

**Title:** Domestic violence and abuse: an exploration and evaluation of a domestic abuse nurse specialist role in acute health care services

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## **Abstract**

**Aims and objectives** The aim of the present study was to explore the experiences of clinical staff in responding to disclosure of domestic violence and abuse (DVA) and to evaluate the effectiveness of training and support provided by a dedicated Domestic Abuse Nurse Specialist across one acute National Health Service (NHS) Trust in the UK.

**Background** The impact of DVA is well documented and is far reaching. Health care professionals have a key role to play in the effective identification and management of abuse across a range of settings. However there is a paucity of evidence regarding the constituents of effective support for practitioners within wider non-emergency hospital based services.

**Design** A qualitative approach semi-structured interviews (n=11) with clinical staff based in one acute care Trust in the UK. Interviews were informed by an interview guide and analysed using the Framework approach.

**Findings** The organisation of the NS role facilitated a more cohesive approach to management at an organisational level with training and ongoing support identified as key facets of the role by practitioners. Time constraints were apparent in terms of staff training and this raises questions with regard to the status continuing professional development around DVA.

**Conclusions** DVA continues to exert a significant and detrimental impact on the lives and health of those who encounter abuse. Health care services in the UK and globally are increasingly on the frontline in terms of identification and management of DVA. This is coupled with the growing recognition of the need for adequate support structures to be in place to facilitate practitioners in providing effective care for survivors of DVA.

**Relevance to clinical practice** This study provides an approach to the expansion of existing models and one which has the potential for further exploration and application in similar settings.

**Keywords** domestic violence and abuse, health care professionals, training, management

### **Summary box**

#### **What does the paper contribute to the global clinical community?**

- Raising awareness of the breadth and scope for presentations of DVA within non-emergency hospital settings
- Demonstration of the effectiveness of a specialist role and model for service development in the effective support and management of DVA within health care settings
- Potential for future development and implementation of the role and model presented in this paper in other hospital/healthcare settings institutions and organisations

## **INTRODUCTION**

It is now widely acknowledged that domestic violence and abuse (DVA) is a significant global health and societal concern (World Health Organisation, WHO, 2015). It is also recognised that DVA impacts significantly on both short and long term physical and mental health ill-health and wellbeing of those who experience abuse (Feder, et al. 2011, McGarry, et al. 2011, Trevillian, et al. 2012).

In the United Kingdom (UK) a number of key national policy directives, for example the National Institute for Health and Care Excellence (NICE, 2014) *Domestic violence and abuse: how health services, social care and the organisations they work with can respond effectively* have clearly identified that all health care professionals and the agencies they work alongside have a central role to play in the prevention and effective management of DVA presentations.

However, to date while there has been an increasing onus on the role of health care professionals in terms of effectively supporting survivors of DVA, it is less clear how this should be institutionally organised (Garcia-Moreno, et al. 2015) or operationalised in practice (Leppakoski, et al. 2014).

Moreover, with a few limited exceptions the majority of exploration to date has occurred within a few specific health care settings for example, emergency services and primary care or where routine enquiry into DVA forms a part of everyday practice (Ellsberg, et al. 2015).

## **BACKGROUND**

Within the United Kingdom (UK) and globally DVA is now actively recognised as a significant societal and public health issue (WHO, 2015). Due to a number of factors including under reporting, prevalence figures for DVA are likely to be conservative. However, the World Health Organisation (WHO, 2015) has recently reported that approximately 30% of women worldwide have experienced physical or sexual violence from a partner. Within the UK it has been estimated that approximately 1.2 million women and 700,000 men have experienced DVA, while every month 7 women are killed by their partner or ex-partner in England and Wales (Office of National Statistics, (ONS) 2015).

The impact of DVA on the lives and health of those affected is now well documented and is recognised as potentially far reaching. In a recent review of the literature for example Dillon et al. (2012) identified that the effect on physical health may include chronic pain, bone and muscle conditions, gynaecology or gastro-intestinal problems, while the consequences for mental health can include poor self-perceived mental health, anxiety and depression and self-harm. DVA also exerts a considerable detrimental impact on the wider family, including children (Hester, 2011) and can continue to exert a detrimental impact on health and wellbeing in later life (McGarry, et al. 2011).

However, Bradbury-Jones et al. (2014) have argued that while health care services “play a central role in recognising and responding to

domestic abuse, there is a double-edged problem” (p3058) in that health care professionals are reluctant to approach the subject of DVA with patients/clients and are equally ill equipped to respond appropriately to disclosure.

In the UK, there have been a number of recent key legislative and policy changes which have served to both develop an understanding of the complexity and breadth of contemporary DVA and to set out core professional responsibilities.

In 2013, in recognition of the complexity of DVA, the UK Home Office revised the formal definition of DVA and encompasses the following:

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

*This definition [...] includes so called 'honour' based violence, female genital mutilation (FGM) [cutting] and forced marriage, and is clear that victims are not confined to one gender or ethnic group (Home Office, 2013).*

While the National Institute for Health and Care Excellence (2014) Report *Domestic violence and abuse: how health services, social care and the organisations they work with can respond effectively* highlighted the pivotal role of health services in the effective recognition and

management of DVA and also set out a series of broad recommendations with regard to the provision of professional education and training (NICE, 2014).

It was against this backdrop of emergent national UK policy, growing recognition of the pivotal role of health services in supporting individuals who have experienced domestic abuse and the continued uncertainty regarding the constituents of effective support that one NHS Hospital Trust in the UK developed a Trust wide domestic abuse nurse specialist role. At inception it was envisaged that this role would focus on all clinical areas within the Trust (both in-patient and out-patient) with the exception of the emergency Department (ED), midwifery and children's services where domestic abuse services and specialist practitioner roles were already in place. The impetus for the development of the trust wide role was based in part on the preceding local evaluation of the ED nurse specialist role and the recognition that there were potential gaps in existing service provision. For example, where patients did not disclose while in the ED but later disclosed their abuse following admission to in-patient settings.

From a strategic perspective, it was envisaged that the nurse specialist role would be situated within a wider intra and inter professional framework thereby enabling a collaborative or 'joined-up' approach to DVA management both within the Trust and through other appropriate agencies for example, specialist agencies.

Utilizing the success of the ED nurse specialist post as a template (author, et al. 2013), the remit of the Trust wide nurse specialist role, which has been described in detail elsewhere (author, et al. 2014) encapsulated the following:

- On-going support and guidance for clinical staff in identification, referral and resources
- Support for survivors of abuse, including referral and signposting to resources
- Liaison and supportive working with specialist DVA nurses in other areas of the Trust
- Liaison and supportive working with other agencies, for example multi-agency specialist DVA services
- The delivery and evaluation of targeted education and training

## **STUDY AIM**

As this was a novel role the aim of the present study was to explore the experiences of clinical staff in responding to disclosure of DVA and to evaluate the effectiveness of training and support provided by a dedicated Domestic Abuse Nurse Specialist (NS) across one acute National Health Service (NHS) Trust in the UK.



## **METHODS**

### **Design**

A qualitative approach using semi-structured interviews with clinical staff based in one acute care Trust in the UK. Interviews were informed by a pre-piloted interview guide and analysed using the Framework approach (Ritchie & Lewis, 2003). Interview data were collected between November 2014 and March 2015.

### **Setting and participants**

The study was undertaken in one NHS Hospital Trust which offers a range of in-patient, out-patient, emergency and specialist services in one region of the UK.

In total eleven members of staff agreed to take part in an interview (Table 1). All of those who participated in the interviews held clinical roles within the organisation. The time held in their current roles ranged from 6 months to 30 years. All participants were female. Recruitment to the study was initially undertaken during the DVA training sessions where study information sheets were distributed to attendees and potential participants were able to return a tear-off slip with contact details in a pre-addressed envelope to the study lead (author) to discuss further if they were interested in taking part in a semi-structured interview.

## **Data collection**

Semi-structured interviews were used to collect data and were carried out with clinical staff at a time and location convenient to them. A pre-piloted interview guide was used to explore participant's experiences of disclosure of DVA and views of the domestic abuse nurse specialist role (NS), the training sessions and how they had used the training to inform their responses to DVA within their own practice. With participants permission all of the interviews were audio-recorded and transcribed verbatim. Typically the duration of interviews was 60 minutes.

## **Data analysis**

Data analysis was informed by The Analytic Framework (Ritchie & Lewis, 2003) which has five key stages; generating themes and concepts, assigning meaning, assigning data to themes/, concepts to portray meaning, refining and distilling more abstract concepts, assigning data to refined concepts to portray meaning. During the study data collection and analysis was iterative. In practice this meant that emerging themes from interviews were pursued in subsequent interviews. A thematic table was developed to organise data and the emerging themes.

## **Ethical approval**

Using the UK Health Research Authority Decision Tool the study was defined as a service evaluation and full ethical approval was not required. However, a formal study protocol was submitted and appropriate permissions were sought and granted by the (NHS) Trust Research and

Clinical Governance Office where the study was undertaken. The study was carried out in accordance with research quality standards for all facets of the study including recruitment, data collection and storage. Informed consent was sought from all study participants.

Due to the sensitive nature of the topic area the study lead was mindful to ensure that appropriate measures were in place to support study participants. This included information regarding local specialist services should these be requested and the availability of the NS directly following the training sessions and for follow-up meetings.

## **FINDINGS**

Following analysis of the data three main themes emerged from the interview data and these were:

- Thinking outside of the box: The complexity of presentations of abuse
- Exploring the avenues: Practitioner-patient relationships
- More likely to have the conversation: The DVA nurse specialist as support

### ***Thinking outside of the box: The complexity of presentations of abuse***

'Thinking outside of the box' is a term or metaphor that is often used in general conversation to describe thinking differently about a problem or issue. In the present study it was a term used by a number of interview

participants either directly as the following quote illustrates, or indirectly, to describe the way in which the training sessions and/or the interactions with the NS had provoked them to reflect on the ways in which they had previously thought about DVA, for example their assumptions about the presentation of abuse:

*I think that when I went to the study day, it made me look more outside that box. Because I think that people, when they think about abuse, you think of all the different types of abuses, and it's kind of a bit cut and dry, where actually I actually think that that isn't the case. I think there's quite, I was going to say quite a few, not quite a few, but there are people who actually are controlled by other people, but they wouldn't class it as abuse **(Participant 2)***

The training sessions, which combined an introduction to the complexity and breadth of possible presentations of DVA for example, using the Duluth Model of Power and Control (DAIP, 2015) to explore issues of psychological control, alongside anonymised case studies and a practical demonstration of assessment tools, was highly valued by participants. Not least because it provided participants with 'time to think' about how they might approach DVA in their own practice and an opportunity to ask questions, rather than the session having purely an 'information giving' focus:

*I mean she was brilliant [the NS], she was really good. She did really make you think, you know...I think really because, I think as nurses you*

*have so much training about different things that you've never allowed yourself that amount of time to sit and think about that. So it allowed you to do that...*

### **Participant 3**

*Now having had the training with [NS] I now know what to look for, the very subtle controlling behaviour, and I wasn't so good at picking that up before. But luckily having done the training with her almost from day one I thought oh all those things that she talked about, all those subtle controlling things I could see in this family (**Participant 6**)*

The focus of the training sessions towards the complexity of possible presentations of DVA in everyday practice also enabled practitioners to reflect on their own areas of work. As the following participant highlighted, while she had thought she was quite knowledgeable about DVA, she hadn't been aware of a significant issue with regard to her own area of practice:

*I thought it was really good [...] going through the different types of domestic violence as well, things that maybe you wouldn't immediately have raised concerns. And I kind of went into that training thinking that I was pretty informed about domestic violence really [...] but she talked a lot about recognising about pregnancy being a very vulnerable time for people. And I hadn't realised that pregnancy alone was a factor for increasing risk of domestic violence. So that was quite enlightening to me to say that I*

*work in an early pregnancy unit and I hadn't been aware that that automatically increased the rate of domestic violence (Participant 5)*

It was also highlighted that practitioners both valued the training in terms of raising awareness about the role of the NS and in terms of developing their skills and knowledge base more generally with regard to DVA:

*It was brilliant, because basically we were asking for information about a service we didn't know about [before the session] but knew that we could use and tap into (Participant 11)*

*[NS education was] very insightful because you wouldn't get that training, unless you've been subjected to it yourself you would never know what domestic violence is like or what to look out for as a healthcare professional... (Participant 10)*

### ***Exploring the avenues: Practitioner-patient relationships***

Contemporary nursing practice is widely acknowledged for the most part as 'fast paced' with little time available to spend 'talking' with patients. In the present study for example, Participant 4 reflected on her prior experience of working in the ED, an area which has received considerable attention as a key location for disclosure of DVA. She then contrasted this to her experience of working in an in-patient environment and the time constraints of the ED:

*If you're working in ED and you then get someone and they start divulging lots of information to you, you can't just say sorry I can't talk to you. So in the back of your mind, although it shouldn't be, you are thinking I've got to get to the next patient. So I don't know whether sometimes ED is the best place to have these long conversations*

**(Participant 4)**

While the ED is undoubtedly a key location for the identification and management of DVA, the present study clearly highlighted that other clinical settings were ideally suited to providing the privacy and 'time' for disclosure, for example as the following participant described the process of the clinical assessment and the opportunity this provided for one-to-one discussion:

*...although we spend the first part of the consultation doing the clinical assessment, that only usually takes about 10 minutes. So you've got 20 minutes to actually explore the avenues that the patients want to explore really. And it does give you time, and it gives you an insight into the family. And sometimes people will leave their family outside, because they want to have that time to discuss things on their own* **(Participant 2)**

Participants felt that being a nurse or practitioner placed them in a position of 'trust' generally where people 'tell you things'. However, more particularly for participants both the longevity of patient relationships within particular care settings and/or the length of stay in hospital

provided the potential to build relationships of trust and to provide a 'safe' environment for disclosure:

*Well we've literally got a lady on the ward now actually who we've referred to [NS] she has come in with [...] excessive nausea in pregnancy. She's eight weeks pregnant and she's [just] disclosed that her partner's been quite verbally abusive towards her... (Participant 5)*

*So it's taken me seven weeks getting to know this mum...and this week she has disclosed to me that there has been domestic violence for a very long time and controlling behaviour (Participant 6)*

*...there was just little hints and drip feeding almost information each week. And then that information put together lent to a private conversation with her. It transpired that she'd been in quite an abusive relationship (Participant 11)*

In addition to the physical proximity of the nurse-patient relationship as described above, in the present study it was also acknowledged that the complexity of the illness or presenting condition might also be bound up in with underlying issues, including DVA:

*[The] pain is a manifestation of an earlier source of distress that comes out in a physical way if you like. So the pain is almost like part of the problem, but all the other stuff needs addressing as well. [The training was] very useful, very useful in terms of people who disclose abuse. And it's having a mechanism for us to be able to seek support to help people with that (Participant 11)*



***More likely to have the conversation: The DVA nurse specialist as support***

All of the participants in the study spoke of how the NS role, both the training and on-going support had been invaluable in enabling them to speak to patients where DVA was disclosed or suspected. Participants also clearly recognised the importance of their role in terms of being a key point of contact for disclosure or identification of DVA.

However, several participants also described how they 'didn't know' how to initiate a conversation about DVA with patients, even when they were experienced practitioners:

*And the first time I had to do that I didn't know how to do it, which is silly because I'm nearly 50 years old. I've got 30 years nursing background, but you're not trained or used to having those conversations. So having the training from [NS] was invaluable for my role, and it empowers you and it makes you much more likely to have the conversation. Because it's very easy not to have the conversation, because then the problem doesn't appear, you don't have to solve it **(Participant 6)***

Moreover, as the following participant identified, while seeking the advice of the NS gave her 'confidence' to ask about DVA, 'probing' into very personal aspects of someone's life did not feel as though it was part of her professional role:

*I rang [NS] and she told me what to do. And that, well I say it gave me the confidence to go and talk to the lady about it, but it was still horrible. Being the first time you've ever done something like that. It's like you're being really personal and probing into somebody's life when you've never done that before, and that doesn't feel like my role* **(Participant 9)**

While asking questions about DVA could be difficult, it was also acknowledged that practitioners were in a position where they might have 'a feeling' that DVA might be occurring. Therefore it was important to put aside feelings of personal discomfort:

*I took a phone call from one of her friends...It wasn't anything she said [outright] but I thought I wonder if this person is the victim of domestic abuse. And I just said to her I need to ask you a question now, but it's for your safety that I do ask. I didn't skirt around and I just literally came out with the sentence, are you the victim of domestic abuse? And she just broke down in tears and cried and said yes* **(Participant 8)**

*...but I think that's one thing that she did reiterate [the NS in the sessions] is 'ask the question', and the worst they can say is no* **(Participant 5)**

Furthermore, the training and continued support of the NS was invaluable both in terms of the development of professional confidence to approach DVA with patients and also in terms of facilitating senior practitioners in supporting members of the nursing team themselves:

*So I wouldn't expect them [members of the team] to deal with a situation, but I would expect them to bring something to my attention.*

*That when they're doing their weights and their blood pressure, if they notice that there's bruising when their arm thing up and they try to cover it up, or even if it's just a gut feeling (Participant 2)*

A senior member of neonatal care team also described how she approached the NS after she had identified DVA within her clinical practice. She also acknowledged the way in which the NS instilled confidence to ask about DVA but also how this initial experience has significantly informed her ongoing practice:

*I hadn't got a clue where to go with it, and I went to [NS] to take advice and she was just brilliant. Not only is she incredibly good at what she does, she doesn't dramatise anything. She's very accessible...So from the probably four families that I've taken advice for, although that probably doesn't seem much over the year, they are four of the most vulnerable babies and mothers that I can think of (Participant 6)*

## **DISCUSSION**

As previously described, within the existing DVA literature the main focus for DVA interventions and on-going support has been towards a limited number of defined areas of healthcare provision (Ellsberg, et al. 2015). However, the findings of this study have highlighted that the presentation of DVA is a significant concern for practitioners across a wide range of hospital based care services. It was also clear that the organisation of the NS role, situated in this instance within the wider safeguarding, ED and

midwifery DVA teams within the Trust, facilitated a more cohesive approach to management at an organisational level beyond the ED. This was central to the facilitation of effective identification and management of DVA, for example where patients might not be physically well enough to respond to questioning in the ED, where privacy and the opportunity to speak to the patient alone might be deemed problematic or where there were overlaps between safeguarding concerns and DVA. Moreover, as van de Wath et al. (2013) have highlighted, the building of rapport or trust, as illustrated in the present study through the longevity of the presenting condition, is highly valued by survivors of abuse (Watt, et al. 2008) and may facilitate disclosure.

The delivery of training to practitioners within the Trust was a central part of the NS role at inception and the format of the training included detailed theory around DVA and practice development. However, early on in the study it became apparent that, due to time constraints, the training would need to be streamlined from the original format. McCloskey et al. (2005) have highlighted elsewhere that the content of training is more important than the length of the training itself. However, there are core elements that need to be included. It has been recognised that alongside practical information, for example how to respond to disclosure, the completion of risk assessment and referral, training also needs to include a consideration of the theory and complexity of DVA in terms of cohesive control (DAIP, 2015). The importance of the theoretical component of training has been highlighted by Westmorland et al. (2004) in terms of

enabling practitioners to “[broaden] the way they viewed domestic violence, with a move away from a narrow emphasis on physical violence” (Westmorland, et al. 2004, p17). In the present study therefore this combined model was retained for training, albeit in a slightly shorter format.

The findings from the present study have highlighted the value of the training sessions overall both in terms of practical advice alongside ‘time to reflect’ and exploration of the often complex or ‘hidden’ nature of abuse. However, the tensions in terms of time allocated for practitioners to attend the sessions cannot be ignored and, as the training sessions were not mandatory also raises wider questions with regard to how DVA training could or should be embedded more widely across organisations to form a part of core professional preparation and development for practitioners (NICE, 2014).

In addition to the educational component of the training, the sessions also provided an opportunity for the NS to raise awareness among practitioners about the nature and scope of her role within the Trust. The findings of the present study have highlighted the value that practitioners placed on the NS as a source of information generally. More importantly, the study has also highlighted the centrality of the NS as a pivotal point of contact for direct ‘on the spot’ guidance and supporting professional confidence among practitioners. This was evident for example, in terms of the complexity of presentations, discomfiture and stigma associated with

asking about 'personal or private issues' or a fear of offending patients by asking about DVA. It may therefore be argued as elsewhere (Yam, 2000) that awareness raising and training is not in itself sufficient and that there is a clear need for an identified individual within an organisation with the requisite skills and expertise to support clinical staff in effective recognition and management of DVA (author, 2015). In a similar vein, Leppakoshi et al. (2014) have also considered the potential for a 'mentor' or 'role model' as an effective part of clinical staff support.

Finally, it has been identified that DVA can be an emotional and 'painful' subject on a personal level for clinical staff (O'Malley, et al. 2013) and in the present study an unintended consequence was the disclosure of DVA among staff, particularly following the training sessions. As a result, the NS has also worked with the Trust to develop clear mechanisms for staff support. Similarly, a number of authors have also examined DVA disclosure for clinical staff in terms of 'emotional impact' more generally (van de wath, et al. 2012, Goldblatt, 2009). This arguably further highlights that the needs of staff, in terms of the requisite organisational structures and support, cannot be underestimated and form an integral part of any planned intervention or model of care delivery.

## **LIMITATIONS**

This was a small scale evaluative study and as such there needs to be some caution exercised with regard to the claims that can be made in terms of transferability. However, to the author's knowledge this role

represents the first of its kind within acute hospital health care services. As such the findings of this study offers a contribution to the growing evidence base and broader debates with regard to effective identification, management and support of DVA within healthcare contexts generally.

## **CONCLUSION**

DVA continues to exert a significant and detrimental impact on the lives and health of those who encounter abuse. Health care services globally are increasingly on the frontline in terms of identification and management of DVA. This is coupled with the growing recognition of the need for adequate support and structures to be in place to facilitate practitioners in providing effective care for survivors of DVA. This paper it is hoped has contributed to the growing body of literature surrounding the development of practice and the provision of effective support mechanisms within the field of DVA.

## **RELEVANCE TO CLINICAL PRACTICE**

To date there has been a limited consideration of how existing deficits in the effective recognition and management might be addressed explicitly within health care organisations. This study both explores the broader clinical context of DVA presentations and provides a structured approach of service delivery. This model has the potential to be explored further in terms of applicability within similar health care settings.

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