approach that… and how to work with same-sex couples. P3: P11

In summary, the uncertainty about how they would approach couples in same-sex relationships suggested that participants lacked confidence and were hesitant. Most participants were unsure as to whom they would ask about abuse, with some focusing on finding out which parent took on the 'mother's role' or was the 'main carer'. Although NICE (2016) guidelines advise that clients should be alone when asked about domestic abuse, participants were unsure and did not always appear to apply the same guidance when clients were in same-sex relationships. Some participants even asked about abuse when there was a third-party present.

Discussion

In the UK, cohabiting relationships and legal recognition of lesbian and gay relationships mean that the characteristics of the family have shifted. However, there appears to be limited understanding of the disparities between violence in same-sex relationships and violence in heterosexual relationships (Harvey *et al.*, 2014; Hester *et al.*, 2012). Health Visitors raised the issue of asking same-sex couples about domestic abuse during the semi-structured interviews. Health Visitors did not feel sufficiently confident to ask couples who were in same-sex relationships about abuse. Health Visitors appear to have had had limited exposure, knowledge, and understanding of how to ask and support same-sex couples. Lack of experience in working with same-sex couples means that Health Visitors would lack confidence when they engaged with this client group. A lack of confidence could result in

missed opportunities to identify domestic abuse within the relationship whereby leaving the victim and children at risk.

On further inspection, it could be seen that there was a lack of consistency with routine enquiry; some Health Visitors asked about abuse when only one party was present, while others, asked when both were present. Considering that NICE (2016) guidelines promote asking about domestic abuse while maintaining the confidentiality of the individual client, it was a significant finding that Health Visitors asked in the presence of both couples. Why would it be appropriate to ask about domestic abuse in the presence of both partners who are in same-sex relationships since the risks posed to possible victims are the same as in heterosexual relationships? This study found that there was no clear guidance to support Health Visitors in addressing same-sex couples that may be in abusive relationships. This issue must not be ignored and requires further exploration as to how to improve the practice of Health Visitors in this area.

Health Visitors indicated that finding out who gave birth to the baby or who was the 'mummy one', was of great importance. Finding out who gave birth to the baby appears to defy the purpose of routine enquiry, which is about protecting adults and children from harm within the family. This issue could be connected to the previous discussion (*5.2.1*) where men who are victims of domestic abuse are not asked if they are suffering, and instead the focus being only on women. With no NHS Trust guidance in place, Health Visitors appeared to flounder and were unsure of best practice. A publication by Dempsey (2011) agreed with this study, suggesting that domestic abuse occurs in same-sex relationships, but is often a neglected area with a lack of information regarding the extent of the problem.

This study has demonstrated the shortcomings that Health Visitors have in providing universal services to clients in same-sex relationships. The Department of Health (2017) advised practitioners to apply their understanding of domestic abuse to determine and provide support to victims regardless of the gender and sexuality of the victim or perpetrator. The findings are significant as some Health Visitors indicated they had never worked with same-sex relationship couples within their caseload. Those who had, faced a

dilemma in terms of whom to ask about domestic abuse. This study found that Health Visitors were looking for more guidance.

Education around same-sex relationships and domestic abuse appears to be a neglected area of practice, with very few resources available that relate to Health Visitors. When considering same-sex relationships, participants expressed difficulty in knowing whom to ask and when to ask about abuse, and they requested further training around this aspect of their role. Having an open dialogue about domestic abuse with same-sex couples was an area where education and training could enhance practice.

Further research is needed to gain a better understanding of how to address the education and training needs of Health Visitors so that practitioners are more inclusive when they ask about domestic abuse. These findings suggest that a lack of knowledge has had an impact on how Health Visitors ask clients who are in same-sex relationships about domestic abuse. With the fear of disclosure and the possible stigmatisation, this client group is unlikely to share their experiences of abuse which is the reason the Department of Health (2017) directed practitioners to support all clients, regardless of gender or sexuality. Further work is required to establish and shape educational programmes to include a component around same-sex relationships. A lack of evidence has highlighted the need for research to focus on this crucial area in relation to Health Visitors.

5.2 THEME TWO: EDUCATION AND TRAINING NEEDS

This theme considers the education and training needs of Health Visitors about domestic abuse. Factors that may influence participants' ability to routinely enquire, identify, and support women were explored to find out if education influenced their ability to carry out their role effectively and what further training Health Visitors would value.

Survey responses

It was reported that 87% of the 24 survey participants, had received training in the past year, and 100% of participants received education and training within the last three years. One participant wanted regular updates either annually or biennially:

Refresher courses or workshops on DVA, maybe yearly or every two years. P1: P10

Six participants wanted to know more about how to encourage women to disclose and manage disclosure, and requested further training:

[More training when] DVA is suspected, but the client does not disclose DVA. P1: P10

[More training on] how to get victims to feel able to open up and disclose to us. P1:P12

Participants were able to identify how often they would like to have focused education and training around domestic abuse and the nature of the training, which included use of scenarios, how to work with other agencies, and how to initiate disclosure:

Online self-training on DVA, offering information and different scenarios. P1: P10

More information and working relationships with the services… P1: P12

All 24 Health Visitors agreed that education and training were likely to influence their attitude about routine enquiry and their response to women who disclose abuse.

Findings from interviews

Participants who were interviewed also identified the need for ongoing education and training, emphasizing the value of regular updates:

I would like regular updates because services change so frequently, so it would be good to keep on top of exactly where you can refer people if you need to. P2: P5

I would like it more regularly because it's like anything, you go to the training, and I make the notes, and at the time I think 'yes, that's really good'. Then come back to work and then [I] might go weeks and weeks and weeks before I have another disclosure… I would just like refreshers... P2: P6

Further, participants described the value placed on education and training and the influence it had on their practice:

I changed my practice; in the way I asked the questions. P3: P3

With the domestic violence updates, you begin to understand about the controlling aspect I never really thought of before. However, it opens you up to all of these things… how to 'ask the question'. P3: P4

When you read the serious case reviews, you see how many had domestic violence as one of the key factors; it's always in the background. The toxic trio is in serious case reviews where children have died, its virtually always there. P2: P2

It updates you on different pathways and different support networks that are available. She [domestic violence lead] also updates the resources folder so you've always got all the up-to-date places that you can tell mums and get support for them. P3: P6

I think we need to practice all the time… P2: P8

The findings suggested that all participants had received education and training around aspects of domestic abuse and routine enquiry within the past three years. Participants identified the importance of regular and ongoing updates to support and enhance their knowledge and understanding of routine enquiry, eliciting disclosure, and supporting women. All agreed that education and training influenced their ability to enquire and respond to women's disclosure.

Discussion

Although Health Visitors in the study had experience asking women about abuse, previous research has shown that victims of domestic abuse benefit from practitioners who have contemporary knowledge and understand the broader issues around domestic abuse (Pratt-Eriksson *et al*., 2014; Ramsay *et al*., 2012). This study confirmed that Health Visitors place great value on the education and training they had received on domestic abuse and routine enquiry. They gave accounts of how regular updates influenced their practice and felt this needed to be ongoing. Ideas on how to elicit disclosure and support women who had been abused were discussed at training sessions, which in turn influenced practice.

Health Visitors were aware of the positive impact education had on their practice as previously suggested by Goldblatt (2009) and Beynon *et al.* (2012). Health Visitors were also aware that education had a positive effect on their judgement and self-efficacy (Hamberger *et al.* 2004). Practitioners explained that a lack of education and training could be an obstacle that prevented them from identifying and supporting women who experienced abuse (Gerbert *et al*., 2000; Ramsay *et al*., 2012). These results reflected those of Baird *et al.* (2017) who also found that Health Visitors wanted education to be ongoing, in order to remain updated on current issues. In answering *RQ2*, the overwhelming opinion

of the participants was that ongoing education and training around domestic abuse has a positive and direct impact on their ability to be confident and competent, by providing an opportunity to refine and build on their existing knowledge (Lazenbatt, Thompson-Cree and McMurray, 2005).

This study confirms that education and training programmes are of value to the Health Visitor. The findings support the view that education, alongside professional experiences, are known to build the self-confidence to have difficult conversations about domestic abuse (Gutmanis *et al.*, 2007; Beynon *et al.*, 2012)**.** With training, practitioners are more prepared and confident to talk about abuse and follow up on disclosure (Gutmanis *et al.*, 2007; Gregory *et al.,* 2010).

CHAPTER SIX: CONCLUSIONS, ORIGINALITY AND RECOMMENDATIONS

6.1 INTRODUCTION

This study aimed to explore factors that could influence the ability of Health Visitors to enquire about domestic abuse and how they make their decisions to escalate those concerns. The further aim was to establish the education and training needs of Health Visitors that could support them in their role.

The study had two primary and one subsidiary research questions. Chapter 4, section one provides answers to *RQ1,* which explored the possible influences on routine enquiry. Chapter 4, section two (*SQ1a)* provides insight into the decisions made by Health Visitors to ensure the safety of clients. Chapter 5 focuses on *RQ2* and provides answers as to what further education and training is needed to support Health Visitors in their practice.

This conclusion is drawn from the findings of this study and brings together key themes and issues that arise from the research questions. Original findings are presented from this study as well as recommendations for future practice. Some of the study's limitations are noted, and the implications for future research are indicated. A closing reflection on the research experience is also included.

6.1.1 CONCLUSION

In response to *RQ1,* some findings raised issues surrounding aspects of practice. Therefore, it is crucial that consideration is given to how these can be addressed in the context of policy, education, and clinical practice. Concerning *RQ1,* five key factors were found to influence Health Visitors' ability to enquire about domestic abuse routinely. Some of the key elements *(Fig 6.1)* relate directly to Health Visitors, but others relate to the environment and the influence of others, such as the victims or interpreters. In effect, there is more complexity to the issue of routine enquiry than previously suggested. While policymakers can promote the identification of abuse as just a simple question, there are multifaceted issues around this. Therefore, addressing the issue of domestic abuse through the Health Visitor's role, requires a comprehensive strategy, one which does not only focus on Health Visitors but also on training, development of policy, environmental factors, and clinical

practice. The key factors that illustrate the complexity surrounding routine enquiry are represented diagrammatically below *(Fig 6.1)*.

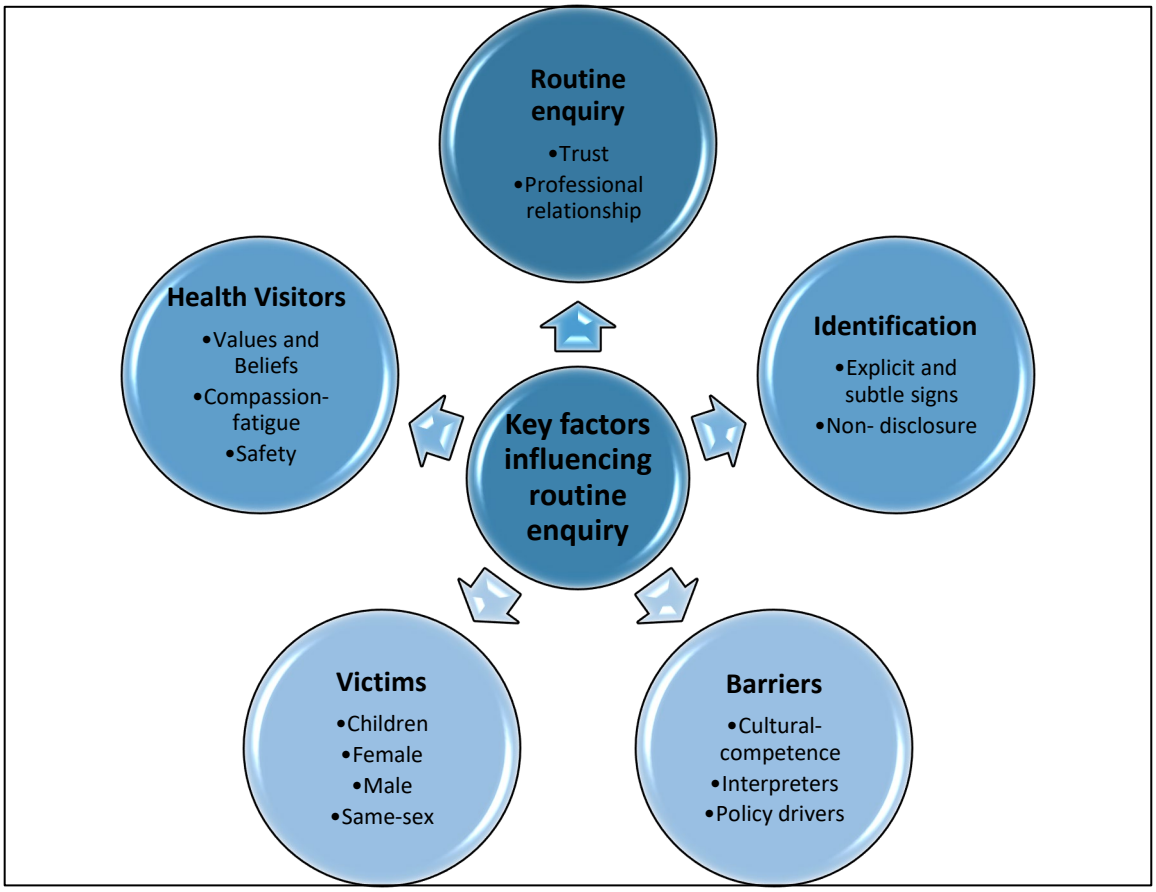

Fig 6.1 Key factors influencing the Health Visitors role in the routine enquiry

Although it is evident that Health Visitors have been trained to identify signs of abuse, not all can recognise the range of abuse presented, or the subtler signs. Therefore, it is necessary to ensure that the level of knowledge and understanding required to detect signs of abuse is consistent within the Health Visiting workforce. Additional training may be needed to address this issue. One conclusion that we can draw from this is that there is a potential gap in Health Visitor preparedness to recognise abuse. Further research will explore whether all Health Visitors can identify signs of abuse; this is a significant issue and one that requires clarification.

Another major factor identified in this study is the role of intuition in detecting the subtler signs of abuse. It is highlighted that intuition is a challenging issue to contend with as it is difficult to identify, teach and monitor. However, using this sixth sense enables Health Visitors to see beyond initial impressions and ask pertinent questions if abuse is suspected. Based on the findings from this study, intuition appears to positively influence the Health Visitors' ability to identify domestic abuse. However, previous studies in this area have not acknowledged the potential role of intuition concerning Health Visitors' recognition of domestic abuse. The sixth sense that practitioners have developed, can influence their assessment of relationships within the family and enhance their ability to detect signs of abuse. Therefore, a crucial question is: can Health Visitors be trained to use their intuition?

Drawing on the evidence from this study, the failure to draw on intuition to identify domestic abuse, may leave women and children at increased risk. In current training, there is a missed opportunity to raise the issue of intuition with Student Health Visitors and newly qualified Health Visitors. The identification of the subtler signs of abuse could be integrated into specialised training designed for Health Visitors. This crucial issue has not been sufficiently examined in this study. Therefore, further work is required to explore the concept of intuition and the role it can play in the identification of domestic abuse.

Timing and opportunity are a crucial aspect of disclosure. *RQ1* showed the need for the Health Visitors to be adaptable when deciding the right moment to ask women about domestic abuse. Health Visitors in this study identified that having a confidential conversation with women increased the likelihood of disclosure, as was highlighted by Baird, Salmon, & White (2013). However, deciding not to ask about domestic if there is a third-party present becomes problematic when organisational restrictions limit the number of times practitioners can conduct home visits. While education and training may address the issue of choosing the right moment, the crucial issues of flexibility and opportunity go beyond training. Choosing the right moment locates this issue in the context of practice guidance provided to practitioners. Beyond this, it can be argued that experience could help practitioners to carve out flexibility and opportunity. However, experience cannot be a standard variable amongst practitioners and, therefore, could not be relied on as a consistent way to ensure standard responses by Health Visitors. Therefore, this is not a reflection on Health Visitors or their preparedness to routinely enquire about domestic abuse. Instead, it

falls within the realm of policy. Hence, any attempts to address domestic abuse during home visits must factor in the role of policy. What this study has shown is that this issue is not a reflection on the competence and preparedness of Health Visitors. There needs to be a commitment from policymakers to acknowledge the limitations of current guidelines and factor that into policymaking.

A crucial issue here is the participants' preference for clear guidance on how to proceed when they suspect that abuse is occurring even when the woman retracts her disclosure of it. With no direct policy that governs how practitioners should provide support in this instance, this issue is left to the individual practitioner's interpretation. The lack of consistency in approach leaves Health Visitors vulnerable to make the wrong decision or even a conscious decision to ignore what might be classified as evidence of abuse. A conclusion that could be reached, therefore, is that failure to identify abuse is not necessarily caused by inadequate knowledge or skill. Instead, it might be a product of insufficient guidance.

One concern emerging from this is the issue of professional relationships and building rapport with families. In order to develop the desired professional relationship, Health Visitors need to establish relationships as 'professional guests' in the family home. However, this is easier said than done. For example, current changes to organisational ways of working within the NHS Trust, it can be argued, has reduced Health Visitors' ability to build a rapport and establish trust as indicated in this study. McCarthy *et al*. (2017) identified that building rapport and trust was necessary for women to feel they can disclose domestic abuse.

This study has shown that Health Visitors thought they did not have a voice, and so could not influence the NHS Trust during organisational changes. Client contacts were reduced as a result of organisational change, thereby building professional relationships were made more difficult. In this context, reduced client contact becomes a key issue. How policymakers incorporate the voice of the practitioners thus becomes an issue. What is clear is that it is essential that Health Visitors within the NHS Trust have the opportunity to contribute their expert opinions and to evaluate service provision.

Health Visitors have acknowledged that they feel less confidence to support women in terms of their immigration status. The critical question here is whether this constitutes a required professional knowledge area for Health Visitors or whether it falls within the remit of other professionals. Does this call for a new form of collaborative working or an expansion of the knowledge base of Health Visitors? There cannot be a ready answer at this point. However, it is undoubtedly an area that needs to be explored jointly by curriculum developers and policymakers.

Another issue involves the use of interpreters, specifically the accuracy of their translation during home visits. Translators may sometimes want to put their own 'spin' on their interpretation of routine enquiry. Further, it is conceivable that some information about domestic abuse is inaccurately relayed to the victims. Surprisingly, this is an issue that has not previously been explored given that language barriers and the use of interpreters, has now been identified as a factor that may influence a Health Visitor's ability to enquire about domestic abuse routinely.

There was also evidence that gender plays a crucial role in this context, as the interpreters' position could be seen to be gender-specific where male interpreters may influence or inhibit the women's ability to be open about abuse. Based on this, the choice of interpreters becomes essential. In the context of this study, concerns about interpreters increased when they were male and required to translate questions related to routine enquiry to the women. It seems therefore, that the potential of using female interpreters in specific contexts, needs exploration, as this may go some way to address this issue of gender. In essence, the choice of interpreters could not merely be informed by skills but also by other factors such as gender, as is echoed by Bacchus, Mezey and Bewley (2002) who supported the use of female-only interpreters.

The cultural competence of practitioners was highlighted as a significant issue, and it has been previously explored by Thurston *et al.* (2013). Practitioners require education and training to gain an understanding of how women from different cultures react to domestic abuse and respond to routine enquiry. Possessing a high level of knowledge about different cultures, can certainly enhance a Health Visitor's ability to ask about abuse and provide

support, but the reality of achieving this is another challenge. Nonetheless, at the least, systems need to be put in place to educate the workforce in terms of cultural awareness.

The influence of personal values and beliefs was another factor identified in the study. Since practitioners deliver the Health Visiting service, it is essential that evidence-based practice is promoted in a way where the impact of personal values and beliefs is limited. It is important to note that this study found that regardless of the practitioners' views and experiences, they focused on the welfare of the women and children, which was the most important aspect of their role.

In relation to *RQ1,* the issue of Health Visitor safety has been sparsely addressed within the literature. What is clear is that if Health Visitors feel unsafe during home visits, it must be addressed. Potentially, this could be tackled during education and training sessions that provide Health Visitors with the opportunity to reflect on their experiences and to discuss the options of how to keep themselves safe. The ability to risk-assess during client visits, and to have difficult conversations while keeping themselves safe, informed by use of case study examples, would be useful. The use of role-playing exercises could be one valuable way to undertake this training in a professional development context.

Concerning *RQ1*, some Health Visitors felt a sense of frustration, particularly when women did not leave the abusive relationship. Silent feelings of frustration meant that some Health Visitors provided support for women even though they did not agree with the client's decision to stay in an abusive relationship. Feelings of frustration and the emotional demands of the role put a strain on Health Visitors personally and professionally. The experience of episodes of feeling emotionally drained, where Health Visitors feel unable to cope with supporting women, could have an impact both on their confidence and ability to routinely enquire about domestic abuse.

Previous studies in this area have not made the links between routine enquiry, identification, and support or the effects it may have on the Health Visitors. If the issue of compassion fatigue is not addressed, it might have an impact on the health and well-being of the Health Visiting workforce. However, practitioners were aware of the importance of resilience when facing challenges within their role. As well as clinical supervision, findings from this study suggested that Health Visitors valued the ability to undertake an element of

self-care as their most desirable option. Considering the evidence of this study, the NHS Trust must look at opportunities to expand the number of Health Visitors who are trained in various self-help activities such as meditation, yoga, and deep breathing exercises to enhance a feeling of mental and physical health and well-being. Providing support to the Health Visitors in this way will enable a workforce that is resilient enough to continue to support victims of domestic abuse.

A subsidiary goal of this study was to identify the point at which Health Visitors decide to escalate their concerns about domestic abuse. Findings showed that Health Visitors were clear about their role to keep the family safe and placed the well-being of the child ahead of their professional relationship with the mother. If the safety and well-being of the child were at risk of being compromised, the Health Visitors would not hesitate to escalate their concerns. In a sense, this finding was to be expected since guidelines and previous studies have confirmed this; so in essence, what this study has done is validate existing claims about escalation (NICE, 2016; Local Government Association, 2017).

A challenge to the escalation of Health Visitors concerns was when social services did not accept the assessment of risk identified by the Health Visitor because it did not meet their threshold of what would require intervention. Often these cases are with families that caused concern to the Health Visitors but where the safety of the children was not acknowledged as being severe enough for social services to accept the referral. Policies need to be clear in terms of the management of families that Health Visitors supports on a long-term basis. These findings suggest the NHS Trust should consider adopting a multidisciplinary approach to discuss the management of families and how they can be supported. A plan of care can be developed whereby the family will be monitored by a range of professionals for possible signs of abuse with a clear pathway of referral to social services if there are concerns about increased levels of risk.

RQ2 sought to find out the education and training needs of Health Visitors that could enhance their ability to identify domestic abuse. Incidentally, in responses to *RQ1* and *SQ1a*, some answers were volunteered that were found relevant for *RQ2,* which have been previously discussed in this conclusion.

In *RQ2*, three needs were identified: support for men who are victims of abuse, support for couples in same-sex relationships, and investment into education and training. When men are the victims of domestic abuse, there is an indication that Health Visitors lacked confidence to ask about abuse and provide support. It is arguable that at the heart of this problem is the assumption based on social perceptions that men cannot suffer abuse and an issue of the prevalent dominant discourse. More importantly, however, this indicates that facilitating a change in mind-set is the first step which policymakers must address, to change practice. The task of educating Health Visitors to ask men about domestic abuse may require further exploration to see how it could be most effectively implemented.

Secondly, Health Visitors acknowledged they lacked confidence in knowing whom to ask about domestic abuse where couples were in same-sex relationships. Practitioners were aware that domestic abuse could occur in these relationships but were unclear on how to address this issue. Although issues of abuse within same-sex relationships are not new, there is the possibility that the more dominant societal norm informs Health Visitors in this context. The key challenge for Health Visitors and those who develop the relevant training is to integrate into education and development programmes ways to approach routine enquiry for same-sex couples.

Overall, the findings in response to *RQ2* suggested that Health Visitors require regular updates in terms of education and training to develop their confidence and competence to recognise the different types of abuse. In summary, there are two clear divides between Health Visitors and outside influences that can impact on practitioners' ability to ask about domestic abuse. The identified needs can be addressed in the classroom during the acquisition of knowledge as well as in practice and through policymakers. This study emphasises the need for curriculum development, policy, and practice to combine in order to address the issue of domestic abuse within society.

6.1.2 ORIGINAL CONTRIBUTION

Essentially, originality is associated with the contribution to knowledge that the findings have promoted and can be assigned in the following three broad areas. Health Visitors' silent views; the use of technology to address issues related to use of interpreters, and a new model of education and training.

This study is the first to reveal that Health Visitors have silent views about women's decisions to remain in abusive relationships. This factor is crucial in the assessment and understanding of abuse. It should, therefore, become a pressing issue both in the development of Health Visitors and in the policies that inform their practice. This was highlighted and discussed in chapter four *(4.5).* This novel finding has implications for both policy and practice and should contribute to how Health Visitor training is developed.

A novel finding from this study is the importance of interpreters. This study has highlighted for the first time how interpreters can influence the Health Visitor's ability to ask about domestic abuse and support clients effectively. A potential contribution to originality is the proposal to introduce the use of technology by way of a mobile phone or iPad application (app) that is presented in the recommendation section *(6.1.3).* Instead of asking about domestic abuse using an interpreter, one solution could be to remove the interpreter from this element of the client contact. Using an online application could enable the Health Visitor to routinely enquire about domestic abuse while also ensuring that women feel safe and confident to respond to this question. The creation of an online application for use by Health Visitors in a range of languages and animated pictures would allow women to respond non-verbally to questions about domestic abuse. Responses could then be uploaded to the Health Visitors' database system. This application can also be used if the client does not feel safe to respond verbally and would mean that the Health Visitor would be able to assess the level of risk before leaving the home visit.

This study found that Health Visitor education and training requirements include a variety of elements, some of which are currently missing. Drawing on the perceived gaps in the current structure and content of Health Visitor training programmes, a new model for the education of Health Visitors is proposed *(fig 6.2).* The new model aims to address the

education and training gaps identified by Health Visitors. The proposed model concludes the findings of the study by formulating a comprehensive education and training framework that addresses the needs of Health Visitors in practice. The model *(fig 6.2)* incorporates four overarching areas of education and development that includes: the clients, identification, influencing factors and resources.

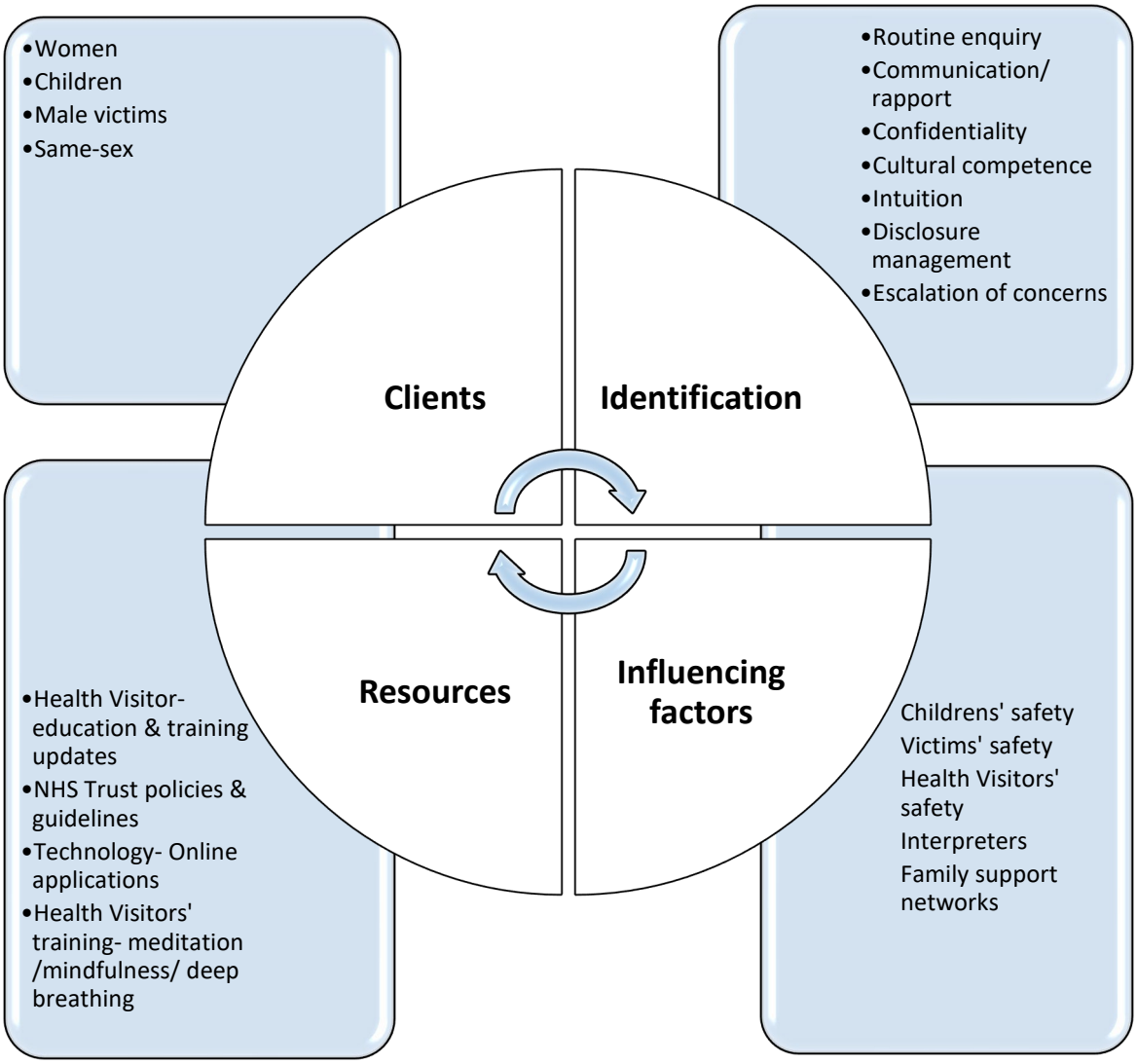

Fig 6.2 **Domestic abuse: Education and training model**

The education and training model presented above is an original contribution to knowledge. The model incorporates several key features identified by Health Visitors that had not previously factored into their training programmes. This model allows the inclusion of the

significant factors that could influence the identification of domestic abuse and links them within components of education and training to change or support practice as identified.

Identification: The addition of cultural-competence training will provide practitioners with the opportunity to explore the different cultural norms and to gain a better understanding in terms of domestic abuse. Being able to have an open discussion about domestic abuse will allow Health Visitors to gain a better understanding of how these women view abuse so that practitioners are able to engage with the women. Health Visitors in the NHS Trust from minority ethnic groups may be willing to share their knowledge with others about their culture with the purpose of educating others about cultural norms and how domestic abuse is viewed.

The inclusion of intuition in training sessions would allow Health Visitors to reflect on how this could be used as an additional tool, to detect signs of domestic abuse. Having seminar discussions about intuition would allow practitioners to consider how this could enhance their ability to identify abuse and support practice.

Clients: Training on how to identify men who have been abused or those in same-sex relationships, will allow Health Visitors to consider how they can ask about abuse and feel confident in doing so. Drawing on data from the crime survey reports will allow Health Visitors to gain insights into how domestic abuse is a significance issue for men and those in same-sex relationships. Using scenarios and role-play will allow practitioners to work through the communication skills necessary so that they can become accustomed to asking and supporting this client group.

Influencing factors: Including the issue of interpreter's values and beliefs in classroom discussions will allow Health Visitors to address the potential problem of inaccurate translation. Practitioners will be able to share their experiences with others to minimise the effect of having a third party in the conversation and reducing the barriers for disclosure.

In considering the safety of women and children, the safety of the Health Visitor is also considered during training sessions. Listening to practitioners concerns and offering practical solutions based on evaluated NHS Trust policies would be a focus of education and training

Resources: The final section is about resources required to support the process of routine enquiry. Simple but effective relaxation techniques could be introduced in training sessions to emphasise the NHS Trust's commitment to build the resilience of practitioners and support for a healthy workforce.

The importance of policy must not be underestimated and the influence this has on the work Health Visitors do. Training sessions are an opportunity to review NHS Trust domestic abuse policies and consider how they can be used to support practice.

This education and training model proposed the use of technology in the form of an online application and has been highlighted in the next section *(6.1.3)*. Training sessions can be used to develop the skills of Health Visitors in using the online application.

6.1.3 RECOMMENDATIONS

The recommendations that follow are based on the findings that emerge from this study and identify three key areas: review of policy; the use of technology to enhance communication and, the facilitation of self-care of Health Visitors.

Policy review: One of the crucial findings in this study is that the current policy does not always support the work of Health Visitors to enquire about domestic abuse routinely. Therefore, a recommendation is to review current policy, bearing in mind the crucial areas of home visits and time limitations, and to enable policy to better reflect the needs of clients. The NHS Trust policymakers need to engage with Health Visitors to draw on their knowledge when reviewing issues surrounding domestic abuse and assess the level of risk associated with limited client contact and ability to routinely enquire about domestic abuse. It is shown in this study that there are gaps in the way that Health Visitors carry out their role which policy can address. However, policymakers are not talking to Health Visitors, and therefore, these gaps are not filled. It is essential for policy reviews to consciously include practitioners when evaluating and updating NHS Trust policies about domestic abuse.

Health Visitors must be given the autonomy to make decisions about the number of home visits required if they have not been able to ask about domestic abuse when the woman is

alone. The suggestion is for the NHS Trust and commissioners to involve Health Visitors in the review of services provided to women if they are unable to enquire about domestic abuse during the first contact visit routinely. Policymakers should fully understand the implications of limited client contact and the risks this can impose on women and children.

Using technology to enhance communication: A significant finding was that interpreters could influence the ability of the Health Visitor to carry out the routine enquiry. Although there are online applications that can be used by women to report abuse, this study's original contribution is the introduction of technology that can be used on smartphones or iPads to remove the need of the interpreter when routinely enquiring about domestic abuse. The idea is that the Health Visitor will adjust the application to suit the language of the mother and, with pre-set questions, will be able to show the mother a range of responses about domestic abuse that can be selected by a touch of the keypad. This information can then be stored and uploaded to current NHS Trust databases whereby allowing the Health Visitor to follow-up on any concerns that have been raised. Having the online application will remove the need for an interpreter who may be male or female, but who may be known to the family or have biased views. Using the online application will also mitigate against the interpreter putting in their own 'spin' on the women's responses whereby giving them the opportunity to disclose.

To reduce the risk of perpetrators finding out that women are disclosing the abuse, using the online application will also take away the need for verbal responses. Therefore, even if the perpetrator is in the home, the women can be shown the online application which will allow them to respond by clicking 'yes' or 'no' to questions in text form. The Health Visitor could then follow up any concerns.

In order to develop the online application for use within the NHS, there would need to be a collaboration between the researcher and those who are more versed in online web development. Funding from the NHS Trust or other sources will be required to facilitate this vital resource that would support the Health Visitors ability to identify potential victims of domestic abuse.

Facilitating self-care: Health Visitors recognise that this is a challenging role that can be emotionally demanding. Based on the findings of this study, it is recommended that employers provide time and funding to support the training of practitioners in areas of self-care. Practitioners understand the importance of self-care in order to sustain themselves so that they can continue to be effective in their role. In order to facilitate self-care, it would be prudent for the NHS Trust to seek the views of Health Visitors to find out if training in the form of meditation, yoga, or deep breathing exercises would reduce everyday stress. Resources need to be put in place to support the self-care of the practitioner in order to build a resilient workforce.

6.1.4 FUTURE RESEARCH

Following the completion of this study, three research areas have been identified in need of further investigation, as follows:

- **Intuition:** A further study is needed to explore the mechanisms behind intuition and the identification of domestic abuse. These instincts enhance the Health Visitors' ability to carry out their role and allow them to be more proactive and reactive when safeguarding the children and families.
- **Resilience:** This study indicated that Health Visitors need resilience to carry out their role in order to prevent 'burn out'. Qualitative research could explore the issue of burnout and resilience in Health Visitors who support families on a long-term basis when clients do not reach the threshold for social services referral.
- **Interpreters:** A further study is required to establish whether the values and beliefs of interpreters, influence their ability to translate accurately during routine enquiry.

6.1.5 LIMITATIONS

As with most research, this study has its limitations. The first is that the study was focused on a single NHS Trust in the south of London. It would have been useful to have compared findings with that of an outer London NHS Trust, and a comparison could be made to determine if the findings were the same or different. However, the purpose of the study was not to claim generalisability but rather to understand the significant themes that emerged from the data and to inform the training of undergraduate and post-registration Health Visiting students at the University.

Another limitation refers to the number of participants in the study. Although confident that the sample was representative, the inclusion of more participants would have made the findings richer. Once the surveys were completed, it would also have been useful to have interviewed those whose survey responses required further exploration. Tracking the participants would have allowed the data from the survey and interviews to be more integrated within the analysis. However, this would have meant that the participants would have been identifiable and may have dissuaded some from participating. It would also have been interesting to bring all of the interview participants together to join a focus group so that their comments could be discussed in an open forum and contribute to richer data.

6.2 REFLECTIONS ON A RESEARCH JOURNEY

This thesis has been a roller coaster ride, particularly with the analysis and findings chapters which I found the most difficult to manage. Making sense out of a large amount of data and going through the thematic analysis process was challenging. However, I found that carrying out thematic analysis within practice allowed me to fully understand the concept and how this is applied to a research study.

Research is about self-development. To become a good researcher, practice needs to be central to this alongside theoretical knowledge. Ironically, I have found that a lot of my learning has been acquired unconsciously. Evidence of my learning is illustrated in my confidence with teaching research methods to undergraduate and postgraduate students at the University. I now feel comfortable to explain various concepts around research because I have gone through the journey myself.

Completing this study has been an invaluable learning and developmental experience. When I decided to start the doctorate, it seemed impossible. Now that I have completed my thesis, I realise how far I have come in the four years since beginning the programme. In conclusion, I will quote my wonderful mother, who was the driving force for me completing this intense programme of study. When I was uncertain that I could carve out enough time to start and complete the doctorate, her advice to me was as follows:

'If you don't start you will never finish. So just start, and you will find the time'. (Mum)

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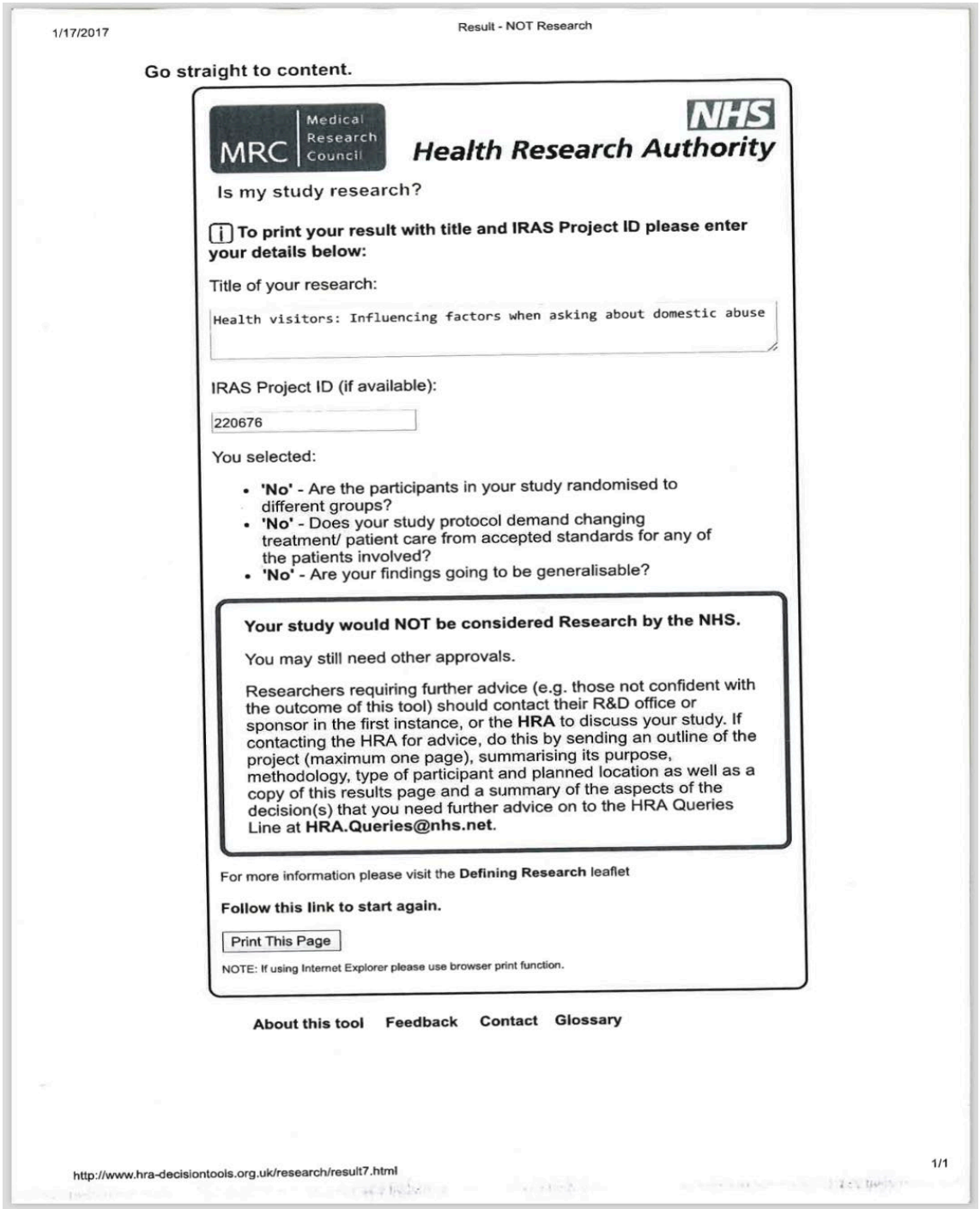
LIST OF APPENDICES

Confidential



1/17/2017 Result - NOT Research

Go straight to content.

MRC Medical Research Council

NHS Health Research Authority

Is my study research?

To print your result with title and IRAS Project ID please enter your details below:

Title of your research:

Health visitors: Influencing factors when asking about domestic abuse

IRAS Project ID (if available):

220676

You selected:

- **'No'** - Are the participants in your study randomised to different groups?
- **'No'** - Does your study protocol demand changing treatment/ patient care from accepted standards for any of the patients involved?
- **'No'** - Are your findings going to be generalisable?

Your study would NOT be considered Research by the NHS.

You may still need other approvals.

Researchers requiring further advice (e.g. those not confident with the outcome of this tool) should contact their R&D office or sponsor in the first instance, or the **HRA** to discuss your study. If contacting the HRA for advice, do this by sending an outline of the project (maximum one page), summarising its purpose, methodology, type of participant and planned location as well as a copy of this results page and a summary of the aspects of the decision(s) that you need further advice on to the HRA Queries Line at **HRA.Queries@nhs.net**.

For more information please visit the **Defining Research** leaflet

Follow this link to start again.

Print This Page

NOTE: If using Internet Explorer please use browser print function.

About this tool **Feedback** **Contact** **Glossary**

http://www.hra-decisiontools.org.uk/research/result7.html 1/1

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Copy of email received 19th January 2017

Hi Helen

Now I've read your proposal in detail, I agree that your study would not be classed as formal research, but rather quality improvement/service evaluation. Please complete the attached (it's relatively brief) and I can then sign off your study.

Do you have any form of contractual status with the trust? Academic researchers are handled using the Research Passport Scheme but I can't do this for your project as it's not research. It may be the case that you'll need to apply for an honorary contract with our HR department. Please let me know re your status and I can advise further.

All the best,
xxx
Research and Knowledge Manager
NHS Trust

Confidential

Quality Project Approval Notification

Following use of the Health Research Authority Decision Tool, this notification confirms that the Service Evaluation/Quality Improvement Project named below has been **approved** by the Research and Development Office of

Title:	*An examination of health visitors' experiences, attitudes, values, beliefs and the impact these may have on their ability for effectively working with women experiencing domestic abuse*
Investigator:	*Helen Elliott*
Supervisor/contact:	
Dated:	*26/01/2017*
Approved by:	
Signed:	

- The investigator will **immediately notify** the Research and Development Office of the Trust should any changes be made to the original protocol as any deviations will render this approval notification void.
- The investigator will send an **executive summary** of the findings of this study to the Trust's R&D Office for uploading to the Trust's intranet.

For further information please contact:

Email: j

1/1

APPENDIX 4 QUALITY PROJECT APPROVAL NOTIFICATION- EMAIL

Confidential

Copy of email received 26th January 2018

Quality Project Approval Notification - "An examination of Health Visitors' experiences, attitudes, values, beliefs and the impact these may have on their ability for effectively working with women experiencing domestic abuse"

Hi Helen

Please find attached the Quality Project Approval Notification for your study "*An examination of Health Visitors' experiences, attitudes, values, beliefs and the impact these may have on their ability for effectively working with women experiencing domestic abuse*".

xxx - you are listed as the supervisor on this study, but this is a 'name only' role and indicates that you are aware of and agree with its aims, and that you may also provide a liaison role between the trust and the researcher.

Helen - as previously advised, you will need an honorary contract with the trust to be in place before any study-related activities take place.

Finally, I wish you every success.

Research and Knowledge Manager
xxx

APPENDIX 5 RESEARCH FLYER

APPENDIX 6 RESEARCH COVERING LETTER

My name is Helen Elliott, and I am a Senior Lecturer at xxx. I am currently undertaking my Doctorate in Education and as part of this will be completing my thesis study at the University of xxx.

The title of the research is 'An examination of Health Visitor' experiences and the impact these may have on their ability for effectively working with women experiencing domestic abuse'.

As you work for an NHS Trust, your input into this study will be valuable. As an under-researched area, this study will explore how Health Visitor personally feel asking women about domestic abuse. It is anticipated that your participation in this study will provide insight and contribute to the development of specialist courses for advanced practitioners that deal with domestic abuse enhancing both clinical practice skills and the delivery of undergraduate and postgraduate programmes.

You are being invited to take part in a survey and semi-structured interview. Please read the following information carefully before you decide whether or not to take part. All the information collected will be treated with complete confidentiality and will be entirely anonymous. The data generated will be kept securely in paper and electronic form.

Taking part in this research is entirely voluntary; you are free to change your mind and withdraw from the research at any time without giving a reason.

If you decide to take part in a semi-structured interview, please contact me on the email below to register your interest. I will contact you to arrange a date, time and venue that is convenient for you, which could be at the University of xxx or within the Trust.

If you require further assistance or information about the questionnaire, interview or the research, please feel free to ask me.

Thank you for taking the time to read this information sheet.

Helen Elliott

APPENDIX 7 INFORMATION SHEET

Information sheet

My name is Helen Elliott, and I currently work at the xxx as a Senior Lecturer for Health Visiting and School Nursing. I am undertaking a Doctorate in Education and will be undertaking a research study as part of this programme.

My study will examine Health Visitors' experiences, attitudes, values, beliefs, and the impact these may have on their ability for working effectively with women experiencing domestic abuse.

Introduction

Domestic abuse is an important public health issue that affects a significant number of women nationally and internationally. As part of my doctoral research, I would like to invite you to participate in this study that is concerned with this important element of your role. I am interested in your experiences, attitudes, values and beliefs, and the impact this may have on your ability to ask about domestic abuse.

Please take the time to read the following information carefully before deciding whether or not to take part.

Why am I undertaking this study?

As an under-researched area, this study will explore how Health Visitors' personally feel asking women about domestic abuse. It is anticipated that your participation in this study will provide insight and contribute to the development of specialist courses for advanced practitioners that deal with domestic abuse enhancing both clinical practice skills and the delivery of undergraduate and postgraduate programmes.

Why have you been invited?

If you answer YES to **ALL** of the following questions, then I would like to invite you to participate in this study.

- Are you a qualified specialist community public health nurse (Health Visitor) or Registered Health Visitor?
- Have you had a caseload that includes clients living in abusive relationships within the last 3 years?
- Are you working for an NHS Trust?
- Are you currently in clinical practice?
- Are you aged between 21 and 65 years of age?
- Do you have experience in managing domestic abuse cases?

What will you have to do if you agree to take part?

Phase 1 Survey:

All Health Visitors' in XXX NHS Foundation Trust will be sent an email providing information about the research study and a web link to the electronic survey. Your consent to participate in Phase 1 of the research will be assumed once you have completed and returned the survey via the electronic link.

Phase 2 semi-structured interviews:

- Please email me on XXX if you would like to participate in a 1:1 semi-structured interview.
- The interview will be a once-only event.
- I will arrange a time and date to meet that is convenient for you. You will have a choice to meet either within the Trust or at the University of xxx in a quiet room.
- I will ask you questions in order to explore your experiences-about domestic abuse and your role.
- The interview will be recorded using a digital voice recorder and a mobile phone recorder.
- The interview will last no longer than 60 minutes.
- Once the interview has been transcribed, I will email you a copy. You will have up to 2 weeks to check that the transcription reflects the interview that took place.

How much of your time will be required?

Phase 1 - no more than 30 minutes

Phase 2 - one interview for no more than 60 minutes

Will your participation in the research remain confidential?

- Your confidentiality and anonymity will be maintained at all times. However, if information is shared that may compromise your safety or the safety of others, this will be reported according to the Trust policies and the NMC 2015 Code of Conduct.
- The electronic survey will be anonymised using codes and numbers.
- You will be given the option to have your interviews either at the University of xxx or at an NHS Trust building to protect your anonymity.
- Your name will not be used during the survey, interview or final write up of the study. Pseudonyms and codes will be used instead.
- The electronic survey data will be password protected and stored electronically.
- Written consent forms will be kept in a locked cabinet.
- Your contact details will never be used for any purpose other than in the process of undertaking the research.
- All audio recordings will be password-protected and deleted once the requirements of the study have been completed.

What are the advantages of taking part?

The results of the anonymised research will be made known to the University of xxx and also xxx NHS Trust. The work will also be published in the future.

This will be an opportunity for Health Visitors' to have an independent voice in raising the profile of domestic abuse and in having the opportunity to contribute to the development of education and clinical practice in relation to this important issue.

As a gesture of thanks for participating in the semi-structured interviews Health Visitors' will be offered a £10 voucher for use at a bookshop to purchase books or other resources as a contribution to continuous professional development. This will be given to Health Visitors' once the interview is completed. This will not be available to Health Visitors' participating in the survey.

Are there any disadvantages to taking part?

Due to a Health Visitors' area of work and experience, it is likely that they will have developed an element of resilience when discussing issues around domestic abuse. However, during the interviews, some Health Visitors' may disclose sensitive issues. The researcher will use an empathetic and sensitive approach to manage the situation. An information sheet that includes helpline numbers and contact details of support services for domestic abuse victims will be available to each participant. The researchers 'supervisor details will also be included as required.

Do you have to take part in the study?

No, participation in this study is entirely voluntary. If you do not wish to take part, you do not have to give a reason. If you do agree to participate, you can change your mind at any time and withdraw at any point in the research process with no repercussions.

Implied consent will be assumed if you decide to complete and return the survey. If you decide to participate in the semi-structured interviews, written consent will be gained.

What happens now?

Phase 1- During March/April, all Health Visitors' will be sent information and an electronic web link to complete the survey. If you are interested in taking part, please complete and return the survey within two weeks.

Phase 2- Please email me if you are interested in participating in the semi-structured interview. I will contact you to arrange to meet at a time that is convenient for you.

If you have any questions or require further information, please email me.

Researcher: Helen Elliott, EdD student University of xxx.

This research has been reviewed and approved by the University of xxx Ethical Research Committee and Research and Development Office. If you have any concerns about any aspect of this study, please let me know in the first instance, or you can contact the supervisors below.

APPENDIX 8 INVITATION FOR PARTICIPATION

Copy of an email message inviting participation in the research.

Dear Health Visitors',

My name is Helen Elliott, Senior Lecturer at the University of xxx and I am currently undertaking my Doctorate in Education. As part of this programme of study I will be undertaking research into Health Visitors' experiences and the impact this may have on their ability for effectively working with women experiencing domestic abuse.

This investigation will allow me the opportunity to ask questions related to the knowledge and experience of Health Visitors' in order to gain more understanding around the issues they are faced with.

Please see the attached information sheet that provides more details about this study. I also aim to attend some local staff meetings to provide more information and an opportunity to discuss this further.

Please contact me on xxx if you have any questions.

Many Thanks

Helen Elliott

EdD student

Research supervisors

David Evans

Francia Kinchington

PARTICIPANT CONSENT FORM

To be completed by the participant. If the participant is under 18, to be completed by the parent / guardian / person acting *in loco parentis*.

- I have read the information sheet about this study
- I have had an opportunity to ask questions and discuss this study
- I have received satisfactory answers to all my questions
- I have received enough information about this study
- I understand that I am / the participant is free to withdraw from this study:
    - At any time (until such date as this will no longer be possible, which I have been told)
    - Without giving a reason for withdrawing
    - (If I am / the participant is, or intends to become, a student at the University of xxx–without affecting my / the participant's future with the University
    - Without affecting any medical or nursing care I / the participant may be receiving.
- I understand that my research data may be used for a further project in anonymous form, but I am able to opt out of this if I so wish, by ticking here. ☐
- I agree to take part in this study ☐

Signed (participant)	Date
Name in block letters	
Signature of researcher	Date
This project is supervised by: David Evans Francia Kinchington	
Researcher's contact details (including telephone number and e-mail address):	

APPENDIX 10 SURVEY

Domestic Abuse Survey

Q1 Are you a qualified Specialist Community Public Health Nurse (Health Visitor) or Registered Health Visitor?

- ○ Yes (1)
- ○ No (2)

Q2 Are you currently in clinical practice?

- ☐ Yes (1)
- ☐ No (2)

Q3 Have you had clients within your caseload who have been victims of domestic abuse within the last 3 years?

- ○ Yes (1)
- ○ No (2)

Q4 If you have answered 'No' to questions 1, 2 and 3 then do not proceed with this survey. Thank you for your time.

Q5 How long have you been qualified as a Health Visitor?

- [ ] Less than 2 years (1)
- [ ] 2-5 years (2)
- [ ] 6-10 years (3)
- [ ] 11-15 years (4)
- [ ] 16-20 years (5)
- [ ] 21-25 years (6)
- [ ] 26 - 30 years (7)
- [ ] 31-35 years (8)
- [ ] 36-40 years (9)
- [ ] 41 years or more (10)

Q6 In which way would you describe your gender?

- ○ Male (1)
- ○ Female (2)
- ○ Transgender (3)
- ○ Other (4)
- ○ Rather not say (5)

Q7 Please indicate your age group

- ○ 22 - 30 years (1)
- ○ 31 - 40 years (2)
- ○ 41 - 50 years (3)
- ○ 51 - 60 years (4)
- ○ 61 - 65 years (5)
- ○ 66 years or more (6)

Q8 How long have you worked in the Trust?

- ☐ Less than 2 years (1)
- ☐ 2-5 years (2)
- ☐ 6-10years (3)
- ☐ 11-15 years (4)
- ☐ 16-20 years (5)
- ☐ 21-25 years (6)
- ☐ 26-30 years (7)
- ☐ 31-35 years (8)
- ☐ 36-40 years (9)
- ☐ 41 years or more (10)

Q9 How would you describe your ethnicity?

Q10 Do you agree with the policy of routine inquiry in asking women about domestic abuse at each client contact as long as it is safe to do so?

- [ ] Strongly agree (1)
- [ ] Agree (2)
- [ ] Neither agree nor disagree (3)
- [ ] Disagree (4)
- [ ] Strongly disagree (5)

Q11 Do you ask **ALL** your clients about domestic abuse if it is safe to do so?

- ○ Yes (1)
- ○ Might or might not (2)
- ○ No (3)

Q12 If you have answered 'Might or might not/ or No' to the previous question (Q11) then please explain further

---

Q13 I feel **confident** in asking women about domestic abuse.

- Strongly agree (1)
- Agree (2)
- Neither agree nor disagree (3)
- Disagree (4)
- Strongly disagree (5)

Q14 I feel **competent** in asking women about domestic abuse.

- Strongly agree (1)
- Agree (2)
- Neither agree nor disagree (3)
- Disagree (4)
- Strongly disagree (5)

Q15 Please provide an example of the **sentence or sentences** you use when asking women about domestic abuse.

Q16 **How long** have you been asking women about domestic abuse?

- 1 year or less (1)
- 2-3 years (2)
- 4-6 years (3)
- 7- 10 years (4)
- 11-15 years (5)
- 16-20 years (6)
- 21 years or more (7)

Q17 When you ask women about domestic abuse, approximately how many have **disclosed** they are currently or have suffered in the past within an abusive relationship?

- None (1)
- 1-5 (2)
- 6-10 (3)
- 11-15 (4)
- 16 -20 (5)
- 21- 25 (6)
- 26-30 (7)
- 31 or more (8)

Q18 What are the signs you look for which may suggest that your client is in an abusive relationship?

Q19 If a client discloses domestic abuse to you, what are your **initial thoughts and feelings** towards this disclosure?

Q20 In cases where you **suspect** domestic abuse is occurring in a relationship but the woman **does not disclose** this information, how do you manage this?

Q21 If a client has disclosed domestic abuse but indicates that they **do not want to leave** the abusive relationship, what steps would you take if you were concerned about their safety?

Q22 In your experience what are the **main reasons** for women not wanting to leave the abusive relationship?

Q23 Do your **professional** experiences of domestic abuse **influence your practice** when asking about domestic abuse and working with women?

- Always (1)
- Most of the time (2)
- Sometimes (3)
- Never (4)

Q24 Please explain your response to the previous question (Q23)

Q25 Do your **personal values and beliefs** influence how you ask about domestic abuse?

- A great deal (1)
- A moderate amount (2)
- A little (3)
- Not at all (4)
- I do not know (5)

Q26 Please explain your response to the previous question (Q25)

Q27 Are there elements of the **domestic abuse policy** that you find difficult to implement.

- Yes (1)
- No (2)
- Sometimes (3)

Q28 If you answered 'Yes' or 'Sometimes' to the previous question (Q27) please explain your response

Q29 Do you find it **emotionally demanding** when working with women who are in abusive relationships?

- Not at all (1)
- A little (2)
- A moderate amount (3)
- A lot (4)
- A great deal (5)

Q30 Please explain your response to the previous question (Q29)

Q31 Is there **support available** from your organisation to help in maintaining your **health and well-being** when undertaking your role in supporting abused women?

- ○ Yes (1)
- ○ No (2)
- ○ I do not know (3)

Q32 If you answered 'yes' to the previous question (Q31) please list available support

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Q33 Do you have any suggestions how you could be further supported in your role?

- ○ Yes (1)
- ○ No (2)
- ○ I do not know (3)

Q34 If you answered 'Yes' to the previous question (Q33) please explain further

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Q35 When was the **last occasion** you received domestic abuse training?

- [ ] Up to 1 year ago (1)
- [ ] 2-3 yrs. ago (2)
- [ ] 4-5 yrs. ago (3)
- [ ] 6-7 yrs. ago (4)
- [ ] 8-10 years or more (5)
- [ ] Never (6)

Q36 Has your domestic abuse training **influenced your attitude** towards asking and responding to domestic abuse in your practice area?

- ○ Definitely yes (1)
- ○ Probably yes (2)
- ○ Probably not (3)
- ○ Definitely not (4)

Q37 Are there any further **training opportunities** you think could be made available to facilitate how you ask about domestic abuse and decisions you make when abuse has been identified?

- ○ Yes (1)
- ○ No (2)
- ○ I do not know (3)

Q38 If you answered 'yes' to the previous question (Q37) please explain further

APPENDIX 11 PHASE 2 SEMI-STRUCTURED INTERVIEW QUESTIONS

How long have you been qualified as a Health Visitor?

Are you currently in clinical practice?

Do you think it is an appropriate part of your role to ask women about domestic abuse? Why?

Do you think that it is appropriate to ask all women in your caseload about domestic abuse or only if you suspect domestic abuse is occurring in the relationship? Why?

Do you have personal experiences that could influence your ability to ask about domestic abuse?

Do you think that your personal values and beliefs influence how you work with women who have experienced domestic abuse? What effect does this have?

When a woman discloses domestic abuse or you have identified abuse is occurring in a relationship- how does that make you feel?

Can you tell me about the systems or processes that are currently in place that supports your ability to be competent and confident when asking about domestic abuse and supporting women? Do you have any alternative suggestions that would support you in this role?

Do you have any suggestions in how education and training could be developed to enhance your practice in this area?

Many thanks for taking the time to contribute to this research.

APPENDIX 12 PHASE 3 SEMI-STRUCTURED INTERVIEW QUESTIONS

1. Do you have a current caseload where clients are or have been in relationships where domestic abuse is a problem? Approx. how many current cases?

2. How do you decide in choosing your moment to ask about domestic abuse?

3. How do you help women to recognise they may be a victim of domestic abuse?

4. How do you manage cases where you suspect domestic abuse, but the woman does not disclose to you?

5. What do you think and feel where you know the mother is being abused but she chooses to remain in the home? (personally/professionally)

6. Are there particular groups of women in terms of ethnicity, religion or background that you feel are more challenging to ask about domestic abuse?

7. How do you make a decision in terms of when to escalate your concerns and when to make a referral to other services?

8. Have you ever felt hesitant about going into a home where you know domestic abuse is within the relationship?

9. Have you had situations when the client is hostile, aggressive or resistant and you still need to ask about DVA? How did you manage the situation?

Victims of Domestic abuse

10. Have you had an incidence where the father of the baby/child is a victim of domestic abuse and if so, how would you manage this?

11. Have you had same sex couples on your caseload and if so who did you ask and how did you ask about domestic abuse- how did you make your decision?

Personal and professional views

12. In reviewing the results from the survey some Health Visitors' have identified that asking and supporting women in abusive relationships can be emotionally demanding – Is this something you relate to and if so how do you manage this?

13. What do you think about women who leave the abusive relationship but then return to the relationship at a later date? Professionally and personally.

14. Is there something about your life experiences that help you to engage with women when asking about domestic abuse?

15. Does that have an impact on the way you support these women?

Education

19. What education and training have you had around domestic abuse and asking/supporting women? Has this had an influence on your practice?

20. What services are available in the Trust that looks after your health and wellbeing and supports you in your role of asking women about domestic abuse?

21. Are there areas of education or support mechanisms that could be put into place to enhance your practice and support you as a practitioner asking about domestic abuse?

Many thanks for making a contribution

APPENDIX 13 SUPPORT SERVICES CONTACT DETAILS

Support services

ADVICE Help lines

Women's Aid 0808 2000 247

National Centre for Domestic Violence: 0800 970 2070 for advice on injunctions

HOUSING Shelter

http://england.shelter.org.uk

Men's advice line and enquiries

0808 801 0327

Advice and support for men in abusive

relationships.

www.mensadviceline.org.uk

http://www.mensadviceline.org.uk/pages/advice-support-for

male-victims.html

Refuge for men

http://www.refuge.org.uk/get-help-now/help-for-men/

Men's Health Forum leaflet

Information for victims and perpetrators

https://www.menshealthforum.org.uk/male-health

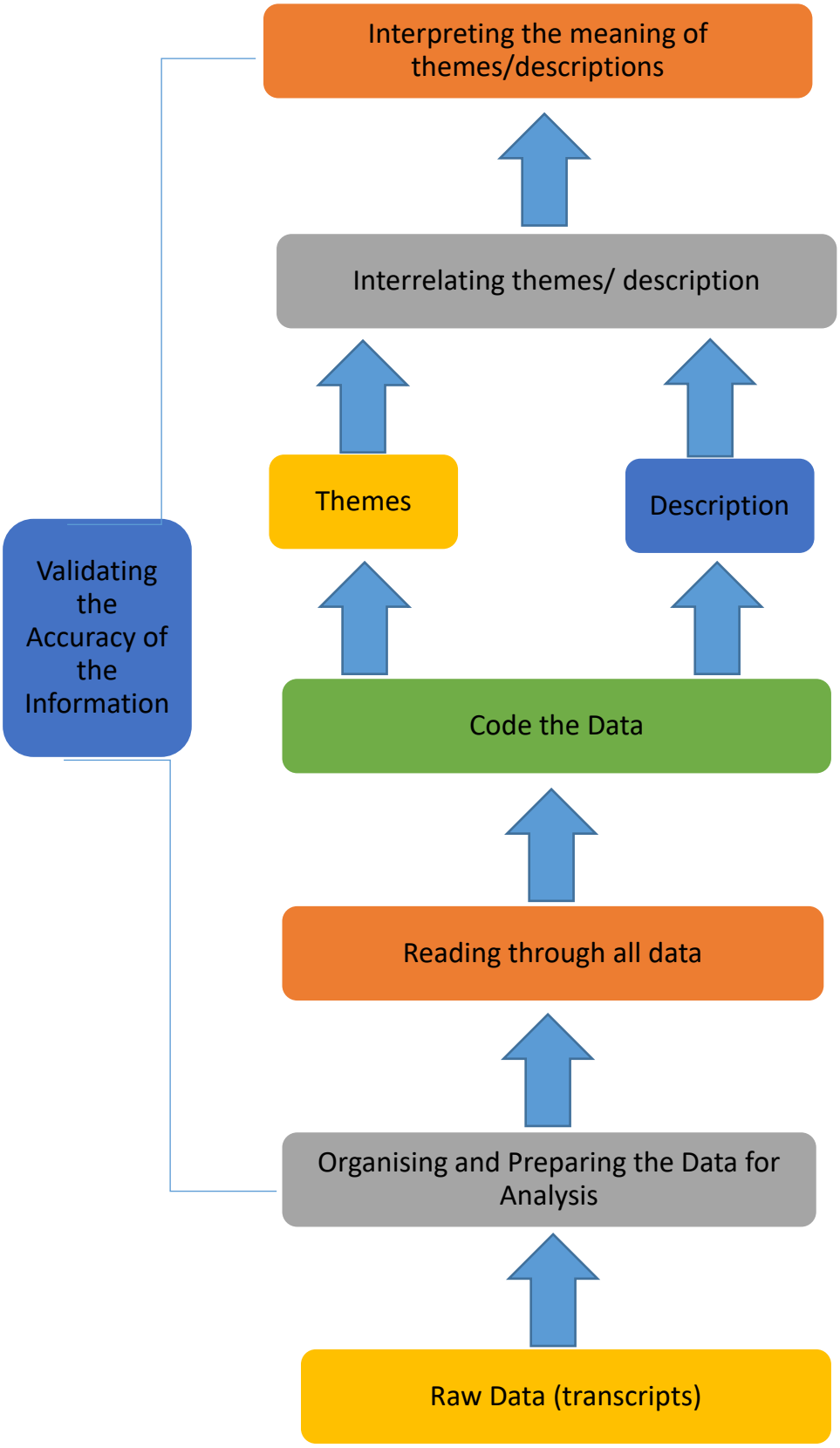
LGB&T+ clients

GLDVP web-site for a list of LGB&T+ domestic abuse

services or email LGB&T+ forum@gldvp.org.uk

APPENDIX 14 ETHNIC ORIGIN OF HEALTH VISITORS

Ethnic Origin	Headcount
White - British	29
Black or Black British - African	19
Black or Black British - Caribbean	3
Mixed - White & Black Caribbean	3
Asian or Asian British - Any other Asian background	2
Not Stated	2
Other Specified	1
Black or Black British - Any other Black background	1
White - Irish	1
Black-African	1
Black British	1
White - Any other White background	1
White Polish	1
Mixed - White & Black African	1
Asian or Asian British - Pakistani	1
Grand Total	**67**



Adapted (Creswell, 2009)

APPENDIX 16 REPORTS AND OTHER GREY LITERATURE USED WITHIN THE THESIS

Biggs, T., Knapman, J., Newland, R., Kelly, T., East, A., Hassell, S., … Tinsley, E. Retrieved from https://heeoe.hee.nhs.uk/sites/default/files/2014/10/ihv_preceptorshippack_v8.pdf	2014	*A National Preceptorship Framework for Health Visiting*
Cunningham, A., & Baker, L. Centre for children & families in the justice system Retrieved from www.lfcc.on.ca/what_about_me.html	2004	*What about me! Seeking to understand a child's view of violence in the family.* Report- National Crime Prevention Centre of Canada
Department of Health. Retrieved from http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4065379.pdf	2000	*Domestic violence:A resource Manual for health care professionals*.
Department of Health. Retrieved from http://www.domesticviolencelondon.nhs.uk/uploads/downloads/DH_4126619.pdf	2005	Responding to domestic abuse: a handbook for health professionals.
Department of Health. Retrieved from https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/597435/DometicAbuseGuidance.pdf	2017	Responding to domestic abuse: a resource for health professionals.
Hague, G., & Malos, E. New Clarion Press: Cheltenham. https://doi.org/10.3233/BMR-2012-0325	2009	Domestic Violence: action or change.
National Institute for Health and Care Excellence.	2016	Domestic violence and abuse.

Office for National Statistics. Year ending March 2017, (March 2017), 1–19.	2018	Domestic abuse: findings from the Crime Survey for England and Wales
Patton, S. 1–180.	2003	Pathways: how women leave violent men
Radford, L., Corral, S., Bradley, C., Fisher, H., Bassett, C., Howat, N., & Collishaw, S. *Nspcc*, 205.	2011	Child abuse and neglect in the UK today.
Women's National Commission. *Asra Housing Association Laura Welti (Bristol Disability Equality Forum); Sarah Learmonth (Coventry Rape and Sexual Abuse Centre Melissa Fulton (Safer Bristol); Bernie O'Roarke (Solace)*. Kate Webb. Retrieved from https://www.endviolenceagainstwomen.org.uk/wp-content/uploads/wnc-report-strategy-focus-groups.pdf	2009	Still we rise: report from WNC Focus Groups to inform the Cross-Government Consultation 'Together We Can End Violence Against Women and Girls'.
World Health Organization. *WHO Library Cataloguing-in-Publication Data*.	2005	WHO multi-country study on women's health and domestic violence against women: summary report of initital results on prevalence, health outcomes and women's responses.
World Health Organization. *Preventing intimate partner and sexual violence against women: taking action and generating evidence*. *Injury Prevention* (Vol. 16). https://doi.org/10.1136/ip.2010.029629	2010	
World Health Organization.	2013	Global and regional estimates of violence against women: prevalence and health effects of intimate partner violence and non-partner sexual violence.
World Health Organization.	2014	Preventing and addressing intimate partner violence against migrant and ethnic minority women: the role of the health sector. Policy brief.

Appendix 17 Analysis of peer reviewed papers

Author in alphabetical order/ Source	Date	Title	Research Design	Sample	Key Findings	Limitations of the Study
Agllias, K. Qualitative Health Research, 21(8), 1136–1146.	2011	Utilizing participants' strengths to reduce risk of harm in a study of family estrangement.	Qualitative Two in-depth interviews and a free-text diary	Twenty-five participants in total: 17 women and 8 men aged between 61 and 80 years	Participants do have strengths, skills, and knowledge that they can and do use in the research process. A strengths approach is not a solution to the various issues that are raised when researching vulnerable populations and sensitive issues. The onus will always lie with individual researchers to facilitate participant strengths and to collaboratively operationalize these findings in relation to safety procedures.	No limitations identified
Agllias, K. *Journal of Social Work Practice*, 26(2), 259–274.	2012	Keeping safe: teaching undergraduate social work students about interpersonal violence.	Qualitative Survey: student evaluation of course	University of Newcastle social work programme: Out of a total of 81 third-year social	70.5% strongly agreed, and 26.7% agreed that the course had improved their knowledge. Student feedback suggests that safety processes to reduce stress, burnout and vicarious trauma, which promote self-care, were effective in	Sample size and low response rate The survey could not be administered until seven weeks after the course had

Appendix 17 Analysis of peer reviewed papers

Author in alphabetical order/ Source	Date	Title	Research Design	Sample	Key Findings	Limitations of the Study
				work students enrolled in a six week (9 hours weekly class time) between 2008 and 2010, ten students participated.	reducing the effects of exposure to traumatic material. Students wanted relaxation techniques in the curriculum. Students wanted a supportive peer culture, personalised sources of support, a transparent and diverse curriculum. Training should have a balance between training and student safety.	completed, which may have contributed to retrospective or recall bias.
Ambuel, B., Hamberger, L. K., Guse, C. E.,Melzer-Lange, M., Phelan, M. B., & Kistner,A. *Journal of Family Violence*, 28(8), 833–847.	2013	Healthcare can change from within: sustained improvement in the healthcare response to intimate partner violence	Quantitative Audits, observation, surveys, interviews	Four sites: two primary family clinics, one paediatric clinic, and one emergency department that received IPV training	Staff reported increased self-efficacy in helping patients experiencing intimate partner violence, increased knowledge of referral resources, and increased knowledge of legal and regulatory requirements. Study sites displayed more patient education material in more locations, added bilingual patient	The study size was from a small sample, which placed limitations on the statistical analysis. The research design, which was primarily a single

Appendix 17 Analysis of peer reviewed papers

Author in alphabetical order/ Source	Date	Title	Research Design	Sample	Key Findings	Limitations of the Study
				and implemented a clinical tool kit There were147 participants in total: 97 physicians, 19 nurses, two physician assistants, one paramedic, 26 administrative and ancillary professional staff (e.g., laboratory and X-ray technicians).	education material, and developed collaborative relationships with local non-profit agencies. Improvements in care were sustained two years after the end of the intervention. Knowledge of intimate partner violence was unchanged.	group, pre-post design was a quasi-experimental design for selected variables. Suggest further caution in generalising the results. Intervention sites received financial incentives. Future research should test the model in a randomized controlled study with a larger number of clinics and health

Appendix 17 Analysis of peer reviewed papers

Author in alphabetical order/ Source	Date	Title	Research Design	Sample	Key Findings	Limitations of the Study
				Two participants did not specify their discipline. Two 'control' clinics were also included.		systems.
Bacchus, L., Mezey, G., & Bewley, S. *An International Journal of Obstetrics and Gynaecology*, 109(1), 9–16.	2002	Women's perceptions and experiences of routine enquiry for domestic violence in a maternity service.	Qualitative study Semi-structured interviews of women in homes and GP surgeries	A purposive sample of ten women who experienced domestic violence in the last 12 months (including pregnancy) Six women who	Women found routine enquiry for domestic violence in maternity settings as acceptable if conducted in a safe, confidential environment by trained health professionals who are empathetic and non-judgemental. Routine enquiry will not be effective if women feel hurried or believe the midwife does not have enough time to deal with the issues.	Did not use a method of a random selection of participants so not possible to generalise the findings

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Author in alphabetical order/ Source	Date	Title	Research Design	Sample	Key Findings	Limitations of the Study
				experienced domestic violence in the past 12 months but not in pregnancy and 16 women with no history of domestic violence	Some women were in favour of an on-site domestic abuse specialist.	
Bacchus, L.,Mezey, G. & Bewley, S. *Health and Social Care in the Community*, *11*(1), 10–18.	2003	Experiences of seeking help from health professionals in a sample of women who experienced domestic violence.	Qualitative In-depth semi-structured	Purposive sampling 16 women. In total, ten had experienced domestic violence in the past 12 months	Women regarded their GP and A+E staff as less helpful compared with their Health Visitors. Very few disclosed domestic violence, and fewer were asked directly about domestic violence. Subjects had high postnatal depression scores and reported	Small descriptive study so findings could not be generalised

Appendix 17 Analysis of peer reviewed papers

Author in alphabetical order/ Source	Date	Title	Research Design	Sample	Key Findings	Limitations of the Study
				(including the current pregnancy) and six who experienced domestic violence in the 12 months but were not currently pregnant Trained midwives screened women booked for maternity care at the first appointment, 34 weeks, and postpartum	episodes of depression, suicidal thoughts, and attempted suicide. Health professionals must enquire about domestic violence sensitively. Lack of privacy, continuity of care, and time constraints prevented women from disclosing domestic violence. Virtually none of the health professionals provided information about community resources such as women's aid, refuge, or legal advice. Domestic violence training is necessary for all health professionals.	

Appendix 17 Analysis of peer reviewed papers

Author in alphabetical order/ Source	Date	Title	Research Design	Sample	Key Findings	Limitations of the Study
				(within ten days).		
Baird, K., Salmon, D., & White, P. *Midwifery*, *29*, 1003–1010.	2013	A five year follow up study of the Bristol pregnancy domestic violence programme to promote routine enquiry.	Qualitative Survey and focus groups.	A follow-up study to evaluate the degree to which practice changes identified in the 2004/200 An acute Trust within the South West of England 58 Midwives completed the survey- 73% had	There was a statistically significant increase in self-reported- confidence in asking women about domestic abuse. There was a statistically significant increase in the degree of self-reported knowledge of how to deal with disclosure when comparing the 2010 data with the 2005 data. Health professionals lacked the awareness, training, and attentiveness to deal with positive disclosure of domestic violence. Universal, rather than selective enquiry avoided the stigmatization of women and prevented the labelling of specific groups.	Barriers continue to exist, which included the presence of a male partner and lack of face-to-face interpreting services. Self-report data meant it was not possible to confirm the findings with other data sources.

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Author in alphabetical order/ Source	Date	Title	Research Design	Sample	Key Findings	Limitations of the Study
				completed the original study in 2004/2005. 11 of those surveyed also participated in focus group interviews		
Boyle, A., & Jones, P. B. *British Journal of General Practice*, 56(525), 258–261.	2006	The acceptability of routine inquiry about domestic violence towards women: a survey in three healthcare settings.	Quantitative Anonymous, confidential interview-based cross-sectional study Self-completed questionnaires Some direct interviews	Three general practice surgeries, one antenatal clinic, and one emergency department in Cambridge 1744 women were approached	Routine enquiry about domestic violence was found to be acceptable for most women. However, 122 women (8.4%) would mind being asked about domestic abuse by healthcare staff. Women in the emergency department and GP surgeries were more likely to find enquiry unacceptable than in the antenatal clinic.	The response rate in the primary care arm was low. Women may give socially desirable answers in a research interview and introduce bias.

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Author in alphabetical order/ Source	Date	Title	Research Design	Sample	Key Findings	Limitations of the Study
				and invited to participate. Response rate of 1452 women (63%)	Women in the antenatal clinic reported lower rates of abuse within one year than at the emergency department or antenatal clinic. Abuse within one year was strongly associated with finding enquiry unacceptable but not lifetime abuse.	
Bradbury-Jones, C., Duncan, F., Kroll, T., Moy, M., & Taylor, J. *Nursing Standard*, 29(43), 35–40.	2011	Improving the health care of women living with domestic abuse.	Qualitative Semi-structured interviews	The study took place in Scotland. A purposive sample of 17 women was recruited via Women's Aid who had experienced domestic abuse	There were inadequate systems of communication, such as a delay in the transfer of records. Most of the women had suffered depression, anxiety attacks, and panic attacks that required specialist health services. Three women had experienced stillbirth or neonatal death. Women explained that low self-esteem and fear of stigmatisation	All participants were given specialist support for women who have experienced domestic abuse. Therefore, their experiences may not be representative of the larger, hidden population of women who experience

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Author in alphabetical order/ Source	Date	Title	Research Design	Sample	Key Findings	Limitations of the Study
					made it difficult for them to discuss abuse. Women experienced difficulties in forming trusting relationships with healthcare professionals and went to great lengths to hide the abuse.	domestic abuse but does not access services. This was a small study conducted in one region of Scotland.
Bradbury-Jones, C., Taylor, J., Kroll, T., & Duncan, F. *Journal of Clinical Nursing*, 23(21–22), 3057–3068.	2014	Domestic abuse awareness and recognition among primary healthcare professionals and abused women: a qualitative investigation.	Qualitative Phase one: Individual semi-structured interviews with health professionals. Phase two: Three focus groups with abused women.	A two-phase, study conducted in Scotland (Data collected in 2011) Phase one: 29 primary health professionals (midwives, Health	There are levels of awareness in the nature and existence of abuse by women who have been abused and primary healthcare professionals. Women go to great lengths to hide the abuse due to feelings of shame and stigmatisation. Women found it easier to hide the abuse than to disclose it. Women may not identify their experiences as abusive, and some are resistant to routine enquiry.	The study was a secondary analysis of existing data with different research questions in mind. Deeper insights into the issue of domestic abuse awareness may have been found if the study had set out to generate

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Author in alphabetical order/ Source	Date	Title	Research Design	Sample	Key Findings	Limitations of the Study
				Visitors' and general practitioners) Phase two: Purposive sampling of 14 abused women	Some midwives and Health Visitors make assumptions about women who are more or less likely to experience domestic abuse. A dual silence can exist where neither woman nor health professional broaches the subject of domestic abuse.	data according to the research questions used for the secondary analysis. Women were recruited through a domestic abuse service, which may have influenced their insights. Small sample size The abuse framework requires refinement, modification, and testing beyond parameters of the

Appendix 17 Analysis of peer reviewed papers

Author in alphabetical order/ Source	Date	Title	Research Design	Sample	Key Findings	Limitations of the Study
						study. This means that caution needs to be exercised when considering its use and transference.
Bryant, S. A., & Spencer, G. A. *Journal of the American Academy of Nurse Practitioners*, 14(9), 421–427.	2002	Domestic violence: what do nurse practitioners think?	Quantitative Stratified random survey	Out of 300 nurse practitioners (NP), 118 completed the survey.	There were significant differences in the domestic violence screening practices among women's health visitors, obstetrics and gynaecology nurses, adult and family nurse practitioners. Women's health visitors and obstetrics and gynaecology nurse practitioners were more likely to ask screening questions and identify victims of domestic violence than others. Additional strategies need to be developed to encourage NPs to	This study cannot be generalized to all NPS because only New York State NPs were eligible to participate in the study. This study had a low response

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Author in alphabetical order/ Source	Date	Title	Research Design	Sample	Key Findings	Limitations of the Study
					incorporate asking, identifying, referring, and reporting domestic violence	
Burch, R. L., & Gordon, G. G. *Journal of Family Violence*, 19 (4), 243-247.	2004	Pregnancy as a stimulus for domestic violence.	Quantitative Questionnaire Semi-structured interviews	Data collected from 258 men convicted of spousal abuse who were referred to a treatment programme	Approximately one out of seven admitted to committing violent acts towards their current partner while she was pregnant. Sexual jealousy, accusations of spending too much time with others, and stopping her engagement with outside activities were evident.	Men tend to minimise or deny the abuse. Therefore, the results reported represent conservative estimates of abuse. This sample group of men had already been convicted of abuse. Social desirability, poor memory, or fear

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Author in alphabetical order/ Source	Date	Title	Research Design	Sample	Key Findings	Limitations of the Study
						of further punishment may have affected their reports of violence, which they may have minimised.
Cann, K., Withnell, S., Shakespeare, J., Doll, H., & Thomas *Public Health*, *115*(2), 89–95.	2001	Domestic violence: a comparative survey of levels of detection, knowledge, and attitudes in healthcare workers.	Quantitative Self-administered questionnaire	A total of 685 community and hospital-based healthcare workers in Oxfordshire working in primary care, obstetrics, gynaecology, mental health, and accident	Most Healthcare workers accepted that domestic violence is a healthcare issue but lacked fundamental knowledge about the issues surrounding domestic violence and appropriate agencies that can help. Healthcare workers did not agree with direct questioning of large, non-specific groups of patients. However, 69% agreed with direct questioning in specific settings.	No limitations identified

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Author in alphabetical order/ Source	Date	Title	Research Design	Sample	Key Findings	Limitations of the Study
				and emergency Consisted of Practice/ district nurses and Health Visitors, healthcare workers in obstetrics and gynaecology, community mental health teams, and accident and emergency in one NHS Trust	Practitioners lacked skills to identify and discuss this issue with patients/clients and welcomed training.	

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Author in alphabetical order/ Source	Date	Title	Research Design	Sample	Key Findings	Limitations of the Study
Chapin, J. R., Coleman, G., & Varner, E. *Journal of Injury and Violence Research*, 3(1), 19–2362.	2011	Yes, we can! Improving medical screening for intimate partner violence through self-efficacy.	Quantitative Post-test surveys	Convenience sample of 320 nurses and medical students in Pennsylvania	Nurses and medical interns exhibit a wide range of self-efficacy in their ability to screen victims of IPV. Participants were better informed about IPV services and the obstacles faced by victims following training.	Individuals who participated in the training were likely to differ from those who chose a different topic to meet their training obligation. The preference for the topic may have resulted in bias among participants and possibly variance in self-efficacy. Measures were taken at the end of training and may have

Appendix 17 Analysis of peer reviewed papers

Author in alphabetical order/ Source	Date	Title	Research Design	Sample	Key Findings	Limitations of the Study
						influenced responses.
Christofides, N. J., & Silo, Z. *Nursing and Health Sciences*, 7(1), 9–14	2005	How nurses' experiences of domestic violence influence service provision: Study conducted in North-west province, South Africa.	Qualitative Interviews using standardized survey	212 female nurses from two South African hospitals and 20 primary healthcare clinics	Nurses with experiences of friends and family in abusive relationships provided better care for patients. Nurses who reported no personal experience of domestic violence, either in their own lives or among family and friends, provided a lower quality of care. Having ever intervened in a domestic dispute was associated with a higher quality of care. The greater the degree to which nurses identify with DV and intervene, the more likely they are to provide a higher quality of care.	Sampling bias may have resulted from self-selection. Small sample size Nurses may have missed cases of domestic violence, which was not included in the data.

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Author in alphabetical order/ Source	Date	Title	Research Design	Sample	Key Findings	Limitations of the Study
Crowe, A., & Murray, C. E. *Partner Abuse*, *6*(2), 157–179.	2015	Stigma from professional helpers toward survivors of intimate partner violence.	Study 1: qualitative in-depth interviews Study 2: Electronic survey consisting of qualitative and quantitative questions	Study 1: Twelve women across two study sites Study 2: 219 participants, larger convenience sample size	Survivors felt stigmatised by mental health professionals, education, parent-related professionals, family/ friends and those within the legal and judicial system. Women felt stigmatised with feelings of being dismissed, denied and blamed.	The study included self-report data and relied on subjective perceptions of experiences from survivors. The sample was not diverse in relation to race, ethnicity, sexuality and socioeconomic status.
Evans, M. A., & Feder, G. S. *Health Expectations*, 19, 62–73.	2016	Help-seeking amongst women survivors of domestic violence:a			Women remained in abusive, controlling relationships for many years without access to support. Women only disclosed after leaving the perpetrator.	The sample may not be representative of women receiving

Appendix 17 Analysis of peer reviewed papers

Author in alphabetical order/ Source	Date	Title	Research Design	Sample	Key Findings	Limitations of the Study
		qualitative study of pathways towards formal and informal support.			Access to specialist support rarely came from GPs but was more often facilitated by police or housing following a crisis. Informal disclosure only led to specialist help if the family member or friend had experience or knowledge of DVA.	help at a DVA agency. The sample also included few women from minority ethnic groups who may have needs that would require further study.
Featherstone, B., & Peckover, S. *Critical Social Policy,* 27(2), 181–202.	2007	Letting them get away with it: fathers, domestic violence and child welfare.	Book chapter		Domestic abuse is now on the policy agenda; however, fathers are not often featured within policy discourses. There is the recognition that domestic violence has an impact on children.	

Appendix 17 Analysis of peer reviewed papers

Author in alphabetical order/ Source	Date	Title	Research Design	Sample	Key Findings	Limitations of the Study
					Men need to be engaged with services to provide support to the whole family.	
Francis, L., Loxton, D. & James, C. *Journal of Clinical Nursing*, 26, 2202–2214.	2016	The culture of pretence: a hidden barrier to recognising, disclosing and ending domestic violence.	Qualitative Phase 1: Semi-structured interviews Phase 2: Three focus groups	Phase 1: A purposive sample of twelve women who had experienced domestic violence Phase 2: Twenty-five professionals from health, social sciences, and law who supported women	The barriers that impede women from disclosing abuse are complex and varied. Women did not always acknowledge or realise their relationship was precarious and often minimised the abuse to cope with domestic violence. Professionals found that women did not always identify or acknowledge abuse in their relationship, which delayed the provision of appropriate services.	No limitations identified

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Author in alphabetical order/ Source	Date	Title	Research Design	Sample	Key Findings	Limitations of the Study
				experiencing domestic violence.		
Gutmanis, I., Beynon, C., Tutty, L., Wathen, C. N., & MacMillan, H. L. *BioMedical Central Public Health*, 7(12).	2007	Factors influencing identification of and response to intimate partner violence: a survey of physicians and nurses.	Quantitative Descriptive cross-sectional study Survey	Random selection of 1000 nurses and 1000 physicians in Ontario, Canada 932 questionnaires were returned- 597 by nurses and 328 by physicians	Inadequate preparation, both educational and experiential, was a key barrier to routine enquiry. Training and professional experience were associated with increased feelings of preparedness and self-confidence.	The selection of questions, while based on the literature and consultation with IPV experts, was not theory-driven and may have missed some key concerns or concepts.
Heffernan, K., Blythe, B., & Nicolson, P.	2014	How do social workers understand and	Mixed method Cross-sectional self-	450 British social workers practising in	All the social workers were concerned about the overall welfare of women and children.	Results do not represent all practitioners, only

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Author in alphabetical order/ Source	Date	Title	Research Design	Sample	Key Findings	Limitations of the Study
International Social Work, 57(6), 698–713.		respond to domestic violence and relate this to organizational policy and practice?	administered survey Follow-up semi-structured interviews Cross-case and within-case analysis	the Midlands were targeted. A response rate of 181 surveys 19 social workers interviewed	They also were clear as to what constitutes domestic violence and generally agreed on its causes. Social workers knew domestic violence exists; however, they are less likely to believe it is happening to their clients.	a select view of social workers from one city in the UK. Recruitment of participants did not include those from a diverse population across health and social care; therefore, the findings were not generalisable. There was a potential source of bias in questions about defining domestic violence but would be identified if the

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Author in alphabetical order/ Source	Date	Title	Research Design	Sample	Key Findings	Limitations of the Study
						term ‘domestic abuse' was used.
Humphreys, C. *Child & Family Social Work*, *4*, 77–87.	1999	Avoidance and confrontation: social work practice in relation to domestic violence and child abuse.	Qualitative Documentary analysis of case files. Semi-structured interviews with social workers	Examination of files from 32 families in which domestic violence was an issue Involved 93 children who were subjects of child protection conferences	Social workers and others working in child protection avoided the issue of domestic violence. It also highlights the importance of addressing wider organizational issues and setting into context issues around domestic violence. There were strong expectations placed on the woman to separate from or remain separated from violent men. Minimisation of the issues of domestic violence was a dominant theme, with reports failing to mention domestic violence as an issue to be considered.	No limitations identified

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Author in alphabetical order/ Source	Date	Title	Research Design	Sample	Key Findings	Limitations of the Study
					There was a concern by social workers who did not want to 'offend the man' by asking about his violent tendencies in order to keep him engaged in less specific discussions.	
Husso, M., Virkki, T., Notko, M., Holma, J., Laitila, A., & Mäntysaari, M. *Health & Social Care in the Community*, 20(4), 347–55.	2012	Making sense of domestic violence intervention in professional health care.	Qualitative Six focus group interviews	30 nurses, physicians, social workers and psychologists working in specialist healthcare in Finland	Health professionals indicated that they lacked training and knowledge about the causes and effects of domestic violence, which lead to feelings of inadequacy and frustration. Developing successful practices both to identify survivors and to prevent further victimisation requires an understanding of the effects of DV.	No limitations identified
Jenner, S. C., Etzold, S. S., Oesterhelweg, L., Stickel, A.,	2016	Barriers to active inquiry about intimate partner	Quantitative Questionnaires	825 physicians in Germany undertook the	Increased enquiry correlates with increased identification rates.	Some participants who could have been involved in

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Author in alphabetical order/ Source	Date	Title	Research Design	Sample	Key Findings	Limitations of the Study
Kurmeyer, C., Reinemann, D., & Oertelt-Prigione, S. *Journal of Family Violence*, 31(1), 109–117.		violence among german physicians participating in a mandatory training.		training, which consisted of midwives, clinical researchers, dieticians, general practice residence. 751 completed the questionnaire.	Experience and confidence in the practitioner asking about domestic abuse increases the rate of inquiry. Structural issues such as time constraints, language barriers, and a lack of safe locations represented barriers for active inquiry.	the study were not reached. The limited response rate from the follow-up questionnaire.
Katiti, V., Sigalla, G. N., Rogathi, J., Manongi, R., & Mushi, D. *Bio-Med Central Public Health*, *16*, 715.	2016	Factors influencing disclosure among women experiencing intimate partner violence during pregnancy in	Mixed method Questionnaire and interviews	339 pregnant women who had experienced emotional, physical and/or sexual violence from	Most women who experienced IPV during pregnancy kept suffering in silence. Less than a quarter (23.3%) of all the abused women disclosed their experience to someone.	The study relied on secondary data, so missing information could not be clarified with participants.

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Author in alphabetical order/ Source	Date	Title	Research Design	Sample	Key Findings	Limitations of the Study
		Moshi Municipality, Tanzania		the Moshi Municipality-Tanzania between April and June 2015.	IPV disclosure was less likely among unemployed women and with an unplanned pregnancy. Participation in community, religious or political groups facilitated disclosure. Abused women preferred to disclose to their family of origin first, turning to friends and then family in-laws.	Participants may have with-held information or provided socially desirable responses to avoid being deviant to their culture or religious beliefs.
Keeling, J., & Mason, T. *Journal of Clinical Nursing*, 20(1–2), 103–110.	2010	Postnatal disclosure of domestic violence: comparison with disclosure in the first trimester of pregnancy.	Quantitative Anonymous and self-administered questionnaire	Convenience quota sampling of 500 women who were invited to participate between 1-5 days postnatal in a large teaching	An emotional inhibitory response to disclosure may occur at specific periods of pregnancy. The timing of asking about DV may be critical to disclosure. The changing needs of women during pregnancy needs to be considered in maternity services.	The effects of the childbirth experience may have negated a woman's desire to recall violence in pregnancy. The sample was drawn from a predominantly white British

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Author in alphabetical order/ Source	Date	Title	Research Design	Sample	Key Findings	Limitations of the Study
				hospital in the UK 221 women participated.		population and therefore may not be generalisable to an area with a more diverse ethnic population. Access to the sample differed according to each clinic, and this may have affected disclosure rates.
Lazenbatt, A., Thompson-Cree., M. L., & McMurray, F. *Midwifery*, 21, 322–334.	2005	The use of exploratory factor analysis in evaluating midwives' attitudes and stereotypical myths related to the	Quantitative Questionnaire	861 hospital and community midwives in Northern Ireland 57% response rate	Younger hospital-based midwives need to be more empowered and confident in addressing domestic violence in their practice. Older midwives require more in-service training to increase awareness and to help change negative stereotypical attitudes.	Data was based on a non-random, purposive sample in Ireland, so it may not be generalizable. The response rate of 57% limited the ability to

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		identification and management of domestic violence in practice.			Training needs to be ongoing as the 'training effect' diminishes rapidly if not reinforced.	extrapolate the findings to those who did not respond. The existing data did not permit adequate analyses of subgroups.
Madhani, I., Karmaliani, R., Patel, C., Bann, C. M., Mcclure, E. M., Pasha, O., & Goldenberg, R. L. *Journal of Interpersonal*	2017	Women's perceptions and experiences of domestic violence: an observational study from Hyderabad, Pakistan.	Quantitative Cross-sectional study Interviews	1,325 women in their 20th to 26th weeks of pregnancy who were permanent residents in Hyderabad (Pakistan) for	Nearly half of the study participants believed that physical violence was violence against women (VAW). Verbal abuse, controlling behaviour by the husband, conflict with in-laws, overburdening domestic work, and threatening to leave or remarry were also considered VAW.	The open-ended nature of the questions allowed participants to respond freely; however, many responses were vague.

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Author in alphabetical order/ Source	Date	Title	Research Design	Sample	Key Findings	Limitations of the Study
Violence, 32(1), 76–100.				a minimum of 6 months	Five participants (0.4%) considered sexual abuse to be VAW. Most women who screened positive for domestic violence responded by remaining silent or verbal fighting back. None sought professional help. Women who decided to remain silent feared that the abuse would escalate or that responding would not help them. Women's lack of autonomy further reduced their ability to take steps against violence.	The interviewers were not trained to prompt the participants to clarify their views, and some data were lost. Due to pregnancy being a happy time, women's feelings and actual responses may have been replaced with 'keeping silent.' Pregnant women may even be more fearful about the potential consequences of disclosing;

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Author in alphabetical order/ Source	Date	Title	Research Design	Sample	Key Findings	Limitations of the Study
						therefore, accurate responses may not have been obtained.
Mauri, E., Nespoli, A., Persico, G., & Zobbi, V. *Midwifery*, 31, 498–504.	2015	Domestic violence during pregnancy: Midwives' experiences.	Phenomenological-hermeneutical qualitative study Semi structured interviews	Northern Italy - A purposive sample of 15 hospital and community midwives working in the local health district of Monza and Brianza	Limited knowledge lead to difficulty in midwives recognising domestic violence. Identified a lack of training, cultural taboos, and women's unwillingness to disclose abuse	Midwives were recruited who were employed by the same health district with community midwives less represented than hospital-based midwives.
McCarthy, M., Hunt, S., & Milne-Skillman, K. *Journal of Applied*	2017	'I know it was every week, but I can't be sure if it was every day: domestic	Qualitative Semi-structured interviews	A purposive sample of 15 women with mild learning disabilities	Women suffered severe and frequent violent attacks.	Small sample Participants were volunteers, which

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Author in alphabetical order/ Source	Date	Title	Research Design	Sample	Key Findings	Limitations of the Study
Research in Intellectual Disabilities, 30, 269–282.		violence and women with learning disabilities'.		who had experienced domestic violence	The violence had a negative impact on their physical and psychological well-being. Awareness of refuges and other sources of help was low.	may have resulted in bias. A lack of Afro-Caribbean women, although Asian women were included Focused on historical cases Experiences of women who had severe learning disabilities were not included.
Minsky - Kelly, D., Hamberger, L. K., Pape, D., & Wolff, M.	2005	We've had training, now what? Qualitative analysis of barriers to	Qualitative Focus group interviews	From two acute hospitals and a large multidisciplinary practice	Barriers were identified in the implementation of DV screening and referral protocols: - Value of screening	Identifying barriers through focus groups with selected staff

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Author in alphabetical order/ Source	Date	Title	Research Design	Sample	Key Findings	Limitations of the Study
Journal of Interpersonal Violence, 20(10), 1288–1309.		domestic violence screening and referral in a health care setting.		752 staff members and stakeholders	- Inadequate provider experience - Concerns around the process of screening - Lack of time and workload priorities - Concerns about the outcome and efficacy of screening	members was a limitation. Participants may have introduced some bias due to having strong views. Used note-takers instead of audiotape could have resulted in bias reporting.
Moe, A. M. *Sociology Faculty Publications*. Retrieved from http://scholarworks.wich.edu/sociolog pubs	2007	Silenced voices and structured survival: battered women's help-seeking.	Qualitative Semi-structured interviews	19 battered women living in an emergency shelter in Phoenix Arizona	Emergency shelter was dependant on the women's compliance with numerous policies. Women remained diligent to remain safe. Family and friends may agree to support the victim on the condition	

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Author in alphabetical order/ Source	Date	Title	Research Design	Sample	Key Findings	Limitations of the Study
					they never contact the perpetrator again.	
Othman, S., Goddard, C., & Piterman, L. *Journal of Interpersonal Violence*, 29(8), 1497–1513.	2014	Victims' barriers to discussing domestic violence in clinical consultations: a qualitative enquiry.	Qualitative In-depth interviews Grounded theory	A purposive sample of 10 women with a history of domestic violence residing at a shelter in Klang Valley, Malaysia.	Cultural values and beliefs were barriers for women living with domestic abuse. Being a 'good wife' alongside endurance, loyalty, maintaining privacy about family matters and the family unit affected their decision to remain in the relationship. The value of 'saving face' along with feelings of shame, self-blame, and financial dependency on the abuser were internal barriers. Unclear about the role of healthcare professionals and negative experiences in clinics were external barriers.	The study was conducted in a single shelter. Findings may not reflect those women who did not access shelter services. Women residing in the shelter may have experienced more severe forms of violence. Recruitment was voluntary, so participants were likely to have been more

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Author in alphabetical order/ Source	Date	Title	Research Design	Sample	Key Findings	Limitations of the Study
						interested in the topic.
Ozçakar, N. €, Ozde, G. €, Iltepe, Y., Okçe Karaman, G. €, Toprak, A., & Onen, E. €. *Journal of Forensic and Legal Medicine*, 40, 1– 7. https://doi.org/10.06/j.jflm.2016.01.03	2016	Domestic violence survivors and their experiences during legal process.	Qualitative Semi-structured interviews	Purposive sampling of 10 women survivors during the legal process	Survivors remained silent due to fear, depression, wanting to protect their family, and not wanting a divorce. This study illustrated the cycle of violence. Survivors mostly had negative experiences with police. Police did not accept their complaint. Women were forced to reconcile with their husbands. Survivors felt the perpetrator was not adequately punished.	The participants were anxious during interviews. Unable to reach all the expected participants
Peckover, S. *Health and Social Care in the*	2002	Focusing upon children and men in situations of	Qualitative Semi-structured interviews	In a northern city between	Domestic violence is a serious issue that Health Visitors are faced with.	

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Author in alphabetical order/ Source	Date	Title	Research Design	Sample	Key Findings	Limitations of the Study
Community, 10(4), 254–261.		domestic violence: an analysis of the gendered nature of British Health Visiting.		Oct 1996 and July 1997 A combination of purposive and convenience sampling selected 24 British Health Visitors and 16 women	This study has made visible the gendered nature of Health Visiting. Health Visitors have concerns about their safety. Men may undermine Health Visitors by presenting themselves as 'plausible'.	
Peckover, S. *Journal of Advanced Nursing*, 44(2), 200–208.	2003a	Health Visitors' understandings of domestic violence.	Qualitative Semi structured interviews.	Convenience purposive sample of 24 Health Visitors	Differences between Health Visitors in their understanding of the extent of domestic violence in their caseloads. Differences in Health Visitors' recognition of the different types of abuse and willingness to name	Small scale study All participants employed by the same NHS Trust Six years since the data was first collected

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Author in alphabetical order/ Source	Date	Title	Research Design	Sample	Key Findings	Limitations of the Study
					incidents other that physical violence as abusive.	
Peckover, S. *Health & Social Care in the Community*, 11(3), 275–282.	2003b	'I could have just done with a little more help': an analysis of women's help-seeking from Health Visitors' in the context of domestic violence.	Qualitative Semi-structured interviews	16 women who had experienced domestic violence and who had small children	All who participated described difficulties in seeking help about domestic violence. Fears for their safety lack of knowledge about where to find support and protection, and concerns with losing custody of their children. Health Visitors may not always respond appropriately. This theme recurred throughout the women's interviews. Women want protection from the domestic violence that they are experiencing.	
Peckover, S., & Trotter, F.	2015	Keeping the focus on children: the	Qualitative Six focus groups	A total of 23 mixed professional	Professionals are aware of and able to recognise domestic abuse.	Small sample size

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Author in alphabetical order/ Source	Date	Title	Research Design	Sample	Key Findings	Limitations of the Study
Health and Social Care in the Community, 23(4), 399–407.		challenges of safeguarding children affected by domestic abuse.		groups included health, education, family support, and early years workers	Those working with children were aware of changes in a child's behaviour or mood, which may indicate domestic abuse. There was little evidence of professional's ability to work with and support children living with domestic abuse. Service provision was limited.	Purposive sample meant that those who took part had a previous interest in the topic. Those who did not take part may have different views and experiences. The study took place in one local authority area.
Ramsay, J., Rutterford, C., Gregory, A., Dunne, D., Eldridge, S., Sharp, D., & Feder, G.	2012	Domestic violence: knowledge, attitudes, and clinical practice of selected UK primary	Qualitative A cross-sectional survey as part of a randomised control trial	272 clinicians in 48 general practices in Hackney and Bristol, UK Participants were GPs and	Identified minimal previous domestic violence training. Clinicians had basic knowledge about domestic violence but had a positive attitude towards engaging with women about this topic.	The study was conducted in urban and suburban practices and may not be representative of

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British Journal of General Practice, *62*(602), e647–e655.		healthcare clinicians.		practice nurses.	Clinicians felt poorly prepared to ask about abuse and to make appropriate referrals with 80% who did not know about local resources. 40% never or seldom asked women abut abuse when they presented with injuries.	practices in rural areas. The tool was supposed to be completed in 15 minutes but took some clinicians 30 minutes- this may have affected their response choices.
Reina, A. S., Lohman, B. J., & Maldonado, M. M. *Journal of Interpersonal Violence*, 29(4), 593–615.	2014	'He said they'd deport me': factors influencing domestic violence help-seeking practices	Qualitative exploratory study Semi-structured interviews and focus group	Ten women of Latina origin who were victims of abuse	Immigration status and the inability to understand domestic violence within cultural norms were a significant barrier to women seeking help from formal agencies. Feelings of shame, isolation and the lack of bilingual service providers	Small sample size, therefore, findings cannot be generalised Some women may not view themselves as victims and will not have sought

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		among Latina immigrants.			Lack of knowledge about resources from new staff members	help or may not have access to advocacy service.
Reisenhofer, S., & Seibold, C. *Journal of Clinical Nursing*, 1–11.	2012	Emergency healthcare experiences of women living with intimate partner violence.	Qualitative Semi-structured interviews Grounded theory	Seven women who had sought emergency department or primary healthcare while experiencing domestic abuse	All women reported ongoing abuse throughout their relationships. All women were social and financially isolated with limited ability to access external care and support. All the women blamed themselves, modified their behaviour while minimising and normalising their experiences. When accessing services, women were treated for physical injuries but felt their psychological needs were neglected.	Small sample group. Interviewing women currently in abusive relationships may have identified changes to the women's experiences and perceptions of the events.

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Author in alphabetical order/ Source	Date	Title	Research Design	Sample	Key Findings	Limitations of the Study
					Health professionals who were judgemental and lacked empathy were damaging for the women.	
Rhodes, K. V, Frankel, R. M., Levinthal, N., Prenoveau, E., Bailey, J., & Levinson, W. *Annals of Internal Medicine*, 147(9), 620–7.	2007	'You're not a victim of domestic violence, are you?' Provider - patient communication about domestic violence.	Qualitative Randomised control trial of a self-administered computer-based health risk assessment tool.	293 audiotaped visits to two emergency departments to screen adult women for domestic abuse	Providers' positive communication behaviours seemed to facilitate patient disclosure of domestic violence and abuse. 77 women disclosed Domestic Violence during the interviews; however, providers documented only 24 of the disclosures and only made referrals for only 19 clients for counselling.	The providers were from one residency programme, so findings are not generalisable. Contact with women was not videotaped, so the study probably missed important non-verbal communication. Interactions could be skewed due to participants'

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Author in alphabetical order/ Source	Date	Title	Research Design	Sample	Key Findings	Limitations of the Study
						awareness of being audiotaped.
Robbins, R. *Social Work Education*, 33(7), 917–929.	2014	'She knew what was coming': knowledge and domestic violence in social work education.	Qualitative Narrative	36 social work students	Women who produced these narratives faced risk and danger. This study has highlighted the fortitude of women. The challenges to ensure a safe place for students to explore their experiences and how it relates to practice remains.	No limitations identified
Rose, D.,Trevillion, K., Woodall, A., Morgan, C., Feder, G. & Howard, L. *The British Journal of Psychiatry : The Journal of Mental Science*, 198(3),	2011	Barriers and facilitators of disclosures of domestic violence by mental health service users: qualitative study.	Qualitative Cross-sectional semi-structured interviews	A purposive sample of 16 community mental health service users and 20 mental healthcare professionals	Service users highlighted barriers to disclosure of abuse to professionals that included fear of consequences, fear of social services and child protection services. Fear that disclosure would not be believed and fear of further violence.	Socio-economically deprived setting with a high proportion of BAME groups; therefore, the findings may not be generalisable

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189–194.					Professionals were concerned about role boundaries, competency, and confidence. Some professionals queried whether enquiry about domestic abuse was part of their role. Mental health services are not currently conducive to the disclosure of domestic abuse.	Selection bias means that those who did not participate may have had different views.
Saberi, E., Eather, N., Pascoe, S., McFadzean, M. L., Doran, F., & Hutchinson, M. *Australasian Emergency Nursing Journal*, 20(2), 82–86.	2017	Ready, willing and able? A survey of clinicians' perceptions about domestic violence screening in a regional hospital	Quantitative Questionnaire	Cross-sectional sample of 76 emergency department clinicians that included nursing and medical staff in New South	Most clinicians supported the idea of screening for domestic violence. Most clinicians did not always feel comfortable screening for domestic violence and had insufficient training.	A small sample that focused on one Australian emergency department limited the generalisability. Participants had difficulty recalling information,

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		emergency department.		Wales, Australia		which may have influenced responses.
Salmon, D., Murphy, S., Baird, K. & Price, S. *Midwifery*, 22, 6–14.	2006	An evaluation of the effectiveness of an educational programme promoting the introduction of routine antenatal enquiry for domestic violence.	Quantitative Pre-training/ Post-training and six months follow up survey.	An acute Trust within the South West of England- 79 community midwives participated in the training with 70 participating at all three stages of the research	The midwives positively received the programme. Improvements in knowledge, attitudes and efficacy at post-test. These levels declined but remained above pre-test levels at six months follow up. Rate of enquiry was lower than anticipated, midwives routinely asking only 50% of the time; however, the presence of a male partner was a key barrier.	No comparison group, small numbers, and using measures not previously validated
Shepard, M. F., Elliott, B., Falk, D. R. & Regal, R. R. *Public Health*	1999	Public health nurses' responses to domestic violence:a	Quantitative Data collected from case files	The population of a small city in	When the protocol was used, there was a higher rate of identification,	Not an experimental study

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Nursing, 16(5), 359–366.		report from the enhanced domestic abuse intervention project.		the Midwest of America 546 women who received home visits in 1994 (the baseline year) 422 women who received visits in 1996 372 women who received visits in 1996	although the difference was not statistically significant. More women were provided with information about domestic violence resources after the protocol was in place, and significantly more women were referred to services in the second year after the protocol had been implemented. The study provides support for the use of a domestic violence protocol to improve health workers' responses to domestic violence.	External factors may have influenced the outcomes. The study relied on written documentation of actions taken. In some cases, screening and referral may not have been documented on the necessary forms. After 1994 slight changes were made to the screening process

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Author in alphabetical order/ Source	Date	Title	Research Design	Sample	Key Findings	Limitations of the Study
						for identifying abuse.
Spangaro, J. M., Zwi, A. B., & Poulos, R. G. *Psychology of Violence*, 1(2), 150–162.	2011	'Persist. persist.': A qualitative study of women's decisions to disclose and their perceptions of the impact of routine screening for intimate partner violence.	Qualitative In-depth semi-structured interviews Data from the survey and clinical notes to triangulate interview material	Ten health services in socioeconomically diverse urban and regional centres Twenty women followed up six months after disclosing abuse in response to screening.	Women disclosed abuse after making judgements about safety. Most women valued the screening. Healthcare workers response to disclosures helped to create a sense of connection.	Reliance on women to volunteer for interview from the survey sample Women at greatest risk were less likely to volunteer.
Spangaro, J. M., Zwi, A. B., Poulos,	2010	Who tells and what happens:	Quantitative	In two health regions of	The main reasons for non-disclosure were not considering that the abuse	Too few participants to

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R. G., & Man, W. Y. N. *Health and Social Care in the Community*, 18(6), 671–680.		disclosure and health service responses to screening for intimate partner violence.	Survey	New South Wales-Sidney Australia 284 women who had experienced IPV completed the survey.	was serious, fear of the offender finding out, and not trusting the health worker. Just over half of the positive and negatively screened groups were given written information about intimate partner violence. Much of the abuse remained hidden and required active efforts to encourage women to speak out.	fully explore differences between client groups Restricted demographic data and non-randomised selection of services The eligibility rate was low, and selection bias was possible. The administration of the questionnaire by telephone to mental health patients limited

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						the comparability of the results.
Stanley, N., Miller, P., & Richardson Foster, H. *Child and Family Social Work*, 17, 192–201.	2012	Engaging with children's and parents' perspectives on domestic violence.	Qualitative Semi-structured interviews and Five focus groups	Two local authorities in the North and South of England between 2007 and 2009 recruited three groups of participants A total of 19 young people from voluntary and statutory organisations that provide	Young people, survivors, and perpetrators need practitioners to listen and validate their accounts. Accounts of domestic abuse may vary between family members. Participants acknowledged the harm domestic abuse had on children. Domestic violence continues beyond separation.	The three groups of participants were recruited separately rather than with members from the same family.

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				support to children 11 survivors of domestic abuse 10 perpetrators were interviewed.		
Stöckl, H., Hertlein, L., Himsl, I., Ditsch, N., Blume, C., Hasbargen, U., Friese, K., & Stöckl, D. *BMC Pregnancy and Childbirth*, 13, 77.	2013	Acceptance of routine or case-based inquiry for intimate partner violence: a mixed-method study.	Mixed method Self-administered survey In-depth semi-structured interviews	401 pregnant women from a University Hospital's maternity ward in Munich	Women showed support for routine or case-based screening for IPV in antenatal care in Germany. There needs to be a window of opportunity for doctors to speak to women about IPV. Women wanted healthcare staff who are trained, have time, and can respond appropriately.	The quantitative survey was cross-sectional, and neither the quantitative survey nor the qualitative interviews were based on a representative sample of pregnant women,

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						which limits the generalisability of the findings. The survey and interviews were restricted to women who could be met alone or spoke enough German, which may have resulted in the exclusion of women who could be at higher risk of domestic abuse. This was a small sample of women.

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Szilassy, E., Carpenter, J., Patsios, D., & Hackett, S. *Violence against Women*, 19(11), 1370–83.	2013	Outcomes of short course interprofessional training in domestic violence and child protection.	Quantitative Questionnaire	177 staff consisted of social workers, nurses, midwives, teachers, doctors, community workers, probation officers and counsellors	There were significant improvements in participants' attitudes, knowledge, and self-confidence by the end of the course.	A 'no-train' control group was not included in the research design, so an increase in scores cannot be entirely attributed to the training. Self-reporting meant that bias might have influenced the outcome. Participants' true feelings and beliefs about domestic abuse may not have been accurately

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						represented in the questionnaire. It could not be established if at 3 months the improvements in attitudes, knowledge, and confidence were sustained over time.
Szilassy, E., Drinkwater, J., Hester, M., Larkins, C., Stanley, N., Turner, W., & Feder, G. *Health and Social Care in the Community*, *25*(6),	2017	Making the links between domestic violence and child safeguarding: an evidence-based pilot training for	Quantitative Survey	Seven LSCBs from four regions of England collaborated in this study. 177 staff participated	A short interactive course for professionals from different disciplines can have a positive effect on self-rated attitudes towards domestic violence. Training is part of the solution.	No limitations identified.

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Author in alphabetical order/ Source	Date	Title	Research Design	Sample	Key Findings	Limitations of the Study
1722–1732. https://doi.org/10.1111/hsc.12401		general practice.				
Taylor, J., Bradbury-Jones, C., Kroll, T., & Duncan, F. *Health and Social Care in the Community*, 21(5), 489–499.	2013	Health professionals' beliefs about domestic abuse and the issue of disclosure: a critical incident technique study.	Qualitative A two-phase study, comprising semi-structured interviews and focus groups	Recruited from two health boards in Scotland using purposive sampling Phase 1: Interviewed a total of 29 health professionals (11 midwives, 16 Health Visitors', 2 general practitioners)	Women are likely to conceal the abuse. Abused women and health professionals did not always share the same views. For example, women wanted to be asked about abuse, but many health professionals did not feel confident or comfortable discussing the issue and were reluctant to do so. Some health professionals believed that women were complicit in their own abuse. Health professionals believed domestic abuse to be a serious health issue, which could impact the	A limited number of GPs were recruited; therefore, the findings need to be interpreted with caution. In phase 2, the focus group had already disclosed domestic violence. The Common-sense Model of Self-Regulation of Health and Illness Model

Appendix 17 Analysis of peer reviewed papers

Author in alphabetical order/ Source	Date	Title	Research Design	Sample	Key Findings	Limitations of the Study
				Phase 2: Three focus groups with a purposive sample of 14 women who were survivors of domestic violence were recruited through Scottish Women's Aid. Two groups were all white women, and one group were all Asian women.	social well-being of women. Most had developed sophisticated techniques to support women, such as adopting 'code talk'.	(CSM) was interpreted broadly. This study was carried out in Scotland so transferability and interpretation of findings may be different in other countries or in a different context.

Appendix 17 Analysis of peer reviewed papers

Author in alphabetical order/ Source	Date	Title	Research Design	Sample	Key Findings	Limitations of the Study
Thurston, W. E., Roy, A., Clow, B., Este, D., Gordey, T., Haworth-Brockman, McCoy, L., Beck, R., Saulnier, C., & Carruthers, L. *Journal of Immigrant and Refugee Studies*, 11(3), 278–298.	2013	Pathways into and out of homelessness: domestic violence and housing security for immigrant women.	Qualitative Longitudinal study Semi-structured interviews	37 abused immigrant women living in three Canadian cities between February 2005- January 2006	The support from individuals and agencies were instrumental in women leaving. The importance of advocacy at policy level	Only women who could speak English enough to converse could be recruited.
Usta, J., Antoun, J., Ambuel, B., & Khawaja, M. *Annals of Family Medicine*, 10(3), 213–221. https://doi.org/10.1	2012	Involving the health care system in domestic violence: what women want.	Qualitative Phenomenology Focus group	Six primary health care centres in Lebanon 72 women participated in the focus groups who	Women suggested that trust in the healthcare professional, confidentiality, caring, unhurried demeanour, listening skills and emotional support were helpful qualities for routine enquiry. Women identified several barriers to creating an effective health care	The findings cannot be generalised to all Lebanese women owing to the small sample size and recruitment from selected primary

Appendix 17 Analysis of peer reviewed papers

Author in alphabetical order/ Source	Date	Title	Research Design	Sample	Key Findings	Limitations of the Study
370/afm.1336.INTRODUCTION				had been routinely screened for domestic violence using the HITS (Hurt, Insult, Threaten, Scream) instrument.	response such as cost of services, failure of confidentiality, and fears of retaliation and increased violence. Women in rural communities expressed feelings of shame and embarrassment when asked about domestic violence and preferred a female physician. Most women favoured a healthcare system that works to prevent domestic violence through routine enquiry and making appropriate referrals. However, they did not believe that the healthcare system alone could reduce or end domestic violence.	healthcare centres. Some women declined to participate and might have introduced bias into the results. The sensitivity of domestic violence as a topic might have introduced bias.
Vanderburg, S., Wright, L., Boston, S., & Zimmerman, G.	2010	Maternal child home visiting program improves	Quantitative A retrospective record review of	Northern Ontario public health unit.	Implementing a protocol to screen women for domestic abuse into an existing home visiting programme improved practices related to the	No limitations identified

Appendix 17 Analysis of peer reviewed papers

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Public Health Nursing, 27(4), 347–352.		nursing practice for screening of woman abuse.	cross- sectional data.	538 records were reviewed in 2001 and 551 records reviewed in 2005.	safety and privacy of women with increased incidence of disclosures.	
Wiehn, J., Hornberg, C., & Fischer, F. *British Medical Council, Public Health*, 18(1005), 1–13.	2018	How adverse childhood experiences relate to single and multiple health risk behaviours in German public university students: a cross-sectional analysis.	Quantitative A cross-sectional study Questionnaire	Conducted in German Universities A random selection of 24 students from May-June 2017	There is strong evidence that Adverse Childhood Experiences (ACEs) are associated with Health Risk Behaviours (HRBs). Reducing the number of ACEs could decrease the HRBs. Findings highlight the importance of trauma-informed health interventions to build capacity among children and adults.	A causal relationship between ACEs and negative health outcomes in adulthood cannot be established based on cross-sectional data. The analysis relied on self-reported data.The low response rate may have caused a sampling bias

Appendix 17 Analysis of peer reviewed papers

Author in alphabetical order/ Source	Date	Title	Research Design	Sample	Key Findings	Limitations of the Study
						(non-representative sample. Results of the study can only be transferred to the population of German Universities. The data may be flawed by recall bias, which may have skewed the findings. Students may have underreported their level of HRBs.