

**Researching Education to Strengthen Primary care ON
Domestic violence & Safeguarding**

RESPONDS

FINAL REPORT

FOR THE DEPARTMENT OF HEALTH

POLICY RESEARCH PROGRAMME PROJECT

**Bridging the Knowledge and Practice Gap Between Domestic Violence and
Child Safeguarding: Developing Policy and Training for General Practice –
115/0003**

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Executive summary

1. Study aims and objectives

To clarify and develop policy and guidance for general practice on the interlinked issues of domestic violence and abuse (DVA) and child safeguarding, developing an evidence-base for training and incorporating that policy, guidance and research evidence into a new training intervention for general practice teams.

- (i) To analyse the DVA content of child safeguarding training for GPs, practice nurses and practice managers.
- (ii) To systematically review evidence on interventions to improve the response of professionals to disclosure of DVA when children are exposed and to identification of child maltreatment when DVA is present.
- (iii) To understand the barriers to developing practice at the interface of DVA and child safeguarding in the context of general practice.
- (iv) To identify and analyse examples of positive practice in this field.
- (v) To formulate specific guidance for general practice about the interface between DVA and child safeguarding.
- (vi) To integrate that guidance into a training curriculum.
- (vii) To evaluate acceptability and utility of that guidance when applied in general practice training sessions.

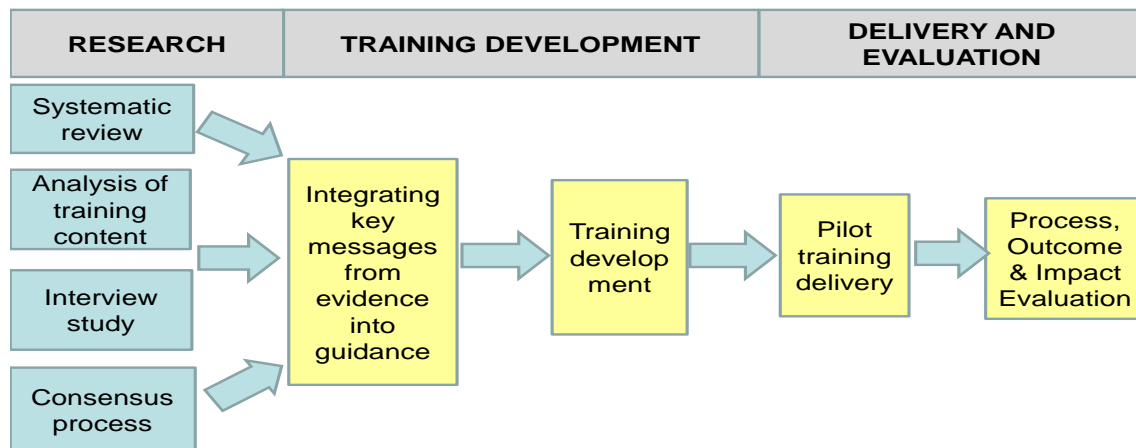
2. Background

The response of health services, including general practice, to DVA should include the needs of children exposed to DVA. There is a direct impact on the health and wellbeing of children in households where DVA is present as well as an overlap between exposure to DVA and other forms of child maltreatment.

The poor engagement of general practice clinicians with DVA and the uncertainty about managing its interface with child protection is a major gap in policy, resulting in missed opportunities to support victims and their children experiencing DVA.

3. Study methods

The RESPONDS study integrated heterogeneous evidence sources into guidance for general practice clinicians and a training intervention to deliver that guidance. The integration by the study team was informed by a consensus process with a multi-professional stakeholder group and meetings with survivors of DVA.



4. Patient and Public Involvement in the research

In the development of the RESPONDS study, we engaged two existing groups of DVA survivors who were advising on other parts of our research programme as well as an organisation that supports young people who have experienced DVA. Once the project commenced we formed the RESPONDS PPI group consisting of four women survivors of DVA with children. This group helped develop our research tools, such as the topic guide for general practice professional interviews, the consensus statements underpinning our guidance, as well as the content of our training intervention; contributed to analysis and interpretation of

our initial findings and two members attended our consensus meeting and project advisory group meetings.

5. Equality and diversity issues

The RESPONDS research team was mindful of inequality and diversity as it is expressed in access to services and a general practice response that is proportional to need, which is influenced by factors such as age, gender, economic status and ethnicity. In the systematic review of interventions for DVA and child maltreatment, we highlighted the socio-demographic profiles and geographic settings of the primary studies in our interpretation of the findings. In the interview study, our sampling took into account local and individual ethnic and socio-economic diversity, as did our pilot sites for the training intervention. In the training intervention we discussed the challenge of variation in cultural norms around DVA. In the evaluation of the RESPONDS training we became aware that we needed a wider ethnicity and, possibly, class profile for characters in the video training vignette.

6. Research evidence streams: findings and discussion

6.1 Systematic review of interventions to improve professional responses to children exposed to DVA

Eighteen studies tested individual training interventions, three tested system level interventions. Three were randomized controlled trials, 12 were pre/post-test design, and three post-test only, with the majority in US paediatric settings. All the training and system-level interventions showed significant improvements in knowledge and most showed improvement in attitude of participants with regards to DVA. The studies also reported improvements in self-reported competence and clinician behaviour change. Only one study measured parental outcomes, finding improvement in patient-rated clinical interactions and none measured outcomes for children.

6.2 Training curricula study

We received 32 questionnaires and 22 examples of training material on safeguarding children training courses that either contained some reference to DVA or specifically focused on DVA. A significant minority were judged good or very good in their DVA coverage. The needs and safety of the non-abusive parent (usually the mother) were not sufficiently addressed in most curricula and guidance on talking with children was virtually absent. Other than LSCB training materials, there is little guidance on collaborative working with other agencies. There is scant attention to management of the tension between keeping confidentiality and maximizing safety of DVA survivors and their children.

6.3 Consensus process: consensus survey and meeting

The consensus process identified particularly difficult issues in general practice at the interface of DVA and child safeguarding. The outcomes of the formal consensus process and the meeting highlighted the complexity of positions around some of these issues. Although a policy and practice consensus was generated, there was a recognition of differing professional perspectives and scope for local specificities and individual practices whilst retaining important principles of safety and confidentiality. The process also broadened the scope and sharpened the focus of the RESPONDS research studies.

6.4 Interview study

Although there were many examples of positive practice, there was generally great uncertainty amongst clinicians about directly responding to the exposure of children to DVA. The lack of clarity in guidance and training for general practice clinicians in responding to the linked issues of DVA and child safeguarding may, at least in part, account for the considerable variation in professionals' responses, approaches to the issues, assumptions and perceptions of harm thresholds.

6.4.1 General practice clinicians' understandings of risks, processes and procedures in relation to DVA and child safeguarding

Awareness of the relationship between DVA and child safeguarding was generally low. Clinicians in our sample had limited experience of identifying DVA in families and it was rare for them to have referred children to children's social services as a result of concerns about DVA.

Clinicians tended to focus on physical abuse of victims and their children, rather than neglect or emotional abuse when identifying and responding to DVA in families with children. They struggled to manage families where the risks were uncertain or judged less than high.

6.4.2 Having difficult conversations around DVA and child safeguarding

Clinicians demonstrated a lack of confidence and experience in having conversations about DVA with patients. Children and young people experiencing DVA were rarely engaged with directly. Some clinicians articulated approaches which could exacerbate risk to DVA survivors and their children or fail to meet the standards set in existing guidelines.

6.4.3 Working together, working apart: General practice professionals' perspectives on interagency collaboration in relation to children experiencing DVA

Clinicians were unfamiliar with procedures for co-ordinating service responses to children who were below the high risk threshold and most did not see themselves as having a role in contributing to a 'jigsaw' of information about children that was shared between agencies.

General practice professionals had poor relationships with children's social services and felt isolated from other professional groups. Limited participation in multi-agency safeguarding procedures restricted their role to referral and information exchange rather than joint work. They were unaware of local and national DVA resources and they lacked understanding of the services they offer. Effective interagency communication and team working was limited by insufficient understanding of other professionals' and agencies' sphere of operations, as well as lack of interagency trust and self-confidence.

6.4.4 Documenting DVA and child safeguarding in general practice

General practice clinicians have a confused and inconsistent approach to documenting child safeguarding in the context of DVA. This is partly due to their lack of awareness of national and local guidance on documenting DVA. General practice clinicians were uncertain about how to resolve conflicting principles of preserving confidentiality and potentially increasing safety when considering documentation of abuse in the records of different family members.

7. The development of the RESPONDS training intervention

We developed an evidence-based, multi-component training on child safeguarding and DVA for general practice professionals. The aim of the training is to bridge the knowledge and practice gap between DVA and child safeguarding.

The training pack was designed and developed collaboratively using multi-professional expertise from health, research, training and practice in DVA and child safeguarding. The training was based on the integration of the four research evidence streams: the systematic review of interventions, the training curricula study, the interviews with clinicians and the formal consensus process. Integration featured in the structure as well as content and delivery method of the training: our strategy was to model integrated working between services through the structure of training delivery.

8. Training pilot and training evaluation

The aims of the mixed-method evaluation study were to assess utility and feasibility of the pilot training and inform further research. We wanted to measure the short and medium term impact of training; assess contextual and individual factors that might affect training outcomes; and inform further refinement of the training structure and content.

Overall the training was well received by primary care clinicians. After the training, GPs were more confident in knowing how to proceed in a consultation when they suspected a child's exposure to DVA or it was spontaneously disclosed and the appropriate next steps. They had a greater awareness of current relevant service provision and referral routes. They also reported increased willingness to engage

directly with children and to discuss this appropriately with their non-abusive parent and this led to some changes in case management. The training increased the total measure of self-reported knowledge and self-efficacy about DVA and child safeguarding. However, there was no evidence of an improvement in the participants' beliefs and attitudes.

9. Policy and practice implications

Policy and guidance on multi-agency partnerships should emphasize the importance of cohesive and consistent responses that link DVA and child safeguarding services.

Both DVA and child safeguarding, and the different issues they entail regarding confidentiality and safety, should be included in policies on documenting and information-sharing by clinicians. The 2014 NICE DVA guidelines provide a useful starting point for inclusion of both DVA and child safeguarding in such policies.

Policy and guidance on training for general practice professionals regarding DVA and child safeguarding should emphasize the complexity in ensuring safety of children and their non-abusive parent where there is DVA, the need for training on the interface between DVA and child safeguarding, and appropriate management of adults and children living with DVA in the same family.

10. Conclusions and further research

In RESPONDS we have integrated evidence from an overview of existing UK child safeguarding and DVA curricula, a systematic review of training interventions, extensive interviews with primary care professionals, meetings with young people and adult survivors of DVA and expert consensus to design a training intervention for general practice on the interface between DVA and child safeguarding. Delivery of that intervention to 11 general practices was well received by participants and resulted in positive changes in confidence/self-esteem and knowledge regarding DVA and plans to change practice.

In addition to providing some evidence that the RESPONDS training has the potential to improve the response of general practice to the interface between DVA

and child safeguarding, a major conclusion from our primary interview-based research is the challenge that clinicians face in engaging with this issue.

As a stand-alone intervention it could be implemented more widely, but there remains uncertainty about its effectiveness in actually changing clinician behaviour, improving outcomes for families experiencing DVA, and its potential for integration with other DVA training for general practice.

Given the problems general practice professionals face in responding appropriately and safely to children exposed to DVA and the positive outcomes of the RESPONDS intervention in our pilot study, we propose further development and testing of the intervention. That would involve integration of training and practice support with regards to *all* adult patients and children exposed to DVA. DVA training streamlined into a single module involving one local advocate team would generate easier access to DVA training and services and would also improve the outcomes of training by increasing identification, documentation and referral to *all* patients experiencing domestic violence and abuse, irrespective of age, gender or victim/perpetrator status.

11. Dissemination plans

We will deliver a programme of dissemination (both academic and non-academic), knowledge mobilisation, and stakeholder engagement to maximize the impact of the RESPONDS research findings on a range of sectors and audiences. Our outputs will have three target audiences: academic, public and practitioners. The training package is freely available online, its delivery facilitated by a toolkit and its usage monitored via registration on our website (bristol.ac.uk/responds-study).

Dissemination and knowledge mobilisation through diverse channels for various audiences will be vital, not only for the appropriate and effective use of the RESPONDS training package but also to inform target audiences of the key findings of our systematic review and primary research on engagement of general practices at the interface between DVA and child safeguarding.



1. Study aims and objectives

Aims

Our study aimed to clarify and develop policy and guidance for general practice on the interlinked issues of DVA and child safeguarding, developing an evidence-base for training and incorporating that policy and guidance into a new training intervention for general practice teams. By linking DVA and child safeguarding, training, enhanced with multi-professional delivery of explicit guidance, we were aimed - in the context of a pilot study - to improve knowledge, skills, attitudes and self-efficacy of general practice clinicians towards the management of children exposed to DVA.

Objectives

- (i) To analyse DVA content of child safeguarding training for GPs, practice nurses and practice managers.
- (ii) To systematically review evidence on interventions to improve the response of professionals to DVA when children are exposed and to child maltreatment when DVA is present.
- (iii) To understand the barriers to developing practice at the interface of DVA and child safeguarding in the context of general practice.
- (iv) To identify and analyse examples of positive practice in this field.
- (v) To formulate specific guidance for general practice about the interface between DVA and child safeguarding.
- (vi) To integrate that guidance into training curricula.
- (vii) To evaluate acceptability and utility of that guidance when applied in general practice training sessions.



2. Background

The role of general practice in the management of DVA

Survivors and victims of DVA do seek support from a range of health care providers including general practice (Britton 2012), although they often do not disclose spontaneously to clinicians (Feder *et al.* 2006). They make an average of seven or eight visits to health professionals, either on their own or on someone else's behalf, before disclosure of violence (Harris 2002).

A focus on general practice is relevant because the prevalence of DVA among women attending general practice, as with other clinical services is higher than in the wider population (Feder *et al.* 2009), and it is a potential setting for DVA interventions (Hegarty 2006). It is a first point of access to care and victims (who are often isolated from other service providers as a result of their partner's controlling behaviour) are more likely to be in contact with general practice than with other agencies. They have an expectation, often unfulfilled, that their doctor can offer them safe and practical support and can be trusted with disclosures of DVA (Feder *et al.* 2006).

GPs have a complex duty to co-ordinate care, facilitate early intervention, and provide ongoing support through repeated contacts with the victim and family members over sustained periods. They are potentially in a position to identify early signs of child maltreatment as they may have contact with children well before their referral to specialist services. National (Department for Education 2013) and professional guidance (Royal College of General Practitioners 2009) require GPs to refer children who are at risk of significant harm consequent to child abuse and neglect, including their exposure to DVA, to Children's Social Services. They can refer patients to other agencies and have a potentially key role in providing information to inform decisions about access to services. It is also part of the general practice remit to receive and store information from other agencies. General practice

teams therefore play an important role in responding to DVA and are also at the frontline of multi-agency work.

Despite their potentially crucial role, general practice clinicians have been criticised for insufficient engagement in DVA. A recent survey of GPs and practice nurses in Bristol and London, found that the majority were uncertain about their role and competence to identify and manage appropriately victims experiencing DVA (Feder *et al.* 2011).

DVA, health and child safeguarding: Policy and training context

A child-centered and co-ordinated multi-agency approach is often advocated as the solution to safeguarding and promoting the welfare of children. There is compelling evidence that effective interagency work is vital at all stages of the child protection system (for example, Ward and Davies 2011). High profile failures in interagency child protection work in recent years (Jay 2014; Laming 2009) have resulted in government guidance emphasising the central role of GPs in multi-agency child protection work (Department for Education 2008; Department for Education 2013; Department of Health 2010). Various measures have been introduced to enhance the role of GPs in this process, including mandatory training, guidance on referral and assessment systems and improved information exchange procedures between agencies.

The impact of changes such as these has been to sensitize health care professionals to the need to ensure that child protection is considered in a systematic and robust fashion. General practice has been identified as having a key contribution to make to interagency child protection, yet the field of DVA still has comparatively little attention in general practice, despite its relationship to child maltreatment when there are children in the family.

Although the NICE (National Institute for Health and Care Excellence) DVA guidelines launched in February 2014 (NICE, 2014) contain specific recommendations about improving the response of health care to children exposed to DVA, there is still a great deal of general uncertainty among general practice

professionals about what constitutes best practice at the interface of these two issues. Despite national and international (World Health Organisation 2013) guidance the health care response to DVA remains inadequate (Feder *et al.* 2011). DVA poses a major challenge to public health, social care and health care services, yet often goes unrecognised by professionals in those sectors. Health and social care professionals can find it difficult to acknowledge and act on the signs of DVA, and may be uncertain about safe and effective responses to victims and perpetrators and to their children. There is especially great uncertainty about what constitutes best practice at the interface between responding to DVA and child safeguarding.

Integrating the clinician response to DVA and child safeguarding is crucial because of the damaging effects on children of being exposed to DVA, the overlap between child maltreatment and DVA, and the negative effects on parenting (Hester *et al.* 2000; Stanley 2011). Yet policy has largely developed on separate 'planets' (Hester 2011). This is particularly striking within the health sector where child safeguarding and DVA are often separate components of policy and – in the context of training for general practice clinicians – are insufficiently discussed together.

Despite the major public health and clinical impact of DVA, the response of general practice clinicians to victims experiencing abuse and to their children is poorly informed and often inappropriate, reflecting its virtual absence in medical and nursing undergraduate education, low profile in postgraduate education and inconsistent presence in continuing professional development (Taskforce on the health aspects of domestic violence 2010). Unlike child safeguarding (Royal College of Paediatrics and Child Health 2014), there is no requirement for training and regular update on DVA and the development of e-learning modules has not fundamentally changed the shortfall in training of general practice professionals about DVA.

We have evidence that even a short, interactive course on DVA and child protection for professionals from different disciplines can have a positive effect on self-rated attitudes toward DVA, increased knowledge of its effects on children, knowledge of child protection policies and procedures, and self-confidence in responding to child protection issues (Szilassy *et al.* 2013). Research however shows that these current

training programs attract a predominantly white female audience and take-up of interagency child protection and DVA training is very low by GPs in general and by male GPs in particular (Carpenter *et al.* 2010). Despite the association of DVA with other types of child maltreatment and the effects of exposure to DVA on the development, educational attainment and mental health of children (Gilbert *et al.* 2009), the issue is not sufficiently addressed in current mandatory child protection training general practice clinicians receive, although its relationship to child maltreatment is recognised.

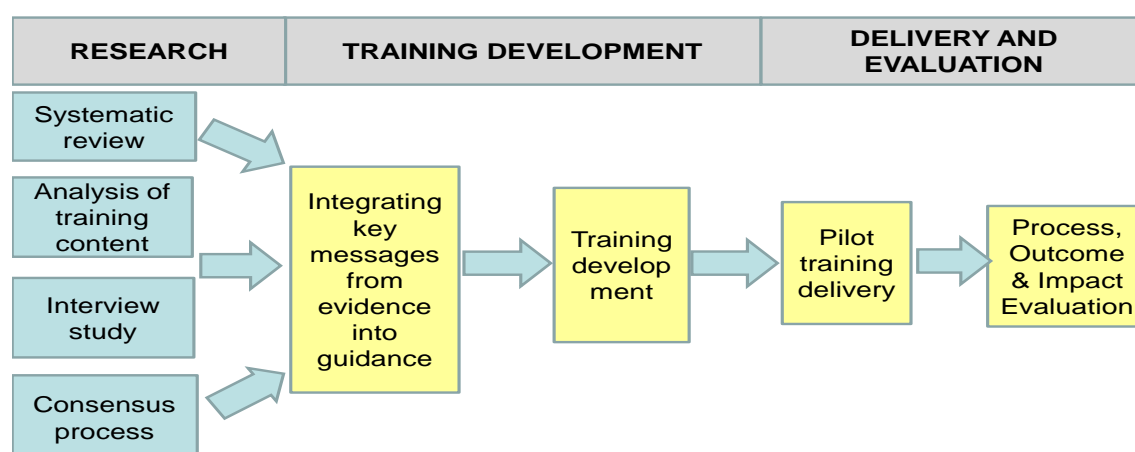
The poor engagement of general practice clinicians with DVA and the uncertainty about managing its interface with child protection is a major gap in policy, resulting in missed opportunities to support victims and their children experiencing DVA.



3. Study methods

The RESPONDS study integrated heterogeneous evidence sources into guidance for general practice clinicians and a training intervention to deliver that guidance. The integration by the study team was informed by a consensus process with a multi-professional stakeholder group and meetings with young people and survivors of DVA.

The RESPONDS study flowchart



Research components

- We systematically reviewed the international literature for effective responses by primary care clinicians to disclosure of DVA when children are potentially exposed and to child maltreatment when DVA is potentially present. By systematically reviewing the evidence we also identified examples of good practice and effective training. (For a detailed methods description see section 6.1 of this report.)

- We assessed the content of current DVA and child safeguarding training available in England for good practice examples and in order to have a better understanding of what is currently being delivered to GPs, GP trainees, and practice nurses. (For a detailed methods description see section 6.2 of this report.)
- We conducted a two-stage consensus process and convened a consensus meeting with expert participation from general practice, child safeguarding and DVA sectors. The consensus process contributed to the clarification of current policy on the intersection of DVA and child safeguarding. The outcome guidance was incorporated into the training intervention. (For a detailed methods description see section 6.3 of this report.)
- We conducted 69 telephone interviews with a national purposive sample of GPs, practice nurses, and practice managers to understand the barriers and facilitators to developing practice at the interface of DV and child safeguarding in the context of general practice. We used vignettes (see Appendix) and topic guides (see Appendix) that probed experiences of responding to DVA and to child safeguarding concerns and the relation between them, experiences of training around child safeguarding and DVA and challenges of the making the link between DVA and child safeguarding. Sampling ensured inclusion of areas where DVA services are well developed and areas where they are less so. Transcripts were coded and analysed thematically using Framework (Ritchie and Spencer 1994). (For a detailed methods description see section 6.4 of this report.)

Training development (for a more detailed description of the methods of training development see section 7 of this report)

- We developed an evidence-based, multi-component and enhanced training on child safeguarding and DVA for general practice professionals.

Training delivery and evaluation (for a more detailed description of the methods of the training pilot and evaluation see section 8 of this report)

- We piloted the training in 11 practices in two English regions.
- We evaluated training delivery and assessed learning outcomes and training impact. The mixed-method evaluation of the training was carried out before and after implementation using a validated questionnaire (Szilassy *et al.* 2013) with additional questions on the interface between DVA and child safeguarding based on the curriculum content, non-participant observation of training, interviews with trainers soon after the training and with clinicians three months post-training to assess impact.

The study was guided by two panels of professional (project advisory group) and service user experts (PPI group) who contributed to developing the research tools and analysis. (For a detailed description of Patient and Public Involvement see section 4 of this report.)



4. Patient and Public Involvement

Early involvement



We were aware that in previous studies we had not addressed the issue of the impact of domestic violence on children. Working with the survivor groups made it clear just how serious a short-coming this was. They encouraged us to pursue this project and not wait another few years. It wasn't simply them saying 'That's a good idea'. They gave us a rationale based on their experience, which is precisely what we wanted. You could do studies on a dozen things... they gave us the reasons to run with this one." (Professor Gene Feder, INVOLVE 2013)

Our research group involved members of the public at the very early stages of this research prior to being awarded Policy Research Programme funding for RESPONDS. We established two groups of survivors of DVA, one is in Bristol, supported by Next Link (a local DVA service provider), and the other in Cardiff, supported by Cardiff Women's Aid. These groups were set up to provide advice to our group's research programme. They have evolved into standing groups that provide input into all new research ideas, and continue to advise on the existing research programme. Both groups were consulted during the development phase of this project, as part of their regular meetings. In addition, staff at Hyndburn and Ribble Valley (HARV) Domestic Violence Team, an organisation that supports young people with experience of DVA were asked to comment on early drafts of the project proposal.

The survivor groups were instrumental in identifying this topic as a priority for research. The groups' views influenced the conceptual framework, the researchers' thinking on what aspects of the research to focus on. They ensured that our focus was on GPs' understanding of the dilemmas women face around disclosing their experience of DVA and their fear of children's services being involved. They also

encouraged us to adopt an approach to research in which survivors of DVA could make choices about the direction the research should take.



What the groups said very strongly was that they wanted GPs to be more understanding of the dilemmas women face around disclosing their experience of domestic violence and their fear of children's services being involved... They also encouraged us to consult young people during the project, which gave us confidence that this was the right thing to do... It's about the underlying conceptual framework, around making choices about what's going to be in the research – there's no doubt they had quite a strong influence that way.” (Professor Gene Feder, INVOLVE 2013)

Invitations and motivations for long term involvement

Once the RESPONDS study commenced, invitations to participate in our PPI group were sent to women with children who were in contact with DVA support agencies. Four women decided to participate in the group, all of whom were mothers and survivors of DVA and had some previous experience of participating in DVA research or training. One member of that group described her motivations for wanting to take part in the research:



I wanted to make a difference and I felt fiercely passionate about the subject. It became apparent to me that as a victim/survivor myself and health professional working in the field, exposure to domestic abuse has been extremely high on many levels and the effects it has are so obviously devastating. My own personal experience has seen the impact it's had on my children and that is on-going. It saddens me that I have tried to get them help early to minimise the damage but was unsuccessful in my attempts particularly within the primary care setting and unfortunately was not believed. One of my children after a visit to see the GP said “Mummy there is no point

telling anyone about what's happened as no one believes us.” (RESPONDS PPI member)

Developing understandings of context and current experience

At our initial meeting two researchers (CL and ES) met with the four PPI members, gave details of the research and obtained their informed consent to participate. They discussed how personal experience may contribute to identifying key areas of focus in research on general practice clinicians' responses to DVA where children are involved.



The refuge was hell, and when I mentioned to the GP I was very concerned about my son because he wasn't coping, I got told the issue was very trivial...if I had just left it to that GP he [my son] would have got no support. I got fantastic support from the refuge... health professionals are very quick to label domestic violence but there is no support for the child...with my new GP the children like her...she listens and asks what would you like. It took three letters from her to get help from a paediatrician. (RESPONDS PPI member)

This highlighted concerns, repeated by other members of the group, regarding taking children's issues seriously and giving support directly to them, the importance of listening and the difference in practice between different GPs. Other PPI members mentioned breaches of confidentiality. Some doctors, without consent, had told abusive partners details of disclosures by women and children. There was also the difficulty of talking directly to clinicians about abuse when abusive partners were always present *“If my son did go to the GP my son, he [my abusive partner] would always take him.”* PPI members also described clinicians not believing children who disclosed that a father or step-father could be harming them, particularly if the father was a professional. There were concerns about mother and their children being 'divided', as mothers were blamed, rather than GPs considering 'how they can

support you as a family unit', although another group member warned that couples counseling would often be inappropriate. There were contrasts in whether or not GPs had provided information about DVA support services. PPI members however showed understanding of the difficulties GPs faced in managing their workloads and the amounts of paperwork *'some say they haven't got time, others make time for you'*.

The group members noted that it is rare for general practice clinicians to see children in on their own but they shared ideas about how this could be done:



'GPs could just ask 'Do you feel safe at home.'

'Do you feel safe with mummy, do you feel safe with daddy, things like that'.

'Even if you are not ready to disclose, at least that puts the idea in your head that there is someone there you can talk to.'

'I'd want the doctor to examine me ...to make sure there is nothing serious and to call the children in and speak to the children' (RESPONDS PPI members)

One PPI group member described her own experience of growing up with domestic abuse and how she wished a GP would have asked to see her on her own so that she could have told someone about her experience *'children should be treated equally with adults'*.

Influence over research tools and analysis

We used the PPI group's initial ideas about context and current experience, together with existing literature, to develop a telephone interview schedule for use with general practice clinicians. At the second meeting this draft and vignettes (see

Appendix) about “Sarah”, “Danny” and their children (see Appendix) were discussed. The PPI members agreed that the vignettes would provide a realistic scenario for clinicians to discuss. They also contributed further vital issues to investigate through the interview schedule and data analysis. They suggested questions about 1) variation in response relative to whether the abuse is physical or mental, how often abuse had been mentioned, and whether the presenting patient was someone they saw regularly; 2) understanding of abuse within young people’s peer relationships; 3) knowledge of information about specialist services and provision of this to patients. They speculated that children would not be seen and, if they were seen, that they would only be physically examined with little consideration of emotional impact or behavioural changes, especially if children have special needs and they emphasised the importance of asking whether children are seen alone and clinician’s understanding of risk, confidentiality and appropriate recording and of considering whether there were clinicians of different genders responded differently. These factors informed the focus of some of our analysis.

At the third meeting the researchers fed back initial findings from the interviews and the PPI members helped formulate statements for the consensus process and made suggestions for the content of the training.

Involvement in research advisory group and governance

Two PPI group members travelled to London to attend the consensus meeting on the 26th September 2013. This was a big step for them both as they described feeling challenged by travelling to unfamiliar places like London or using the Underground (see their personal accounts in Extract from Domestic Violence and Health PPI Newsletter in Appendix). Their presence at this meeting gave them a real chance to understand the whole research process and to monitor the research team’s progress:



*By the end of the meeting I felt encouraged that focus was now on children living in homes with domestic violence and improvements in services from within the health profession was now being taken seriously.
(RESPONDS PPI member)*

Although only two members could make it to the meeting (with three completing the consensus survey), as with every stage of the process, we sought to move beyond ideas of voice to ensure that PPI members had direct influence over research decisions and analysis. Their impact on the consensus event was ensured in two ways. The group as a whole selected the items that would be discussed in the consensus process, setting the agenda for the meeting (i). The two members who were able to balance family and work commitments to attend the meeting in London contributed to the meeting as experts by experience, giving specialist advice to the consensus participants (ii). PPI members had dedicated support from a research team staff member to ensure they felt comfortable and could choose which moments to contribute. The chair enabled PPI members to have dedicated time to contribute their ideas and was responsive to moments when they indicated they wished to contribute. Their voices were therefore given priority. The two PPI members who attended the consensus meeting subsequently joined the research project advisory board meetings and continue to attend.

Lessons learned

The PPI group engaged in all stages of RESPONDS, although we still need to discuss the findings of the pilot evaluation with them. In future studies addressing the needs of children we will seek to involve child survivors of DVA.

The women involved with this PPI group described the experience as rewarding and empowering and have enjoyed the opportunity to potentially improve the response of general practice for other women and children in similar circumstances in the future.

The research team has greatly benefitted from their involvement as it ensured that the research was focused on key areas of practice and concern, sometimes reminding us of issues that we were in danger of overlooking. They have enabled us to explore some of the tensions in patient clinician relationships when DVA is disclosed and have highlighted the range of responses that survivors would wish to experience, for themselves and for their children.

Successful involvement requires starting from a patient's everyday concerns, ensuring research is relevant, providing adequate information so the PPI is meaningful and responding to further suggestions and concerns as they arise by altering direction within a research project. To be able to take this approach a study needs a sufficient budget to provide sufficient support for PPI over the entire project and encourage development of research themes in response to patient and public concerns.



5. Equality and diversity issues

Addressing equality and diversity issues in RESPONDS

Throughout the study, the RESPONDS research team was mindful of inequality and diversity as it is expressed in access to services and a general practice response that is proportional to need, which is influenced by factors such as age, gender, socio-economic status and ethnicity.

In the systematic review of interventions for DVA and child maltreatment we highlighted the socio-demographic profiles and geographic settings of the primary studies in our interpretation of the findings. In the survey of curricula we explored the extent that diversity and inequality were addressed. In the interviews our study sampling took into account local and individual ethnic and socio-economic diversity, as did our pilot sites for the training intervention. In the training intervention we discussed the challenge of variation in cultural norms around DVA. In the evaluation of the RESPONDS training we became aware that we needed a wider ethnicity and, possibly, class profile for characters in the video training vignette.

Here we discuss in more detail several issues related to equality and diversity, including a critique of the insufficient representation of diversity in our training materials.

Diversity and PPI membership

We did not explore diversity in PPI membership in detail as the number of women who responded to the invitations to participate was relatively low, and we chose to follow self-selection rather than targeting recruitment. A relatively diverse group of women chose to participate (including a range of ages, social class, employment status). It is significant, however, that they were all white British and this is an issue

we will consider in recruitment to future research PPI groups, to ensure that invitations to participate are sent to groups with diverse membership.

Having difficult conversations around DVA and child safeguarding

There is an apparent age-based discrimination in engagement with children exposed to and experiencing DVA. There is evidence of a generalised assumption that general practice clinicians can rely on adult proxies to identify children's needs. Whilst it remains important to recognise that adult victims have their children's best interests at heart, clinicians engaging directly with children do not necessarily undermine this. Rather, as described by members of our PPI group, where clinicians engage directly with children and young people this may support mothers in keeping their children safe as well as providing additional support directly to children and young people.

Particular concerns about confidentiality within families arose for women who may need translation services or women from BME communities who may be chaperoned when they attend a GP practice.

As noted in section 6.4.1, clinicians tended to focus on physical abuse of victims and their children, rather than neglect or emotional abuse when identifying and responding to DVA in families with children. They struggled to manage families where the risks were uncertain or judged less than high. PPI group members were concerned about this lack of understanding of the range of ways that exposure to DVA may impact upon children in different social positions. One PPI group member drew attention to the needs of disabled children and reported a GP failing to accept that learning delays may arise as a result of exposure to DVA. A second PPI group member raised concerns about social class, reporting a failure to recognise that middle class children may also be harmed in families where DVA is occurring. These examples, together with the concerns about age based discrimination and need for cultural awareness highlight the need for clinicians to develop understanding of the complex intersection of different aspects of disadvantage that children may experience.

Training pilot and delivery

All participants interviewed for the evaluation were GPs – no practice nurses or other clinicians opted to take part. 22% of the training participants were non-white British and we ensured that a similar proportion of interview respondents were South Asian. We interviewed male and female GPs, but there were more females in our sample. We did not analyse survey responses by ethnicity, as our sample was not sufficiently large to allow this to be a reliable basis for modifying the intervention.

Concerns about training content and delivery

Interviews with training participants raised several important issues about diversity in the training content, including a suggestion that we include wider range of culturally specific maltreatment practices, represent more diversity in our training videos and a plea to address the needs of men more explicitly. Below we present illustrative quotes from interviews that illustrate concerns about gender, socio-economic, cultural and ethnic diversity. (We are not able to specify the gender of informants because of our commitment to preserving their anonymity).

Informants identified the need for training to look broadly at issues specific to **different cultures and ethnic groups:**

“*The way in which you might have to try and dig the information out ..., you know, the, the ways you relate to them, ..., you know, a sort of middle aged Asian woman from a working class family, how they would present is very different to like if it's a middle class white would present. ...if you're trying to get across the variety of, you know, of how these present, then using videos which only show a white ethnic group I think would be very, wouldn't promote, it wouldn't demonstrate it as well as maybe [there should be] a selection of video clips with different ethnic minorities in that...*” (TGP02. GP, South Asian)

“ We are a very homogenously white British community so it's not a huge issue for [name of surgery] but I certainly struggled before and actually quite recently with people who don't speak English or who are from cultures where it's considered almost, not acceptable but much more acceptable to, to use physical force between husband and wife, [...] that's quite difficult to negotiate when you're in a consulting room, didn't have a lot of, lot of that sort of discussion [in the training]. [...] If you've got, like, you know, sort of non-English speakers or, you know, Islamic culture for example, they're all separate model scenarios could run couldn't you?” (TGP03. GP, white British)

One training participant suggested that video content should be produced to prompt discussion of **gender**:

“ Having dealt with, with some men who have undergone that [DVA], and they tend to, they tend to present either later or not at all or only after you, you've kind of built a really good rapport with them, they find it very difficult to, to attend and to discuss such things because I think they, they tend to find it as a, you know, some, it belittles their masculinity, I think that's how they feel generally and then they're also not sure of the support networks available, ...I think with, with the, the training you did but I think actually maybe sharing a couple of videos with, with men in there, would also help, ... you expect patients to, to present and break the taboos but if you're not doing that with health professionals as well and get them used to it.” (TGP02. GP, South Asian)

Two respondents raised dilemmas about portraying the character's **socio-economic position and social class** in the video:

“ I think is probably not a bad thing because obviously that [having a well-presented middle class patient in the video] challenges some of the presumptions around domestic violence but we have virtually no patients like that.” (TGP05. GP, white British)

Another informant stressed that having a middle class patient in the video had made the discussion around the case too 'straightforward':

“ *The scenario ...a bit clear...it was quite a sort of middle class English family, ...maybe it's good to use something a bit more subtle and a bit more complicated, something to get your teeth into.*” (TGP08. GP, white British)



6. Research evidence streams: Findings and discussion

6.1. Systematic review



SUMMARY AND KEY MESSAGES

In this systematic review we report educational and structural or whole-system interventions that aim to improve professionals' understanding of and response to DVA survivors and their children. Searches on 22 bibliographic databases were conducted for studies reporting quantitative outcomes for any type of intervention aiming to improve professional responses to disclosure of DVA with child involvement. Interventions for physicians, nurses, social workers and teachers were identified. Twenty-one studies met the inclusion criteria: three randomised controlled trials (RCTs), 18 pre-post intervention surveys. There were 18 training and three system level interventions.

Key Findings

- Educational interventions generally had positive effects on participants' knowledge, attitudes towards DVA and clinical competence.
- Key elements of successful training include interactive discussion, booster sessions and involving specialist DVA practitioners.
- The results from the RCTs were consistent with the before-after surveys.
- Results from system-level interventions aiming to promote co-ordination and collaboration across agencies appear promising but require funding and high levels of commitment from partners.

AIMS

To determine the effect of interventions to improve the responses of professionals to DVA when children are potentially exposed and to other forms of child maltreatment when DVA is potentially present.

METHODS

Protocol and registration

The protocol for this review is registered with the PROSPERO database of systematic reviews (<http://www.crd.york.ac.uk/prospero>; registration number CRD42013004672).

Eligibility criteria

Types of studies

No restriction on type of quantitative study design. Comparisons of interest were no intervention, pre-intervention, waiting list control, and alternative interventions.

Types of participants

We considered interventions aimed at any professional who are in contact with women (aged 16 years and over) and their children who work in any setting including health care, education, criminal justice facilities, and DVA agencies.

Types of interventions

Any type of intervention or significant change in the national or local policy/practice intended to facilitate and improve professionals' response to disclosure of DVA or intimate partner violence (IPV) with child involvement and improve professionals' response to child maltreatment in the context of DVA. Studies could include face-to-face and online single- or multi-agency training and could be delivered in any setting.

Types of outcome measures

The main outcomes of interest were:

- (i) Professionals' attitudes, knowledge and competence perception(s) in the assessment and responding to DVA disclosure with child involvement;

- (ii) Rates of DVA referrals by professionals to other agencies or the police.

Information sources

We searched 22 bibliographic databases for studies published until July 2013 without any language or date restrictions:

Selection of studies

Three review authors independently screened titles and abstracts in order to exclude studies. Papers considered potentially eligible by at least one of the reviewers were retrieved. The full texts were then screened by two members of the review team to determine study eligibility based on the inclusion criteria. Any disagreements about eligibility were resolved by another review author.

Data extraction and management

Data were extracted by WT, with GF performing a validation check on 10% of the primary studies.

Assessment of risk of bias

Two reviewers independently assessed the risk of bias for each study, using the Cochrane risk of bias tool (Higgins 2011) with additional criteria for trials of complex interventions from the Cochrane EPOC Group (EPOC 2009).

Measures of treatment effect

For individual trials the summary of effect for dichotomous outcomes was reported as odds ratios with 95% confidence intervals. For continuous outcomes, where data was available, this was reported as standardised mean difference (SMDs) with 95% confidence intervals. SMDs are appropriate for data synthesis where different outcome measures are used across studies (Higgins 2011).

Data synthesis

Studies were grouped according to study design. Results for randomised controlled trials (RCT), controlled clinical trials (CCT) and controlled before and after studies (CBA) outcome data are reported separately. Due to substantial and irreconcilable heterogeneity, meta-analysis was not feasible and therefore we presented a

narrative synthesis of the studies based on study design, quality, the size, direction and significance of observed effects and consistency of findings (number of studies using an approach reporting a similar sized same effect out of the number of studies using the approach reporting no effect).

RESULTS

Results of the search

The majority of the hits (n= 7552) produced through the electronic searches were deemed ineligible at the first screening stage. Fifty-one of the 76 papers that were potentially eligible were excluded leaving 21 studies reported in 23 papers.

Included studies

Eighteen studies tested individual level and three tested system level interventions.

Individual – level interventions

(see Table 1 for details in Appendix)

Study characteristics

A total of 2018 participants were included in the 18 studies, the majority being clinicians. Three of the 18 studies were RCTs (one a cluster-RCT), twelve studies utilised a pre-/post-test survey design and three used a post-test only design. The majority of the studies were conducted in paediatric settings in the USA.

Individual-level interventions were all educational or had an educational component; they all focused on promoting prevention of IPV by targeting participants' attitudes towards IPV and knowledge of its detrimental effects followed by practical measures that professionals could take.

Eight discrete training programmes were identified. In two studies the interventions were multifaceted (e.g. the SEEK model of paediatric care (Dubowitz *et al.* 2011; Feigelman *et al.* 2011)). Contents of, or topics covered in the training programmes, were not consistently reported in the majority of studies. Teaching methods were

also not clearly reported. We could discern that teaching methods were either exclusively didactic or instructional.

Programme delivery formats were reported in the majority of studies; these included group presentation, small-group training, film and video and bibliotherapy. Six interventions were brief and seven were longer lasting from 90 minutes to one day (8 hours). Booster training sessions (lasting between 1 hour to 90 minutes) were included in three studies (Berger *et al.* 2002; Dubowitz *et al.* 2011; Feigelman *et al.* 2011).

System – level interventions

System-level interventions aimed to affect changes in organisational practice (Wills *et al.* 2008) and inter-organisational collaboration between child welfare and DVA service providers (Banks *et al.* 2008b) to implement strategies in the prevention of DVA (Shye *et al.* 2004). (See Table 2 for details in Appendix.)

Design

All system-level intervention studies used a pre-/post-test survey design.

Location

With the exception of the New Zealand study (Wills *et al.* 2008) they were all conducted in the USA.

Scope of system-level interventions

The *Greenbook* demonstration initiative is reported in three papers (Banks *et al.* 2008a; Banks *et al.* 2008b; and Banks *et al.* 2009) reporting on the rationale and results of the initiative's multi-site evaluation which aimed to put into practice *Greenbook* principles and recommendations over a 5-year demonstration period. *Greenbook* principles for guiding reforms in child welfare systems refer to the establishment of collaborative relationships with DVA agencies and juvenile/dependency courts; assuming leadership to provide services and resources to ensure family safety for those experiencing child maltreatment and adult DVA; developing service plans and referrals that focus on safety, stability, and the well-

being of all victims of family violence; and holding DVA perpetrators accountable (NCJFCJ 1999).

The study by Wills *et al.* (2008) reports on a formal organisational change approach involving the implementation of the New Zealand Family Violence Intervention Guidelines. The approach included obtaining senior management support, community collaboration, developing resources to support practice, research, evaluation and training.

Finally, the effectiveness of two system-level multifaceted quality improvement approaches (Basic Implementation Strategy (BIS) and Augmented Basic Implementation Strategy (ABIS)) to enhancing the secondary prevention of domestic violence in primary care settings was compared in the Shye *et al.* (2004) study.

Outcomes

Refer to Table 1 (for individual-level) and Table 2 (for system-level interventions) for a summary of outcome measures used in the primary studies.

Effects of interventions: Summary of findings

Knowledge

In the majority of the pre-/post, post-test only studies significant improvement in participants' knowledge scores was reported. Training interventions tested under randomised controlled conditions had similar findings. Results from the three system-level intervention studies also report similar significant increases in participants' knowledge.

Attitudes

The majority of the pre-/post-test only studies reported significant improvements in participants' attitudes towards a number of DVA-related attitude items. Only the Feigelman *et al.* (2011) RCT reported improvements on this domain. Of the system-level intervention studies, only the Wills *et al.* (2008) study reported positive changes in participants' attitudes.

Competence

In all of the pre-/post-test only studies significant improvements in participants' self-perceived competence scores were reported post-intervention. Results from two RCTs were consistent with this finding, though IPV-specific data were not available. Only one of the system-level interventions (Wills *et al.* 2008) studies found positive changes in participants' competence.

Screening practice

All of the pre-/post-test only studies reported significant improvements in participants' self-reported screening practice scores post-intervention. Results from two RCTs were inconsistent for this outcome.

Two system-level interventions studies provided data for this outcome. In the Banks *et al.* (2008) study, results from caseworkers' surveys did not show any significant changes on a number of clinical practice items. In the Wills *et al.* (2008) study both screening and referral rates were increased.

Behaviour change

The significant improvements in IPV identification/screening practice and referral is consistent with the positive results from the self-reported knowledge, attitudes and competence outcome measures reported above. The same pattern was observed for both individual- and system-level intervention studies.

Parent and children outcomes

With the exception of the Feigelman *et al.* (2011) study, outcomes for parental and children's outcomes were not measured in any of the primary studies. In that study patient-rated clinical interactions were significantly more positive compared to control doctors.

DISCUSSION

Our overall interpretation is that training programmes aiming to improve the response of professionals to the exposure of children to DVA or intimate partner

violence, of the types described in the individual-level interventions section of this review, improve participants' knowledge, attitudes and clinical competence up to a year after the intervention. Elements of effective interventions included an added experiential or post-training discussion component (alongside the didactic component), incorporating 'booster' sessions at regular intervals after the end of training, advocating and promoting access to local DVA agencies or other professionals with specific DVA expertise, and finally, drawing from a clear and well-articulated protocol for intervention.

Our synthesis of primary studies documented multi-dimensionality in training programmes' contents, methods and delivery. This is an important finding in itself. Most programmes we reviewed were multifaceted with multiple components. Programmes covered multiple topics, used teaching strategies in combination such as discussion, modelling, role-play, rehearsal, and feedback, and integrated active/passive and behavioural/instructional approaches in one session.

There was some evidence that improvements in perceived competence can be translated into changes in clinical practice as documented by clinical records audits. However, perceived competence gains were not sustained consistently over time indicating the need for reinforcement (e.g. booster sessions). The consistency of results for similar outcome measures evaluated in the three randomised controlled trials strengthens the evidence. On the other hand, in the absence of measures of harm, it is unclear whether a) these training programmes may also have harmful consequences in the form of parental anxiety and child fear or anxiety, and b) result in greater odds of disclosures of past or current DVA from mothers and children.

The results of the handful of system-level interventions studies are encouraging and point to the importance of co-ordinating system change activities in child welfare agencies with other collaborative activities between primary partner systems and DVA specialist organisations. The commitment for continuous work by all partners was highlighted as one of the most challenging aspect of collaborative initiatives aiming to deliver an integrated DVA policy and practice and improve outcomes for families. Further studies are needed to identify the optimal operational parameters of such strategies.

6.2 Training curricula study



SUMMARY AND KEY MESSAGES

- There is a wide range of current safeguarding training that either contains some reference to DVA or specifically target DVA. The various materials show a considerable heterogeneity in terms of course content and methods of delivery.
- 12 of 32 analyzed materials contained 'good' or 'very good' mention of DVA in relation to child safeguarding.
- The longer the training and the more specific the focus on DVA, the stronger and the more sophisticated the link between DVA and child safeguarding. The DVA focus in current child safeguarding training materials tends to be on knowledge of policies and procedures for safeguarding children. The discussion about the needs of the parent experiencing abuse is typically missing or is relatively marginalized.
- There is little scope in current training on developing skills and self-efficacy that are required to address the complexity of appropriate management of patients experiencing DVA and their families. There is no specific course content explaining how to support the parent who is a victim of DVA whilst protecting his/her safety and autonomy and ensuring the safety of his/her children.
- There is hardly any reference in current training to communication with children in relation to DVA.
- Attitudes to working together and knowledge of how to work together in safeguarding with other professionals/agencies is only addressed in safeguarding training provided by LSCBs and is largely missing from the majority of other materials.
- There is no specific course content explaining how to keep appropriate records of DVA in the patient's and his/her family's medical notes and how to manage patient confidentiality issues.
- The tension between maintaining confidentiality and safety for the non-abusive parent who is being victimised, yet responding appropriately to potential maltreatment of the children is not generally addressed or reflected in current training.

- The analysis of training materials highlighted the need for training on the interface between DVA and child safeguarding.

AIM OF THE STUDY

The aim of this component of the study was an overview of the content of current training materials on DVA in relation to child safeguarding. We wanted to gain an insight into the range of training materials that are currently being offered to general practice professionals (clinicians and administrators) in England.

The study did not map training provision and it was not representative, nor systematic. We did not evaluate training materials or the quality of delivery and we did not assess course impact. Our aim was to identify the current range of learning outcomes, delivery methods, and target audiences.

METHODS

Data Collection

We collected information (through a questionnaire survey) and training materials (PowerPoint slides, handouts, training curricula, etc.) on safeguarding children training courses across England that either contain some reference to DVA or specifically focused on DVA. We approached 250 providers (based on a national list of designated nurses; national list of Local Safeguarding Children Boards (LSCBs); list of third sector organisations).

Despite three general postings and many individualised requests and reminders, we had difficulty assembling materials due to low response rate and general reluctance to send us materials. Data collection was challenging because of emerging intellectual property issues. We often received incomplete and apparently randomly selected materials.

Sample

We received 32 completed questionnaires and 22 training materials. The majority of materials were received from designated nurses, but we also received materials from LSCBs.

Most private training providers were extremely protective of their materials and did not wish to share them with us. The explanations for declining participation were typically the following: risk of a negative evaluation of their training program in the public domain, the complexity of copyright issues and fear of generating competition and assisting a potential competitor. Despite addressing these concerns in our information sheet and in our initial and subsequent communications with the training providers, only two charitable sector organisations participated in the study.

Analysis

The study looked at the various delivery methods and explored the content of training curricula in relation to DVA and child safeguarding. We received information on delivery from the providers and trainers and extracted the key learning points from the materials. We also determined to what extent the training engaged with the interface of DVA and child safeguarding.

The high diversity of materials (core training documents, background materials, handouts, brochures, etc.) and often little explanation attached to them, together with the wide variations in training delivery (level, length, target audience) limited the analysis and made it methodologically impossible to compare course contents. A more nuanced interpretation of the content and quality of materials was also impossible and was beyond the scope of this exercise. We judged the extent to which the training materials that were available to us covered the topic areas relevant to our study. We determined to what extent the training engaged with the interface of DVA and child safeguarding and mapped the relative scope of DVA coverage in relation to child safeguarding by ranging the materials on a 4-point scale from 'very good mention' to 'no mention at all'. We also identified a range of core or peripheral themes, approaches, learning outcomes and a range of often or rarely used teaching/learning instruments and handouts. The exercise was completed independently by two researchers against a set of criteria and the results were then

compared and discussed. Whenever a disagreement emerged, the two researchers sought the opinion of a third researcher.

FINDINGS AND DISCUSSION

Training delivery (data extracted from questionnaires N=32):

		Number of materials		Number of materials		Number of materials
Level (RCPCH 2014)	Level 1	6	Level 2	15	Level 3	11
Audience	Interagency	6	Single-agency (primary care)	26		
Location	External location	11	Practice	7	Both in the practice and external	9
Length	1-3 hours	22	4-8 hours	9	More than 1 day	1
Format	Face to face	31	Online	1		
Fees	Fees	10	No fees	19		

DVA with relevance to child safeguarding (CS) (Data extracted from training materials N=22):

Coverage ranking	Number of training materials
Very good mention of DVA-CS	5
Good mention of DVA-CS	7
Little or very little mention of DVA-CS	9
No mention of DVA-CS	1

Learning outcomes (data extracted from 'good mention and very good mention' materials n=12)

Learning outcome	Explicit mention or good coverage	No mention or missing data
Definitions of DVA	8	4

Recognise signs, risk and protective factors, impact on children	10	2
Frontline professional role, communication with adult patient/victim, response to disclosure	11 (but not only GP)	1
Referral pathways general	6	6
Referral pathways local, local resources	6	6
Interagency work	5	7
DVA prevalence, historical context, legislative framework	6	6
Records keeping	2	10
Managing confidentiality	4	8
Serious case reviews	2	10
Diversity	3	9
Working/communicating with fathers/perpetrators	4	8
Working/communicating with children	2	10

We received 32 questionnaires and 22 examples of training material on safeguarding children training courses that either contained some reference to DVA or specifically focused on DVA. The materials showed a considerable heterogeneity in terms of course content and methods of delivery.

The longer the training (4-8 hours or more) and the more specific the focus was on DVA, the stronger and the more sophisticated the link was between DVA and child safeguarding. The DVA focus in current child safeguarding training materials tended to be on knowledge of policies and procedures for safeguarding children (recognising the signs of abuse; how to make a child protection referral), with the needs of the parent experiencing abuse relatively marginalised. At the same time there was little scope in current training on developing skills and self-efficacy that would be required to address the complexity of appropriate management of patients experiencing DVA and their families. We found no specific course content explaining how to support the parent who is a victim of DVA whilst protecting his/her safety and autonomy and ensuring the safety of his/her children. In addition, we found hardly any reference in current training to communication with children in relation to DVA.

Attitudes to interagency partnership and knowledge of how to work together in safeguarding with other professionals/agencies were only addressed in safeguarding training provided by LSCBs and were largely missing from the majority of other materials.

The tension between maintaining confidentiality and safety for the non-abusive parent who is being victimised, yet responding appropriately to potential maltreatment of the children was not generally addressed or reflected in current training. We found no specific course content explaining how to keep appropriate records of DVA in the patient's and his/her family's medical notes and how to manage patient confidentiality issues.

CONCLUSION

In terms of DVA coverage, we judged as good or very good a minority of training materials available for analysis. The needs and safety of the non-abusive parent (usually the mother) were not sufficiently addressed in most curricula and guidance on talking with children was virtually absent. Other than LSCB training materials, there was little guidance on collaborative working with other agencies. There was scant attention to management of the tension between keeping confidentiality and maximizing safety of DVA survivors and their children. The analysis of training materials highlighted the need for training on the interface between DVA and child safeguarding.

Finally, our study also indicated that the creation of a commercial market in professional training has led to a reluctance to share positive practice. The poor response rate highlights the importance of ensuring that training packages or other outputs of commissioned research are openly available.

6.3 Consensus process: consensus survey and meeting



SUMMARY AND KEY MESSAGES

- The consensus process identified difficult areas in general practice at the interface of DVA and child safeguarding. These areas were: how to manage difficult conversations (talking to the abuser; talking to children); the role of general practice in the management of DVA; when and how to seek patient consent before referral to other services; when, how and where to document DVA in GP medical records.
- The consensus meeting generated a constructive multi-professional debate around these issues. It also identified areas where the debate impacted on our experts' opinions and resulted in a change of opinions, hence generated consensus.
- The discussion around controversial themes was particularly valuable as it shed light on the complexity of perspectives around some of these questions and also suggested the need for a more flexible approach which takes into account professional perspectives, local specificities as well as individual practices while retaining important principles of safety and confidentiality.
- The consensus process also demonstrated that there are particularly difficult areas where further research work and the synthesis of findings from all research components were needed in order to translate the outcomes of the consensus meeting into guidance and training.

INTRODUCTION

We sought expert advice and judgment on a range of controversial statements in relation to DVA and child safeguarding. The aim of the consensus process was to clarify difficult areas of practice and to develop specific guidance on the interface of DVA and child safeguarding in general practice with input from relevant professional

groups. Our ultimate goal was to integrate this guidance into our training curricula for GPs, practice nurses and practice managers.

THE RESPONDS CONSENSUS PROCESS

We identified 36 experts in the fields of DVA, child safeguarding and general practice. We invited them (see invitation letter in Appendix) to take part in the 2-stage consensus survey and in a 1-day consensus meeting. Twenty-eight experts accepted our invitation (see list of expert participants in Appendix).

The expert panel received a list of initial statements about good practice for incorporation into training. The statements focused on contentious or ambiguous areas of practice and were developed through a focus group discussion with our PPI members. The research team finalised 41 statements and converted them into an online survey format.

The survey, together with an information sheet, was sent out to 28 panel members. We asked participants to score the statements and signal their agreement, uncertainty or disagreement on a nine point scale (from strongly agree to strongly disagree) and return it to us before the meeting. Responses to the survey were confidential. We asked participants to score the statements based only on their own judgment, without regard to current resource availability or to current guidance. The survey was completed by 21 experts.

The aim of the survey was not to assess participants' knowledge and attitudes or to have one 'objective' score based on aggregating many 'subjective' scores. Our goal was to tease out important areas of agreement and important areas of disagreement and see whether these are at odds with existing guidelines and current research evidence – and with the interim results of RESPONDS.

We collated and analysed findings from the survey before the consensus meeting. Individual scores for each statement were collated with those of other panel members. The consensus meeting participants received in advance their personalised panel reports, summaries with interim findings from the research, the program of the day and the main areas for discussion. The personalised reports contained the participants' own ratings; the median of the whole panel, the range of

the whole panel, and the standard deviation (indicating the extent of disagreement within the panel).

The meeting was attended by 25 professionals from general practice (GPs, practice nurses, practice managers), child safeguarding professionals including social workers, professionals from DVA organisations, policy experts, researchers, senior academics and training professionals. Two PPI members, advisory group members and the full RESPONDS research team also attended the meeting.

The first part of the meeting was devoted to introducing the aim and background of the research and to getting to know each other. The research team members also presented interim findings from the systematic review, survey of curricula, interview study and the consensus survey. Participants then had the opportunity to debate the statements in plenary sessions and in small groups. The discussions were guided by six clusters of statements and related difficult areas of practice (talking to the abuser, talking to children, role of general practice, referral and ongoing care, consent, recording) and were moderated by chairs. The discussions focused on important areas of disagreement and important areas of agreement where these seemed to be at odds with existing guidelines and current research evidence.

After the meeting, expert participants had the opportunity to re-score their statements in the light of the discussion. The discussion was audio recorded and transcribed verbatim. We circulated all the presentations, the notes summarising the discussion and the two-stage survey results among all participants following the meeting. Feedback from our experts on all these documents have been collated and then integrated into the development of the content of the RESPONDS training.

AREAS OF PRACTICE AND DEGREE OF EXPERT CONSENSUS

Unambiguously non-controversial areas of practice

There was a wide agreement across the panel with reference to the following 27 statements before the meeting (T1). The meeting did not change our expert participants' opinions/attitudes towards these questions and the group consensus remained largely constant after the meeting (T2). Statements were separated into

separate GP and nurse statements in the survey, but they are grouped together below due to space limitations:

Q2-3 GPs/practice nurses should always suspect domestic violence when children present with symptoms of disturbed behaviour.

Q 4-5 It is the GP/practice nurse's role to ask questions about domestic violence when there are child safeguarding issues in a family.

Q6-7 GPs/ practice nurses should always tell patients who are parents that domestic violence has an impact on their children.

Q8-9 GPs/practice nurses should not ask about domestic violence if there are no local resources to support patients who experience domestic violence.

Q10-11 GPs/practice nurses should not ask about domestic violence if they feel they do not have the necessary skills, knowledge and confidence to help the patient who are experiencing domestic violence.

Q12-13 As a first step GPs/practice nurses should always seek advice from specialist domestic violence agencies when they suspect domestic violence and there are children in the home.

Q 24-25 GPs/ practice nurses should always refer parents disclosing domestic violence to domestic violence services.

Q 26-27 GPs/practice nurses should always refer to children's social services if domestic violence is disclosed and there are children in the household.

Q 28-29 GPs/practice nurses should always tell the patient that they will be speaking to other professionals about their disclosure of domestic violence.

Q 32 If consent is withheld, referral should still take place.

Q 33 It is all right to discuss issues concerning families experiencing domestic violence within health services, this is not breaking confidentiality.

Q 36-37 GPs should ensure that their practice has strong links with all local domestic violence service.

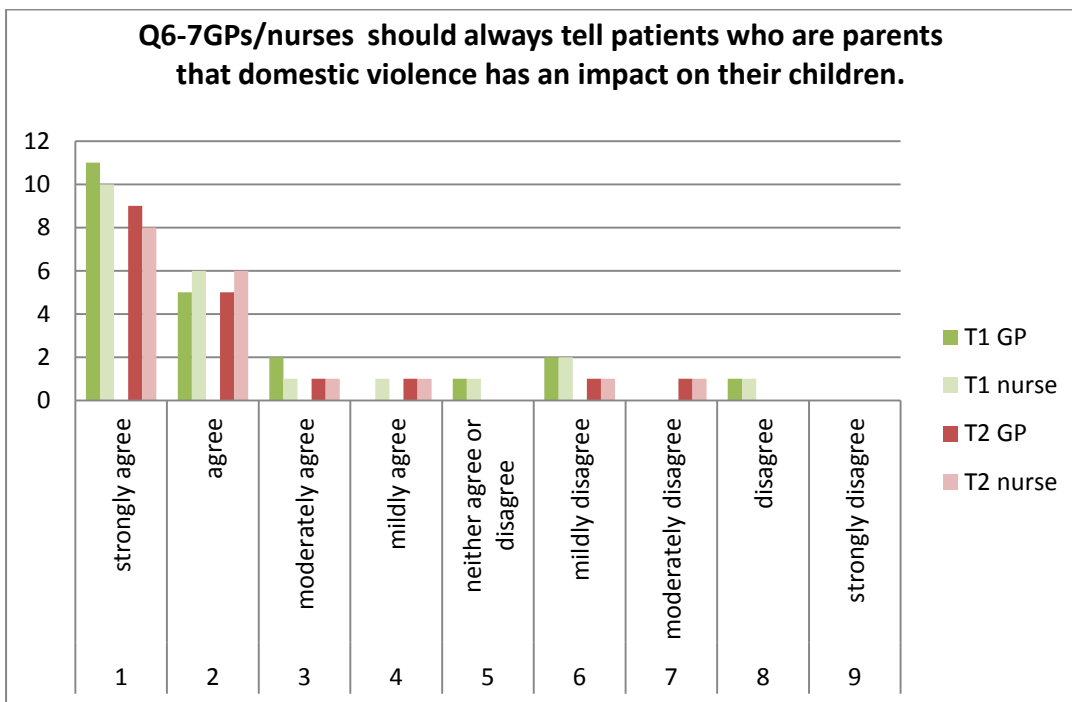
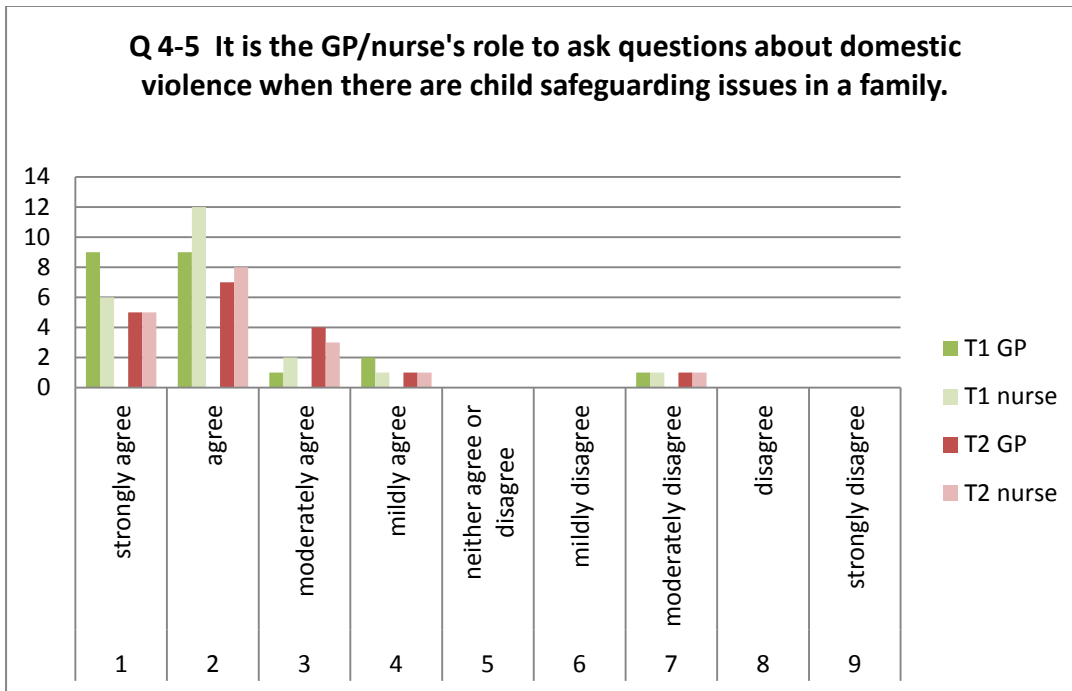
Q 38-39 Domestic violence training for GPs should be integrated into child safeguarding training.

Q 40 Domestic violence and child safeguarding training should take place for one practice team only rather than multiple practices together.

Q 41 Primary health care clinicians should be trained separately from administrative/managerial staff in domestic violence and child safeguarding.

Q 42 One hour of domestic violence training should be mandatory per year.

For example:



Moderately controversial areas of practice

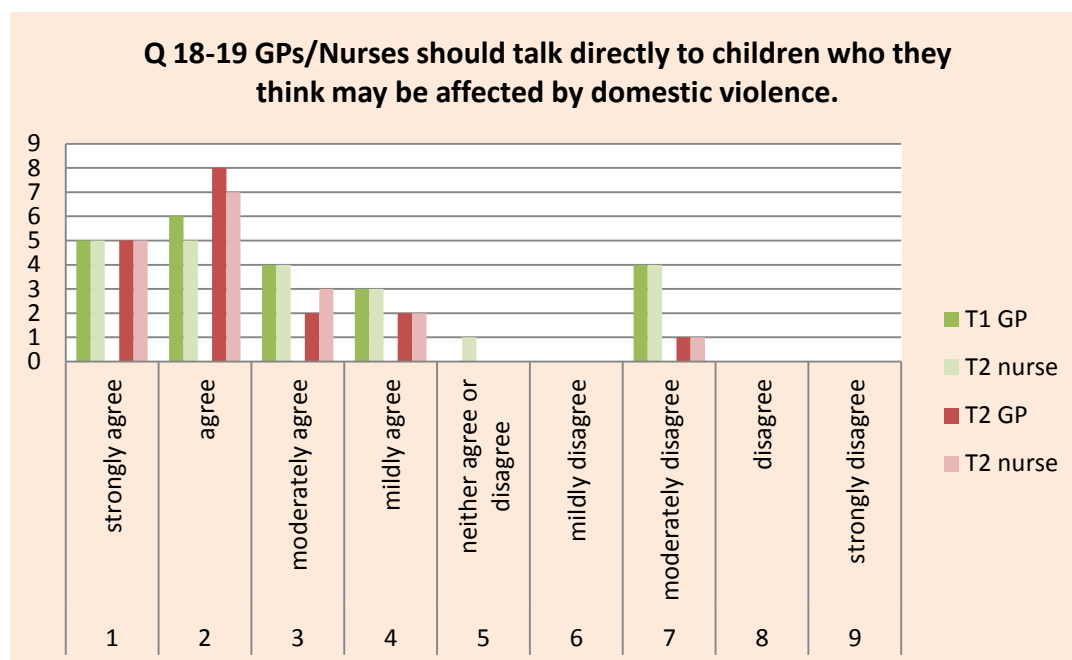
There were statements where we observed some change in our expert participants' opinions and attitudes after the consensus meeting. We identified two initially controversial statements where initial disagreement moved towards group-consensus as a result of the meeting:

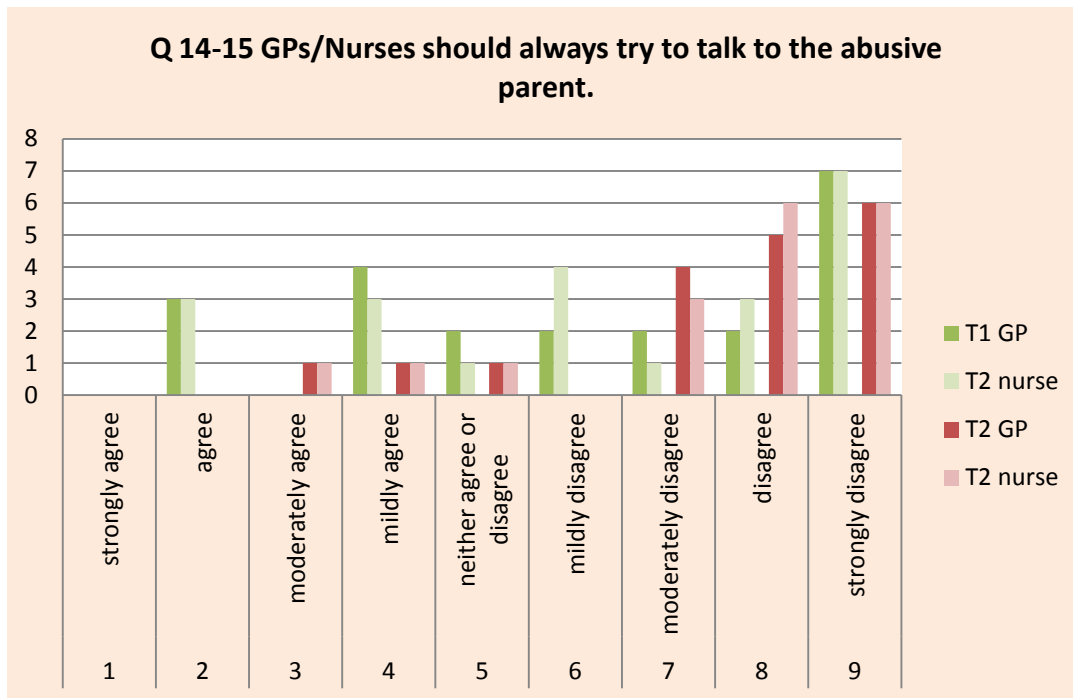
Q 14-15 GPs/practice nurses should always try to talk to the abusive parent.

Q 18-19 GPs/practice nurses should talk directly to children who they think may be affected by domestic violence.

While before the meeting (T1) some participants did not think that general practice clinicians should talk directly to children affected by DVA, they tended to agree with the idea and practice of engaging with children directly after the meeting (T2):

Before the meeting (T1) some participants thought that it is always a good idea for general practice clinicians to talk to the abusive parent. After the meeting (T2), however, their opinions shifted significantly and moved towards a group consensus that this was not a good idea.





Substantially controversial areas of practice

We identified statements which showed a wide distribution across the scale before the meeting (T1) and also polarised the group during the discussion. The discussion around these themes was particularly interesting and constructive as it shed light on the complexity of perspectives around some of these questions. It also suggested the need for a more flexible approach which takes into account professional perspectives, local specificities as well as individual practices while also grounded in important principles of safety and confidentiality. The survey showed that ten initially controversial statements remained equally or even more controversial following the consensus meeting (T2). Further research work (as originally planned) was needed to be done in order to be able to translate and interpret the outcomes of the consensus meeting into guidance and training on some of these difficult issues.

Q 16-17 GPs/Nurses should never see the abused parent together with their partner after domestic violence has been disclosed.

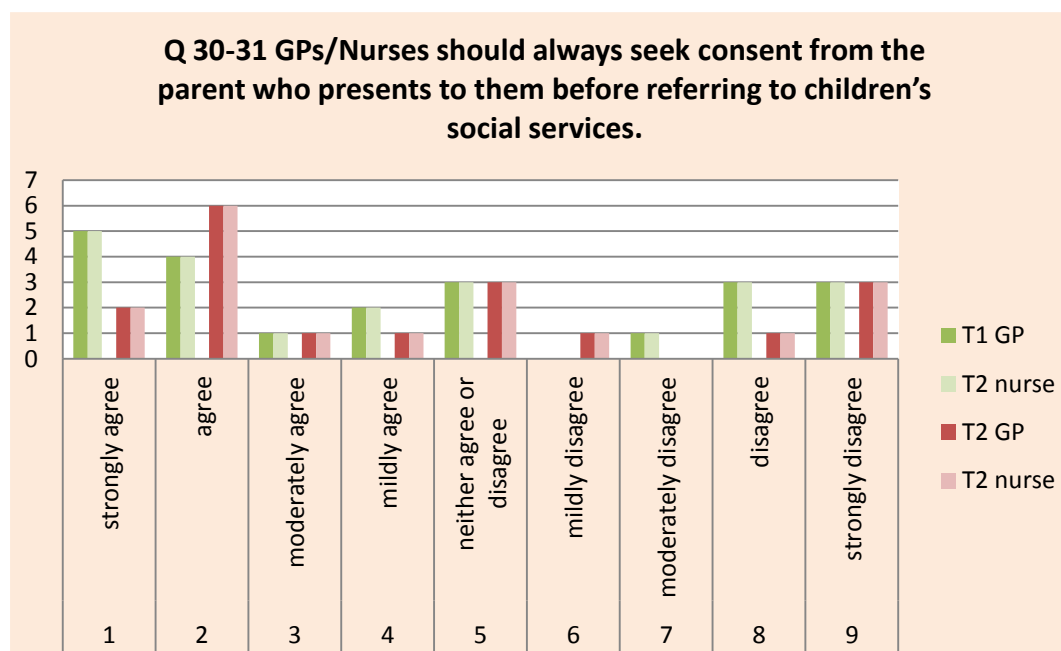
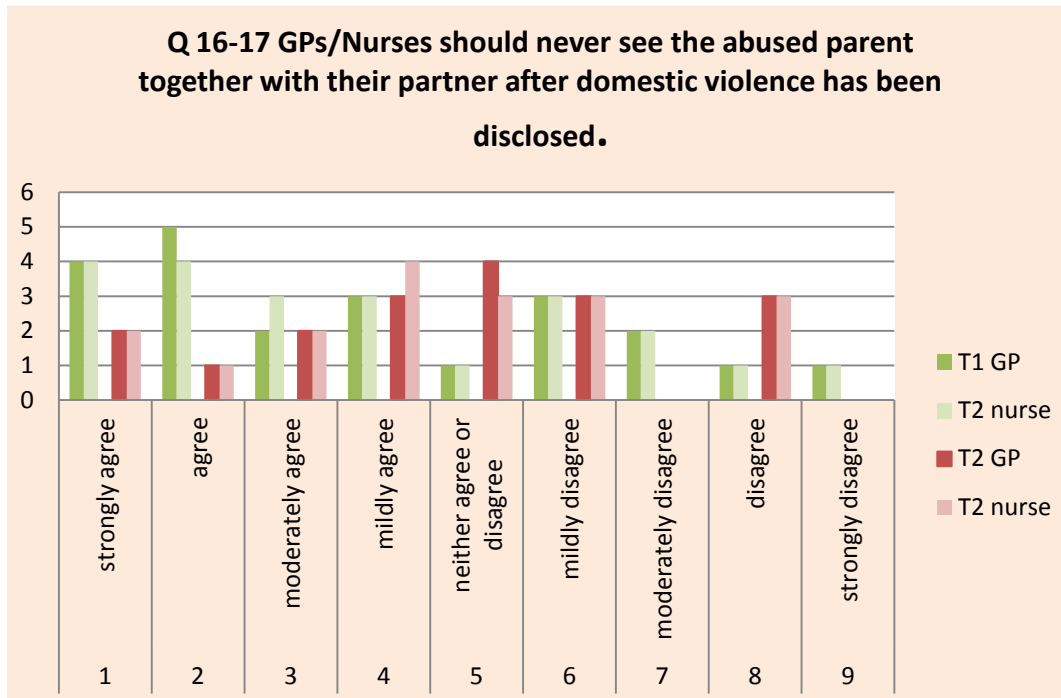
Q 20-21 GPs/Nurses should always talk to children over 8 years exposed to domestic violence on their own.

Q 22-23 The role of the GPs/nurses is to refer on families where there is domestic violence to other specialist agencies, rather than to provide ongoing care.

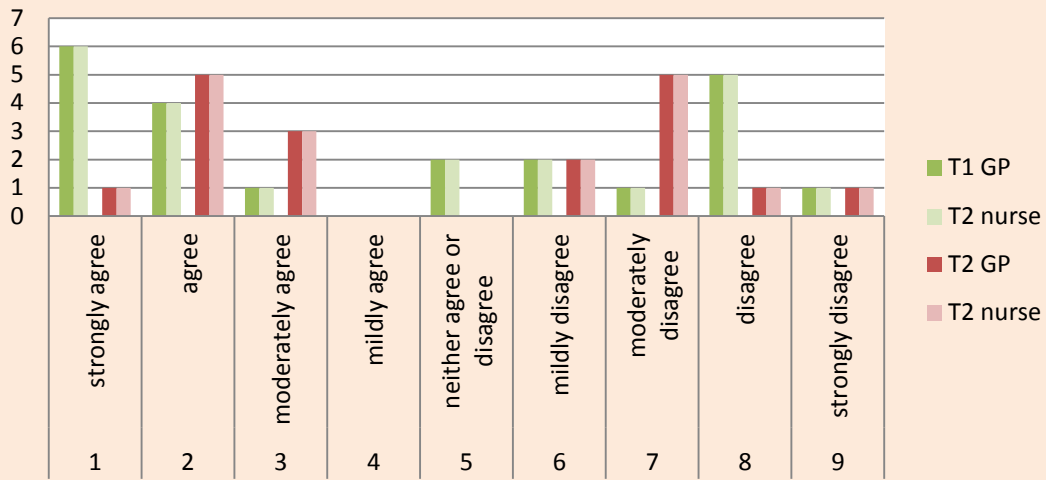
Q 30-31 GPs/Nurses should always seek consent from the parent who presents to them before referring to children's social services.

Q 34-35 Following a disclosure of domestic violence, GPs/nurses should record full notes in all family members' records.

For example:



Q 34-35 Following a disclosure of domestic violence, GPs/nurses should record full notes in all family members' records.



6.4 Interview study

Aims

The aim of the interview study component of the RESPONDS project was to explore general practice responses to disclosure of DVA when children are exposed and to understand the dilemmas and challenges general practice clinicians face when confronted with children's exposure to DVA. The study also explored the links general practice professionals make between identification of child maltreatment and the possibility of DVA being present. Our objectives: (i) to identify and analyse examples of positive practice in the field, capture the variations in current practice while appreciating the difficulties and tensions in responding to this complex area of practice; (ii) to gain insights into how general practice professionals communicate with patients and their families, and how they work with issues of confidentiality, recording and patient safety; (iii) to understand the current institutional and practical barriers and facilitators to effective interagency partnerships in the context of DVA and child safeguarding; (iv) to understand general practice professionals' roles in relation to DVA and child safeguarding and what training and resources they would find useful.

We interviewed general practitioners and practice nurses, as well as practice managers (who have a key role in implementing practice policy with regards to training).

Methods

We conducted qualitative semi-structured telephone interviews with 69 general practice professionals across six sites in England between May-December 2013.

Informants' demographic and professional background:

		GPs (42)	Practice nurses (12)	Practice managers (15)
Gender	Male	17	0	4
	Female	25	12	11
Age Range (years)	21-34	8	2	0
	35-44	11	0	2
	45-54	15	8	7
	55-64	5	1	4
	Not Known	3	1	2
Experience managing DVA (number of cases)	More than five	5	0	
	A few	13	1	
	One	0	2	
	None	18	8	
	None, but aware of case at surgery	6	1	
DVA service provision	Sparse	16	6	6
	Established	26	6	9
Location	Metropolitan	11	3	5
	Urban	16	5	6
	Semi-rural	15	4	4
Region	North	14	3	4
	Midlands	7	4	4
	South	21	5	7

The six sites were chosen to represent different levels of domestic violence service provision and included metropolitan, urban and semi-rural locations across the north and south of England and the Midlands.

The interviews lasted between 25 and 60 minutes. The interviews started with a short vignette (see Appendix) which outlined a scenario involving physical violence by “Danny” against “Sarah” and describing controlling behavior towards three children aged seven, five and two years. The vignettes elicited practitioners’

accounts of their work with parents and children experiencing DVA. The vignette gave a common point of departure for our discussions and was particularly helpful in situations where the informants did not have direct experience of dealing with such cases.

Following a discussion around the vignette, a series of questions (see *Topic guide for interviews with GPs and nurses*; *Topic guide for interviews with practice managers* in Appendix) was asked about identification of DVA, referral, interagency work, recording, communication with patients and their families and training.

All interviews were audio recorded with consent, transcribed verbatim then loaded onto qualitative data analysis software (NVivo) and analysed thematically using Framework (Ritchie and Spencer 1994). The multi-disciplinary research team developed the initial coding frame based on the literature which guided our initial interview schedule and on other concepts which emerged in the course of data collection. It was tested in three pilot interviews and subsequently revised. Each researcher then took a lead on identifying themes within elements of the analysis framework and these were revised and interpreted through research team discussions.

6.4.1 General practice clinicians' understandings of risks, processes and procedures in relation to DVA and child safeguarding



SUMMARY AND KEY MESSAGES

- General practice clinicians in the sample had limited experience of identifying DVA in families and it was rare for them to have referred children to children's social services as a result of concerns about DVA.
- Awareness of the relationship between DVA and child safeguarding was generally low across the sample.
- Clinicians were more likely to conceptualise risks to children in terms of direct physical harm or to emphasise the vulnerability of very young children. However, some of those interviewed identified the emotional harm associated with DVA and/or recognised that children's exposure to DVA could be harmful in itself.
- Only half the group who would refer the vignette family to children's social services identified a need to discuss with or tell the mother about the referral. The risks of such a referral provoking further DVA were often not recognised.
- Clinicians struggled to manage families where the risks were uncertain or judged less than high. A few would consult the practice's safeguarding lead or felt able to have informal discussions with social workers, but this was not common practice.
- Clinicians were unfamiliar with procedures for co-ordinating service responses to children who were below the high risk threshold and most did not see themselves as having a role in contributing to a 'jigsaw' of information about children that was shared between agencies.

Clinicians' understanding of DVA and risks for children

Generally, the practitioners interviewed demonstrated low awareness of the relationship between DVA and child safeguarding and this was reflected in their limited experience of DVA in the context of general practice. Over half (57%) the general practice clinicians in the sample had not identified any patients who were

victims, perpetrators or children living with DVA in the last two years. Thirty per cent had had five or fewer such cases and five doctors had worked with more than five DVA cases in that period. Of the 42 GPs interviewed, only three had made a child protection referral to children's social services in respect of concerns about a child's exposure to DVA.

Although most of those interviewed had no difficulty establishing a link in theory between DVA and the potential harm it represented for children, about one third of practitioners only made this link when prompted by the interviewer. Moreover, more than half of GPs and nearly all practice nurses interviewed said they would not necessarily make a link between child safeguarding concerns and the possibility that DVA might be an issue in a family. Some of the reasons given for not exploring the possibility of DVA when child safeguarding concerns arose included DVA not being 'first on your radar or list of things to ask about' (GP31) and the problem of 'finding the time to do [it] all' (GP28).

Given the lack of relevant experience in the sample, the vignette (see Appendix 1.) used in the interviews provided a useful means of exploring practitioners' attitudes to and understandings of children's experience of DVA. A quarter of the clinicians interviewed thought that they would definitely refer the family in the vignette to children's social services.

A number of factors appeared salient in determining that a primary care clinician would refer a family to children's social services. Direct violence towards a child and the young age of the children involved were both identified as factors that would trigger a referral and these factors are consistent with those that social workers themselves and the police use to identify high levels of risk (Stanley *et al.* 2010). A couple of GPs considered that the father's heavy alcohol use would increase their levels of concern. However, a few of those interviewed were also alert to the dangers of emotional abuse and neglect for children and four GPs were clear that witnessing DVA was in itself sufficient to prompt a referral:



I know there's a lot of evidence about it, the damaging effects that it has on children, and that, that also, so even if they're not actually being hit or abused themselves... it's still a form of abuse towards them...I would be

thinking...Do Social Services need to know about this? Are they, you know, are they safe in that situation? And if they're, even if they're safe is it, is it acceptable? (GP24)

Another three GPs judged that the level of physical violence towards the mother specified in the vignette was in itself sufficient for them to contact children's services. Two GPs took a more dynamic approach towards assessing risk and suggested that any decision to refer to children's social services might be influenced by a picture of escalating abuse coupled with a lack of change:

“ *it [referral to children's social services] would depend on a situation but it certainly would alter if things were escalating in terms of violence or abuse or, you know, whatever is escalating and nothing was changing and she wasn't doing anything about it, I think it would have to change, otherwise it's going to get worse. (GP22)*

Processes and procedures for referral to children's social services

The 13 clinicians who would refer the vignette family to children's social services were clear that the risks to the child outweighed any concerns about confidentiality or anxieties about preserving their relationship with the mother. Six of these practitioners noted that they would discuss the referral with the mother or tell her about it. Although a couple of GPs were keen to elicit the mother's consent to such a referral, most felt the discussion would involve them informing or telling the mother of the referral rather than asking her:

“ *I'd have to tell her that, because of the children, I would basically be needing to involve child protection services. I would reassure and inform her as much as possible as to what that would involve, but yes, I'd have to make her aware that, you know, it wasn't actually up to her whether I, because I often get into arguments about 'oh no, but they'll take the children...(GP30)*

There was limited awareness of the risks of precipitating further DVA consequent on such referrals: only one GP mentioned this.

Where the risks were evident and child protection concerns were clearly identified, formal protocols for contacting children's social services could be evoked. However, clinicians reported struggling with 'the ones in the middle' (GP24) where the level of risk was uncertain or less than acute. For most GPs, colleagues were the first people to be consulted about difficult decisions. In a few practices where there was a designated safeguarding lead, clinicians valued the opportunity to discuss uncertainties about referring children with him or her but this did not appear to be a standard procedure across the sample.

Four clinicians suggested that where they were unsure about whether to refer they would be able to have an informal discussion with a social worker in order to establish the appropriateness of a formal referral. This process seemed more established in some of the localities than in others:

“*...you can talk it through with Social Services without actually having to formally refer to Social Services (GP11)*

A couple of clinicians from different research sites described how relevant training events had increased their confidence about making referrals to children's social services and their willingness to discuss cases with social workers on an informal basis:

“*Since I went to the last [training event] when they were talking about this, I think she's one of these that I could raise with Social Services as a, maybe not do anything but just discuss it with them to make sure if they, if they know anything about her...because I'm just getting her side of the story but it could be that other people have brought it to Social Services attention...(PN08)*

However, this recognition that the primary care perspective comprised one part of a 'jigsaw' was rare and was only articulated by a couple of clinicians.

Only one respondent, a practice nurse, mentioned invoking the Children's Assessment Framework (CAF) or Team Around the Child procedures which are used for children in need of support who are judged not to reach the child protection threshold. Such procedures would involve sharing information with education and a range of other agencies as well as children's social services.

In some practices, hierarchical structures seemed to restrict opportunities for communication with children's social services. Three of the 12 Practice Nurses interviewed were explicit that making referrals to children's social services was someone else's job:

“...it wouldn't be my remit to do this, this will be something that I would hand over to the patient's GP who would liaise with the Health Visitor who would liaise with the Social Services... it would not be my responsibility, my responsibility is to, is to actually make sure that I am reporting my concerns to the appropriate people. (PN05)

6.4.2 Having difficult conversations around DVA and child safeguarding



SUMMARY AND KEY MESSAGES

- Clinicians demonstrated a lack of confidence and experience in having conversations about DVA with patients. Children and young people experiencing DVA were rarely engaged with directly – their experience tended to be assessed through others.
- Approaches which could exacerbate risk to DVA survivors and their children or fail to meet the standards set in existing guidelines were apparent.
- There were examples of clinicians' good practice in some responses to DVA and child safeguarding which could inform improvements in practice.

Background

General practice clinicians are used to having difficult conversations about various issues, but previous research (Taft *et al.* 2004; Feder *et al.* 2011) has shown that clinicians lack confidence and skills in responding to disclosures of DVA.

Sample

This section is based on interviews with general practice clinicians: 42 GPs and 12 nurses (nurse practitioners and practice nurses).

Children exposed to DVA

Few clinicians would routinely seek to directly engage with the children concerned. Some might in some circumstance, after undertaking other actions such as talking to others (e.g. health visitors); or if an opportunity arose or excuse could be made. More than half would not seek to engage directly with children.

“ *Probably wouldn't actually go and say engage with the children... so might, might... put a code in their notes (GP29)*

Fear of the consequences of misunderstanding was evident as three clinicians were concerned that children could ‘*twist things that adults say*’ (GP10), noting the potential for children to misunderstand or for children to let slip to perpetrators that DV had been discussed.

Those who would see children were hesitant about whether they would see children alone but some of those who would described seeking the non-abusive parent’s permission for this and being led by a child’s wishes as to whether seeing them alone was appropriate.

“ *[I would say] ‘Would you mind if I just had a word with them [your child] on my own for a few minutes? Just to, just to explore whether there are any issues that they, you know, that they wanted to talk about that they didn't feel comfortable to raise in, in front of mum or dad. (GP34)*

Two examples were given of GPs overcoming the lack of time and giving young people information directly about relevant services they could access or giving children:

“ *The sense that it's okay to come and talk to you about anything that worries them. (GP21).*

Adult victims

General practice clinicians tended to describe responding to adult victims of DVA by validating disclosure, actively listening and showing empathy or warmth. Some described engaging with patients using open direct questions to understand the nature and extent of the DVA. A few clinicians would provide patients with information about additional sources of support (DVA helplines or services, police or other non-specialist agencies such as housing). A few clinicians said they would

arrange a home visit, or a return visit. A small number reported asking patients direction about what support they would like to receive, or supported patients to build their confidence over time, in order to make decisions about the action they wished to take. It is of concern that clinicians did not consistently include all of these elements in their initial response to patient disclosure of DVA, but where they occur together these strategies are generally consistent with the sort of responses that DVA survivors have requested (Feder *et al.* 2006).

Where children were present in households experiencing DVA most, but not all clinicians discussing the vignette said they would engage with the presenting adult patient to explore the risks posed to the children. Later in the interviews, when reflecting on both their own cases and the vignette to answer the question 'What background information would you seek when DV is disclosed?' some, but not all clinicians, said they would ask about the impact on children. When prompted directly, however, all but one respondent said they would ask.

Concern was expressed by some about maintaining a positive relationship with an adult victim who discloses when there may be need to refer to a child safeguarding team. The need and legitimacy of breaking confidentiality to inform social services when a child was at risk of harm was broadly understood, but thresholds for referral varied. Clinicians had developed a range of strategies for managing confidentiality including practice policies, taking a lead from the patient and routinely asking to see patients alone. However, not all of the GPs were clear on appropriate boundaries within families.

Abusive partners

Over half of the clinicians interviewed said they would seek to engage with abusive parents. This might be to talk to perpetrators only about related issues such as alcohol-use or anger, but without raising the issue of DVA directly or proactively asking the victim's consent about whether to name and raise the issue directly with a perpetrator. Some would confront the perpetrator but showed no awareness of the risk posed to the victim and their children by breaking confidentiality. The clinicians who would raise the issue directly tended to be older, male and have no relevant training. Clinicians who showed a clear concern for safety and risk would either not

attempt to raise the issue unless perpetrators raised it themselves. A significant minority of GPs would seek to see both members of a couple together. This might be to hear the abusive partner's perspective or to attempt to resolve differences. The willingness of GPs to engage with couples is particularly worrying given that previous research (Taft *et al.* 2004) has identified the risks of a couple centered approach.

Differences in approaches to children and adults

There were some key similarities in the factors that influenced whether clinicians would engage with a child, an adult victim or an abusive parent (opportunities consequences and risks; consent and confidentiality). Adults, however, tended to be engaged with directly, regardless of whether they were experiencing or perpetrating abuse; whereas general practice clinicians tended to assess children's needs and experience through a proxy adult (such as the non-abusive parent). Some clinicians expressed concern about their lack of competence in communicating directly with children; indeed this often seen as a specialist role which lay with other child health specialists or services. Lack of time was perceived as a barrier to working with children, as was children's lack of direct access to health services. Lack of time to engage with perpetrators was not mentioned.

A key issue was the extent to which survivors (present at initial disclosure or affected by the DVA disclosed) were trusted as competent informants. A few clinicians suggested they may not entirely trust the presenting patient's accounts of her experience. They suggested the need to not take a patient's word at face value or identified how allegations might be untrue if they were inconsistent with claims they had heard made by the partner who was alleged to be abusive. Some clinicians went further and would actively seek abusive patients' perspectives either through conversations with the couple together, or with the abusive partner alone. In contrast, some GPs gave a sense that they would spend time together with the patient to build a shared understanding, reflecting the clinician's recognition that non-abusive parents have their children's best interests at heart.

Very few clinicians would actively seek to be informed by children themselves about their experience of the DVA. This is in striking contrast to GMC guidelines on child safeguarding (2012: 16) which state doctors working with children and young people

have a duty to listen and talk directly to them; to make sure they know who they can go to for help or support; to seek consent for information sharing from those children who have capacity; and, regardless of their capacity, to take account of children's wishes when making judgments about their best interests.

6.4.3 Working together, working apart: General practice professionals' perspectives on interagency collaboration in relation to children experiencing DVA



SUMMARY AND KEY MESSAGES

- There is a substantial variation between general practice professionals in their perceptions of the nature and strength of connections between DVA and child safeguarding.
- There are salient differences in clinicians' expectations regarding interagency collaboration. These differences raise concerns for the safety of children experiencing DVA.
- There are many examples of positive practice. However, mounting pressures on the health care system, the increased fragmentation of child protection services, and the lack of a cohesive and co-ordinated approach to the complex problem of DVA can seriously undermine the overall effectiveness of these individual responses.
- While the roles of general practice professionals in child safeguarding are now more clearly defined, they lack relevant training on the interface between child safeguarding and DVA as well as space and time to interact and reflect on this area of work.
- Despite important recent improvements in procedures and guidance, professionals still operate on different 'planets' and connections between planets are limited by lack of institutional knowledge, interagency trust and self-confidence which limit effective communication and team working.

- General practice professionals in the sample had poor relationships with children's social services (limited participation in the process restricts their role to referral and information exchange rather than joint work). They lacked feedback from children's social services and felt isolated from other professional groups.

- Respondents had limited knowledge and insufficient understanding of other professionals' and agencies' sphere of operations (lack of 'institutional empathy').
- General practice clinicians heavily relied on health visitors' access to information about families, but relationship with health visitors has been significantly weakening due to geographical relocation.
- General practice professionals were unaware of local DVA and other resources and they lacked understanding of the services they offer. Informants had almost no relationship with specialist DVA organisations.

Introduction

The research component presented in this section illuminates general practice perspectives on interagency collaboration and communication with key professional groups in this process. The narratives of general practice professionals describing their interactions with DVA services, children's social services, health visitors and non-primary care professionals presented here provide us with a unique understanding of the current institutional and practical barriers as well as facilitators of effective interagency partnerships in relation to the management of DVA when children are affected.

Relationships with specialist DVA services

Across the sample, there was general ignorance of existing DVA services and general practice professionals expressed reservations about the relevance of such services for their patients. Although NICE (National Institute for Health and Care Excellence) 2014 DVA guidelines recommend that 'staff know about the services, policies and procedures of all relevant local agencies for children and young people in relation to domestic violence and abuse' (p. 16), the majority of our respondents were unaware of local or national DVA services and did not know if the practice had any links with them. This lack of awareness was particularly surprising given that about half of the practices included in the study displayed information (posters or leaflets) about DVA services in the waiting room or in the women's toilets.

“ No idea, I've never had to access it [the local DVA service], said one GP (GP19)

“ I have never had any contact from them or, do know actually any, about what they really do other than sort of what I've Googled and interneted with the patient in the room. (GP03)

Relationships with children's social services

General practice professionals gave mixed accounts of the quality of their relationships with children's social services. Their narratives not only reflected the variety of social work practices in England, but they also shed light on the respondents' lack of confidence and familiarity in liaising with social workers.

“ No, no, I don't talk to them [social workers], I mean I would if I had to, I wouldn't have a problem but at the moment I've never had to. (PN10)

We also found a varying but generally low level of general practice engagement in child protection work in relation to DVA beyond the point of referral.

Informants in this study felt that general practice still operated on the periphery of the child protection system. Their limited participation in the process restricted their role to referral and information exchange rather than joint work.

“ They [Children's Social Services] seem to lack understanding in what a general practitioner's job involves... and not really involve us in a way that we'd like to be involved. (GP03)

A consequence of this was that this GP and her colleagues could feel left out or excluded from child protection processes and from key decisions:

“ *we get these notifications that case conferences have happened and you think well actually I would have liked to have known about that if I'd had a bit more information, a bit more time and you'd made it at a time that we could go to. (GP03)*

GPs' low attendance at and contributions to child protection case conferences has been identified by many commentators (for example Devaney 2008; Tompsett *et al.* 2010). Twelve GPs and three Practice Nurses in our study were aware of this and noted that the timing of meetings together with short notice mitigated against their attendance. Referring to GPs' poor reputations in relation to their attendance at interagency child protection meetings, this GP remarked:

“ *I went to a case conference of a child recently and the Social Worker was quite amazed. (GP38)*

However, other GPs did not consider that their role extended beyond the referral process:

“ *...so we don't necessarily need to attend, particularly if they haven't got much to contribute. (GP21)*

The lack of feedback, the one-way flow of information and the perceived insensitivity of social workers to the GP's position represented an obstacle to effective decision

making. Some GPs said they would have liked to be involved in the child protection process beyond the early identification stage.

“ *They [Social Services] wouldn't speak to us, and I found it hugely frustrating. I still felt the child was at risk...It's all about communication and factor sharing, and if we could do that better. (GP10)*

“ *I haven't had any feedback from the social worker that I spoke to but I didn't, neither did I expect it....but it would be nice to know what's happening...has somebody acted on that? (PN11)*

Relationships with other health care professionals

Informants gave relatively few details about how partnerships with other health professionals affected their practice with children experiencing DVA. In a small number of accounts hospital paediatric consultants, community paediatricians or designated safeguarding nurses were involved in the assessment process; these were all complex cases involving high levels of physical violence.

Most communication with other health professionals involved health visitors. Nearly all GPs and practice nurses mentioned involving or wanting to involve them in relation to child protection cases. However, interviewees explained that these relationships had been undermined by the geographical relocation and loss of named health visitors for each general practice. About half of the practitioners reported that reorganisation of health visitor services had reduced their contact:

“ *I haven't personally seen our health visitors in probably eighteen months. (GP39)*

Others, however, continued to use health visitors as their conduit to children's social services and consequently had little direct communication with social workers:

“ *The only contact I have with Social Services is by keeping up to speed with our Health Visitor. (GP22)*

Despite major shifts in the relationship, in most cases, health visitors' access to information and knowledge about families was seen as crucial.

School nurses were referred to by clinicians in just three instances. These accounts described problems in the relationship and portrayed some major deficiencies in joint work and communication.

“ *In theory, good idea, it's how to track them [school nurses] down (GP17).*

Strengths and weaknesses of general practice response to the interface between DVA and child safeguarding

One of the strengths of general practice is that it can offer direct responses to multiple family members, including victims and perpetrators of DVA and their children. It is also well placed to make a key contribution to a multi-agency whole system response to the interface of DVA and child protection. General practice responses to DVA when both adults (whether victims or perpetrators) and their children are involved are thus complex and emerge in the context of joint working. Multi-agency solutions are required to co-ordinate care and interventions for all family members and to assess the risks for both adults and children.

Insufficient understanding of the processes and contexts of other professionals' roles constituted a major source of frustration for the practitioners participating in this study.



What we miss out on is, is knowing who the Social Workers are and what makes them tick, what sort of work they can be doing with these families. (GP21)

A lack of 'institutional empathy' (Banks, Dutch and Wang 2008) restricted general practice professionals' ability to gauge thresholds for child protection referral and their understanding of the consequences of referral. It also explained deficiencies in communication and negatively impacted on efficacy in relation to risk assessment when concerns arose for a child experiencing DVA.



I think I'd probably like, like some more clarity on, you know, what, what the Police response would be [...] maybe even talk to people like solicitors and people involved further along the chain, to say well what actually happens to these women, what are the outcomes? [...] I think just further down the chain I'd like to know what happens rather than just my end of it. (GP01)

Our respondents also recognised the importance of informal communication between professionals in relation to DVA and children and regretted its absence. Communication at an individual level, reinforced by formal methods of interagency interaction, were identified as key to effective interagency work. Limited knowledge of the other agency's sphere of operations, poor engagement in joint decision making, low awareness of DVA services, a perceived lack of feedback and isolation from other professional groups can all have an adverse impact on practitioners' decision making. They can also have a negative effect on their self-confidence in responding to DVA in families.

Despite important recent improvements in procedures, training and guidance, our study shows that professionals still operate on different 'planets' (Hester 2011) and connections between planets are limited by lack of institutional knowledge, interagency trust and self-confidence which limit effective communication and team working. Doctors have become better trained to detect child abuse and they have

clear child protection responsibilities. NICE (2014) guidance on DVA now urges all service providers, including general practice, to be informed about the procedures and services of all relevant local agencies for children and young people. However, while the roles of general practice professionals may be more clearly defined, they lack relevant training on child protection and DVA as well as space and time to interact and reflect on this area of work.

The diversity of perspectives identified by our research indicates substantial variation between general practice professionals in their perceptions of the nature and strength of connections between DVA and child protection. Our findings also point to some salient differences in their expectations regarding interagency collaboration. These differences may raise concerns for the safety of children experiencing DVA but they also provide examples of positive practice among general practice professionals. However, mounting pressures on the health care system, the increased fragmentation of child protection services, as identified by the recent Jay Review on child sexual exploitation in Northern England (Jay 2014) and the lack of a cohesive and co-ordinated approach to the complex problem of DVA can seriously undermine the overall effectiveness of these individual responses.

Conclusion

In light of these findings, attempts to shift responses to child maltreatment into general practice without at the same time providing the necessary support and resources (training, reflection time, supervision, etc.) and without focusing on improving systems for interagency collaboration cannot be feasible. GPs' work in the field of DVA and child safeguarding will be safe and effective only as long as it is understood and managed within a context of interagency work.

Specialised interagency training is not a panacea, but it constitutes an important part of the answer to bridging the gap between child protection and DVA (Szilassy *et al.* 2013). We know from previous research that general practice professionals are poorly represented on the advanced inter-professional child protection courses, including training on DVA (Carpenter *et al.* 2010). This research evidence and the findings reported above have informed the design and content of the RESPONDS training intervention (section 7.) that aims not only to increase general practice

professionals' confidence and skills in managing the complexity of DVA when children are affected, but also aims to improve interagency collaboration.

6.4.4 Documenting DVA and child safeguarding in general practice



SUMMARY AND KEY MESSAGES

- General practice clinicians have a confused and inconsistent approach to documenting child safeguarding in the context of DVA. This is partly due to their lack of awareness of national and local guidance on documenting DVA.
- General practice clinicians are more confident regarding documenting child maltreatment concerns than DVA. This may be related to having received more child safeguarding than DVA training.
- General practice clinicians are uncertain about how to resolve conflicting principles of preserving confidentiality and potentially increasing safety when considering documentation of abuse in the records of different family members.

Background

In the UK, clinicians are required to record all patient contact, with policies and procedures about what and how it should be recorded and stored (General Medical Council 2014; Health and Social Care Information Centre 2014). General practices use electronic patient records to document consultations, other clinical contact and third party information to ensure all relevant information is available to support clinical decision making and to help improve continuity of care (Downs 2014). In 2014, general practices were contractually obliged to enable patients to view parts of their medical record online and online access is an increasing policy directive and trend (NHS Employers 2014). Documentation has been raised as a key issue in several serious case reviews involving child safeguarding and DVA (Wonnacott and Watts 2014). Recording information is seen as a first step in information sharing, and recording in multiple family members' records is promoted to raise vigilance about child safeguarding (General Medical Council 2012). Our review of training curricula revealed that in some localities there are mandatory policies about recording child maltreatment in cases of DVA. However, there was little explicit guidance within

these curricula on the importance of maintaining confidentiality to protect victims of DVA following disclosure. Given the importance placed on documentation, we asked all our interviewees about their usual practice and local policies.

How general practice clinicians document DVA and child safeguarding

The interviews with both GPs and practice nurses revealed diverse methods for recording both DVA and child safeguarding in the patient record. The methods ranged from using established Read codes (national list of coded clinical terms (Downs 2014)), to hidden alerts within the patient record, to formal and informal messaging systems between practice staff. Clinicians were more familiar with child safeguarding Read codes, and some discussed a practice policy of using these codes. However, one GP pointed out that there are 26 different Read codes for child safeguarding, which could cause confusion. Clinicians were less familiar with possible DVA Read codes and two GPs discussed coding DVA as depression. Hidden alerts were discussed as mechanisms to record DVA or child safeguarding so that clinicians reading the record would know there was an issue, but it was not actually named within the patient record, protecting confidentiality. Some clinicians reported avoiding documenting in the patient record, but making relevant practice staff aware of DVA and child safeguarding by sending messages either through the internal messaging system, which provided an audit tool, or via external NHS email.

Inconsistency in documentation

As there were so many mechanisms for recording both DVA and child safeguarding it is perhaps unsurprising that there was little consistency in documentation. This inconsistency was at a national, local, and practice level. In one study site, a GP informed us that they used Read codes that were updated regularly by Children's Services. At another practice in the same area, they reported developing their own practice policy with no input from Children's Services. A strength of our sample is that we interviewed GPs and nurses within the same practice. There were a few occasions when clinicians gave conflicting accounts of the recording policy within one practice. In addition, in other sites, clinicians admitted that they did not know what the recording policy was. One GP described knowing that there was a recording policy, but acknowledged that they had never read this. Other clinicians were uncertain as to whether the practice had a policy.



To be honest we haven't had this discussion, I'm not actually sure we have a practice policy. (GP01)

Differences in documenting also revealed differences in perceived roles regarding managing DVA and child safeguarding. Generally, doctors were more aware of how to document DVA. The nurses were less confident, and one nurse said that recording DVA should be the doctor's role.

Whose record to document in?


The inconsistency in documentation related to an uncertainty not only about how to document but within which record. Clinicians discussed different approaches depending on whether they were considering documentation in the notes of the abused parent, the child, or the perpetrator. They gave a number of reasons for documenting in the abused parent's notes. These included making a legal record of injuries, providing a legal record of what was said in the consultation to providing continuity of care for the patient and to alert other members of the practice team. However, some clinicians discussed reasons for not recording in the abused parent's notes. These included not knowing what to record, but also concerns about the safety of the abused parent and family. Clinicians were concerned that the perpetrator may discover the disclosure in the patient record. Some clinicians (mainly after prompting) also mentioned concerns about online patient records which might be access by a controlling partner. Overall, clinicians appeared to want to document something in the abused parent's record, but there was uncertainty about how to record and maintain safety.

Clinicians had a slightly different dilemma when discussing recording parental DVA in a child's notes. The majority of clinicians were aware that it was good practice to record DVA in children's notes in the interests of safeguarding. Some discussed the importance of this to encourage information sharing and to remind all clinicians within the practice to be alert to child safeguarding issues. Some clinicians discussed this as something they should be doing because it was the policy. Other clinicians expressed concerns about the safety implications of recording in the child's notes. They were concerned that the perpetrator had access to this record and could use it to find out what their partner had disclosed. This could potentially put the abused

parent and child at greater risk. A small minority of clinicians expressed concern that they should not be recording in the child's notes because the DVA was an allegation and not proven. Again, some clinicians would record in the perpetrator's notes because it was part of the local child safeguarding policy. The reason given was to alert clinicians about the context of DVA in the family. However, one GP described using this as an opportunity to challenge the perpetrator about their behaviour. A larger proportion of clinicians were concerned about documenting in the perpetrator's record. As in the case of children's notes, there were two sources of concern: a small group were concerned that it was just an allegation and not a fact; a larger group were concerned that by documenting disclosure from the partner in the perpetrator's notes, this could increase the risk of harm to the abused parent and children, as the perpetrator has a right to see his own record.

Tangled between confidentiality and safety

These findings show that there is considerable uncertainty surrounding the best mechanisms for ensuring safety when documenting DVA in families. The decision to document exemplifies the tension clinicians face between sharing information to promote the safety of the child, and limiting information to maintain the confidentiality and safety of the abused parent. There were a small number of good examples where clinicians balanced the issues by discussing their strategy with the abused parent, asking for her permission to break confidentiality and then explaining how and where it would be documented.

 *In your vignette there, I would talk to Sarah about documenting that in her, in her notes, so I would document it as she's, as she's told me really in her, in her notes. If she didn't want me to we also have a, a system where we can write a note that wouldn't go into her notes but that would be available to, to me next time. (GP16)*

However, the majority were not confident about managing this dilemma. All informants had some child safeguarding training and were aware of the child safeguarding policies regarding the importance of information sharing. However, few had DVA training and were unsure of how to manage and protect the abused parent. There was also an issue of attitudes towards DVA. Some informants were uncertain

about documenting in the patient's record as they did not always believe the disclosure, did not think there was a serious risk, just coded it as depression, or felt it wasn't their responsibility. In the absence of DVA training and local guidance on documenting, clinicians are basing their actions on their child safeguarding training. This prioritises the child's safety, without sufficient consideration of the abused parent. This demonstrates the dangers highlighted by Hester's (2011) three planets model which illustrate the conceptual and practice gaps between the spheres of DVA and child protection. It also highlights the importance of integrated DVA and child safeguarding training and policies for documenting (Hester 2011).



7. The development of RESPONDS training intervention

Background

The development of the training package (see Trainers Pack in Appendix) for general practice professionals was led by SafeLives (formerly Co-ordinated Action Against Domestic Abuse, CAADA). SafeLives were asked to partner with the RESPONDS project for this purpose. SafeLives are a national charity supporting a multi-agency and risk-led response to DVA. SafeLives provides practical help to support professionals and organisations working with DVA victims, including training development.

The RESPONDS team brought together extensive experience from health, research, training and practice, in DVA and Child Safeguarding. This collaborative approach formed the foundation from which the training developed and reflected the benefits of working together toward the prevention and mitigation of DVA and child maltreatment (HM Government 2013a; HM Government 2014; HM Government 2015). The team met and communicated regularly to discuss design and content of the training package, which on completion was to be piloted and evaluated in 11 practices across two geographical areas [see details on practices and training participants under section 8]. The intervention as a whole therefore included a 'Train the Trainer' event and identification of professionals to deliver the training. The RESPONDS training collaboration provided an excellent opportunity to integrate research and practice and develop training based on clear evidence of effectiveness, particularly in terms of practitioner's confidence and ability to respond appropriately at the interface of these two complex issues. The aim of the training was to bridge the knowledge and practice gap between DVA and child safeguarding. The approach we took to achieve this aim is outlined below.

Integration

Through consensus the team developed an educational model which reflected common ground between a range of perspectives (Street *et al.* 2013). Findings from the systematic review (see section 6.1), review of existing curricula (see section 6.2), the consensus process (see section 6.3) and interviews with general practice professionals (see below and section 6.4), as well as the experience of the team provided the evidence from which the training was developed. The integrated approach was preferred, highlighted in the systematic review to include “teaching the importance of DVA identification for children’s health as well as addressing barriers to screening and intervention” in general practice (see section 6.1). It was agreed that the training should highlight the interconnected nature of DVA and child safeguarding and encourage general practice clinicians and other health professionals to have ‘low thresholds’ for asking questions about DVA and potential impact on children and young people (NICE 2014). Integration featured in design as well as content, as it was decided that trainers should be recruited from health and children’s social care services to jointly deliver the training in each identified practice. Our strategy was to model integrated working between services through the structure of training delivery. Modeling is a useful and effective technique when training general practitioners (Street *et al.* 2013) or, indeed, any professionals.

The content and format of the training drew heavily from information gathered in the 69 semi-structured interviews with general practice professionals (see below and also the detailed analysis in section 6.4), particularly as the systematic review had found reporting on content of effective interventions to be limited and inconsistent (see section 6.1).

In terms of the 69 general practice professionals’ training preferences and what training and resources they would find useful, opinions varied, but the majority of clinicians were in agreement about the preferred format, location and training content. They clearly indicated that they would prefer face-to-face training (as opposed to e-learning) delivered in their practice. They were also in agreement about the length of training and all favoured short sessions (two or less than two hours long). As one GP remarked ‘nearly every time we get training we think, you

know, your heart sinks and you think how am I going to be able to fit that into today's work?' (GP03). 'Make it shorter, make it simpler' (GP31); or 'keeping it compressed' (GP17) stressed other clinicians.

Preferences for training audiences varied: some GPs indicated strong preference for practice-based training for GPs only (6 respondents), others suggested training for the whole practice team including administrators (9 respondents). Some interviewees opted for local clinician-only training, including clinicians from other practices (5 respondents), while other informants would have preferred the 'everyone together' approach, including other local professionals (8 respondents). It is interesting to note that despite the popularity of the multi-agency training approach none of our respondents attended (or remembered having attended) inter-professional child safeguarding training organised by Local Safeguarding Children Boards.

Interviewed clinicians generally welcomed the idea of having input from a local social worker in the delivery of training:

“ *I think it would be useful, maybe if there was somebody who could come in to the practice and just speak about specific practice issues [...] somebody from social care or someone who was experienced and had knowledge [...] explain so that kind of services are available and also have kind of a bit of hard to ask questions and things that we should look for. [...] I think that's a massive thing is asking the question [...] just to make people a bit more confident in what to ask, what to look for and then what they might do with that. (GP24)*

As for training content and format, interviewed clinicians clearly articulated a need for interactive training that allows time for discussing complex real life cases or scenarios. They would have also welcomed training opportunities that would address the appropriate management of difficult situations/conversations with patients, including children, about DVA.

“ One of the things that you worry about is this feeling that [...] you're not really, not an expert in these matters but that you don't want to make a situation worse, either for the woman or their partner or the children but equally you don't want to stand by when something dreadful happened. We don't get any training as things stand specifically aimed at domestic violence. [...] There needs to be good information, there needs to be good training and communication skills because if you haven't got good communication skills, you haven't got a hope of, of really managing this type of thing effectively, you need to be able to communicate empathically and effectively with the patient. (GP42)

“ My main concern is how to approach things with children, and that to me the most difficult area. (GP23)

Our informants expressed a need for additional signposting resources and handouts such as 'a summary of the pathways and who is in charge of what' (GP15), flow charts and improved websites containing national and local links to DVA information and resources.

“ Because it's a fairly uncomfortable area, we also, almost need some protocols and some more directives on what to do. (GP41)

“ You need printed information, a summary sheet of who to contact about what and what the process is... (GP15)

Challenges to addressing DVA and child safeguarding had been raised throughout the interviews and included DVA not being a high priority in terms of enquiry, not having adequate time to deal with such issues, worries regarding 'difficult conversations' and an assumption that children's services would be dealing with these issues already. General practice clinicians struggled with cases 'in the middle' where the level of risk posed to children was not clear and expressed a need for

information about support services and more guidance on recording (see more on this in sections 6.4.1; 6.4.2; 6.4.3; 6.4.4).

Considering all the information and listening directly to general practice clinicians themselves, the content of the training was designed to address the following:

1. Linking Child Safeguarding and DVA in practice
2. Holding difficult conversations (in which safety and multi-agency working are considered)
3. Confidentiality
4. Speaking directly with children and young people
5. Child Protection Thresholds
6. Supporting victims of DVA, and negotiating referrals
7. Role of primary care after disclosure of DVA
8. Record Keeping

Training curriculum design

We decided that the training curricula should set out to address challenges in these key areas and provide guidance to general practice clinicians that would increase their knowledge and confidence when dealing with issues of DVA and child safeguarding. The RESPONDS team agreed that the most effective way to do this was to design training which was motivational and enabling as opposed to one where general practice professionals are informed from the outset about significant failings of their profession (Marsden *et al.* 2013; Haringey LSCB 2008). Working with strengths and resources, as opposed to limitations, can be effective in terms of overcoming barriers to change and is an approach often adopted in general practice to improve mental health and emotional well-being outcomes of patients (Stensrud *et al.* 2013).

Findings from the systematic review highlighted length of time for delivery of interventions in this area varied greatly (see section 6.1) and prompted much discussion amongst RESPONDS team members. Practice experiences amongst the group reflected the variability identified. It was decided that the training should be a 2-hour session and this decision was largely based on input from interviews as well

as on team members' practice knowledge and experiences of general practice DVA training sessions in the context of the IRIS programme (Feder *et al.* 2011).

The training methods we used were developed through a process of consensus amongst RESPONDS team members (Street *et al.* 2013). Again, under-reporting of training methods was a feature of effective interventions identified by the systematic review. The main method chosen, using a filmed clinical scenario was, however, utilised in three of the interventions. It was decided that the RESPONDS team would film a scenario themselves as part of creating an enabling approach that could demonstrate *how* general practice clinicians can approach DVA and child safeguarding issues in practice. Demonstrations of specific skills are a method often used in training for general practice clinicians, particularly where the emphasis is on improving communication with patients to achieve better outcomes (Stensrud *et al.* 2013). The team developed a scenario in which a GP enquires about DVA, speaks individually to a child to elicit further information, and works in partnership with Children's Services. The scenario depicts the GP holding difficult conversations in a confident but sensitive manner. Throughout the film, the scenario was interspersed with 'talking head' inputs from general practice clinicians. These excerpts provided guidance on overcoming the challenges faced in general practice when dealing with DVA and child safeguarding. Other training methods used were discussion and didactic input, particularly for providing the evidence base of the interrelated nature of DVA and child maltreatment (Munro 2011) and information on local services.

All individuals who took part in the filming were members or associates of the RESPONDS team and therefore familiar with this area of work, with the exception of the child actor. Ethical considerations are important throughout all aspects of research (Long and Johnson 2007) and we were careful in our handling of the actors as the subject matter was potentially upsetting and they may not have considered it before or related to their personal experience in any way.

Training intervention

Trainers were recruited from the two geographical areas in which the pilot practices were situated by identifying those who delivered child safeguarding training in health and children's social care and asking for their engagement in the pilot project. The challenge was that whilst we had good contacts in one pilot area, we had limited

knowledge of professionals in the second one, resulting in an extended period of identifying trainers who were able to deliver the sessions in their local practices. This was made more difficult because we were looking for one trainer from health and another from Children's Social Services.

As previously stated, the intervention included a 'Train the Trainer' session. The training content was developed into a pack for trainers which was distributed on a 'Train the Trainer' day, delivered and hosted by SafeLives. The aim of this day was to ensure that the trainers that were recruited understood the background to the training, the key messages that we had written into the programme and felt confident to deliver them. The pack contained guidance for session delivery, an accompanying PowerPoint presentation and a copy of the film. The training day included a run-through of the training as well as opportunity to feedback and discuss as a group which further refined the training materials before being finalised.

Conclusion

The evidenced based training curriculum developed by the RESPONDS team was designed to encourage general practice clinicians to overcome barriers and engage more extensively with all patients experiencing DVA, as well as linking the need to safeguard children living with and managing the consequences. It was hypothesized that the impact of the training content, accompanied by information delivered by the trainers in the intervention as a whole, would have a positive effect on the knowledge, confidence, attitudes and motivation of general practice professionals exposed to the training.



8. Training pilot and evaluation

SUMMARY AND KEY MESSAGES

- Delivery of the intervention to 11 general practices was well received by participants
- The training increased participants' self-reported knowledge and self-efficacy/self-esteem about DVA and child safeguarding.
- However, there was no evidence of an improvement in training participants' self-reported beliefs and attitudes about DVA and child safeguarding.

- After the RESPONDS training GPs were more confident in knowing how to proceed in a consultation and the appropriate next steps.
- GPs had a greater awareness of current relevant service provision and referral routes.
- GPs reported increased willingness to engage directly with children and to discuss this appropriately with their non-abusive parent and this led to some changes in case management.
- Some participants from practices without previous DVA training (IRIS) learned about recording and were developing new systems.

BACKGROUND

The form of training delivery was guided by general practice clinicians' comments on past experiences of effective training and recommendations for training content and delivery style in this area of practice. This was combined with effective training strategies identified from the systematic review of training interventions for professionals responding to DVA concerns (see section 6.1).

Based on this, the training had the following objectives:

- a. provision of engaging and trustworthy training materials and delivery styles
- b. provision of opportunities for reflection
- c. group engagement by all training participants
- d. provision of local and multi-agency information
- e. promotion of a follow-up activity to embed learning

The training content was developed to address the challenges that general practice clinicians had identified in interviews and to share some of the learning from examples of good practice. It also drew on existing academic knowledge of barriers to effective interventions with children and DVA and examples of previous course curricula in this area. The training was evaluated against these **outcomes**:

1. increased feelings of self-efficacy, and self confidence
2. improved attitudes towards DVA and child safeguarding
3. increased knowledge (of internal policy, procedure and role expectations plus understanding of other agencies' roles and procedures)
4. more reflection on own role/ practice

METHODS

Our mixed method approach was designed to assess the extent to which the training was delivered in accordance with the intervention planned objectives and the initial anticipated outcomes indicated in the research team's theory of change (see the RESPONDS theory of change logic model in Appendix).

Quantitative evaluation of the pilot training used a before-and-after design with three time points for data collection. General practice professionals who attended the training completed an on-line questionnaire survey (see Training Evaluation Survey in Appendix) before the training (T0), at the end of the training (T1), and 3 months post-training (T2). Administrators in participating practices e-mailed all primary care staff planning to participate in the training an invitation to the study and a link to the web-based survey one week before the training; 5 days later they sent a reminder. Administrators re-sent the invitation and the survey web link followed by three reminders immediately after the training and 3 months post-training.

Measurement

We administered a questionnaire requesting information about gender, age, job position, job experience, safeguarding role and previous IRIS training. Gender was a binary measure (Female/Male). Age was classified in four intervals (<26-34/ 35-44/ 45-54/ 55-64). Job title was assessed with a categorical variable (GP/ Practice nurse/ Practice manager/ Other). Job experience was measured in years since qualification with an ordinal variable (0-9/ 10-20/ 20+). Participants were asked whether they had a named/designated safeguarding role (Yes/ No) and whether they were IRIS-trained (Yes/ No).

A modified version of the Domestic Violence and Safeguarding Children (DVSC) questionnaire (Szilassy *et al.* 2013) was used to assess training participants' confidence and self-efficacy, beliefs and attitudes, and knowledge about DVA and child safeguarding (see Appendix). The original questionnaire was modified by a group of six DVA experts. The modified scale consisted of 27 items with responses endorsed on a 1-5 scale (1 = 'Strongly disagree', 5 = 'Strongly agree'), possible score 1-135. There were three subscales within the scale: Confidence/Self-efficacy (14 items), Knowledge (16 items) and Beliefs/Attitudes (8 items). We used the scales and sub-scales as continuous measures of the scale and sub-scales for the analyses.

As this was a modified questionnaire, we tested its reliability with 29 social work students, administering it twice with a 2-weeks gap. Total scores and sub-scores at both time points were highly correlated: (i) Total score ($r(27) = 0.79$; $p = 0.000$); (ii) Confidence/Self-efficacy sub-score ($r(27) = 0.74$; $p = 0.000$); (iii) Knowledge sub-score ($r(27) = 0.76$; $p = 0.000$); (iv) Beliefs/Attitudes sub-score ($r(27) = 0.69$; $p = 0.000$). The Cronbach alpha for the questionnaire was 0.86 at the first time point and 0.91 at the second time point.

Statistical analysis Questionnaire responses were downloaded from Survey Monkey and imported into Stata. All further analyses were run in Stata v13. To assess test-retest reliability of the modified DVSC a Pearson's product-moment correlation was used to measure the relationship between the two sets of repeated

questions. Internal consistency of the modified questionnaire was assessed with a Cronbach's alpha. Descriptive statistics were used to describe the sample at the three time points. The Pearson's Chi square test was used to compare socio-demographic profiles of the sample at three time points. Outcome variables were DVSC total score and three sub-scores at baseline and follow-ups. Linear regression analysis was used to explore predictors of pre-training and post-training scores. Exploratory variables were demographic factors, profession, years in practice, safeguarding role and IRIS training. Linear regression analysis was used to explore predictors of pre-training scores at T0. Variables that were associated at >1% level in univariable analysis were included in the multivariable model to calculate regression coefficients and 95% confidence intervals (CI). A one way repeated measures ANOVA was used to determine if there were differences in DVSC score and sub-scores due to the training. We first ran ANOVA on a sample of all respondents (main analysis) and then repeated it on a sub-sample of those who provided data at all three time points (sensitivity analysis). Results of the two analyses were compared.

Qualitative evaluation included non-participant observation of the Train-the-Trainers event and each training session with general practice clinicians (see RESPONDS training observation framework in Appendix). This was followed by interviews with all six trainers (T1) and nine training participants (T2). The trainer interview schedules (see trainer evaluation interview schedule in Appendix) were informed by themes that arose from the observations. Interviews with the training participants (see training participant evaluation interview schedule in Appendix) were informed by, and sought to enrich, the findings of the survey. Qualitative data were analysed against the output and outcome measures.

SAMPLE

Training was delivered to 11 practices, (5 Midlands; 6 south) (see sample invitation letter for pilot practice in south in Appendix). All training sessions were observed. All six (female) trainers were interviewed. One pair of trainers worked with the Midlands, the other two pairs worked in the south. Six practices had previous training on DVA within the IRIS programme, all in the south.

Training was delivered to 88 participants (31 male, 57 female; 60 GPs, 6 GP trainees, 17 nurses, 1 practice manager, 4 other professionals; 69 white, 17 South Asian, 2 African/Caribbean, 2 other; all aged 25-65 years; 55 in the south and 33 in the Midlands).

Of these 88 participants, in total 82 general practice professionals enrolled in the survey (see Flow of participants through questionnaire survey in Appendix), 55 were female and 27 were male. Ages of the participants ranged between 25 and 64 years. All age groups were equally represented. Participants came from different professions. General practitioners were disproportionately over-represented (77%), followed by practice nurses (17%), other professionals (4%) and practice managers (2%). 'Other professionals' included one health care assistant, one phlebotomist, and one pharmacist. Nearly equal proportions of the participants had been practicing for up to 20 years (54%) and of more than 20 years (46%). Most training participants (79%) did not have a designated safeguarding role and were not IRIS-trained (61%). (See Socio-demographic characteristics of training survey evaluation participants table in Appendix.)

Despite all our efforts recruiting training participants (one GP and one nurse per practice) for the follow-up telephone interview, we only managed to interview nine training participants all together (7 female, 2 male; 2 South Asian, 7 white; all GPs; 1 aged 25-34; 2 aged 35-44; 2 aged 45-54; 2 aged 55-65; 2 safeguarding leads; 7 in the south and 2 in the Midlands). Our recruitment efforts included providing information about the evaluation study and collecting initial consent and contact details for a follow-up interview at the training events. We also included an optional space for comments at the end of the survey where training participants had the opportunity to signal their initial willingness to be contacted by the research team for the follow-up interview. 25 training participants (21 in the south and 4 in the Midlands) signaled their willingness to be contacted for the telephone interview. We tried to establish contacts with all these 25 training participants via email or telephone. Four training participants have moved practice or went on maternity/long term sick leave and were no longer available for the interview. Seven initially interested training participants did not reply to our emails or return our phone calls. Five training participants would have been keen to talk to us and share their views,


but their current workload did not allow them to devote time for the follow-up interview.

FINDINGS

We have ordered findings by our pre-specified objectives.

A. Engaging and trustworthy training materials and delivery styles

Training participants reported that appropriate information was well and thoroughly delivered. Trainers were described as *'non-threatening'* (TGP02) and the materials were compatible with participants' existing knowledge base. Training participants were observed to engage well with the video; it was *'realistic...very good'* (TGP03) and *'very powerful'* (TGP07) because it involved:

 *...seeing the GP actually talk to the child and all the different stages, ... and then discussing it, ...that was really useful, very different from just talking about it". (TGP07)*

Two respondents did not 'remember the video too well' (TGP02) or the child (TGP01) but saw the video as making them 'more alert' (TGP01) or provoking 'thoughts and ideas' (TGP02). One respondent who thought the video was unnatural and unrealistic saw the video as a prompt for team discussion on approaches that 'we all felt were more appropriate' (TGP09). In observations and trainer interviews, the suggested broad filter questions to patients experiencing DVA, were particularly valued with some saying 'I will definitely use that' (Obs04) or 'that's a good thing to ask' (Tr01).

However occasional resistance to the message was observed, particularly in three practices. One general practitioner responded to the video by saying 'well if she will nag' (Obs1) and some were described as 'old school' (Tr02).

Suggested improvements included creating video clips that were 'bite sized ... concise and punchy' (TGP07) and 'a more multi-ethnic approach' (TGP02) and a class diverse approach in 'separate model scenarios' (TGP03), that is something 'a

bit more complicated, something to get your teeth into' (TGP08). Some participants felt that the training should address drug and alcohol use, parental non-consent and how to deal with 'an incredibly dysfunctional under-resourced market' of referral services.' (TGP05).

B. Opportunities for reflection

All training participants concurred that there were enough or 'Definitely enough' opportunities for reflection, and that this time and space enabled them to see 'how my colleagues deal with it... they [could be] sort of more, more open to the problem'" (GPT01). However we observed, and all training participants interviewed agreed, that there were substantial variation in the extent to which training delivery enabled reflection on participants' own real life case scenarios. Two respondents suggested this case work element could be a follow up "RESPONDS personal' ...or 'RESPONDS in the practice' and just what is our practice experience' (TGP04) or 'getting people to sort of sit together and just chat to their neighbours a bit' (TGP09).

C. Group engagement by all training participants

The participants we interviewed stated that most of their colleagues engaged; it was 'authoritative but low key ... very much, you know, sort of join, join in and everybody felt very safe.' (TGP04) and 'one of the best things' (TGP09). But in some practices we observed a marked lack of engagement in group discussions, as on one occasion trainers felt 'we were just talking into an empty space' (Trainer 3) and repeatedly 'there seemed to be like one doctor who would do a lot of the talking and it was usually the most senior person' (Tr01). However talking a lot could mean 'they genuinely had a lot of questions and a lot to say' (Tr03) whereas 'not talking' did not mean 'not participating' (Tr02). One trainer suggested facilitating greater parity of engagement or participation through 'small groups, all at a similar [knowledge] level' (Tr02).

C. Provision of local and multi-agency information

Each observed training session involved delivery from both health and social service perspectives. Trainers reported the importance of multi-agency frontline worker delivery and this was echoed by participants:



‘I think it’s absolutely fantastic having professionals who are dealing with this day and day out ...you [frontline workers] become the specialists ...then we can ask, you know, what happens through the different pathways.’
(TGP06)

This ‘Social Services input was that extra thing’ (TGP08) that took training delivery beyond that delivered through IRIS. The trainer being someone who was ‘able to defend that [social services] message rather than somebody who is just [a trainer]’ (TGP05).

D. Follow-up activity to embed learning

Only one IRIS practice completed the whole practice follow up activity which we had included in the pilot training (development and communication back to the RESPONDS team of a revised practice policy on DVA recording in the context of children’s exposure) based on evidence from the systematic review that this increased the effectiveness of the training. In a second non-IRIS practice one informant described this activity as on-going.

Survey outcomes

In total, 82/88 training participants completed baseline questionnaire, 73 provided data post-training, and 42 completed follow-up survey at 3 months; however, only 38/88 (43%) trainees completed the survey at all three time points (see figure 1 in Appendix).

Loss to follow up. Those trainees who completed the study were more likely to be IRIS trained, compared to those who dropped out (see table 3 in Appendix).

Pre-training scores. Pre-training scores suggested poor baseline knowledge, confidence and attitudes about child safeguarding and DVA. In the best fitted regression model, total DVAC score was predicted by job position ($F(4, 72) = 8.10$, $P < 0.001$, $R^2 = 0.31$). Thus, compared to GPs, nurses’ score was 12.6 points lower (95% CI -19.1 6.1; $P < 0.001$), practice managers/administrators’ total score was 26.5 points lower (95% CI -42.1 -10.9; $P < 0.001$) and other professions’ total score

was 12.6 points lower (95% CI -25.4 0.1; $p < 0.001$). Those primary care professionals who were IRIS trained had pre-training scores 3.3 points higher than their non-IRIS trained colleagues, however, the difference was not statistically significant (95% CI -1.7 8.5; $P = 0.20$).

Pre-/post-test scores. Main analysis of all survey responses showed a statistically significant increase in mean DVSC score after training (see table 4 in Appendix). There was an increase in the post-training Knowledge sub-score and Confidence/Self-efficacy sub-score. However, difference in the Attitudes/Beliefs sub-scores was not statistically significant. Sensitivity analysis on the sub-sample of participants who completed measures at all three time points produced similar results.


Although we used a standardized outcome measure, these quantitative findings should be interpreted with caution because (i) the survey was limited by the small sample of participants completing post-training questionnaires; (ii) nearly all study completers were IRIS-trained, while nearly all non-IRIS-trained participants dropped out of the study; (iii) we relied on a self-reported measure, which could be hindered by social desirability and memory biases. Thus, these findings could not be generalised to all primary care clinicians who took part in the training.

Taken separately, the sub-scores (self-efficacy/self-confidence, knowledge, attitudes) indicate different rates of change against each outcome measures, as explored in the detailed sections below.

1. Increased feelings of self-efficacy and confidence in self and skills

The survey results indicate that confidence and self-efficacy were raised as the post-training Confidence/Self-Efficacy sub-score increased.

Six participants explained their 'general improved confidence' (TGP05) was 'sort of built up' (TN2) through being given information about role expectations, 'owning the subject' (TGP04) and developing understanding of how to proceed in consultations:

 *[The training] made me feel particularly confident about discussing this with children, you know, being able to ask them how it was affecting them*

...being able to raise that with the mum It has changed my management a bit of a couple of patients I've seen since.” (TGP07)

Confidence remained ‘still not very high’ where ‘the child is ... indirectly affected [by DVA].’(TGP01), where the survey respondent had not had time to apply the learning in practice (Survey GPa) or because they had increased awareness of ‘*the reality of the limited service on offer by social services to support children if there is not consent.*’ (Survey GPc).

2. Increased Knowledge

The survey results indicate that the post-training knowledge sub-score increased and knowledge was raised.

All eight GPs interviewed described some new or ‘refreshed’ (TGP06) knowledge. This included ‘quite powerful learning about the impacts on children of domestic violence’ (TGP04), and that ‘people are actually very happy to just have the questioned asked’ (TGP03). Knowing ‘the next steps’ was seen to enable ‘better conversation with the, with the mother” (TGP06) and had led this GP to decide:



The next time that I do [a referral], that's what I'm going to do...because if we're going to be all proactive, we want to make sure that we're involved in the loop, stuff that's happening.” (TGP03)

Learning about appropriate recording was, for IRIS practices ‘[not] anything we hadn't already heard’ (TGP05). However it was striking that in three non-IRIS practices the content on coding appeared to be new, especially for junior colleagues (Obs 2, 4 & 5). This led in one practice to ‘a very positive impact’ as they were developing a new recording system (TGP02).

Current information about ‘where to send them for help’ (TGP01) (e.g. a website for young people, MARAC, the Social Services Early Help Scheme) was valued in both IRIS and non-IRIS practices. Those who knew all the agencies mentioned nonetheless felt the training enabled them to ‘know who to speak to’ (TGP07) or it provided ‘a lot more of a framework in my thinking’ (TGP03) on how to access support. Understanding social services was particularly important for one GP who

had previous experience of no action following a referral to social services, and who said:

“ I think if I hadn't had the training I might have listened to him [saying the children are fine, attending school, and not referred].” (TGP05)

This increased knowledge of local services and referral mechanisms enabled respondents to have ‘an understanding of where [the referral] goes’ (TGP04). And one respondent described they would

“ more readily [make] a referral to Social Services for, you know, a sort of a supportive basis, than I would have done previously...that's more appealing I think to families, [...] [training was useful] in terms of perhaps lowering the threshold when I might talk to them.” (TGP09)

One survey respondent, however, “actually felt more muddled after this training’ because ‘there does seem to be an impressive array of disjointed services available.’ (GPb)

Impact of this increased knowledge of referral mechanisms appeared to be emerging, as Trainer 2 said ‘one of the practices had [subsequent to the training] made a referral, so something had obviously gone in’.

3. Improved attitudes towards DVA, child safeguarding and connections between these

The survey responses indicated no significant change in attitudes as the Beliefs/Attitudes sub-score remained unchanged post-training.

Participants in three sessions were observed (Obs 2 & 5) to make the link from DVA to child safeguarding when they had not done so before or ended up ‘agreeing with the whole idea that you need to ...treat it as a safeguarding issue’ (Tr05). However Trainer 4 remained concerned that training participants in other sessions seemed ‘were still speaking of them as two separate issues’. Five interview respondents

nonetheless identified changes in their attitudes about the effect exposure to DVA may have and the need to screen child, contrasting this to their previous approach.

Although some training participants 'looked quite shocked that the GP in the video suggested talking to the child,' encouragement to talk to a child alone came through discussion by colleagues (Trainer 3). Putting this into practice after the training in one consultation the GP 'was really surprised at how able he [the boy] was to talk about his feelings' leading to a significant impact on this GP's management of cases:

“ *Before that I might have felt very uncomfortable, I might have glossed over it a bit, ...but I was able to say to Mum, “Can you tell me about the shouting he's talking about?” Which was quite a tense moment for all of us, [laughs] you know, and she was quite honest about it.” (TGP07)*

For those who remained hesitant about talking to children, this was because they 'possibly would not look for the child' if the mother had not brought the child in (TGP01); they felt 'unclear [what] my role is in terms of actually bringing the child in for a separate consultation' (TGP05); or, were 'generally much happier to talk to children' but still reluctant 'to muddy the waters' by talking to a child directly in a specific case (TGP03).

The lack of change in attitude may relate to focus of the training and experience of the participants. In three training sessions, observations recorded trainers did not make the link from DVA to children in the first hour or more. The trainers identified having 'not enough of a focus on this' (Tr04) or the need to feel 'a bit more confident in challenging and stuff' which would require delivering 'the training it more than four times to, you know, to, to get yourself to that point' (Tr02). One GP attributed the lack of change in his attitudes to his existing positive attitude and experience in a paediatric post and as safeguarding lead.

4. Engagement in more reflection on own role and practice

Engagement in reflective practice was not addressed by a sub-scale in the survey and there is no evidence of significant change on the one statement most directly indicative of reflective practice 'I understand how my own experiences may influence my capacity and willingness to engage with issues of domestic violence and abuse'.

In nine practices the follow-up reflective activity was not completed and changes in reflective practice were not mentioned by the training participants we interviewed. When asked directly, one participant said the practice was already 'quite keen on training and then encouraging reflective practice' (TGP02) and a second said training had provided a rare opportunity to reflect.

As with previous research (Szilassy *et al.* 2013) attitudes appear slow to change and a one-off training activity, without reinforcement or on-going reflection, may not be enough to generate this shift.

CONCLUSION

After the RESPONDS training primary care clinicians were more confident in knowing how to proceed in a consultation when they suspected exposure of children to DVA or this was disclosed and the appropriate next steps. They had a greater awareness of current relevant service provision and referral routes. Participants also reported increased willingness to engage directly with children and to discuss this appropriately with their non-abusive parent. This led to some changes in case management.

Although our results indicate positive impact of the RESPONDS training, further research is required to establish that the improvements in outcomes are a direct result of primary care practitioners participating in the training.



9. Policy and practice implications

SUMMARY AND KEY MESSAGES

The recommendations below are relevant for bodies that have specific responsibilities for education and training: Health Education England (HEE); Department for Education (DfE); Local Safeguarding Children Boards (LSCBs); Royal College of General Practitioners (RCGP) or safeguarding: NHS England; Department of Health (DH); Home Office; General Medical Council (GMC); Ministry of Justice (MoJ); LSCBs; CQC (Care Quality Commission) as well as commissioning, co-commissioning of or reviewing general practice services: NHS England; CCGs (Clinical Commissioning Groups); CQC. The research findings also provide evidence of 'what works': Public Health England (PHE).

- Although there is GMC guidance directing GPs to talk directly to children, our study found many GPs do not and would not talk directly to children about their experiences of DVA. Training and guidance on safeguarding should highlight the GMC guidance and its relevance for the children of patients experiencing DVA. (Recommendation relevant for DfE, RCGP, GMC, HEE, LSCBs, CQC)
- Policies on safeguarding children should also address the needs of the parents experiencing DVA particularly their safety. This will enable practitioners to adopt coherent and consistent approaches that increase rather than compromise safety for all family members. (Recommendation relevant for DfE, Home Office, NHS England, CCGs, PHE, MoJ, CQC)
- Policy and guidance on multi-agency partnerships such as 'Working Together to Safeguard Children' should have a more robust emphasis on the importance of and consistent responses that link to DVA and child safeguarding services. (Recommendation relevant for DfE, DH, Home Office, PHE, NHS England, CQC)
- Both DVA and child safeguarding, and the different issues they entail regarding confidentiality and safety, should be included in policies on documenting and information-sharing by clinicians. NICE guidelines provide a useful starting point for inclusion of both DVA and child safeguarding in such policies. (Recommendation relevant for DH, GMC, PHE, NHS England, CCGs)

- Policy and guidance on training for general practice professionals regarding DVA and safeguarding should emphasise DVA and safety issues for both children and adults, the need for training on the interface between DVA and child safeguarding, the complexity in ensuring safety of children and their non-abusive parent where there is DVA, and appropriate management of adults and children living with DVA in the same family. (Recommendation relevant for DfE, LSCBs, HEE, CCGs, CQC)

Children and DVA

By comparison with child safeguarding which has benefited from the policy framework provided by the Children Act 2004 and subsequent legislation and policies including the Working Together guidance (HM Government 2013a; HM Government 2015) and other important guidelines (for example Sharpen 2009; Taskforce on the health aspects of domestic violence 2010), DVA lacks an integrated policy approach. While child safeguarding in the United Kingdom has developed within a statutory child protection policy framework where relevant health care professionals are required to receive training and have clearly articulated responsibilities to report maltreatment, there are no such integrated statutory mechanisms with regard to DVA. Policy and guidance has developed incrementally and the fragmented policy context is reflected in the lack of any formal requirement for interagency training and education.

DVA has increasingly been recognised in policy as a context and indicator for child maltreatment (Adoption and Children Act 2002; Children and Families Act 2014), but without commensurate policies to ensure safety for both children and adults affected by DVA. The Government's action plan for ending violence against women and girls (HM Government 2013b) emphasizes the importance of the health care sector in tackling DVA, with training for health visitors and nurses to provide support to families when they suspect violence against women or children may be a factor, commissioning of services, and inter-ministerial discussion as part of the plan. No specific mention is made in the plan of the role or involvement of general practice

professionals, although it does refer to the NICE guidelines, which explicitly include general practice services (NICE 2014).

Following the Children and Families Act 2014, the RCGP and NSPCC have developed a safeguarding children toolkit that includes guidance on children and DVA (RCGP/NSPCC 2014). It urges health practitioners whether or not they see children directly, to 'Think Child, Think Parent, Think Family, and maintain a child focused approach with an emphasis on the best possible outcomes for children and young people'. The emphasis is mostly on the child, although the toolkit also highlights the needs of abused parents:

“Domestic violence advocacy services, which will be able to support the parent experiencing abuse, also have the expertise to assess children’s needs and the need for referral. These services also undertake risk assessment for the parent and their children, a task beyond the capacity of most general practices. Supporting the parent experiencing domestic violence is crucial to protecting children exposed to that violence. Stopping the violence towards a parent is the most effective way of protecting children and reducing adjustment difficulties associated with exposure.” (p.61)

We suggest that policies on safeguarding children should explicitly address the safety and wellbeing of parents experiencing abuse. This will enable practitioners to adopt coherent and consistent approaches that increase rather than compromise safety for all family members.

A key finding from our research is that many GPs do not and would not talk directly to children about their experiences of DVA. GMC guidance on communicating with 0-18 year olds notes that clinicians should make themselves available to see children and young people on their own and should listen to them and involve them on discussion (GMC 2007). Similarly, GMC guidance on safeguarding children (GMC 2012) advises clinicians to talk directly to children, take their views seriously and to consider seeing them on their own. It is apparent that this guidance is not being systematically applied to children who experience DVA; safeguarding training should

highlight current guidance and its relevance to the children of patients experiencing DVA.

Multi-agency co-ordination

Multi-agency co-ordination is a key plank in both policies on DVA and safeguarding of children. The main guidance on safeguarding, 'Working Together to Safeguard Children' (HM Government 2015), unlike the previous 2013 edition (HM Government 2013a) does now mention DVA or links between DVA and child safeguarding with reference to early help services and the organizational responsibilities of the police. In contrast, however, with the 2010 edition of the 'Working Together' (HM Government 2010) which explicitly and extensively addressed DVA and its implications for safeguarding children, the current guidance does not address the complexities of the safeguarding process in relation to DVA. The previous edition, for example, articulates the roles and responsibilities of different health services, multi-agency work, core safeguarding processes and suggested safeguarding training content. This is absent in the current edition.

The Government's action plan for ending violence against women and girls (HM Government 2013b) refers to local multi-agency models to support safeguarding responses for children and vulnerable people such as Multi-Agency Safeguarding Hubs (MASHs), but these may not include DVA agencies. NICE (2014) guidance on DVA now urges all service providers, including general practice, to be informed about the procedures and services of all relevant local agencies for children and young people. GPs' work in the field of DVA and child protection will be safe and effective only as long as it is understood and managed within a context of interagency work.

Our study, however, found a lack of understanding by general practice professionals of the existence and work of both DVA and child safeguarding agencies, lack of consistency in linking with such agencies and lack of cohesion in approaches to multi-agency engagement. The range (or lack) of services to refer to and specific needs of different groups of patients also created difficulties.

The literature review found evidence for the success of 'whole system' interventions in improving collaboration and co-ordination between organisations involved in child protection and DVA and that such approaches usually include the co-location of services. Our interview data also suggest that where general practice and health visitors were co-located, communication seemed better. We therefore suggest trialing whole system approaches in the UK or making more use of co-location of services and involving general practice in such initiatives.

National guidance, such as 'Working Together to Safeguard Children' needs to emphasise the importance of interagency communication and collaboration that operationalises the links between DVA and child harm. This should include the NICE guidelines recommendation (Recommendation 2) that general practice and other health professionals should participate in strategic multi-agency partnerships to prevent DVA. Our research suggests that such direct participation may prove difficult for many general practice professionals due to limited time. However designated safeguarding leads in primary care should have the capacity to take on this role and should have clearly defined responsibilities for improving communication and collaboration with both children's social services and the specialist DVA sector.

Documenting and information-sharing

There is a policy expectation that clinicians record all patient contact (General Medical Council 2014; Health and Social Care Information Centre 2014), using electronic patient records (Downs 2014), and allowing patients to view parts of their medical record online (NHS Employers 2014). Our study found that gaps in knowledge and understanding regarding DVA meant that clinicians were more likely to prioritise children's safety with regard to confidentiality and information-sharing, with possible risks to the safety of the abused parent. This highlights the importance of including both DVA and child safeguarding in training and policies for documenting and information-sharing by clinicians.

The NICE guidelines recommend the adoption of clear protocols and methods for information sharing within and between agencies about people at risk of, experiencing or perpetrating domestic violence and abuse (Recommendation 7,

NICE 2014). The guidelines form a useful starting point for inclusion of both DVA and child safeguarding in policies for documenting and information-sharing by clinicians. Possible discrepancies between confidentiality and information sharing in circumstances involving adults, children and DVA are mentioned. They suggest that information should be shared only with the person's consent unless they are at serious risk, and within agreed multi-agency information-sharing protocols.

Training

Policies and guidance on DVA and children articulate the importance of training for health and other professionals. Our study found that training available to general practices on DVA and children tends to emphasise knowledge of policies and procedures for safeguarding children but does not deal with the complexity and appropriate management of adults and children living with DVA in the same family.

The NICE DVA guidelines recommend that specific training is provided for health and social care professionals in how to respond to DVA (Recommendation 15, NICE 2014), but this does not include guidance on training content to deal with complexities across DVA and child safeguarding. There is also a recommendation relating to identification and referral of children affected by DVA (Recommendation 10, NICE 2014), but this does not address the complexities of that process and responding appropriately and safely.

A priority for policy and guidance is training on DVA and child safeguarding that addresses positive practice aimed at ensuring the safety of children and their mothers where there is DVA, with content regarding appropriate management of adults and children living with DVA in the same family. The RESPONDS project has developed and piloted a training intervention with those priorities in the general practice setting.



10. Conclusions and further research

Conclusions

In RESPONDS we have integrated evidence from an overview of existing UK child safeguarding and DVA curricula, a systematic review of training interventions, extensive interviews with primary care professionals, meetings with young people and adult survivors of DVA and expert consensus to design a training intervention for general practice on the interface between DVA and child safeguarding. Delivery of that intervention to 11 general practices was well received by participants and resulted in positive changes in confidence/self-esteem and knowledge regarding DVA and plans to change practice. Some of the challenges in training about the DVA/safeguarding interface raised in the systematic review, particularly conflicting organizational cultures, uncertainty about accountability and (time) resources emerged, were also visible in the RESPONDS training. We observed resistance to the main messages of the training, differential participation of practice teams and non-completion of the follow up activity (formulation of a practice policy).

In addition to providing some evidence that the RESPONDS training has the potential to improve the response of general practice to the interface between DVA and child safeguarding, a major conclusion from our primary interview-based research is the challenge that clinicians face in engaging with this issue.

As a stand-alone intervention it could be implemented more widely, but there remains uncertainty about its effectiveness in actually changing clinician behaviour, improving outcomes for families experiencing DVA and its potential for integration with other DVA training for general practice. In further evaluation we will also focus on potential harms.

Proposed further research

Given the problems general practice professionals face in responding appropriately and safely to children exposed to DVA and the positive outcomes of the RESPONDS

intervention in our pilot study, we propose further development and testing of the intervention. The further development will take on board the evaluation of the pilot, particularly with regards to content of the teaching material, with regards to diversity. Ultimately we do not think that RESPONDS should be a stand-alone training intervention, but should be integrated into other DVA training for general practices, combining it with training about the identification of and response to women and male survivors. For women, we already have the IRIS training programme, that has now been commissioned in 20 areas of England and is also being implemented in south Wales (<http://www.irisdomesticviolence.org.uk/iris/>). For men, we have a pilot study of HERMES, a training and support intervention modelled on IRIS. We aim to combine these interventions with RESPONDS into an integrated programme and test its effectiveness in a cluster randomised controlled trial, powered to detect difference in identification and appropriate referral of men, women and children exposed to DVA (Williamson *et al.* 2014). We will seek to answer two questions:

1. Is an integrated training, support and referral programme for general practice that addresses needs of men and women experiencing DVA and their children feasible and acceptable?
2. Is the integrated programme effective and cost-effective?

The rationale for further research, integrating training and practice support with regards to *all* adult patients and children exposed to DVA, is the current absence of this training, systematic review evidence that training interventions with system support benefit DVA victims, and a strong finding from our HERMES pilot that primary care teams want integrated training and a referral pathway that includes advocacy for men as perpetrators and victims. Feedback from RESPONDS participants suggested that while they welcomed additional training on DVA and children, they would prefer to have the training streamlined into a single module involving one local advocate. That would generate easier access to DVA training and services and would also improve the outcomes of training by increasing identification, documentation and referral to *all* patients experiencing DVA, irrespective of age, gender or victim/perpetrator status.

Other research that is needed to improve the health care response to children's exposure to DVA needs to focus on interventions to improve the adverse behavioural, mental health, and educational sequelae of this exposure. Our research group has recently completed an evidence synthesis of these interventions, finding large gaps in evidence of effectiveness and cost-effectiveness (Howarth *et al.* under review).



11. Dissemination plans

2015 will offer the opportunity to undertake sustained work on issues around dissemination (both academic and non-academic), knowledge mobilisation and stakeholder engagement to maximise the impact of the RESPONDS research findings on a range of sectors and audiences. Dissemination and knowledge mobilisation will be vital, not only for the appropriate and effective use of the RESPONDS training package but also to inform diverse audiences of the key findings of our systematic review and primary research on engagement of general practices with the interface between DVA and child safeguarding.

Our completed and planned outputs are grouped in three interlinked main areas:

1. **Academic outputs**
2. **Public outputs**
3. **Website and training pack**

1. ACADEMIC OUTPUTS

Completed/submitted publications

These manuscripts have been completed and submitted for publication/peer review:

- Turner W, Broad J, Drinkwater J, Firth A, Hester M, Stanley N, Szilassy E and Feder G. Interventions to improve the response of professionals to children exposed to domestic violence and abuse: a systematic review. *Child Abuse Review*. 2015.
- Szilassy E, Drinkwater J, Hester M, Larkins C, Stanley N, Turner W and Feder G. Working Together, Working Apart: General Practice Professionals' Perspectives on Interagency Collaboration in Relation to Children Experiencing Domestic Violence. In: Humphreys C, Stanley N, editors. *Domestic Violence and*

Protecting Children: New Thinking and Approaches. London: Jessica Kingsley Publishers; 2015 pp. 214-31.

- Larkins C, Drinkwater J, Hester M, Stanley N, Szilassy E, Feder G. General practice clinicians' perspectives on involving and supporting children and adult perpetrators in families experiencing domestic violence and abuse. Oxford Family Practice. 2015
- Lewis N, Larkins C, Stanley N, Szilassy E, Turner W, Feder G. Outcomes of a pilot training on domestic violence and child safeguarding in general practice: a mixed method evaluation study. BMC Family Practice, under review.

Completed conference presentations and talks

- Presentation by Feder at '**Protecting children from harm - issues and controversies**' event on the **22 January 2013, Royal Society of Medicine, London**. *Presentation title:* Domestic violence and children
- Presentation by Larkins and Stanley at **13th ISPCAN European Regional Conference on Child Abuse and Neglect, 15-18 September 2013, Dublin**. Presentation title: Working at the interface of domestic violence and child protection: the general practice response
- Presentation by Szilassy at **South West SAPC (Society for Academic Primary Care) meeting. 6-7 March 2014, Bristol**. Title: '*If there's children at home...it's a whole different ball game...*' Working at the interface of domestic violence and child protection: The general practice response
- Talk by Stanley at the **Local Safeguarding Children Boards Conference, 1 May 2014, Coventry**. The talk addressed the service response to children experiencing domestic violence and included a section on the RESPONDS study.
- Presentation by Szilassy at **UK Domestic Violence and Health Research Forum, 29 May 2014, Nottingham**. Title: Working at the interface of domestic violence and child safeguarding in general practice. The RESPONDS Study.

- Presentation by Drinkwater at **SAPC (Society for Academic Primary Care) Conference, 9-11 July 2014, Edinburgh**. Title: Tangled between confidentiality and safety: Domestic violence and child safeguarding in general practice.
- Presentation by Szilassy at the **109th ASA (American Sociological Association) Annual Meeting, 16-19 August 2014, San Francisco, USA**. Title: Working at the Interface of Domestic Violence and Child Protection in the UK: the Family Physicians' Response.
- Presentation by Stanley at the **XXth ISPCAN International Congress on Child Abuse and Neglect, 14-17 September 2014, Nagoya, Japan**. Title: Communicating with Children, Families and Other Professionals at the Interface of Domestic Violence and Child Protection: Challenges in Primary Care.
- Poster presentation about Patient and Public Involvement by Szilassy at **School for Primary Care Research Showcase: Promoting excellence and impact, 26 September 2014, Oxford**. Poster title: RESPONDS.
- RESPONDS Pecha Kucha presentation and poster by Szilassy at the **PROVIDE Conference, 19 November 2014, Bristol. Domestic Violence Abuse and Health: What does it mean for you and your sector?**
- **9th BASPCAN (British Association for the Study of Child Abuse and Neglect) Conference, 12-15 April 2015, Edinburgh**. 'New Directions in Child Protection and Wellbeing: making a real difference to children's lives.' Workshop title: Working at the interface of domestic violence and child protection: developing skills and confidence in general practice (Stanley, Larkins, Szilassy).
- Paper presentation by Szilassy at the **Intersections between violence against children and violence against women policy expert meeting, 22-24 April, 2015, London**. Presentation title: 'How to strengthen primary care on intimate partner violence and child safeguarding.'
- Paper presentation by Szilassy at '**Celebrating 25 years of the Centre for Gender and Violence Research @ Bristol Policy Studies' Conference, 15 June 2015, Bristol**. Presentation title: Working at the interface of domestic violence and child protection in general practice

Planned publications

Further academic dissemination activities during 2015-2016 will include the completion of additional academic publications:

- Eszter Szilassy, Jodie Das, Jessica Drinkwater, Marianne Hester, Adam Firth, Cath Larkins, Jo Morrish, Nicky Stanley and Gene Feder, *RESPONDS training paper*.
- Jessica Drinkwater, Cath Larkins, Nicky Stanley, Eszter Szilassy and Gene Feder *Tangled between confidentiality and safety: Domestic violence and child safeguarding in general practice*
- Nicky Stanley, Jessica Drinkwater, Marianne Hester, Cath Larkins, Eszter Szilassy and Gene Feder *General practice clinicians' perspectives on the risks of DVA to children and their understanding of the child protection referral threshold*

Planned conferences, talks, workshops

In addition to this, academic dissemination activities will include participation at the first **European Conference on Domestic Violence** at Queens University, Belfast delivering a workshop about RESPONDS on the 7th September 2015 and participating in a Pecha Kucha Domestic Violence and Protecting Children Book launch session presenting the 'Working Together, Working Apart: General Practice Professionals' Perspectives on Interagency Collaboration in Relation to Children Experiencing Domestic Violence' book chapter on the 8th September 2015.

At the workshop we will present findings of the evaluation and will report on the extent to which the RESPONDS training has impacted on practitioners' levels of knowledge, confidence and skills in engaging with victims and children as well as their approaches to recording and collaboration with other agencies. We will also identify challenges in training delivery and implications for future training in this field. The workshop will offer participants opportunities to use and critique the training pack as well as learning about the underpinning research and evaluation of the training. They will also learn about the development and piloting of the training program and will gain insights about issues of feasibility and wider applicability. The

workshop will also offer an excellent opportunity to explore the wider dissemination, development and application of this tool with practitioners and researchers.

2. PUBLIC OUTPUTS

The year following the project completion date will be a crucial time for creating connections which would facilitate the translation of RESPONDS findings into practical application. Creating public outputs and increasing their visibility and impact will include engaging with stakeholders (named safeguarding clinicians, domestic violence agencies and commissioners). Maximising the impact of the study will also involve work on identifying the research knowledge that is relevant for various audiences (health service staff, NHS commissioners, general practitioners, third sector agencies, public health, social services, education sector and patients) and identifying and using the correct knowledge transfer medium for these various audiences.

Public outputs will include dissemination in lay journals and in non-academic professional magazines including *Safe* (Women's Aid quarterly magazine), *Pulse* and *GP*, *Nursing Times*. It also includes the development and regular updating of the RESPONDS website (see below). The main policy makers with regard to postgraduate training of GPs and practice nurses are the RCGP and RCN respectively. Janice Allister, RCGP clinical champion for children and former child safeguarding lead is part of our advisory group and will guide dissemination via the college. We will consider seeking endorsement from the RCGP for the RESPONDS training material, although this may be trumped by incorporation into an integrated training that we will want to evaluate further (see above). We will produce a report for dissemination to LSCBs and local named clinicians for safeguarding, as well as local DVA multi-agency fora. Our knowledge mobilisation strategy for RESPONDS will draw on our experience with the Building Capacity for Knowledge Mobilisation Scheme (Avon Primary Care Research Collaborative and University of Bristol School for Social and Community Medicine) with which we have learned to articulate pathways to impact and translating our research findings for different audiences.

We are also actively seeking ways in which PPI members can continue to be involved in dissemination. They will be invited to co-present at local conferences and seminars whenever these opportunities arise. PPI members wrote some of the first

publications about the project (see their personal accounts about RESPONDS in the Domestic Violence and Abuse Research PPI Newsletter 2013). We are also planning a joint article with PPI members in which they will reflect upon the research process, exploring where they felt able to influence the research and this will provide guidance on future PPI involvement. PPI members will be invited to co-author lay outputs in journals and in non-academic professional magazines such as the above mentioned Safe, Pulse and GP, Nursing Times.

3. WEBSITE AND TRAINING PACK

We have produced an evidence-based multi-component, multi-agency training intervention that draws on a range of knowledge and skills and has been developed with multi-professional input. Although the pack is ready to use by those trainers who attended the Train-the-Trainer session and participated in the pilot training delivery programme, we are also making it freely available in the public domain and ensure its wider usage. Transferring the training package into the public domain and making sure that it is used appropriately and effectively, however, required a significant amount of additional work. This included developing a website about the RESPONDS project around the package so that training professionals fully understand the usage, purpose and limitations of the training pack and they can remain faithful to the original ethos of the training.

We have made the training materials and toolkit, including a re-edited video vignette, freely available via the University of Bristol website. The website includes a registration survey portal allowing us to monitor who is using the material and requesting feedback on its application in practice (bristol.ac.uk/responds-study).

The Centre for Academic Primary Care, University of Bristol and SafeLives (formerly CAADA) will be also disseminating the website and the learning from the project via their communications departments. This will include blogging and tweeting about the report and the website and developing infographics of key data to use. They will launch the website using their E-distribution lists and also link to the RESPONDS website via their E-Newsletters. A link to the RESPONDS website will be also published in the Autumn edition of the Domestic Violence and Abuse Research PPI Newsletter 2015.



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Appendix

Patient and Public Involvement

Extract from Domestic Violence and Abuse Research PPI Newsletter, Issued by Centre for Academic Primary Care, School of Social and Community Medicine, University of Bristol

Your Newsletter Autumn 2013

News and Updates

Page 3

Researching Education to Strengthen Primary care ON Domestic violence & Safeguarding (RESPONDS)

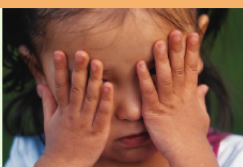
- This Department of Health funded programme of research, featured in the last Newsletter, aims to bridge the gap between domestic violence and child safeguarding.
- There are regular project progress meetings. These meetings also include our advisory group members (or Patient and Public Involvement—PPI - members) and a recent meeting in London was attended by Paula and Maria who here offer personal accounts of their experience and why they decided to volunteer as members of the PPI group for this project.

Paula's Account

"I joined the PPI Advisory Group because I wanted to make a difference and I felt fiercely passionate about the subject. It became apparent to me that as a victim/survivor myself and health professional working in the field, exposure to domestic abuse has been extremely high on many levels and the effects it has are so obviously devastating. My own personal experience has seen the impact it's had on my children and that is on-going. It saddens me that I have tried to get them help early to minimise the damage but was unsuccessful in my attempts particularly within the primary care setting and unfortunately was not believed. One of my children after a visit to see the GP said "Mummy there is no point telling anyone about what's happened as no one believes us."

This has driven me to try and make a difference because I see how my children are struggling. Attending the meeting in London was particularly hard for me as travelling to places alone and particularly in London has been a challenge left with me regarding confidence and ability, an effect from years of lowering my self-confidence. I worried about it for weeks and convinced myself I couldn't do it looking for an excuse not to attend. I felt the meeting was so important that it forced me to face my fears and I was so glad I did. Meeting all those professionals and hearing their passion made me feel a difference is being made and that I am not alone. I spend my life seeing people's eyes glaze over because they really do not understand domestic abuse/violence and now a roomful of people really do understand how important this really is and the difference that can be made.

It's an exciting project and one I am proud to be involved with".



Maria's Account

"I was very pleased to be invited to this London meeting but anxious about attending as many professionals would be present and I wasn't sure what part I could play. I had to make arrangements for my children weeks in advance as my son has special needs and dislikes any change in routine. I've never travelled on the London Underground and the thought did increase my anxiety levels, but I believe in RESPONDS and how important it is to future children living in domestic abuse environments. Eszter really looked after me so I needn't have been so anxious at all.

The meeting was just so inspiring and the amount of research that had been clearly undertaken, the group discussions and different opinions were extremely interesting. The different points of views from different sectors and how they work or struggle to cope with this issue depends on many things. I did feel that children with special needs weren't well represented and it should be remembered that children from Domestic Violence environments will sometimes present with delayed learning development.

By the end of the meeting I felt encouraged that focus was now on children living in homes with domestic violence and improvements in services from within the health profession was now being taken seriously. Hearing from different sectors also made me realise and understand the difficulties they face when dealing with safeguarding issues. RESPONDS is really important as children shouldn't witness violence and they have a right to be protected and grow in a safe, loving, secure environment. Children do die needlessly from the effects of domestic violence and better safeguarding may not be able to protect all, but it's a positive step forward.

I hope my part within the PPI group can bring personal experience and reality to benefit the research"

Maria Rees

Systematic review

Table 1 Characteristics and outcomes in studies with individual-level interventions

Study	Study design	Intervention	Main Outcome Results
Location	Sample		
<p>Berger et al. (2002).</p> <p>Children's Hospital of Pittsburgh, Pa, USA</p>	<p>Pre/post-test survey design</p> <p>Trainees (n=57; 51 pediatric and 6 medicine-pediatric residents) Staff (n=27; 5 registered nurse practitioners and 22 faculty)</p>	<p>Initial session A 30 minute didactic session.</p> <p>3-months after the initial session, a 90-minute teaching session (15-minute didactic, 12-minute videotape testimony from DV victims and a 45-minute role-play session).</p>	<p>1. Attitudes and beliefs about DV; There was a high rate of correct responses to the knowledge questions in all groups at baseline. As a result the only knowledge-based question in the post-intervention was related to mandated reporting. After the training, there was no overall change in the number of correct responses to this question.</p> <p>2. Change in the frequency of routine screening practices improved after the intervention. 79 participants (96%) believed that screening for the presence of DV was part of their role as pediatric HCP. At baseline, 17 (21%) of the 82 participants reported that they were routinely screening for signs of IPV during well-child care visits compared with 39 ((46%) after attending the education programme (p=.005). Among participants who attended both educational sessions 25% (9/36) were routinely screening for DV prior to the intervention compared with 46% (16/35) after the intervention (p=.008). At baseline, 33 (40%) of the 82 participants had identified at least one case of DV in the prior 6 months compared to 45 (53%) after training. Prior to training, 18 participants (22%) were aware of resources for DV victims compared with 45 (53%) after training (p<.001).</p>
<p>Bournnell & Prosser (2010)</p> <p>Emergency Department, New South Wales,</p>	<p>Pre/post-test survey design</p> <p>Most ED participants (n=49) were Registered Nurses (84% pre, 86% first post-test, 89% second</p>	<p>Collaborative project (quality improvement study) The first phase involved the development of clear guidelines and frameworks acceptable to both ED nursing staff and those from VAN (Violence, Abuse and Neglect) Prevention team. This was followed by the development of a flowchart, designated as a 'pathway' for use in the identification of domestic violence in ED. The further phases of the project involved the training program, focus groups to assess</p>	<p>1. Awareness of DV policy; Nurses' self-reported awareness of the policy relating to DV increased significantly after they had completed the training program</p> <p>2. Awareness of responsibilities to DV; Prior to training, approximately half of the nurses (52%, n = 25) said that they were not aware of their responsibilities in DV cases. When they completed the post training surveys, this had decreased to only one staff member continuing to report lack of awareness of these</p>

Australia	post-test). The others were enrolled nurses or student nurses.	<p>the on-going usefulness of the project and finally a series of file audits which sought to also assess improvements in practice.</p> <p>The training program involved instruction on how to identify three key actions in the pathway for domestic violence presentations in the ED.</p>	<p>responsibilities.</p> <p>3. Responding to DV indicators of DV; One month after training, fewer nurses (18%, n = 4) reported that they did not feel confident whilst most (82%, n = 18) of their nurses reported that they felt that their ability to identify DV had increased. The same finding occurred at the 6-months follow up with most nurses (74%, n = 14) reporting that they still felt confident about their improvement in practice due to the project, with only a few of the nurses (25%, n = 5) reporting that did not feel that their improvement in practice had been maintained.</p> <p>4. Knowledge about referral; After training the number of nurses who reported lack of ability to refer was reduced considerably (27%, n = 6) and remained relatively steady 6 months afterwards (32%, n = 13). Following training, the percentage of participants that reported being able to identify and respond appropriately increased from 48% (n = 24) to 82% (n = 18). This change was sustained at the second follow up occasion where a similar number (84%, n = 16) reported believing themselves able to respond appropriately.</p>
Study	Study design	Intervention	Main Outcome Results
<p>CDC (2000)</p> <p>Boston, Massachusetts, USA</p>	<p>Pre-/post-test survey design</p> <p>Child health care providers (HCPs) n= 14 HCPs, 642 patients and 1352 patient visits</p>	<p>The Pediatric Family Violence Awareness Project (PFVAP), a training project for maternal and child HCPs, promoted prevention of and intervention for IPV.</p> <p>Phase 1 followed a 2-hour group training session to teach HCPs to implement a brief screening protocol of female patients and mothers of pediatric patients aged 0–12 years during routine visits using a recommended screening schedule.</p> <p>Phase 2 followed implementation of on-site victim services that offered weekly support groups separately for battered women and children using the identical protocol as in Phase 1. Between the end of phase 1 and the beginning of phase 2, there was a 3-month period.</p>	<p>Patient’s screening status; Each patient’s final screening status (ever or never screened) was based on combined data from each phase and was evaluated relative to patient demographics and visit characteristics by two separate logistic regression models.</p> <p>Eleven (79%) of 14 HCPs did not demonstrate increased screening during phase 2, following on-site services implementation.</p> <p>Unadjusted individual HCP screening rates varied during both phases from 1.8% to 92.8% during phase 1 and from 0 to 94.9% during phase 2. The degree of change in HCP screening rates also varied widely.</p>

<p>Coonrod et al. (2000).</p> <p>Maricopa Medical Centre, Phoenix, Arizona, USA</p>	<p>Randomised control trial.</p> <p>Participants were randomised prior to recruitment (using a computer and stratifying by sex and specialty)</p> <p>Maryland, Medical residents entering in 1995 and 1996.</p> <p>Experimental group: n=53/68 randomised Control group: n=49/68 randomised</p>	<p>Experimental group:</p> <p>1995: A 20-minute video presentation "Domestic Violence: More Prevalent Than You Think," emphasizing the importance of screening for domestic violence.</p> <p>1996: A 20-minute programme comprising a nine-minute videotape, "Domestic violence: The bottom line" and a role-play demonstrating interview techniques for detecting DV.</p>	<p>1. self-reported diagnosis of a case of DV sometime between the intervention and the follow-up (9 - 12 months after the intervention. 71% of the residents in the experimental group diagnosed DV; 52% in the control group did so (RR, 1.35; 95%CI 0.96-1.90; p=.07) in the 9 to 12 months post intervention. Rates of diagnosis differed by specialty (p<.01)</p> <p>2. Change in knowledge on DV; There was a significant effect (p<.002) of group on post-intervention: 11 residents in the control group scored a mean percentage correct of 56%; in the experimental group (n=12) the mean percentage correct was 73%</p>
<p>Cross & Cerulli (2007)</p> <p>Midsized city in upstate New York, USA</p>	<p>Post-test survey design</p> <p>Law Guardian Program attorneys</p> <p>Conference group (n=41) Comparison group (n=28)</p>	<p>The conference, entitled "Understanding Children Exposed to Community Violence: A Conference for Attorneys Committed to Children," was a typical single-day professional development training. The conference featured four local speakers who provided information on community violence, local community statistics, evidence-based research on the impact of violence on children, and the rationale and specific strategies for interviewing children as part of the law guardian role. The main goal was to increase law guardians' knowledge about community and domestic violence and to assist them in identifying and providing appropriate service for child clients.</p> <p>Each participant was provided additional reference materials including articles on the topics and copies of the presentations.</p>	<p>Attendees and a comparison group of non-attendees also completed a 15-item questionnaire that was based on a validated instrument designed to test trainees' knowledge, attitudes/efficacy, beliefs, and intended practice behaviors following training on intimate partner violence (Short <i>et al.</i> 2004).</p> <p>Results showed that the comparison and conference groups were not significantly different on any demographic variable. T-tests were conducted to test differences on knowledge, efficacy, and practice behaviors for the two groups. Results showed that the groups differed on two of the three variables. Conference participants had statistically significantly higher scores on efficacy and practice behaviors. There was a trend for the conference group to have higher knowledge scores.</p>

Study	Study design	Intervention	Main Outcome Results
<p>Dubowitz et al. (2011).</p> <p>Maryland, Baltimore, USA</p>	<p>Cluster randomised trial</p> <p>18 private practices stratified for size (small, medium, large). Practices ranged from solo to 1 with 32 HPs.</p> <p>Experimental group: 7 practices, median practice size = 5, range = 1-32. 56 participants</p> <p>Control group: 11 practices, median practice size = 3, range = 1-12. 46 participants</p>	<p>The SEEK Model</p> <p>Experimental group: HP Training</p> <p>The focus was on the significance of targeted problems (parental depression, major stress, substance abuse, and IPV) for children's health, development and safety, how to briefly assess identified problems, including principles of motivational interviewing.</p> <p>The parent Screening Questionnaire</p> <p>A 20-item yes/no screen for the targeted psychosocial risk factors. It was to be given to ALL parents bringing their child (<5) for a check-up. Optimal completion</p> <p>Parent Hand-outs</p> <p>Customized parent hand-outs for each practice (i.e., local resources) and a Web-based directory of community resources.</p> <p>Social Worker: A project social worker spent a half or full day per week in each SEEK practice. She was available by telephone to HPs and parents during the regular work week.</p>	<p>1. The Health Professional Questionnaire (HPQ); Comparing baseline scores with 6-, 18-, and 36-month follow-up data, the HPQ revealed significant (P .05) improvement in the SEEK group compared with controls on addressing depression (6 months), substance abuse (18 months), intimate partner violence(6 and 18months),and stress(6,18,and36 months),and in their comfort level and perceived competence (both at 6, 18, and 36 months).</p> <p>2. Review of children's medical records; Before the study, SEEK and control HPs rarely screened for the problems. By medical record data, SEEK HPs improved by >20 percentage points in screening for each risk factor. Controls barely changed.</p> <p>3. Observation of HPs conducting Child Health Supervision Visits; SEEK HPs screened for targeted problems more often than did controls based on observations 24 months after the initial training and the medical records (P.001).</p>
<p>Feigelman et al. (2011).</p> <p>Primary care continuity clinics of a medium-sized inner city pediatric practice, Maryland, Baltimore, USA</p>	<p>Randomised control trial.</p> <p>Categorical pediatric & combined medicine-pediatrics residents who provided care in continuity clinics</p> <p>Experimental group: 50 participants</p> <p>Control group: 45</p>	<p>The SEEK Model (for description see above)</p>	<p>1. The Physician Questionnaire (PQ) on residents' knowledge, attitudes, comfort level, perceived competence, and practice. Intervention group residents improved more than control subjects on 3 psychosocial problem scales: Depression, IPV, and Stress. This improvement was sustained over 18 months (P<.01, P<.03, P <.04, respectively).</p> <p>2. Children's medical records were reviewed toward the end of the study to determine physician practice in addressing the risk factors. After the training, intervention residents were far more likely than control subjects to screen parents for the targeted risk factors.</p> <p>3. Parents' satisfaction regarding doctor-parent interaction. Parents of children seen by intervention doctors were more satisfied</p>

	participants		with their child's doctor compared to those seen by control doctors (17.4 vs. 16.9; P <.01). Group differences were not found, however, at the 6-month evaluation.
Haas et al. (2011) West Virginia, USA	<p>Post-test survey design</p> <p>Child protection workers(n=146 total)</p> <p>Survey respondents represented two samples.</p> <p>1st sample (n= 75) completed the survey on-site prior to the start of the first training module (comparison group)</p> <p>2nd sample (n-71) received survey six months after attending training (training/treatment group)</p>	<p>The curriculum was designed to provide participants with an understanding of the dynamics of domestic violence, the process that follows a report of child abuse and/or neglect, and the impact on families when these problems co-occur. Participants were also exposed to the guiding principles of the three main systems (i.e., child protective services, domestic violence services, and courts) as well as law enforcement. Each system was described in terms of their respective roles and responsibilities, risk assessment, and safety planning.</p> <p>The curriculum was to be delivered by a multidisciplinary training team—to a multidisciplinary audience—of domestic violence advocates, child protective service workers, law enforcement officers, and court representatives. A series of 10 regional cross-disciplinary workshops were conducted throughout the state.</p>	<p>1. Knowledge (on extent of understanding the legal and/or procedural roles and responsibilities of DV advocates, law enforcement officers, and court personnel). The findings indicate that the training did not result in statistically significant changes in the mean levels of these measures. However, there is evidence that the training resulted in some improvements and that these changes varied across domestic violence advocates, law enforcement personnel, and court representatives.</p> <p>2. Attitudes toward collaboration with their inter-agency partners; whether participants had a positive or negative view of their collaborations with each of the three groups over the past six months. Knowledge of the legal roles and responsibilities of other co-occurrence partners and attitudes based on prior collaborations were shown to be more favourable in the post-training sample in most cases as there were statistically significant correlations with CPS workers' self-reported levels of collaboration. Both composite measures between the knowledge and attitudes of CPS workers and levels of collaboration were statistically significant in the comparison and post-training sample.</p> <p>3. Perception of the presence or absence of barriers to collaboration. A greater proportion of CPS workers viewed barriers to be related to system-level factors. Such system-level factors as high turnover rates, time constraints, and too few staff were perceived to be important barriers prior to and after the training. Over sixty percent of CPS workers in both groups reported these to be important barriers to collaboration. On the contrary, forty percent or fewer of respondents viewed individual-level barriers to be important in curtailing collaboration. There were significant reductions in the perception of some barriers among CPS workers. An examination of the mean scores showed statistically significant declines for "too few staff" (t = 3.011; p = .003) and "lack of contact between agencies" (t = 2.617; p = .010) as perceived barriers to collaboration. Likewise, the perception of "lack</p>

			of interpersonal relationships” as an obstacle to collaborative efforts was lower in the post-training sample ($t = 3.720$; $p = .000$). The “lack of confidence in counterpart knowledge” was significantly lower in the post-training group ($t=2.820$; $p=.006$).
Johnson et al. (2013) Freestanding tertiary care Midwestern children’s hospital, USA	Pre-/post-test survey design (with 3-month follow-up) Registered nurses (n=68 total, female=65, male=3)	The 30-minute educational curriculum for IPV screening. As part of the educational session, nurses in groups of 2 or more viewed a 20-minute hospital-produced video about IPV, read through a scripted role-play, and had a discussion	Factor analysis was performed on the baseline Self-efficacy for Screening for Intimate Partner Violence Questionnaire by using varimax rotation. Five factors were identified: conflict, fear of offending parent, self-confidence, appropriateness, and attitude. Only fear of offending parent was significantly different from times 1 to 3, indicating that nurses were less fearful after the training. Nurses reported significant improvement (baseline to 3-month follow-up) in several self-efficacy items.
Knapp et al. (2013) Children’s Mercy Hospitals & Clinics, Kansas City, Mo USA	Pre-/post-test survey design (with 6 -month follow-up) Pediatric Emergency Department staff (physician, nurses, and social workers) n=79	An instructional program called <i>It’s Time to Ask</i> to aid in the identification and intervention for IPV in the pediatric acute care setting. The 2-hour course consisted of 3 modules and included an evaluation component. <u>First module</u> : basic definitions and concepts regarding IPV in the pediatric health care setting. <u>Second module</u> : addressed attitudes, beliefs, and behaviours identified as barriers to screening and intervention. <u>Third module</u> : presented a model protocol for use in the pediatric acute care setting.	1. Attitudes and beliefs Participants had consistent, positive changes in attitudes after training that persisted at the 6-month follow-up for 5 items on the questionnaire. Attitudes that did not change showed baseline means already in disagreement with questionnaire statements. 2. Self-efficacy ; Participants reported significant, positive changes for all 7 self-efficacy statements at 1 or both of the post-training evaluations. 3. Behaviours/Clinical practice ; The only changes in behaviour were observed at 6 months.
Lelli (2010) Catholic liberal arts college in south-eastern Pennsylvania, USA	Pre-/post-test survey design 40 undergraduate students from three classes of a reading methods course which is generally taken during senior year	Bibliotherapy: reading professional literature and children’s literature pertaining to domestic violence.	The pre and post survey responses were analysed and coded to determine if preservice teachers’ attitudes and views about identifying signs of domestic violence changed after the professional development and readings of the given literature. The results showed an increase in preservice teachers’ knowledge and skills pertaining to recognizing signs of domestic violence in behaviors of the students they teach. The data further revealed that the increase was due to the use of children’s literature as part of instruction and trade journal articles as a part of teachers’

	prior to student teaching.		professional development.
Study	Study design	Intervention	Outcome Measures
McCauley et al. (2003) Baltimore, Maryland, USA	Pre-/post-test survey design 120 physicians and 172 other personnel (e.g., nurses, social workers) at 24 sites associated with four academic medical centres completed paired questionnaires.	The video, ASSERT: A Guide to Child, Elder, Sexual, and Domestic Abuse for Medical Professionals , was developed by experts from medicine, social work, nursing, and law. The video featured role-plays to demonstrate different approaches to these difficult clinical encounters. The settings for watching the video and completing the questionnaire varied from staff meetings, to in-services, to CME meetings called specifically to view the video.	A questionnaire with 13 knowledge and 12 attitude variables was specifically developed to assess knowledge and attitude changes. 120 physicians and 172 other personnel (e.g., nurses, social workers) at 24 sites associated with four academic medical centres completed paired questionnaires. There was significant improvement for physicians in 77% of the knowledge items and 75% of the attitude items from pre- to post-viewing questionnaires. A total of 73% of viewers would recommend the video to colleagues.
McColgan et al. (2010) Urban tertiary care pediatric hospital Philadelphia, PA USA	Pre-/post-test (3- & 8-months) survey design Pediatric residents (n=52 baseline/ 72 recruited)	The multifaceted IPV intervention consisted of the following: IPV screening and intervention protocol. Pediatric residents were trained to screen all female caregivers for IPV according to the Family Violence Prevention Fund consensus statement. Establishment of on an onsite IPV counsellor; available on-site Monday through Thursday (continuity clinic days) and via pager on Friday. Resident “champions” in each continuity clinic. Responsibilities of the resident “champions” included: preparing and presenting a 25-minute talk for their clinic team about “IPV screening in the pediatric setting,” encouraging IPV screening, and obtaining monthly feedback from fellow residents about barriers to screening for IPV. IPV training for the social work staff, attending physicians, and resident “champions”. Five of the 8 APC attending physicians and the four resident “champions” attended a 2-hour training session on IPV screening in the pediatric setting. The medical Social Work Department received 5 hour of IPV	Program efficacy was evaluated through (1) resident surveys and (2) chart reviews. 1. Resident questionnaire assessing their perceived knowledge, comfort, attitudes, barriers, and screening practices regarding IPV. Changes in attitudes, and perceived knowledge of IPV. Compared to baseline, the 3-month follow-up survey revealed significant improvements in perceived knowledge of appropriate IPV screening questions (47.1% vs. 100%), referral sources (34.3% vs. 82.9%), and the relationship between child abuse and IPV (52.9% vs. 97.1%). Changes in barriers to IPV screening. “Knowledge of how to screen” and “not knowing where to refer positive screens” did not appear as barriers in the 3-month follow-up survey. 2. Chat review: Documentation of IPV screening and Referrals to IPV counsellor. Chart review: Changes to documentation of IVP screening. Significant and sustained improvements in documentation of IPV screening were noted. IPV screening rates improved from .9% at baseline to 36% at 3 months, and remained elevated to 33% at 8 months.

		<p>training.</p> <p>Training of pediatric residents. Consisted of the following: a 1 hour “grand rounds” presentation to the medical staff; two 1-hour “noon-conference” talks on IPV for the residents; and one 25 minute “pre-clinic talk” on IPV screening presented by the resident “champion” of that continuity clinic team.</p>	<p>Chart review: IPV counsellor’s charts. The IPV counsellor had received 107 referrals for IPV during the first 12 months of the intervention: 50 during the first 6 months and 57 during the next 6 months. Of these, 25 (23%) were from the ambulatory pediatrics clinic and 77% were from other hospital departments.</p>
<p>Mills & Yoshihama (2002)</p> <p>Orange County, Los Angeles, USA</p>	<p>Pre-/post-test survey design</p> <p>Children’s services workers (CSWs) n= 179</p>	<p>Two types of training were developed and offered in 1995:</p> <p>The One-Day Program consisted of didactic teaching and a role play exercise that encouraged CSWs to test their new skills in a practice interview with a battered woman.</p> <p>The Fellow’s Program consisted of six monthly one-day workshops and was designed to provide in-depth and leadership training for a selective group of CSWs and supervisors.</p>	<p>At post-test, the participants in the One-Day Program were significantly less tolerant of domestic violence ($t = -5.44, 12 < .001$) and more likely to view domestic violence as a social problem ($t = 2.32, 12 < .01$). They were more likely at post-test to consider assessing whether the mother is being abused as one of the first tasks of a CSW ($t = 3.93, 12 < .001$).</p> <p>The likelihood of referring the mother and father to couples counselling decreased slightly following the training but not significantly. Participants were significantly less likely to view battered women as incapable of protecting children and more likely to view women staying in abusive relationships due to their fear of losing custody of the children ($t = -3.92, 12 < .001$; $t = 7.66, 12 < .001$, respectively). Participants perceived themselves significantly more competent to respond to domestic violence cases following the training ($t = 10.21, 12 < .001$).</p>
Study	Study design	Intervention	Main Outcome Results
<p>Prather (2003)</p> <p>USA</p>	<p>Post-test survey design (study 2)</p> <p>Post-test scores of participants on the KAQ were compared with a matched control group selected from participants of Study 1.</p> <p>Participants were recruited from</p>	<p>Study 2 was designed to use the KAQ, Scenario Responses (SR) and student journals (JR) to evaluate the impact of the Child Abuse and Family Violence Course (CAFVC) on these obstacles.</p> <p>The child abuse and family violence course (CAFVC) included specific content and pedagogy in order to directly address the barriers that keep professionals from effectively responding to child abuse and family violence. The course was taught at a large public university in the fall quarter of 2000. Course length was 10-weeks, with class meeting for 2 hours of instruction once a week. The</p>	<p>Study 2 measures:</p> <p>1. The Knowledge and Attitudes Questionnaire (KAQ) developed and empirically evaluated in Study 1. & used to examine changes in participants’ avoidant reactions, prejudicial attitudes, attitudes about oppression, and recognition of abuse. Results indicate the CAFVC was effective in reducing the barriers of limited knowledge, avoidant reactions, beliefs about role, and sexist attitudes in the context of abuse.</p> <p>2. Scenario Responses (SR). Participants were presented a hypothetical case and asked how they would respond. The same case scenario was used in the pre- and post-tests. Paired-sample t-tests of participants’ SR scores indicated the CAFVC</p>

	<p>members in the National Association of School Psychologists (NASP), attendees at the British Columbia/Washington Association of School psychologists' Annual conference and students from training institutions that prepare school psychologists.</p> <p>Study 1: n= 186 Study 2: n= 23 students</p>	<p>interdisciplinary guest speakers were used to provide information to participants as well as to allow students to form collaborative working relationships with them.</p>	<p>increased the application of effective interventions.</p> <p>3. Journal Response (JR). Participants were also asked to keep a weekly journal as a reflection of their thoughts, feelings, and concerns in response to the CAFVC (to provide a means to evaluate whether there were negative effects of the course on participants & to examine affective reactions and avoidant behaviors). JR qualitative analyses indicated a three-stage pattern of emotional activation that resulted in decreased avoidance.</p>
<p>Saunders et al. (2006)</p> <p>USA</p>	<p>Two types of evaluation designs were used: post-test only and pre-and post-test</p> <p>Post-test evaluation (n=192) (May 1998 and October 1998).</p> <p>Pre-/post-test evaluation (n=67) (July 2000 and December 2000)</p>	<p>The state's domestic violence training unit conducted the training and encouraged welfare managers and workers to attend a one-day training session aimed at helping them to identify and understand domestic violence, develop safety plans, and make referrals. It specifically covered several key issues: the definition and nature of domestic violence, ways victims try to protect themselves and their children, guidelines for interviewing clients, initial interview questions, identifying domestic violence, lethality indicators, helpful interventions, and safety planning tools. A highly experienced domestic violence specialist conducted 63 trainings at 10 sites throughout the state.</p>	<p>Two vignettes were constructed for the study: one with obvious content about domestic violence and one with domestic violence risk markers but no mention of domestic violence. Including this second vignette helped with the assessment of the ability to detect abuse. Participants indicated the likelihood, from 0% to 100%, of their making various responses if they were interviewing the hypothetical client. Items were derived from the goals of the training & current policy.</p> <p>Training effects: Trained workers reported a greater likelihood of referring clients to couples counselling, developing a safety plan, and reporting to child protection services (CPS). However, the latter two findings did not hold after controlling for demographic and background variables. The difference on the safety planning item was not significant after controlling for gender, educational level, years of experience in social services, and prior information obtained about domestic violence. The difference on CPS reporting did not hold after controlling for years of experience. There were no significant differences on any of the other items.</p>

Study	Study design	Intervention	Outcome Measures
<p>Shefet et al. (2007)</p> <p>Israel Center of Medical Simulation (MSR), Israel</p>	<p>Pre-/post-test (6-month) survey design.</p> <p>Physicians (including general practitioners, residents and specialists in relevant primary care fields, from both outpatient and inpatient settings).</p> <p>Pre-/post-test (n=74) (recruited n= 141)</p>	<p>The program included three branches: intimate partner violence, child abuse and elder abuse. All branches shared common educational goals, and differed in unique emphases related to each. Each branch developed an eight-hour workshop, based on SPs. Each workshop was developed by a national committee of DV experts and included eight scenarios reflecting common DV-related encounters with patients and/or family members and care takers. Each physician encountered two scenarios, and actively viewed, via a one-way mirror, four others. All encounters were audio-visually recorded. Encounters lasted 12 minutes each, after which four minutes were allotted to documentation and comments, and another four minutes for a private, undocumented oral feedback by the actor. At two points during the workshop—halfway through and at the end—the participants assembled in a debriefing room and viewed selected segments of recordings from each encounter. Key points from each of the scenarios (content and/or communication skills) were discussed under the instruction of both a physician and a social worker specializing in DV.</p>	<p>1. Perceived capabilities, Perceived capability in diagnostic skills, communication skills, knowledge of favourable intervention, graded on a scale of 1 (not at all capable) to 4 (capable to a large extent), had increased by 0.29 to 0.6. All increments were statistically significant ($p < 0.05$).</p> <p>2. reported case management; Frequency of routine screening of DV (on a scale of 1=always to 4=never) has increased (mean score decreased by 0.19,$p<.03$). Reported actions: Participants were given a list of nine actions, and were asked how often, upon encountering a case suspicious of DV, they take these actions (on a scale of 1=never, to 4=always). All frequencies of reported actions taken were increased, including documentation of the violence in the medical chart, empowering the patient, providing the patient with relevant information and referring him/her to relevant agencies for treatment. All but one increment were of statistical significance.</p> <p>3. Perceived intervention barriers. At follow-up, lack of knowledge and lack of communication skills, as well as unfamiliarity with support systems ('I don't know where to refer') and psychological difficulties ('I am afraid it will find it difficult to cope emotionally') all received significantly lower scores, which indicates an improvement in the physicians' attitudes regarding these barriers.</p>
<p>Young et al. (2008)</p> <p>Four counties (18 different locations) in rural Western New York,</p>	<p>Pre-/post-test survey design</p> <p>644 school personnel</p>	<p>The "Helping Child Victims of Domestic Violence: Implications for School Personnel" training included information about the dynamics of domestic violence, the effects on children, interventions, and community resources.</p> <p>The training was presented by personnel from the RJI. Primary presenters included a doctoral level school psychologist and an educational specialist.</p> <p>When scheduling permitted, the local domestic</p>	<p>Scores in knowledge and attitudes regarding domestic violence (12 statements at pre-test, 11 items at post-test).</p> <p>Overall results were favourable, with 10 out of 11 questions showed significant improvement ($p < 0.001$) from pre-test to post-test.</p>

USA		violence service provider also participated in the training by presenting the program introduction (dynamics of domestic violence) or providing the audience with a presentation of their services at the end of the training. The workshop training was approximately an hour and a half in length	
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Table 2: Characteristics and outcomes in studies with system-level interventions

Study	Study design	Intervention	Main Outcome Results
<p>Banks, Landsverk, & Wang, (2008b).</p> <p>USA</p>	<p>Pre/post-test survey design</p> <p>Five sites Direct service workers N=578 (total)</p> <p>Cases reviewed (across sites) Time1: 616 Time 2: 642 Time3: 562</p>	<p>The Greenbook Demonstration Initiative</p> <p>A multisite developmental evaluation of six demonstration sites that received federal funding to implement <i>Greenbook</i> principles and recommendations over a 5-year demonstration period.</p> <p><i>Greenbook</i> principles for guiding reforms in child welfare systems include establishing collaborative relationships with domestic violence service providers and dependency courts; assuming leadership to provide services and resources to ensure family safety for those experiencing child maltreatment and adult domestic violence; developing service plans and referrals that focus on safety, stability, and the well-being of all victims of family violence; and holding domestic violence perpetrators accountable (NCJFCJ, 1999).</p>	<p>Surveys of child welfare caseworkers showed significant changes in several areas of agency policy and practice, including regular domestic violence training, written guidelines for reporting domestic violence, and working closely and sharing resources with local domestic violence service providers.</p> <p>Case file reviews show significant increases in the level of active screening for domestic violence, although this increase peaked at the midpoint of the initiative.</p> <p>These findings, coupled with on-site interview data, pointed to the importance of co-ordinating system change activities in child welfare agencies with a number of other collaborative activities.</p>
<p>Banks, Dutch, & Wang (2008a).</p> <p>USA</p>	<p>Pre/post-test survey design</p>	<p>The Greenbook demonstration initiative (for description see above)</p> <p>This article examines how the demonstration sites developed collaborations in accordance with the Greenbook foundation principles and associated recommendations, including the following: How did the collaborations organize and plan their work? Did the collaborative bodies reflect the Greenbook guidance? What facilitators and obstacles were most salient to the work? How</p>	<p>A stakeholder survey aiming to capture the dynamic factors contributing to project planning, activity implementation, and the status of the collaboration at each site showed that the measures clustered around three factors: leadership, community context, and resources. Stakeholders were most likely to agree that senior managers and directors of key organizations saw the co-occurrence of DV and child maltreatment as a problem in the community and were least likely to agree that the community already had resources, such as available data, funding, and a high level of expertise and training, invested in the issue of co-occurring child maltreatment and DV.</p>

		<p>were they addressed? What activities did the collaborations plan to implement policy and practice change in the three primary systems?</p>	<p>Stakeholder interviews on the process and perceived impact of collaborative work. Comparing responses over time, stakeholders were significantly less likely to agree that existence and accessibility of data was an obstacle. Stakeholders were significantly more likely to agree that the following were obstacles at follow-up: lack of resources, burnout of participants, conflicting organizational cultures, lack of leadership buy-in, and lack of accountability. The top collaborative facilitators (e.g. involvement, commitment, and leadership) did not change much over time, given that the top six rated facilitators at baseline were also the top six at follow-up. At follow-up, the relationships among collaborative members and agency staff received the highest ratings by survey respondents. Over time, only one facilitator showed significant changes in agreement. Stakeholders were significantly less likely to agree that the involvement of key agencies and groups was a facilitator at follow-up.</p>
Study	Sample	Intervention	Main Outcome Results
<p>Banks et al. (2009).</p> <p>USA</p>	<p>Pre/post-test survey design</p> <p>Three of the demonstration sites as case studies¹</p>	<p>The Greenbook demonstration initiative (for description see above)</p> <p>The purpose of the study was a) to examine collaborative activities occurring between child welfare agencies and domestic violence service providers and b) to investigate whether there was a relationship between collaborative efforts and domestic violence policy and practice in child welfare agencies.</p>	<p>Findings from the cross-sectional data revealed that in almost three-quarters of the communities, formal collaborative activities existed between child welfare and domestic violence agencies. The data did not demonstrate a relationship between these activities and child welfare policy and practice related to domestic violence. Longitudinal case study findings from the Greenbook evaluation did reveal some changes in child welfare policy and practice in association with the implementation of activities that increased collaboration between child welfare and domestic violence service providers. Improvements were found in child welfare agency screening and assessment, advocacy for adult domestic violence victims, and multidisciplinary approaches to case planning. The extent to which changes were observed varied across the sites, and appeared to be</p>

¹ The three sites for the case studies were selected based on a combination of factors: completeness of the data collected, representativeness of the challenges and obstacles encountered by all six demonstration sites, and generalizability to other communities.

			related to the specific planning approach undertaken in each community
Shye et al. (2004).	Clinicians ² n= 273 Female Patients ³ n = 1925 and n = 1979 for the pre- and post intervention	Two Implementation Strategies Basic Implementation Strategy (BIS). The task force's implementation strategy included - writing and disseminating a DV guideline ⁴ , traditional continuing medical education (CME) ⁵ , and clinical ⁶ and environmental supports and cues to increase clinician inquiry ⁷ and patient self-disclosure ⁸ of DV exposure. An article describing the signs and dynamics of DV and encouraging HMO members to discuss DV problems with their primary care clinicians appeared in the HMO's member newsletter. The HMO allotted 4 hours/month to the pediatrician cochair of the task force to oversee implementation. Augmented Basic Implementation Strategy (ABIS). The ABIS augmented the BIS by giving medical office social workers ⁹ paid time, funded by the research project, to assume a structured role as DV social change agents (5.2 months of full-time	The ABIS was associated with significantly greater improvement only on knowledge relating to the pros of routine inquiry ($\beta= 0.32, p<.0001$). The ABIS was associated with significantly greater improvement on process of change ($b= 0.38, p<.0001$). Post intervention scores on perceptions of the medical office social workers as DV experts indicated that improvement was strongly associated with exposure to the social workers' social change agent role in the ABIS arm. The ABIS had no greater effect on inquiry rates than the BIS. Rather, inquiry rates were a function of patient characteristics and clinician specialty.
USA			

² Participants included all IM, FP, health appraisal (HAP), pediatric, and OB/gyn physicians, physician assistants, and nurse practitioners in the HMO's main metropolitan area

³ Response rates for the pre- and post-intervention female patient surveys were 85.8% (n =1652) and 80.7% (n = 1598), respectively.

⁴ The guideline adopted a "routine inquiry" rather than a universal screening approach, recommending that primary care clinicians routinely ask about DV exposure of female patients and mothers of pediatric patients at "health maintenance visits" (e.g., visits for no acute care including routine check-ups, routine pregnancy visits, and "well-baby" care) and of all patients whose symptoms suggest abuse.

⁵ The task force organized a half-day conference to train DV response team members and other clinicians.

⁶ The task force charged local medical office managers with setting up DV response teams (consisting usually of nurses, medical assistants, social workers, and occasionally a female physician) to intervene with identified DV-exposed persons.

⁷ Two primary care clinician task force members wrote an article describing the clinician's role in response to DV for the HMO's local medical journal.

⁸ 30 Plastic dispensers containing "calling cards" with information about community resources for DV victims were placed in all the HMO's restrooms. Printed materials were developed and distributed, including patient brochures and pocket reminders for clinicians about screening, safety assessment, safety planning, and community referral resources.

⁹ The social workers' role involved (1) conveying information to clinicians about DV prevalence and risk markers, dynamics of abusive relationships, etc; (2) advocating an active primary care clinician role in secondary prevention; (3) elucidating the appropriate goals of screening and intervention activities; and (4) modelling secondary prevention skills (ie, asking patients about DV, danger assessment, documenting abuse, etc). They undertook these activities in department meetings and in individual "academic detailing"-style contacts with clinicians.

		employment for the 18-month study period for all the ABIS social workers together).	
Wills et al. (2008). New Zealand	over 700 staff	A formal organisational change approach was used to implement the New Zealand Family Violence Intervention Guidelines in a mid-sized regional health service. The approach included obtaining senior management support, community collaboration, developing resources to support practice, research, evaluation and training ^{10 11} .	Referrals . It is reported that the number of notifications from HBDHB to CYFS had increased from 10 per quarter to 70 per quarter . CYFS reports indicated that notifications were appropriate and informative, and that interagency relationships were strengthening. Screening for partner abuse is also reported to have been increased in most services, with rates between 6% and 100% recorded during the 2005/06 years, although there was considerable variability in the rate of screening between services. The number of women disclosing abuse was also increased, as was the amount of referral information provided.

¹⁰ Formal pre–post evaluations were conducted of the training Identifications of partner abuse.

¹¹ Training in child and partner abuse is mandatory in services primarily serving women and children. Training occurred only after the other systems (e.g. policy, documentation and supervision) are in place. Adult education principles are applied. Full-day training is provided including lectures, interactive sessions and modelling and practising risk assessment using role play. Staff is taught to routinely include a question about partner abuse in their social history and the ‘dual assessment’ model was taught.

Training curricula study

Cover letter and questionnaire for designated nurses



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Gene Feder
Professor of primary health care

T +44 (0)117 331 4548

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<http://www.bristol.ac.uk/primaryhealthcare/staff/federg.html>

8th October 2012

Dear Colleague

The University of Bristol in collaboration with the University of Central Lancashire is leading a research study on the primary care response to domestic violence and abuse (DVA) and child safeguarding: **Researching Education to Strengthen Primary Care on Domestic violence & Safeguarding (RESPONDS)**. The research is commissioned and funded by the Department of Health Policy Research Programme (Bridging the Knowledge and Practice Gap between Domestic Violence and Child Safeguarding: Developing Policy and Training for General Practice, 115/0003).

Primary care clinicians (GPs and their employed staff) vary in their response to DVA and are often uncertain about managing its interface with child safeguarding. This uncertainty may result from lack of knowledge, experience or confidence in dealing with these issues, which may lead to GPs and their staff not taking any action to protect either the adults or children exposed to DVA. Our study will help to close the gap, both informing policy on the primary care response to DVA in relation to child safeguarding and developing an enhanced training for GPs and practice nurses.

The research involves collecting safeguarding children and domestic violence training materials for GPs, practice nurses and practice managers. We will then look at their content in relation to domestic violence and determine to what extent they engage with the dilemmas faced by clinicians on disclosure of domestic violence by women with children.

As a designated nurse you can play a crucial role in the research by providing information and training materials on **safeguarding children training course(s)** in your area that **either contain some reference to domestic violence or/and specifically target domestic violence**.

We are kindly asking you to complete and return the attached **brief questionnaire**, send us your **training matrix** (if you have one) and send us any **safeguarding children training materials** that you have (power point slides, handouts, training curricula, etc.).

Please send the completed questionnaire and the training materials in digital formats to: eszter.szilassy@bristol.ac.uk.

You can also send us the completed questionnaire and the training materials via post to:

Eszter Szilassy
Centre for Academic Primary Care, NIHR School for Primary Care Research
School of Social and Community Medicine
University of Bristol, Canynge Hall
39 Whatley Road
Bristol, BS8 2PS

If you have difficulties accessing/assembling or sending us these materials, but would be happy to be contacted by the research team, please email us on eszter.szilassy@bristol.ac.uk or call: (0)117 9287234.

If you respond to this survey and let us know your contact details, we will be happy to provide you with a summary of our analysis, which you may find useful for your work and which may help inform your future training.

Thank you for reading this letter and thank you in advance for assisting the team in this research programme. If you have any questions or would like to obtain more information about the research, please do not hesitate to contact me or Eszter.

Yours sincerely,



1	Have you got a training matrix for GP's and/or their practice staff?	Yes	No
2	Do you organize safeguarding children/DV trainings for general practices?	Yes	No
3	Do you personally deliver safeguarding children/DV training for general practices?	Yes	No
4	What level(s) is/are these training(s) aimed at? (levels related to those in the Intercollegiate Document 2010)	Level 1 Level 2 Level 3	
5	Do you charge for these training courses?	Yes	No
6	What is the length of these training courses?	hours	
7	Where do you have these training courses?	In the practice External location	
8	Do you know of any Child Protection and Domestic Violence training provided in your area that is promoted to GP practices? If yes, please provide details.	Yes	No
9	Would you be happy to be contacted by the research team? If yes, please provide your contact details.	Yes	No

Please send:

completed questionnaire, your training matrix, your safeguarding children/DV training materials (power point slides, training packs, handouts, training curricula, etc.) to:

eszter.szilassy@bristol.ac.uk

or to Eszter Szilassy

Centre for Academic Primary Care, NIHR School for Primary Care Research
School of Social and Community Medicine
University of Bristol, Canynge Hall
39 Whatley Road, Bristol BS8 2PS

Thank you!

Cover letter and questionnaire for third sector organisations

The RESPONDS research is commissioned and funded by the Department of Health Policy Research Programme (Bridging the Knowledge and Practice Gap between Domestic Violence and Child Safeguarding: Developing Policy and Training for General Practice, 115/0003

The University of Bristol and the University of Central Lancashire are researching the **primary care response to domestic violence and abuse and child safeguarding**. Our study will inform policy and will enhance training for GPs and practice nurses on the primary care response to domestic violence in relation to child safeguarding.

As part of this, we will create a set of 'train the trainers' materials, which we hope will build on existing good practice, and provide a consistent basis for the training of primary care practitioners on these issues. **These will be freely available and we hope you will find useful in your own work.**

In order to do this, we would like to **analyse the existing training materials** that are used with primary care practitioners.

As a training provider you can play a crucial role in the research by providing **information and training materials** on your **safeguarding children training course(s)** that **either contain some reference to domestic violence or/and specifically target domestic violence**.

We are kindly asking you to:

- **complete and return the brief questionnaire on the page below**
- **send us your training brochure**
- **send us any training materials** focusing or referring to safeguarding children and domestic violence that you or your trainers have (power point slides, handouts, training curricula, etc.).

If you respond to this survey and let us know your contact details, we will be happy to provide you with a summary of our analysis and with our guidance on commissioning which **you may find useful for your work and which may help inform / support your future training**.

Our aim is to identify the range of learning outcomes, the range of delivery methods, and the range of professionals trained and their needs so that we can reflect this in our programme and other recommended guidance for primary care professionals. Your training **materials will be used for research purposes** only and will not be copied or reproduced. We will not evaluate your training programme, nor will our analysis of existing training make reference to any specific programmes. We may want to reference your work as an example of good practice, both in our course and in our final report. We would seek your specific permission to do this.

Please send the completed questionnaire and the training materials to:

eszter.szilassy@bristol.ac.uk. You can also send us the completed questionnaire and the training materials via post to Eszter Szilassy to the address below.

If you have difficulties accessing/assembling or sending us these materials, but would be happy to be contacted by the research team, please email us or call: (0)117 9287234.

Thank you for reading this letter and thank you in advance for assisting the team in this research programme. If you have any questions or would like to obtain more information about the research, please do not hesitate to contact us.

Yours sincerely,

- **Gene Feder**, Professor of Primary Health Care, University of Bristol
- **Marianne Hester**, Professor of Gender, Violence & International Policy, University of Bristol
- **Nicky Stanley**, Professor of Social Work, University of Central Lancashire

RESPONDS	Researching Education to Strengthen Primary care on Domestic Violence and Safeguarding. Centre for Academic Primary Care, School of Social and Community Medicine, University of Bristol, Canynge Hall, 39 Whatley Rd, Bristol, BS8 2PS. Tel: (0)117 9287234. Email: eszter.szilassy@bristol.ac.uk
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Safeguarding Children – Domestic Violence Training Questionnaire		
		Please tick/mark
1	Do you offer safeguarding children (SC) training on domestic violence (DV) or SC training with reference to DV?	Yes
		No
	Is this training(s) aimed at the following professional groups? (Tick as many as appropriate)	GP
		Practice nurse
		Practice manager
	Do the following professional groups come to this training(s)?	GP
		Practice nurse
		Practice manager
	What is the length of this training (hours)?	
	Do you charge for these trainings?	Yes
		No
2	Do you offer SC training on DV or SC training with reference to DV for <u>general practices?</u>	Yes
		No
	Which professional groups are the target audience of this training(s)?	GP
		Practice nurse
		Practice manager
	Which of the following professional groups come to this training(s)?	GP
		Practice nurse
		Practice manager
	What is the length of this training (hours)?	
	Do you charge for these trainings?	Yes
		No
	Where do you have this training(s)?	In the practice
		External location
3	Do you offer online training on SC and DV or SC training with reference to DV?	Yes
		No
	Are any the following professional groups in your target audience (if yes, which ones)?	GP
		Practice nurse
		Practice manager
	Which of the following professional groups complete this training(s)?	GP
		Practice nurse
		Practice manager
4	Do you know of any other CS and DV training provided in your area that is promoted to GP practices? Who is the provider? Please provide details.	Yes
		No
5	Would you be happy to be contacted by the research team? If yes, please provide your contact details.	Yes
		No

Cover letter and questionnaire for LSCBs

The RESPONDS research is commissioned and funded by the Department of Health Policy Research Programme (Bridging the Knowledge and Practice Gap between Domestic Violence and Child Safeguarding: Developing Policy and Training for General Practice, 115/0003

The University of Bristol and the University of Central Lancashire are researching the **primary care response to domestic violence and abuse and child safeguarding**. Our study will inform policy and will enhance training for GPs and practice nurses on the primary care response to domestic violence in relation to child safeguarding.

As a trainer you can play a crucial role in the research by providing **information** and **training materials** on **safeguarding children training course(s)** in your area that **either contain some reference to domestic violence or/and specifically target domestic violence**.

We are kindly asking you to:

- **complete and return the brief questionnaire on the page below**
- **send us your training brochure**
- **send us any training materials** focusing or referring to domestic violence that you or your trainers have (power point slides, handouts, training curricula, etc.).

If you respond to this survey and let us know your contact details, we will be happy to provide you with a summary of our analysis, which **you may find useful for your work and which may help inform your future training**.

Your training **materials will be used for research purposes** only and will not be copied or reproduced. We will not evaluate your training program, and we will not post evaluations of your training in the public domain. In our final report we would like to make statements on the particular elements that we believe characterize a good training program while preserving **full anonymity** of your organisation. At the same time, if you are happy for us to do that, we **will provide full acknowledgment** for your organization whenever we highlight examples of good practice. Our final summary report and the training resource we are aiming to develop for general practitioners will be freely available.

Please send the completed questionnaire and the training materials to:

eszter.szilassy@bristol.ac.uk. You can also send us the completed questionnaire and the training materials via post to Eszter Szilassy to the address below.

If you have difficulties accessing/assembling or sending us these materials, but would be happy to be contacted by the research team, please email us or call: (0)117 9287234.

Thank you for reading this letter and thank you in advance for assisting the team in this research programme. If you have any questions or would like to obtain more information about the research, please do not hesitate to contact us.

Yours sincerely,

- **Gene Feder**, Professor of Primary Health Care, University of Bristol
- **Marianne Hester**, Professor of Gender, Violence & International Policy, University of Bristol
- **Nicky Stanley**, Professor of Social Work, University of Central Lancashire

RESPONDS	Researching Education to Strengthen Primary care on Domestic Violence and Safeguarding. Centre for Academic Primary Care, School of Social and Community Medicine, University of Bristol, Canynge Hall, 39 Whatley Rd, Bristol, BS8 2PS. Tel: (0)117 9287234. Email: eszter.szilassy@bristol.ac.uk
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Safeguarding Children – Domestic Violence Training Questionnaire		
		Please tick/mark
1	Do you offer inter-agency safeguarding children (SC) training on domestic violence (DV) or SC training with reference to DV?	Yes
		No
	Is this training(s) aimed at the following professional groups? (Tick as many as appropriate)	GP
		Practice nurse
		Practice manager
	Do the following professional groups come to this training(s)?	GP
		Practice nurse
		Practice manager
	What is the length of this training (hours)?	
2	Do you offer single-agency SC training on DV or SC training with reference to DV for <u>general practices?</u>	Yes
		No
	Which professional groups are the target audience of this training(s)?	GP
		Practice nurse
		Practice manager
	Which of the following professional groups come to this training(s)?	GP
		Practice nurse
		Practice manager
	What is the length of this training (hours)?	
	Where do you have this training(s)?	In the practice
		External location
3	Do you offer online training on SC and DV or SC training with reference to DV?	Yes
		No
	Are any the following professional groups in your target audience (if yes, which ones)?	GP
		Practice nurse
		Practice manager
	Which of the following professional groups complete this training(s)?	GP
		Practice nurse
		Practice manager
4	Do you know of any other CS and DV training provided in your area that is promoted to GP practices?	Yes
		No
	Who is the provider? Please provide details.	
5	Would you be happy to be contacted by the research team? If yes, please provide your contact details.	Yes
		No

Consensus process

Invitation letter



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<http://www.bristol.ac.uk/primaryhealthcare/staff/feder.html>

11th February 2013

Dear

The University of Bristol in collaboration with the University of Central Lancashire is leading a research study on the primary care response to domestic violence and abuse and child safeguarding: **Researching Education to Strengthen Primary Care on Domestic violence & Safeguarding (RESPONDS)**. The project aims to address the barriers to practice at the interface of domestic violence and child protection for GPs, practice nurses and practice managers in England with the ultimate aim to develop policy and training for general practice. The study is funded by the DH Policy Research Programme. (Bridging the Knowledge and Practice Gap between Domestic Violence and Child Safeguarding: Developing Policy and Training for General Practice, 115/0003). Please find a short summary of the project enclosed.

I would like to invite you to be a member of our consensus panel. As a member of the panel you will be able to contribute to RESPONDS by participating in a two-stage formal Delphi consensus process and a meeting. The aim of the Delphi process will be to formulate specific guidance for primary care clinicians about the interface between domestic violence and child safeguarding.

If you accept our invitation to take part, you will receive a list of initial statements about good practice for incorporation into training around early July 2013. You will be asked to score the statements and return it to us within a month. You will be also invited to attend a consensus meeting with expert participation from general practice,

child safeguarding and domestic violence sectors. The meeting attendees will debate the statements and will develop a consensus on practice issues related to domestic violence and child safeguarding. The ultimate outcome of the consensus process will be a development of policy guidance on the interface of domestic violence and child safeguarding in general practice, and the integration of this guidance into a model training curricula for GPs, practice nurses and practice managers.

The consensus meeting will take place in London, on the 26th September 2013 between 11 am and 3.30 pm (venue to be confirmed).

I hope that you will accept this invitation to join the consensus expert team and the date of the consensus meeting is possible for you. Please let me know, copying in Eszter Szilassy, RESPONDS research associate: eszter.szilassy@bristol.ac.uk

With best wishes

A handwritten signature in black ink, appearing to be 'G. Szilassy'.

RESPONDS Consensus (survey or/and meeting) expert participants

Polly Baines	Independent Social Worker and Trainer
Kate Mulley	Action for Children Head of Policy and Research
Gwynne Rayns	Development manager children under 1 theme NSPCC
Briony Ladbury	Safeguarding children and child protection specialist Safeguarding First
Dr Clare Ronalds	GP, Manchester
Mhairi McGowan	Head of Service ASSIST, GCSS
Jacalyn Mathers	Designated Nurse for Safeguarding Children Bristol Clinical Commissioning Group
Professor Danya Glaser	Visiting professor, UCL Honorary Consultant Child and Adolescent Psychiatrist, Great Ormond Street Hospital for Children
Jade Levell	Children and Health Co-ordinator Standing Together Against Domestic Violence
Medina Johnson	IRIS Implementation Lead
Annie Howell	IRIS Implementation Lead
Professor Ruth Gilbert	Professor of Clinical Epidemiology UCL
Siddiq Obaid	Practice Manager, Walsall
Professor Hilary Tompsett	Professorial Fellow in Social Work Faculty of Health, Social Care and Education, Kingston University, London, RESPONDS Project Advisor
Professor John Carpenter	Professor of Social Work and Applied Social Science, University of Bristol
Dr Alex Sohal	GP, RCGP clinical champion, RESPONDS Project Advisor
Carol Craig	Specialist Nurse Safeguarding Children Primary Care Manchester
Dr Victoria Wright	GP, Manchester
Claire Phillips	Deputy Director - Violence, Social Exclusion and Military Health, Department of Health
Malcolm Ross	Former Senior Police Officer, Expert in Domestic Homicide Reviews
Dr Kate Mansfield	GP Partner, Yate, Named Dr for Safeguarding Children for South Gloucestershire, Clinical Lead for Domestic Abuse for South Gloucestershire
Dr Janice Allister	GP, RCGP Clinical Champion for Child Health, RESPONDS Project Advisor
Alison Spencer-Smith	Practice Nurse Advisor, Bristol
Tony Stanley	Principal Child and Family Social Worker Group Manager AEI Children, Schools and Families London Borough of Tower Hamlets
Amy Weir	Safeguarding Specialist and Chair Coventry Local Safeguarding Children Board
+ 3 PPI expert participants	

Interview study

Interview study information sheet



RESPONDS

Safeguarding – Primary Care – Domestic Violence

Information Sheet for Primary Health Care Professionals

This research is commissioned and funded by the Department of Health Policy Research Programme (Bridging the Knowledge and Practice Gap between Domestic Violence and Child Safeguarding: Developing Policy and Training for General Practice, 115/0003).

An invitation to take part in our research study

You are being invited to take part in a research study. Please read this information sheet which will inform you why this research is being done and what taking part would entail. Please contact us if you would like more information.

What is the RESPONDS study about?

The RESPONDS (Researching Education to Strengthen Primary Care on Domestic Violence and Safeguarding) project studies the primary care response to domestic violence and abuse and child safeguarding. The study will inform policy and will enhance training for GPs, practice nurses and practice managers on the primary care response to domestic violence in relation to child safeguarding.

Why am I being asked to take part?

You are invited because you are a primary health care professional and we are interested in your views and experiences regarding primary care, child safeguarding, and domestic violence.

Do I have to take part?

It is for you to decide whether or not you take part. If you do take part you will be asked to give us verbal consent prior to the interview but you will still be free to change your mind and leave the study at any time and without giving a reason.

What will happen if I take part?

You will be asked to participate in a telephone research interview. This interview will be held at a time that suits you. You will be offered an opportunity to enter a prize draw to win a tablet computer.

The telephone interview will be conducted by researchers using a short vignette (or scenario). You will be sent the vignette prior to the interview. The interview will last around 20 to 30 minutes, depending on how much you want to talk about your views and experiences. You can stop at any time. If you agree, the interview will be audio recorded and then typed up so that we had an accurate record of what was said. Transcripts will be confidential and all references to individuals will be anonymised.

Will my taking part be kept confidential?

Any information you give us, including what you said during the interview, will be treated as confidential. In addition, once the interview is typed up, any names and any identifiable information mentioned will be removed so that the written record is anonymous. The audio recording will then be destroyed. We will store information collected in the study in locked filing cabinets and on password protected databases.

What are the benefits of taking part?

Your views about the link between domestic violence and child safeguarding in the primary health care setting will help inform our research findings and potentially influence policy and training on the primary care response to domestic violence in relation to child safeguarding.

At the end of the interview you will be also asked to signal your willingness to be entered into a prize draw for a tablet computer among those respondents who completed an interview.

What will happen to the results of the study?

The results will be published in medical journals and presented at conferences to health care professionals and researchers. If you wish, you will be sent a copy of the summary research report.

Who is organising and funding the study?

The study is organised by the University of Bristol and the University of Central Lancashire. The funder is the DH Policy Research Programme.

Who has approved the study?

The project is approved by the University of Bristol, Faculty of Medicine and Dentistry's Ethics Committee and will be conducted in accordance with the PCT's Research Governance requirements.

What do I need to do if I want to take part?

Please give your contact details to the person who gave you this form, so that they can pass on your details to us. We will then contact you directly to arrange an interview time that suits you.

Contact for further information

If you have any questions about the study, please contact the lead researcher, Professor Gene Feder by telephoning 01173314548, emailing gene.feder@bristol.ac.uk or by writing to:

Gene Feder
Professor of primary health care
Centre for academic primary care
School of Social and Community Medicine
University of Bristol
Canyng Hall
39 Whatley Road
Bristol BS8 2PS

You can also contact the co-Principal investigators:

Marianne Hester
Professor of Gender, Violence and International Policy
University of Bristol, School for Policy Studies, 8 priory Rd. Bristol, BS81TZ
Tel: 011799546626
Email: Marianne.Hester@bristol.ac.uk

Nicky Stanley
Professor of Social Work
University of Central Lancashire, Dept Social Work, Preston, UK, PR12HE
Tel: 1772893655
Email: NStanley@uclan.ac.uk

You can also obtain **independent information or advice** about being involved in this research study by contacting:

Dr. Emma Williamson, Senior Research Fellow and Chair of the School for Policy Studies
Research Ethics Committee - Centre for Gender and Violence Research

by telephoning 0117 9546788 or emailing E.Williamson@bristol.ac.uk or by writing to:
University of Bristol, School for Policy Studies, 8 Priory Road, Bristol, BS8 1TZ.

Interview vignettes

For GPs

Sarah Lane comes to see you for the third time in the last two months. Previously, she has complained of nausea, sleeplessness and feeling 'down' and you have prescribed anti-depressants. She tells you that the anti-depressants aren't helping and then confides tearfully that things aren't going well with her partner Danny. When encouraged to talk, she tells you that Danny is very controlling; he won't allow her to phone friends or family and he has punched her and locked her in her bedroom when he has suspected her of talking to other people about him. He is very strict with the children, aged 7, 5 and 2, and won't let them watch television although he likes to watch TV. He makes them go to bed at 6pm every evening. This is causing conflict at home. Danny is also a patient at the practice and you have discussed his heavy drinking with him in the past.

For Practice Nurses

You have been seeing Sarah Lane regularly over the last fortnight to dress a nasty burn on her shoulder that is slow to heal. She comes in to see you on Monday morning very distressed. She confides tearfully that things aren't going well with her partner Danny. When encouraged to talk, she tells you that Danny is very controlling; he won't allow her to phone friends or family and he has punched her and locked her in her bedroom when he has suspected her of talking to other people about him. He is very strict with the children, aged 7, 5 and 2, and won't let them watch television although he likes to watch TV. He makes them go to bed at 6pm every evening. This is causing conflict at home. Danny is also a patient at the practice and you have discussed his heavy drinking with him in the past.

For Practice Managers

A practice receptionist tells you about an incident that took place in the waiting room yesterday. Sarah Lane was waiting to see the health visitor with her partner Danny and Jo, aged 2, who is the youngest of their three children. There are concerns about Jo's development which is being monitored. The health visitor was behind schedule and Danny, who may have been drinking, was seen to be angry and agitated. An argument broke out between them in the course of which Danny was seen to pull Sarah's hair and she pushed him. No-one else was involved. The couple were told to leave the premises and to come back another time. They have been sent a standard letter warning them that aggressive behaviour is not acceptable.

Interview schedules

Topic guide for interviews with GPs and nurses

Introductions

Thank you for agreeing to take part in this telephone interview.

Just to recap the information that you have already been given, this interview is part of a DH/PRP funded project, led by the University of Bristol, looking at supporting the primary care response to domestic violence and child safeguarding.

Our aim is to find out more about current practice and to develop training and resources that will help GPs, and other primary healthcare practitioners.

To do this we are asking interviewees about the challenges they face in this area and what sort of further training and resources might be needed in this field.

There are no right or wrong answers to our questions and we are very much interested in any relevant experiences with patients in your practice including difficulties or where you feel you have been successful.

What you tell me will remain confidential to the research team, we may use parts of what you say in a report, but we will not identify you in any way. The one exception to this is if you inform us of a situation where a child is at immediate risk of significant harm, and this has not already been reported.

You can stop the interview at any time.

Can I just confirm that I have your consent to be audio recorded while this interview takes place.....

I'll turn the recorder on now then, and for the record state:

Today's date is..... my name is..... and your name is and I have your consent to this interview? (yes)

Background

1. Can you give me an idea of the area where your practice is based and the sorts of patients you have attending your surgery?
Prompts: socio-economic and demographic characteristics, recurrent health issues.

Introduce vignette (sent prior to interview), ask them to refresh their memory of the vignette and ask questions relating to vignette.

Awareness

1. Have you had experience of patients who have presented problems relating to domestic violence in the last two years?
 - a. (If yes) Were they also parents?
 - b. (If yes) Were there any concerns regarding their children?
2. What signs would indicate to you that domestic violence or abuse may be occurring?
 - a. Are there any particular considerations or challenges when these patients are parents?

Suspicious

3. If you suspect domestic violence, but this is not disclosed, how would you proceed?
 - a. Are there particular challenges and do you have any examples of how you've managed these challenges?
4. If you are involved with a family where child safeguarding issues have already been identified, would you think to ask about domestic violence?
 - a. If so, how might you do this?

Disclosure

5. How about when a patient discloses they are experiencing domestic violence, what would your initial response be towards the patient?
6. Would how you respond vary according to:
 - a. Whether this is the first occasion when it has been mentioned
 - b. The nature or extent of the violence or controlling behaviour being described
 - c. Whether the person disclosing is your own patient/ someone you see regularly
7. From what age would consider there would be a possibility of patients experiencing violence in relationships.
8. Would you follow up with any further action once the patient has left?
9. Have you encountered particular challenges or successes in responding to disclosure? If so, can you give me details?
10. How much background information would you try to get?
11. Would you check their parent status?
12. Would you think to ask about the impact on their children?
13. Would you seek to talk to the partner/ children about the domestic violence?
14. Are there any differences according to age –e.g adolescents vs. children?
 - a. Would you see children alone?

Safety and Confidentiality

15. Regarding patient confidentiality, what sort of concerns do situations involving domestic violence and children raise if, any and how do you respond to these?
16. What sort of patient safety concerns do these situations raise if any, and how do you respond to these safety issues?

Documenting

17. Thinking about documenting or recording now, how would you document disclosures of domestic violence?

- a. Would recording go beyond 'we had a chat'?
- b. Do you flag records (eg, DV, perp, not for disclosure)
- 18. How would you record concerns about the impact of domestic violence on children?
- 19. Would you record in multiple sets of records?
- 20. Would you consider whether perpetrator may see details if he asks to see his case notes?
- 21. Does your practice have a documentation policy?
- 22. Does the move towards open or online records raise any concerns?

Collaboration and additional sources of support

23. Now we are getting towards the end of the interview. Can you tell me what sort of relationship the practice has with children's services?

Prompt: Is the collaboration positive or problematic?; What are the challenges?.

24. What is the practice relationship like with specialist domestic violence services?

Prompt: Is the collaboration positive or problematic?; What are the challenges?.

25. Do you know of any agencies in your area who can offer support to children and their parents in these situations?

- a. Do you display any information about these services in your practice?

Training

26. Finally on to training. What sort of training have you received around responding to domestic violence?

Prompts: In house, individualised or with other local professionals? How many hours? What level? Adequate to perceived needs? Who delivered it?

- a. How would you rate it on a scale of 1-10?
- b. How would you improve it?

27. Are there additional support or resources you would find useful to help you respond effectively?

28. Are there any further comments you would like to make or things you would like to say that we have not already discussed?

Thank you

Topic guide for Interviews with Practice Managers

Introductions

Thank you for agreeing to take part in this telephone interview.

Just to recap the information that you have already been given, this interview is part of a DH/PRP funded project, led by the University of Bristol, looking at supporting the primary care response to domestic violence and child safeguarding.

Our aim is to find out more about current practice and to develop training and resources that will help GPs, and other primary healthcare practitioners.

To do this we are asking interviewees about the challenges they face in this area and what sort of further training and resources might be needed in this field.

There are no right or wrong answers to our questions and we are very much interested in any relevant experiences with patients in your practice including difficulties or where you feel you have been successful.

What you tell me will remain confidential to the research team, we may use parts of what you say in a report, but we will not identify you in any way. The one exception to this is if you inform us of a situation where a child is at immediate risk of significant harm, and this has not already been reported.

You can stop the interview at any time.

Can I just confirm that I have your consent to be audio recorded while this interview takes place.....

I'll turn the recorder on now then, and for the record state:

Today's date is..... my name is..... and your name is and I have your consent to this interview? (yes)

Background

1. Can you give me an idea of the area where your practice is based and the sorts of patients you have attending your surgery?
Prompts: socio-economic and demographic characteristics, recurrent health issues, list no.
2. *Introduce vignette (sent prior to interview), ask them to refresh their memory of the vignette and ask questions relating to vignette.*

Awareness

3. Do you know if your GP or practice nurse colleagues have had experience of patients who have presented problems relating to domestic violence in the last two years?
 - a. If so, were they also parents?
 - b. Were there any concerns regarding their children?

Your involvement/support to GPs and practice nurses

4. Have your GP or practice nurse colleagues contacted you to discuss difficult cases, decisions regarding patients who have presented problems relating to domestic violence in the last two years?
5. Do you mind giving an example?
6. Were you able to help your colleague?
7. What is the type of support you as a practice manager is able to provide to your colleagues?
8. What are your colleagues (GPs and practice nurses) expectations towards you when they come to you with these difficult/complicated cases?

Documenting

9. Does your practice have a documenting policy?
10. Does the move towards open or online records raise any concerns?

Collaboration

11. Can you give us any examples of positive collaboration or challenges in working with children's services? How is the practice relationship with social services? Prompt: Is the collaboration positive or problematic?; What are the challenges?.
12. Can you give us any examples of positive collaboration or challenges in working with specialist domestic violence services? How is the practice relationship with specialist domestic violence services? Prompt: Is the collaboration positive or problematic?; What are the challenges?.
13. Where other agencies have ended their intervention with a family, are you alerted?
14. Do you monitor child protection referrals?

Additional Sources of Support and Training

15. Are there agencies you know of who can offer support to children and their parents in these situations?
 - a. Who are they?
 - b. What sort of support?
 - c. Do you display any information about these services in your practice?
16. What sort of training have you received around responding to domestic violence?

Prompts: In house, individualised or with other local professionals? How many hours? What level? Adequate to perceived needs? Who delivered it?

 - a. How would you rate it? How would you improve it?
17. Are there additional support or resources you or your colleagues would find useful to help you respond effectively?
18. Are there any further comments you would like to make or things you would like to say that we have not already discussed?

Thank you

Pre-interview data collection form



RESPONDS

Safeguarding – Primary Care – Domestic Violence

Informants - data collection form

Name						
Job Title						
Age Range Delete inapplicable	Under 25	25-34	35-44	45-54	55-64	65 and over
Gender			Ethnicity			
Professional Qualification			No of years in practice following professional qualification		Qualifying training in UK or elsewhere	
Organisation						
Detail any additional responsibilities						
CCG						

[Practice Name]
[Address]

18th March 2014

Dear [Practice Manager Name],

As part of the ongoing domestic violence research programme that created the IRIS model, which your practice is implementing, we have turned our attention to the interface between domestic violence and child safeguarding, a challenging terrain for general practices. The RESPONDS project is led by myself at the University of Bristol and is funded by the Department of Health's Policy Research Programme. (Bridging the Knowledge and Practice Gap between Domestic Violence and Child Safeguarding: Developing Policy and Training for General Practice, 115/0003)

<http://www.bristol.ac.uk/primaryhealthcare/researchthemes/responds.html>

We have developed a brief training session based on evidence from interviews with GPs and practice nurses, a review of training curricula, a systematic review of training programmes in this field and a consensus meeting with key stakeholders, including GPs, social workers, and domestic violence specialists.

We would like to pilot the training with IRIS practices in Bristol and hope you and our clinical team can join us. The 2-hour practice-based RESPONDS session **counts as level 3 training** and aims at improving the practice's response to victims and children who experience domestic violence. We will provide **certificates of attendance**. At the end of the session we will give the clinicians an exercise to try to apply over the subsequent weeks completely compatible with their daily practice.

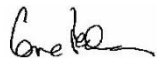
The evaluation of the pilot involves a brief pre- and post-training questionnaire for all participants, observation of the training by a researcher, and short phone interviews with one or two clinicians in your practice.

As this is an **NIHR portfolio study**, your participation counts towards our research target as a PCRN practice. We can also pay the practice **£500 for participation** in the pilot training and evaluation.

Over the years we have appreciated your engagement with IRIS and HERMES and hope you will help us test a solution to one of the thorniest issues that GPs. We want [name of practice] to be the first practice in the pilot, so we can modify the training before rolling it out to 6 [name of first city] and 6 [name of second city] practices. It would be great to do the 2-hour session on Monday 12th May (provisional date subject to trainer availability) but if that is not possible for all the clinicians, we can be flexible.

I will pitch this at the clinical meeting tomorrow and then follow it up with a phone conversation with you

With warm wishes



Gene Feder
RESPONDS principal investigator
Professor of primary health care, University of Bristol

Researching Education to Strengthen Primary care ON
Domestic violence & Safeguarding (RESPONDS)

THINK CHILD – THINK FAMILY – THINK SAFETY

Trainers Pack

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This pack was developed in partnership between:



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Introduction

This trainer's pack has been designed for professionals rolling out RESPONDS training and awareness sessions which aim to 'bridge the knowledge and practice gap between domestic violence and child safeguarding'

The training session is 2 hours in duration. It is designed to be delivered face to face to an audience of primary care professionals with specific emphasis on GPs. The 2 hour session covers the following topics which are divided into sections throughout the training:

9. Welcome and Context Setting
10. Linking Child Safeguarding and Domestic Violence in practice
11. Holding difficult conversations (in which safety and multi-agency working are considered)
12. Confidentiality
13. Speaking directly with children and young people
14. Child Protection Thresholds
15. Supporting victims of domestic violence and abuse (DVA), and negotiating referrals
16. Role of primary care after disclosure of DVA
17. Record Keeping

Each topic has a specific session within the training course and has key messages attached which clarify what you want your audience to take away with them. Any adaption's you make, for example if you decide to shorten the session to fit with your audience, should ensure that the key messages are still delivered.

When running training or workshops it is important to consider the following and plan how you will create a safe environment for learning. This needs to be a consideration even when delivering 'in house' to your own colleagues.

Language

Victims of domestic abuse are referred to as 'victim', 'patient', 'survivor' and 'client' interchangeably depending on the context of the point being made. We also use 'child' or 'young person' throughout and by this we mean 0-18 year olds. The use of the term young person is not to in anyway negate that those under 18 are legally children and it is essential that trainers keep a focus on abuse within this age group being a child protection issue.

Learning Environment

Trainers will need to make sure everyone feels it is a safe learning environment and monitor this throughout the session. Often it is preferable to invite participants to ask questions or to make comments as they arise throughout the training. This makes for better engagement and discussion between the trainer and the learners and amongst learners.

It is common to form an agreement about how this and other ways of working will be managed. For shorter sessions, creating a group agreement in conjunction with participants will take up disproportionate amounts of your session time so instead you might create a simple list of points for learners to consider and present this to them. Commonly group agreements include;

- Sticking to time.

Both in terms of arrival and coming back after breaks/group work – this is a group experience and not being on time delays the start of the session and impacts on others. Considering the topics to be covered during the training, time is of the essence!

- Giving everyone space to participate.

People learn differently, some by asking questions and debating points whereas others are more reflective. It is important that everyone thinks about the needs of others. Encourage participants to ask questions but to also consider holding back when they know they have contributed a lot to the discussions so that quieter group members can also have an opportunity. Acknowledge that some debate may need to be limited due to time constraints

- Respecting difference.

In terms of professional background and level of experience; everyone has something to contribute however experienced they are in this field or their role. It is also important that participants remember that we are all diverse and that some diversity is not visible. Ask participants to think carefully about the language they use and how this could impact on others. You may have an agency policy on discrimination and equality that you want to remind learners of. Or you may want adapt the following for your use: "It is the responsibility of the entire group to ensure that: this training actively contributes to developing a diverse learning environment which leads to the delivery of appropriate services; The particular needs of each person are recognised and respected whether they are training participants or clients."

- Confidentiality.

Whilst we want participants to take their learning and share it widely for the benefit of patients, this does not include details of disclosures that other participants may have made about their personal or professional life. Participants must remember that sensitive information should be left in the room. Trainers have a duty of care; where you have concerns that someone may be at risk in their personal life or if you have concerns about their practice you will need to speak to them about this and potentially escalate concerns. Be transparent about this from the outset, but reassure participants that you would consult with them privately first. Link this to GP's own duty of confidentiality and care toward their patients

- Self-care.

There is no requirement or necessity for participants to make personal disclosures. We know that many people have personal experiences of DVA and child abuse and some participants may choose to share this. Encourage participants to think carefully before doing so as it may impact on how comfortable they feel within the group for the remainder of the session. This may be particularly so if they are training alongside people they know and work with. Although many participants will be exposed to upsetting and challenging situations daily in their work, when on

training participants are not in their usual professional environment and this can mean that material upsets them in a way they were not expecting. Normalise this and encourage participants to look after themselves; opting out of exercises or taking time out when they need to.

Jargon

Trainers may wish to list and display unusual terms and acronyms; professional 'jargon', on flipchart e.g. DVA, CS, SafeLives DASH RIC, IDVA, CAF etc and invite learners to highlight any jargon used throughout the session for inclusion on the list. You will find a glossary at the back of this pack. Highlight at this point that names of services can be confusing e.g. social services v children's services. Explain that social services formerly applied to adult and children services combined but these are now separated across all local authorities. Throughout the training the terms children's services or children's social care will be used to refer to the social services focused on the welfare of children and young people. It is also important to point out that during the RESPONDS interviews with health professionals, some GP's talked about children's services when they were referring to health services for children and young people

Participants prior knowledge

For each session, the trainer(s) may choose to start with introductions to establish prior knowledge and also encourage contribution. In particular, establish what if any specific domestic violence training participants have had.

Gender

Non-abusing men are key allies in the work against domestic violence. Current data shows that the majority of high risk victims are female and domestic violence is widely acknowledged as a gendered issue. It is helpful to try and use gender neutral language to remind learners that domestic abuse can be perpetrated within same sex relationships and by women against male partners. However it must be acknowledged that women (particularly young women) are more at risk. If one or more participants are keen to debate this point, remind them that time is of the essence and suggest that they read some of the research about 'who does what to whom?' (Hester 2009)

Preparation for delivery

Please check the list of resources needed for each session (listed at the start of the session scripts). The majority of the resources will be at the back of your training pack. In addition you will need to;

- Personalise PowerPoint slides where applicable: PowerPoint slides are available to support the sessions in this pack. Notes to assist trainers in delivering them are contained within the script for each session. There are some slides that are blank for you to tailor to the session you are running e.g. the slide of local resources/services

- Training DVD: Most of the sessions use the training film as a learning medium. Check the facilities you will have available to you before the session to ensure you can show the DVD. Consider what you will do if there is a technical problem. For example, the film scenarios could be available as a written case study. You will need to check there is adequate audio and that the DVD can be played on any equipment you are using
- Identify any other domestic violence training in your area and any strategies that include such training. It is important they know you are rolling out the training so that training pathways can be established
- Speak to your local MARAC co-ordinator. Your local MARAC co-ordinator will collate MARAC referrals and can tell you the process for this in your area. You can use this information to personalise the MARAC information
- Speak to your local domestic abuse service: ask your local domestic abuse service for a summary of what they offer and copies of leaflets etc. These can be displayed at training to encourage learners to make referrals. In the case of an IRIS practice, communicate directly with the IRIS advocate educator.

Background reading and sources of further information

Suggested background reading:	Overview
<p>National Institute for Health and Care Excellence</p> <p>Domestic Violence and Abuse – how services can respond effectively 2014</p> <p>http://guidance.nice.org.uk/PHG/Wave20/60</p>	<p>Public health guidance, PH50 - Issued: February 2014. Domestic violence and abuse is a complex issue that needs sensitive handling by a range of health and social care professionals. The recommendations cover the broad spectrum of domestic violence and abuse, including violence perpetrated on men, on those in same-sex relationships and on young people. Working in a multi-agency partnership is the most effective way to approach the issue at both an operational and strategic level.</p>
<p>National Institute for Health and Care Excellence</p> <p>Domestic Violence and Abuse Pathway</p> <p>http://www.nice.org.uk/Search.do?searchText=domesticviolence</p>	<p>Fast, easy summary view of NICE guidance on 'Domestic violence and abuse'</p>
<p>Working Together to Safeguard Children – A guide to inter-agency working to safeguard and promote the welfare of children. HM Government March 2013</p> <p>http://www.workingtogetheronline.co.uk/documen</p>	<p>The guidance covers the legislative requirements and expectations on individual services to safeguard and promote the welfare of children and provides a clear framework for Local Safeguarding Children's Boards (LSCB's) to monitor the</p>

ts/Working%20TogetherFINAL.pdf	effectiveness of local services.
<p>Responding to domestic abuse – Guidance for general practices</p> <p>http://www.safelives.org.uk/sites/default/files/resources/SafeLives_GP_guidance_manual_STG1_editable_0.pdf</p>	This document provides guidance to general practices to help them respond effectively to patients experiencing domestic abuse. It is produced collaboratively between RCGP, IRIS and SafeLives
<p>Safeguarding Children and Young people: roles and competencies for health care staff</p> <p>Intercollegiate Document September 2010</p> <p>http://fflm.ac.uk/upload/documents/1290784237.pdf</p>	<p>To protect children and young people from harm, all health staff must have the competencies to recognise child maltreatment and to take effective action as appropriate to their role. The document describes six levels of competencies and provides model role descriptions for named and designated health professionals.</p> <p>(Updated from 2006, further updates were due in 2013)</p>
Section on domestic violence in updated RCGP/NSPCC toolkit	Not published yet, so not in public domain; included as Appendix B to this pack
<p>CAADA Insights 2: In Plain Sight: effective help for children exposed to domestic abuse (February 2014) – policy report</p> <p>http://safelives.org.uk/sites/default/files/resources/Final%20policy%20report%20in%20plain%20sight%20-%20effective%20help%20for%20children%20exposed%20to%20domestic%20abuse.pdf</p>	<p>This policy report examines the grave impact domestic abuse has on the children forced to live with it, challenges policy makers and commissioners to act now and provides practical recommendations about what to do.</p> <p>(Evidence taken from Insights Database – information relating to those identified as high risk victims of domestic abuse)</p>
Suggested Research	Overview
<p>Pearson, C. Hester, M. Harwin, N. (2006) <i>Making an Impact – Children and Domestic Violence A Reader</i>. Jessica Kingsley Publishing</p>	This fully updated Reader provides a comprehensive review of recent research and legislation relating to domestic violence and its consequences for children, and identifies the implications for practice
<p>Stanley, N. (2011) <i>Children Experiencing Domestic Violence: A Research Review</i>. Research in Practice</p>	This research review explores the research and evidence around children’s experience of domestic violence and the role of multi-agency service responses and interventions
<p>Hester, M. (2009) <i>Who Does What to Whom? Gender and Domestic Violence Perpetrators</i>, Bristol: University of Bristol in association with the</p>	This research explores how male victims and perpetrators of domestic violence may differ from female victims and perpetrators with regard

Northern Rock Foundation	to the nature and number of domestic violence incidents recorded by the police. The report explores 'who does what to whom', taking into account both context and consequences
Suggested websites	Overview
The Royal College of General Practitioners (RCGP) http://www.rcgp.org.uk/clinical-and-research/clinical-resources/domestic-violence.aspx	Advice and guidance for general practice on responding to domestic violence and abuse. This site also contains an e-learning package which is free to access and contains some useful resources
IRIS – Identification and Referral to Improve Safety http://www.irisdomesticviolence.org.uk/iris/	IRIS is collaboration between primary care and third sector organisations specialising in DVA. It is a general practice-based domestic violence and abuse (DVA) training support and referral programme that has been evaluated in a randomised controlled trial.
IDAS http://www.idas.org.uk/training/index.asp	A free online e-learning tool on the dynamics of domestic abuse. This is ideal for professionals. Learners can test their knowledge and print off a certificate when completed.

Section	Activity	Duration
1	Welcome and Context Setting - introductions, background to training and experiential exercise	15 mins
2	Linking Child Safeguarding and Domestic Violence in practice - Training DVD, Group Discussion, power point	15 mins
3 and 4	Holding difficult conversations and confidentiality - Training DVD, Group Discussion, power point	20 mins
5 and 6	Speaking directly with children and young people and child protection thresholds - Training DVD, Group Discussion, power point	20 mins
7 and 8	Supporting victims of domestic violence, negotiating referrals and the role of primary care after disclosure of dva - Training DVD, Group Discussion, power point	30 mins
9	Record Keeping - Training DVD, trainers to set task, power point and handouts	10 mins
10	End of Course Reflections - comment from each learning participant	10 mins

1: Welcome and Context Setting: Timing 15 mins

Aim of section	To welcome participants, provide an overview of the training session and give a background to its development
Methods	Trainer presentation, individual learner input and experiential group exercise
Materials	PowerPoint slides 1-3 Space for group to stand in a circle

Key Messages

- **Training has been designed based on evidence from RESPONDS research findings in particular listening to what GPs want from training on links between domestic violence and child safeguarding**
- **There is no ‘magic wand’ but by considering positive practice and reflecting on our own practice, we can ensure that we are seeing multiple perspectives of risk in families and therefore focusing on safety of all individuals involved**

Welcome, Introductions and context setting (15 mins)

- Welcome participants to the session and introduce yourself. Remember to type in your name on power point!
- Inform participants that the training lasts for 2 hours and it is preferable to work straight through, however be mindful of learners’ diverse needs – this may have to be negotiated with the group.
- Set the context of the training by informing participants:
 - - Training has been designed based on evidence from emerging findings from RESPONDS. RESPONDS is a 2 ½ year project, funded by the Department of Health policy research programme, aiming to bridge the knowledge and practice gap between domestic violence and child safeguarding: developing policy and training for general practice. A variety of research methods have been employed, including a systematic review of training evaluations, interviews with 69 frontline primary care professionals and scrutiny of DV content in CS training for GPs. The training has been designed in particular listening to what GPs want from training on the issues of domestic violence and child safeguarding
 - The session therefore will be:
 - focusing on unfolding a case study that will be viewed on screen throughout the training and
 - discussing collectively issues associated with responding to DV and CS and sharing practice ideas. These are two key methods GPs indicated they would find useful

Inform participants it would be impossible to capture every scenario that a health professional may face and the hope is that this will be a guide to reflecting on other presentations of domestic abuse and child maltreatment

The session aims to encourage health professionals to be proactive in making links between the issue of domestic abuse and child maltreatment and address the complexities of doing so (as identified by GPs in the RESPONDS research)

- Depending on group size, ask learners to introduce themselves providing their name and their role. This should be a swift round although it will be useful to get an understanding of how much training participants have done. It may well be that all participants know each other but if they don't, for e.g. multi agency group - introductions will be important as working in partnership with other services is a key aspect of the training. The experiential exercise is optional to allow trainers to decide if they need to spend more time on introductions
- You may want to show a working together agreement or present one of your own. Inform learners that while discussion is an important component of the training – time is of the essence! It may be an idea to negotiate with the group how you will close down discussions and move on when necessary.

Experiential Exercise: Optional but great for illustrating key points

Trainer: ask group to stand in a circle. Ask for a volunteer from the group to stand in the middle or take this position yourself. If asking for a volunteer inform the group that the person won't have to do anything silly but will be required to stand still in one position for a few minutes. When the person is in the middle ask 2 or 3 group members who are in different positions in the circle to comment on what they can see only in terms of the person in the middle's eyes, ears and hands. NB. This needs to be carefully managed as sometimes participants wish to provide huge amounts of information about what they can see – we are only wanting to know fact i.e. two hands, back of two ears, but can't see any eyes. It is important for the trainer to keep this snappy and quick so that it doesn't become patronising.

Key messages to pull out very quickly with group:

- We all have different perspectives
- Some parts are invisible
- We may make assumptions about what is there or not there
- We will need to share information if we are to get a full picture of what is going on

Inform the group that the person in the middle represents a victim of domestic abuse

Ask the group to consider 'if a participant from one part of the circle wants information about the person in the middle from a participant in another part of the circle, how should they approach them? (consider formalities around information sharing e.g. directly? request in writing?, pick up the phone? It will also be important to have an understanding of the role of the person you are obtaining information from)

Ask the group to consider 'now they both have more information about the person in the middle, who is responsible for them?' (we want the group to recognise that both people have responsibilities regarding the person in the middle)

Ask the person in the middle – how does it feel with everyone looking at you? Or comment on this yourself if it is you (it is important to recognise that the situation may feel overwhelming for a victim and they may want everyone to stop looking at them, therefore sensitivity is needed in our responses to intervening in families experiencing domestic abuse)

It is important we focus on safety with victims of domestic abuse and keep them central in our work but who remains invisible? (children maybe, perpetrators definitely!)

- Introduce Aims of the session
- **Show PowerPoint slides 2 & 3**

2: Linking Safeguarding Children and Domestic Violence in Practice

Timing: 15 mins

Aim of section	To provide knowledge of link from CS to DV and DV to CS and to strengthen self-efficacy in when to go for further investigation
Methods	Training DVD scenario 1 and Talking Head 1, group discussion, trainer input
Materials	PowerPoint slides 4-10 Flip Chart to document learner responses

Key Messages

- **Think Child, Think Family, Think Safety**

Training DVD – scene 1 Opening Scene (5 mins)

Key learning point:

For learners to appreciate that children and young people's behaviour may be indicative of witnessing and experiencing domestic violence and abuse and primary care professionals have a significant role to play in responding to and safeguarding both children and adults in these situations

- Show training DVD – scene 1 Opening Scene

- Hold discussion with training group asking the following questions
 - What are they thinking about Jake?
 - What are they thinking about Susan?
 - Would you consider domestic violence and abuse as an issue affecting this family? Why might it be important to do so?
 - What are the indicators?

This is a generally snappy discussion to gather the initial thoughts of the group. As a trainer you are likely at this stage to be assessing the general knowledge levels and attitudes of the group. It is very likely that they will vary! Your aim is to motivate participants' 'curiosity' in patients' situations and to encourage them from the outset to think about wider issues in family life that may be interconnected e.g. aggression and violence, alcohol, depression, children's behavioural issues. Guide the discussion to make these points and highlight the importance of early identification

Power Point and discussion (10 mins)

Key learning point

To be aware of the evidence of the links between child maltreatment and domestic violence and abuse and begin to consider health professionals' responses to families where these issues could be occurring

- **Show power point slide 4 , 5 and 6** to confirm the above points and suggest that the opening scene viewed on the DVD is the sort of situation in which GPs should have the issue of child maltreatment and domestic violence in their minds
- Hold further group discussion and ask the following questions;
 - How might they proceed with the appointment?
 - What are the challenges in practice?
- Collect ideas and issues raised on the flip chart (it may be helpful to have 2 columns 1- ideas for proceeding appointment 2 – practice challenges) but do not delve too deeply into discussion as hopefully issues raised will be covered as we progress through the training DVD. Write them onto the flip chart as questions/issues
- Ideas for proceeding with appointment will hopefully include asking questions about domestic abuse, thinking about speaking with Jake, thinking about safety, recognising the need for further appointments
- Challenges may include 'difficult asking questions about domestic abuse', 'not having time to address it', 'people might not want help', 'they may not acknowledge that's what is happening' 'we might be jumping to conclusions', 'not having time to ask everyone', 'difficult to speak with children', 'might make things worse'

- Ask the group further about their practice in terms of asking questions about domestic abuse. Do they feel it's important? How and when can this be done? Ask for examples. Acknowledge complexities involved in this but encourage participants to think creatively
- Inform participants that it can be helpful to obtain different perspectives of people working in the field. Throughout the training, perspectives of practitioners from Health and Social Care have been incorporated to stimulate further thinking and provide helpful suggestions from research and practice – introduce and play training DVD **GP perspective 1**
- Following the excerpt ask participants what further practice information did they gain? Draw out the point that it is important not only to prepare to ask questions, but to think what information you may need from the initial consultation.
- Round up discussion **using power point slide 7, 8, 9 and 10**. Highlight the key message here, that we are encouraging GP's and health professionals to 'think child, think family, think safety' – a proactive and holistic response to protecting children and victims of domestic abuse
- Some trainer prompts are below to help guide the discussions outlined above but be mindful of time – you want to extract the key points swiftly. It is important to be familiar with the training content so you know what will be covered later during the training. The information column can be used to address discussion points raised

Issue	Information	Discussion points
Asking questions about domestic violence and abuse	<p>NICE guidelines recommend that health and social care organisations should create an environment in which DVA can be disclosed and frontline staff are trained to ask questions about it</p> <p>HARKS provides a model of asking http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2034562</p> <p>Children are suffering multiple physical and mental health consequences as a result of exposure to domestic abuse (CAADA 2014)</p>	<p>Should we ask women and men? Together or separately? In what circumstances? What may create an environment that will encourage disclosure? (posters, leaflets, information in waiting areas)</p> <p>Should concerns raised about children prompt questions about domestic violence and abuse?</p> <p>Do you have a policy and is everyone familiar with it?</p>

When to ask about domestic violence and abuse	<p>RESPONDS research highlighted GPs more likely to consider child protection issues when they encounter DV than they are to look for DV in child protection cases</p> <p>RCGP training online explores indicators of domestic abuse</p>	<p>What might the benefit be of asking if we had a child protection concern?</p> <p>Trainers can bring into discussion point raised in Talking Head 1: There is no evidence to suggest that screening increases safety but thresholds for asking about domestic violence and abuse should be low</p>
Privacy	<p>NICE guidelines highlight the enquiry should be made in private, on a one to one basis in an environment where the person feels safe, in a kind, sensitive manner.</p>	<p>What if the partner is present? (many creative examples of obtaining privacy are adopted in a number of health settings e.g involving other members of trained staff to ask while they obtain specimens or suggesting follow up appointments)</p> <p>What if children are present? (it is not recommended that questions are asked when children over the age of 3 are present)</p>
Limited Time	<p>RESPONDS research highlighted that time was a barrier for GP's exploring issues such as domestic abuse</p>	<p>Trainers can bring into discussion point raised in Talking Head 1: Viewing relationship with patient as continuous and ongoing helps address a barrier such as time. You don't have to do everything at once!</p>

Section 3 and 4: Holding difficult conversations and confidentiality

Timing 20 mins

Aim of section	<p>To provide examples of holding difficult conversations and increase participant's awareness of support services and interagency working</p> <p>To raise the issues of confidentiality and record keeping and provide guidance for practice</p>
Methods	<p>Training DVD scenario 2 and Talking Head 2, group discussion, trainer</p>

	input
Materials	PowerPoint slides 11 - 13 Flip Chart to document learner responses

Key Message

- **GP's and frontline health professionals should ask questions where appropriate about domestic violence and abuse and the safety of all those concerned. They cannot however be responsible for managing potential risks alone. It is essential to work with other services when domestic abuse is disclosed and there are children in the family**

Training DVD scene 2 – Progression of appointment (10 mins)

Key learning point:

Practitioners should handle difficult conversations sensitively, have knowledge of services that can offer support to victims of domestic abuse and their children and consider safety of all family members

- Ask participants to hold in their minds, thoughts about how they may progress the appointment started in scene 1. Explain we will now see how the appointment progressed in this case. **Show training DVD, scene 2**
- Following the scenario, collect some initial thoughts from the group about the approach they have seen.
- Ask the group 'what risks have you identified from what you have seen?'

Group exercise and power point presentation – options available to GPs when supporting patients experiencing domestic violence and abuse (10 mins)

Key learning point:

Knowledge of local services and systems can improve the range of support GP's can offer patients

- Ask participants on their tables (or in small groups) to discuss if there is anything else the GP could have done/suggested? Would they do anything differently? Give the groups time to discuss but remind them that they will only have a few minutes. You are only asking them to make one or two suggestions

- Collect an example from each table/group (group size permitting – there may of course be one group if numbers are small)
- As examples are given, it will be interesting to see if any suggestions relate to the perpetrator. Stress that interventions here must always consider safety to all family members – however opportunities may present e.g. if the perpetrator is registered at the same practice, if alcohol is identified as an issue, if routine health checks can be suggested. But beware of severe risk to DVA survivor if her disclosure is inadvertently revealed to the perpetrator, including information put into his medical record.
- Notice if suggestions include all family members i.e. the 4 year old daughter. She may be easily missed and if this happens it is an important learning point! – how easily children can become invisible to practitioners – a point raised in many SCRs. If she is not mentioned, ask the group directly about her, what are the risks in assuming she is ‘good as gold’ as suggested by her mother? The role of the health visitor may be crucial here to ensure all children are safeguarded.
- Play the training DVD – **GP Perspective 2)** the services that are available to GP’s and addressing the issue of confidentiality
- Following this excerpt **show power point slide 11**

Working in partnership after disclosure of domestic abuse

- Consider risks presenting to all family members
- Initiate a health visitor review where appropriate
- Inform patient where relevant that you will be working with other services e.g. school, school nurse
- Ask if this is ok
- Inform patients about specialist domestic abuse support services
- Seek consent to make a referral
- Ask if it safe for them to go home
- Provide domestic abuse basic safety information e.g.consider what you may do if you had to leave your home suddenly, in an emergency call 999



Working in partnership	Trainer's Notes
Consider risks presenting to all family members	Remind practitioners to gain as much information about who is in the home and who may potentially be at risk of serious harm
Initiate a health visitor review where appropriate	If children under 5 are present the health visitor can be a key professional in obtaining further information which may inform courses or action. They may be able to initiate a CAF or involve the relevant services who can. Health visitors can be lead professionals in safeguarding issues and interventions may be very effective if GP's and health visitors collaborate, sharing both information and decisions about safeguarding families
Inform patients where relevant that you will be working with other services e.g. school, school nurse	Being specific about who you will talk with and why is important. Victims of domestic abuse may be particularly worried about who gets to hear what is going on. Information gathering from other professionals does not necessarily need to involve information sharing without consent
Ask if this is ok	Seek consent where possible from patients regarding information sharing. If you believe that there is imminent risk of serious harm to children or adults you may have to share information without consent. SafeLives has an information sharing without consent form that may be useful to refer to which can be found on the SafeLives website
Inform patients about local specialist domestic abuse services	Remind practitioners to have information about these services available. If the practice is an IRIS practice, ask if everyone is aware of the direct referral pathway. Inform participants that domestic abuse services will most likely conduct a risk assessment with the victim when they receive referrals. If they are considered high risk they may be referred to MARAC. The next power point slides will cover this
Provide domestic abuse basic safety information	Ask participants to remember to check out how safe someone feels to return home. Name abusive behaviour where possible and reassure a victim that it is not ok and is not their fault. Remind them that they can phone 999 if they ever feel afraid of someone in their home and ask them to consider what they may do in an emergency e.g. if they had to leave the house suddenly

- **Show power point slide 12** to highlight the sorts of services patients and GP's can expect from a domestic abuse service



- Stress that most Domestic Abuse services will assess levels of risk and tailor the support offered to the needs of the patient/client depending on their assessed level of risk e.g. if high risk is identified a referral to MARAC will be made
- If GP's wish to know more about risk assessment or MARAC, direct them to local MARAC training and/or the SafeLives website <http://www.safelives.org.uk/>
- It is important to highlight to training participants that they should not assume referrals to children's social services would automatically be made by the domestic abuse service. If a GP has concerns about harm to the children they should follow child protection procedures which we will be moving on to consider in more detail.
- **Show power point slide 13** – trainers will need to tailor this slide to their local area to provide key service information for group participants

Section 5 and 6: Speaking directly to children and young people and Child Protection Thresholds

Timing 20 mins

Aim of section	To highlight ways health professionals can speaking directly to children and young people and consider thresholds for child protection intervention
Methods	Training DVD scenario 3
Materials	Trainers should equip themselves and make available to participants any local safeguarding children's board threshold of intervention information

	<p>PowerPoint slides 14 - 15</p> <p>Flip Chart to document learner responses</p>
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Key Message

- **Important information can be gained by speaking with young people on a one to one basis and therefore doing so can lead to health professionals making more accurate decisions relating to risk and intervention**

Acknowledge/remind the clinicians that they have great expertise in managing consultations with adults and children, but probably less experienced in speaking to child patients on their own. They are however familiar with talking with children and young people in sensitive situations such as when they are conducting a physical examination

Group discussion and training DVD – (10 mins)

Key learning point:

Being listened to and taken seriously can have a positive impact on the resilience of children who have experienced and witnessed domestic violence and abuse

- Explain to the group that RESPONDS research highlighted that GPs and health professionals found examples from others helpful when considering their own practice. In relation to talking to children directly, GPs interviewed varied in whether they did this or not and a number of those who said they didn't do so, thought on reflection that they should. Some of those who had done so in the past said that they now believed that it was important to do as children may not have anyone else they can talk to about DVA. The following excerpt from the training DVD demonstrates ways in which conversations with children and young people can be handled by GPs. Ask the group to note as they watch it aspects that they think are particularly effective when talking to a child.
- **Show scene 3 on training DVD**
- Take some feedback following the scenario and the notes that group members made while they were watching
- Ask the group the following questions

-Would they do anything differently so far? [Prompt: how would they modulate the intensity of the consultation?]

-What risks are identified and what does this mean in terms of actions? (this can be done in groups if time)

- Trainers will need to guide the discussion toward the issue of whether GPs and health professionals would involve children's services and gain an idea from participants of who would and wouldn't be
- **Remind participants to consider the needs of the 4 year old in the family – again highlight how easily children can become invisible!**

Group discussion and power point – (10 mins)

Key learning point:

By looking at children's needs on a continuum, GPs and other health professionals can match the child/young person's needs with the appropriate assessment and provision.

- The following model should be linked to GP's Child Safeguarding Training and is being used here to extend the model to DVA exposure. **Show power point slide 14.** The Continuum of Need model (windscreen) provides a multi-agency, whole systems approach to assessment, prevention and intervention for children, young people and their families and directly supports the full implementation of the CAF.
- Explain this model has been developed by the Torbay Safeguarding Children's Board and variations of it are used by many local authorities across England and Wales to provide guidance around 'thresholds of intervention'.
- Hand out local documents where possible
- Explain this model is dynamic and provides a needs led, outcome driven matrix of need and vulnerability which, when used effectively, can match the child/young person's needs with the appropriate assessment and provision.
- The Continuum of Need model describes the spectrum of support and the relationship between the different levels of need. It illustrates how a child's level of need can move forward and backwards across the continuum, highlighting the importance of integrated service delivery.
- It also reinforces the need for an effective seamless process to ensure continuity of care when a child or young person moves between different levels of support.
- The view of a 'whole systems' approach highlights the importance of there always being a practitioner in place to co-ordinate service activity and to act as single point of contact whenever a child or young person requires integrated support. Ask the group who they think this practitioner should be and what is the role of health in this process?

- The model is also referred to as the 'Child's Journey' (e.g. in Torbay, Gloucestershire) and identifies four levels of vulnerability and need to assist practitioners to identify the most appropriate service response for children, young people and their families.
- **Show power point slide 15** and ask GP's what indicators they may see at each level in children and young people exposed to DVA and crucially what their role is in supporting them and what they can do at each level ;

Levels of Vulnerability and Need

Level 1 Universal	Children with no additional needs. Children who make good overall progress in all areas of development and receive appropriate universal services.
Level 2 Additional Needs	Children with additional needs. Children whose health and development may be adversely affected and who would benefit from extra help in order to make the best of their life chances.
Level 3 Complex Additional Needs	Children with complex needs. Children whose health and/or development is being impaired or there is a high risk of impairment.
Level 4 In Need of Protection	Children who are experiencing significant harm or where there is a likelihood of significant harm.

Section 7 and 8: **Supporting victims of domestic violence, negotiating referrals and the Role of Primary Care after disclosure of DVA**

Timing 30 mins

Aim of section	To demonstrate ways that GP's can negotiate referrals to ensure the safety of children and to know what they should expect from children's services as well as actively supporting victims of domestic violence and abuse. This section highlights the process as an ongoing relationship with the family.
Methods	Training DVD scenario 4 and Talking Heads 3 and 4
Materials	Trainers should be familiar with local safeguarding procedures and

	<p>include local referral information</p> <p>PowerPoint slide 16</p> <p>Flip Chart to record responses</p>
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Key Message

- **GPs and health professionals have an ongoing role to play in supporting both threshold and sub-threshold patients and an appreciation of the role of children's services can assist with understanding how best to do this**

Group discussion and training DVD – (10 mins)

Key learning point:

Negotiating referrals is an area which should be handled sensitively with patients who should be informed of all actions taken and encouraged to see the support that other services can provide

- Ask the group from what they have seen so far in the scenario, what do they think the GP will do next?
- Take a couple of comments from the group
- Explain that you will now show the outcome to this particular scenario and recognise that not all situations may progress like this
- **Show training DVD scene 4**
- Following the scenario ask the group for their thoughts on how the GP handled this situation
- In particular ask the group for key learning points around how the referrals were negotiated with Susan and Jake
- **Show slide 16 and ensure participants are clear of local procedures**
- Ask for thoughts around what would happen if Susan disengaged or Jake did not want to speak alone – how would the negotiations have to change?
- Be ready for question about some area policies (e.g. London) to refer all children exposed to DVA. If this were implemented, children's services would be quickly overwhelmed and, paradoxically, increase risk for the children with greatest needs. So, as we do in relation to potential direct maltreatment, we need to make a judgement, helped by the DVA agency if the parent has agreed to referral or the local named safeguarding lead
- (At this stage, trainers may need to highlight the statutory duty of care we all have when identifying high risk of harm. SafeLives has produced information sharing without consent form which can be accessed on the SafeLives website. This may be useful to refer to as it contains a decision making process for professionals to follow when they are faced with difficult decisions such as sharing information without consent)

The Role of Children's Services

The Training DVD 'Children's Services Perspective' (15 mins) is available for this section. Use of this section of the training film is OPTIONAL. To reduce overall film use, which is extensive throughout this training package, trainers may prefer to explain directly to GP's what they can expect from Children's services following a referral. The film can be made available to GP's following the training should they wish to directly view the perspective of children's services

Key learning point:

Information for GPs and frontline health professionals about the role of children's services, what they can expect following a referral and what referral information is most helpful to provide

- Explain to the training participants that GPs interviewed as part of the RESPONDS research clearly stated that they wanted more information about the role of children's services so they could be clear about their expectations when working with this service
- The following excerpt has therefore been recorded to help GPs and health professionals increase their understanding of children's services and consider the information they provide when making a referral
- Show training film Children's Services perspectives

The Role of Primary Care after disclosure of DVA– Group Discussion and Training GP perspective 1 & 2 (5 mins)

Key learning point:

Whether patients have met the threshold for children's services referral or not, the GP has an ongoing role to play with families experiencing domestic abuse

- Ask the group now that a referral has been made, has the GP fulfilled their role? (Hopefully the answer will be no!)
- Highlight to the group the importance of ensuring support is in place for the adult patient as we shouldn't assume that a survivor of domestic abuse will get appropriate support as a result of a children's services referral
- Ask what more the GP can do for Susan and/or Jake?
- Should they be taking any action with regard Dave (the perpetrator of domestic abuse)?
- Collect responses from group on flip chart (you may want to divide the flip chart in 3 columns e.g. Jake, Susan, Dave)
- Inform the group that the final section of DVD to play them is again the perspective's directly from GP's
- **Play training DVD GP perspective 1 & 2**

Group discussion and action learning (homework!) task – Recording Information (10 mins)

Key learning point:

RESPONDS research has highlighted that practice differs in terms of recording information about domestic abuse and this is an area which is being debated nationally

- Show training DVD **Talking Head Recording DV and CS issues**

Introduce a task that the RESPONDS project is keen to set. Encourage participants to see the task in the context of contribution to practice development. **Use slide 17** as a backdrop to discussing the task. The task is as follows and this information can be found in the appendix so that it can be given as a handout along with **Use of codes in relation to child safeguarding/DVA interface and Aspects of practice policy in relation to domestic violence and child safeguarding;**

Trainers to set group members the following task

Evidence from the Responds interviews shows that there are multiple methods of recording both CS and DV – different codes, within the text, flags, and hidden messages. Interviews suggest there were differences between general practices and *within* general practice – so you all probably do it differently. Serious case reviews suggest the most important thing is to have a consistent recording system that everyone in the practice understands and uses consistently, including locums, trainees, and new members of staff. NICE also recommend this approach and suggest using codes.

Currently there is no national guidance about which codes to use and your organisation needs to be confident and familiar with the recording system and ensure that there is a consistent approach to the way DVA and CS are recorded

There are some difficult areas – what codes? Which family members notes and under which circumstances? Do the people that redact notes know the policy? Because everyone does it differently you need to develop a policy

We suggest you hold a practice meeting to draw up a practice policy for how you record DV and CS, which codes you will use, and how you record in different family members' records. You will also need to develop a strategy for making sure everyone in the practice uses the codes and knows about the codes – we suggest an audit cycle. Advice is available at <http://www.clininf.eu/maltreatment/> and we (the trainers) can help

Also available information at

<http://www.rcgp.org.uk/clinical-and-research/clinical-resources/clinical-audit/safeguarding-children-multi-site-audit.aspx>

If you already have a policy please review this after the training, make sure you are happy with it and make sure everyone in the practice knows about it and agrees with it.

The RESPONDS team would like to request your input into practice development in this area and would very much appreciate a copy of your completed practice policy (including any existing policies) on recording DVA and CS. Please send us a copy so that we can start to collect different policies and spread good practice.

We would be most grateful if this could be emailed to your trainer or to Eszter.Szilassy@bristol.ac.uk within 2 weeks following RESPONDS training.

Section 9: End of course messages, reflections and evaluation

Timing 10 mins

Aim of section	To close the training and ensure GP's are taking away key messages and actions
Methods	Trainer to obtain reflection from each group member
Materials	Discussion

- **Show slide 18 and 19 to highlight end of course messages**
- Thank participants for their time and ask for a closing reflection from each participant
- Ensure participants have completed evaluation form

Glossary of terms

Actuarial assessment	This involves the use of risk factors to compute the probability of harm occurring. In domestic abuse the risk factors identified and used in actuarial risk assessment of victims relate to the likelihood of homicide occurring.
Clinical assessment and professional judgement	The clinical assessment of dangerousness is based on an individual practitioner's judgement of a situation, based on knowledge and professional experience.
Common Assessment Framework	The CAF is a shared assessment and planning framework for use across all children's services and all local areas in England. It aims to help the early identification of children's additional needs and promote co-ordinated service provision to meet them
CS	Child Safeguarding
DASH	Domestic Abuse Stalking 'Honour'-Based Violence
DVA	Domestic Violence and Abuse
IDVA	Independent Domestic Violence Advisors. Work with high risk victims of domestic abuse. Attend MARACs to represent the voice of the victim.
MARAC	A Multi-Agency Risk Assessment Conference is a multi-agency meeting to address the safety of high risk victims of domestic abuse.
Multi-agency	This refers to a context in which a variety of agencies contribute towards achieving a common goal, for example client safety. A multi-agency approach is the most effective route to risk management, and IDVAs should always work in a multi-agency context.
Risk assessment	In the context of domestic abuse, this relates to the probability of further harm or homicide based on an understanding of visible risk factors and professional judgement. This information is used to inform safety planning and risk management measures.
Risk indicators	Factors that have been found, through research, to correlate to the likelihood of serious harm or homicide occurring in intimate partner relationships. These indicators have been used to create domestic abuse risk assessment tools.
SARC	Sexual Assault Referral Centre. A SARC is a one-stop location where female and male victims of rape and serious sexual assault can receive medical care and counselling, and have the opportunity to assist the police investigation, including undergoing a forensic examination.
Safety plan	Refers to a personalised plan completed with a client to address safety concerns, based on the risk assessment. This forms a key part of risk management.

Appendix A

Trainers to set group members the following task

Evidence from the Responds interviews shows that there are multiple methods of recording both CS and DV – different codes, within the text, flags, and hidden messages. Interviews suggest there were differences between general practices and *within* general practice – so you all probably do it differently. Serious case reviews suggest the most important thing is to have a consistent recording system that everyone in the practice understands and uses consistently, including locums, trainees, and new members of staff. NICE also recommend this approach and suggest using codes.

Currently there is no national guidance about which codes to use and your organisation needs to be confident and familiar with the recording system and ensure that there is a consistent approach to the way DVA and CS are recorded

There are some difficult areas – what codes? Which family members notes and under which circumstances? Do the people that redact notes know the policy? Because everyone does it differently you need to develop a policy

We suggest you hold a practice meeting to draw up a practice policy for how you record DV and CS, which codes you will use, and how you record in different family members' records. You will also need to develop a strategy for making sure everyone in the practice uses the codes and knows about the codes – we suggest an audit cycle. Advice is available at <http://www.clininf.eu/maltreatment/> and we (the trainers) can help

If you already have a policy please review this after the training, make sure you are happy with it and make sure everyone in the practice knows about it and agrees with it.

The RESPONDS team would like to request your input into practice development in this area and would very much appreciate a copy of your completed practice policy on recording DVA and CS. Please send us a copy so that we can start to collect different policies and spread good practice.

We would be most grateful if this could be emailed to your trainer or to Eszter.Szilassy@bristol.ac.uk within 2 weeks following RESPONDS training.

Use of codes in relation to child safeguarding/DVA interface

REFERENCE TO MALTREATMENT		
U3.11 Non accidental injury	Every relevant child record	
13IB000 Child in foster care	Every relevant child record	These children often need high levels of continuing care
13W3 (13W3.) Child abuse in the family	Every relevant child record, including close family/household contacts of index case	Note the nature of the abuse and the relationship of the child to the index case
13VF (13VF.) At risk of violence in the home	Every relevant adult or child record	Note the nature of the abuse
14X3 (XaJhe) History of domestic violence	Every adult who has perpetrated DV AND disclosed it themselves	<i>Do not record unsubstantiated allegations – code should only be used when perpetrator themselves discloses or information from 3rd party (e.g. police report). Not safe to record in perpetrator's record if information comes from victim. If recorded in children's records, be aware of risk that perpetrator may discover disclosure through these records</i>
HISTORY / CAUSES FOR CONCERN		
13IS child in need	Every relevant child record	
13IF.00 child at risk	Every relevant child record	Note the nature of the risk
13If (XaMzr) Child is cause for concern	Every relevant child record	
Z613.00 other parent-child problems	Every relevant child record	

Aspects of practice policy in relation to domestic violence and child safeguarding

OUTCOME	TASK(S)
Practice Policy and Procedures	
1. The practice has a clearly defined and understood policy in place regarding safeguarding children, young people and at-risk adults that also addresses domestic violence and elder abuse issues. This policy is known to all members of the Primary Care Team, who can access these documents whenever required.	Develop a safeguarding practice policy which is regularly reviewed and updated.
2. Safeguarding and domestic violence are regularly addressed in practice meetings.	Include safeguarding and domestic violence as

	regular agenda items in practice meetings.
3. Any hospital communications to GPs raising potential concerns about children subject to a Child Protection Plan should be regarded as 'urgent' rather than 'routine' and followed up accordingly	Ensure that hospital communications to the practice about children subject to a Child Protection Plan are regarded as 'urgent' and followed up accordingly.
4. Reports received by GP practices from other health providers [A&E services] should take into account the content of the report and consider any actions required to safeguard children and/or vulnerable adults within the household.	Risk assessment process in place to consider the need to share information with other agencies where indicated.
	Record made of actions taken by the practice
5. Each general practice has a facility for flagging 'child at risk' / 'vulnerable family' which can be seen and acted upon by all health professionals involved in the care of at risk/or potentially at risk children and their parents/carers. Action is taken immediately a domestic violence issue arises and processes for ensuring this is followed up in the longer-term are in place.	Ensure that a facility for flagging a 'child at risk' in electronic patient records is in place and ensure that this is consistently used.
	Put in place a process for following up domestic violence issues in both the short, and longer-term. Ensure that this procedure is understood and used by all GPs and practice staff.
6. Disclosure of domestic violence by the victim should be entered in their record, if possible disguised (e.g. "HARKS +") so that if they are accompanied at the next consultation by the perpetrator this is not visible. The problem should not be entered into the perpetrator's record, as this is a breach of confidence that potentially endangers the victim.	Ensure that this procedure is understood and used by all GPs and practice staff.
7. Information about domestic violence from a 3 rd party (e.g. Police) should be entered into the victim's, perpetrator's and their children's records	Ensure that this procedure is understood and used by all GPs and practice staff.
6. When a printed copy of records from the electronic records system is transferred to another practice, or made available for serious case reviews, steps are taken to ensure that the copy includes all relevant entries and scanned summaries from the records.	Take steps to ensure that any printed copy of records transferred to another practice or provided for a serious case review include all relevant correspondence and Case Conference summaries
7. When a child is made subject to a Child Protection Plan, a record, including the category of the Child Protection Plan, is made in their medical notes and also when they are removed from a Child Protection Plan	Put in place a procedure to ensure Child Protection Plans are recorded in the child's notes, and also when Plan is removed.

Appendix B - "Pre-publication draft: not for further dissemination"

Exposure of children to domestic violence

What is domestic violence?

In the UK domestic violence is defined as any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality.

This can encompass, but is not limited to, the following types of abuse:

- psychological
- physical
- sexual
- financial
- emotional

Domestic violence is a devastating breach of human rights as well as a major public health and clinical problem. The 2010–11 British crime survey reports lifetime partner abuse prevalence of 27% for women and 14% for men; 7 and 5% respectively had experienced abuse in the previous 12 months. The British Crime Survey also measures *non-partner* domestic violence (termed ‘family abuse’), reporting a lifetime prevalence of 10 and 7% for women and men, respectively. The starkest gender difference in prevalence is for sexual assault (lifetime experience: 17% women and 2% men), and women generally experience more severe, repeated abuse from male partners, with more significant injuries and long term health consequences than men.

Impact of domestic violence on children

The damaging health and psychosocial effects of domestic violence cascade through the generations. Exposure to domestic violence during childhood and adolescence damages health across the lifespan. There is a moderate to strong association between children’s exposure to interpersonal violence and internalising symptoms (e.g. anxiety, depression), externalising behaviours (e.g. aggression) and trauma symptoms. Children exposed to domestic violence are 2-4 times more likely than children from non violent homes, to exhibit clinically significant problems. Children’s exposure to domestic violence also damages social development and academic attainment. There is considerable variation in children’s reactions and adaptation. This is partly explained by the presence or absence of other adversities in children’s lives. For example, children exposed to domestic violence are at increased risk of being maltreated directly or neglected, with higher rates of maladjustment amongst children experiencing this ‘double jeopardy’. The overlap with direct maltreatment ranges from 40 to 60% of children exposed to domestic violence, who may also experience a range of other adversities such as poverty, parental mental ill health, substance misuse and antisocial behavior. The more adversities a child is exposed to the greater the risk of negative outcomes. The impact of domestic violence on children does not require witnessing of violent acts.

Presentations of children’s domestic violence exposure

The most likely route of disclosure will be via the non-abusing parent’s account of domestic violence, although this is unlikely to be a spontaneous disclosure and is more likely if the GP asks directly about domestic violence, preferably after training.¹² By the same token, spontaneous disclosure by a child, particularly in the presence of a parent is rare. When should a GP suspect that there is domestic violence in a family? Some of the presentations that should bring the question to mind, many the same as those that should raise the suspicion of direct child maltreatment: anxiety of fear related behavior or unexplained illness, running away from home, constant worry about possible danger or safety of family members, evidence of injuries.

Identifying a child or young person’s exposure to domestic violence and immediate response to disclosure

A central feature of good practice is speaking to the child or young person on their own in a way that is safe for them and the parent who is experiencing domestic violence, seeking that parent’s permission to do so. Other features¹³ of good practice for primary care professionals include: be realistic and honest about the limits of confidentiality (but promise to keep the child informed of what is happening); help the child or young person to understand that they are not to blame for the domestic violence and that they are not alone; let them know that domestic violence is never acceptable; be careful to acknowledge their experiences and help them understand that it is not their responsibility to protect the non-abusive parent, while validating their concern and any action they may have taken to protect that parent. Children and young people can find it hard to talk for many reasons, such as shame, guilt, torn loyalties, threats as to what will happen if they tell anyone, not wanting to leave home or split up the family, or simply not having the language to express what is

¹² <http://www.rcgp.org.uk/clinical-and-research/clinical-resources/~media/Files/CIRC/Domestic%20Violence/RCGP-Responding%20to%20abuse%20in%20domestic%20violence-January-2013.ashx>

¹³ <http://www.avaproject.org.uk/our-resources/good-practice-guidance--toolkits/improving-safety-reducing-harm-children-young-people-and-domestic-violence-%282009%29.aspx>

going on. If you are the first person a child has disclosed to, you are a very important person for that child. Police and social services are trained to interview children. If a child discloses to you, it may be tempting to ask a lot of questions, but this is *not your role*. You will need to find out enough to determine whether a referral is necessary, but try to use open-ended questions. Should the case go to court, the court will need to ensure that words or suggestions have not been put in the child's mouth.

Further response

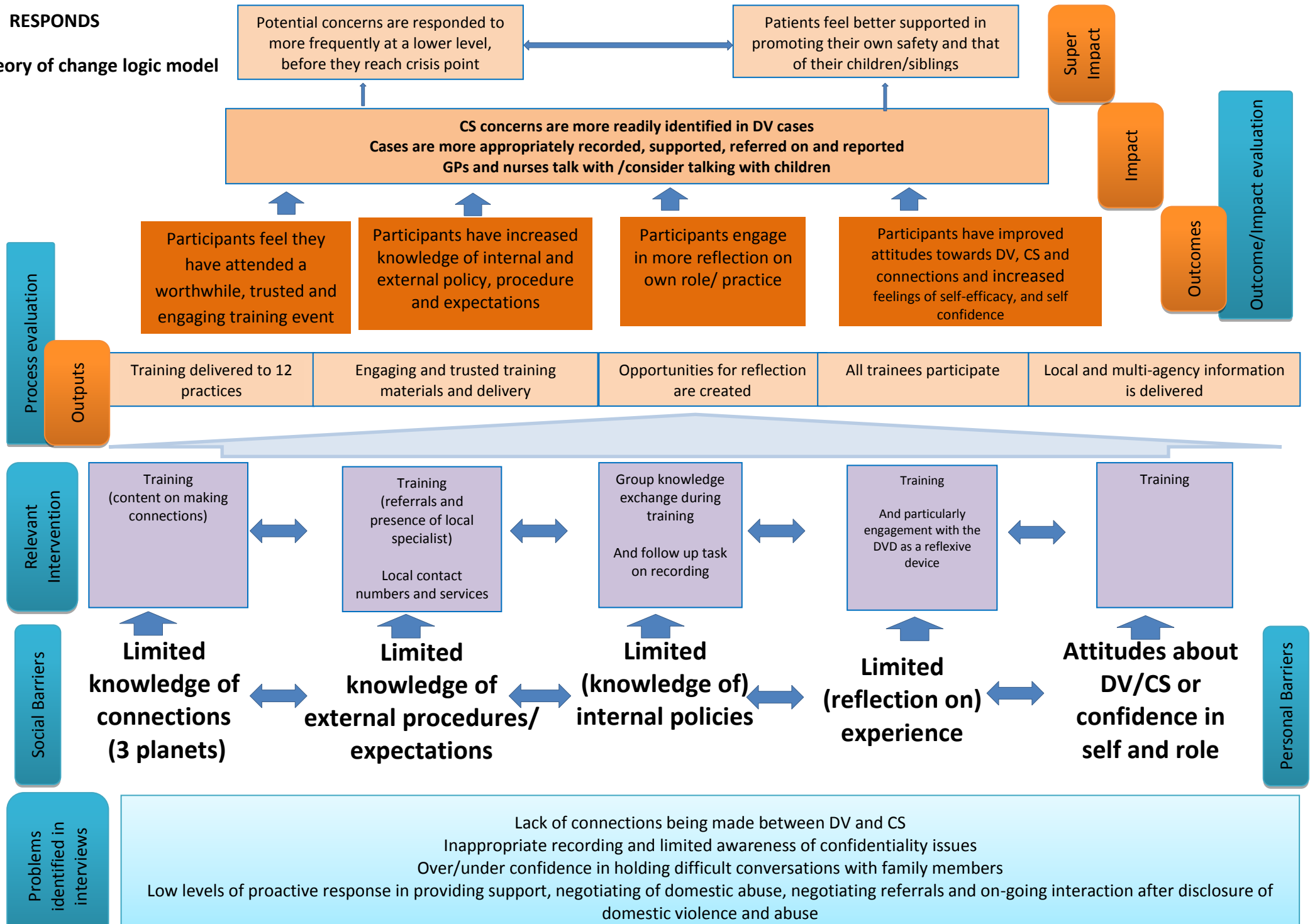
If a child is at risk of harm, the local safeguarding children board procedures should be followed immediately. The decision to refer to children's social services is a fine judgment in relation to domestic violence exposure in the absence of direct maltreatment hinging around the concept of significant harm: 'any impairment of the child's health or development as a result of witnessing the ill-treatment of another person, such as domestic violence'. Some localities have a policy – impossible to implement – that *all* children in families where you suspect domestic violence should be referred. Discussion with your practice's safeguarding lead is essential and – if you are that person – discussion with your local named nurse or doctor for safeguarding will be helpful in reaching a decision about referral. The common assessment framework has a section on domestic violence within the parenting capacity section that can inform the referral decision by identifying children's level of need. Domestic violence advocacy services, which will be able to support the parent experiencing abuse, also have the expertise to assess children's needs and the need for referral. These services also undertake risk assessment for the parent and their children, a task beyond the capacity of most general practices. Supporting the parent experiencing domestic violence is crucial to protecting children exposed to that violence.

Information sharing

Domestic violence is a key issue for safe information sharing. It is crucial to ensure that perpetrators of domestic violence do not receive information about what their victim and/or children have said about the abuse except in exceptional circumstances. Risks to the safety of the non-abusing parent and their children through inappropriate sharing of confidential information must be recognized and prevented. Information about domestic violence sent to the practice from a 3rd party (egs. police, multi-agency risk assessment conferences) should be noted in the medical records of children in the family, but not on the front screen in an easily recognizable form. That information should not be entered in the perpetrator's record unless there is assurance that they are already aware of the allegation. If children's records are requested by the perpetrating parent, these need to be redacted so as not to endanger the children and the non-abusing parent. The same holds for disclosures by the non-abusing parent: that information should be noted in the children's records in a disguised format and *must not* be entered into the perpetrator's medical record

Training pilot and training evaluation

RESPONDS
Theory of change logic model



Training online evaluation survey

(preview format imported from Survey Monkey)

RESPONDS Training Evaluation Survey, Bristol 05

Welcome to the RESPONDS Survey

Thank you for agreeing to complete the RESPONDS survey.

Your participation in this 5-minute survey will help us to evaluate the RESPONDS training programme.

We are evaluating the effects of the training course - not you! We are interested in the average learning and behavioural impact of the training session; we are not concerned with individual answers and individual results will be strictly confidential.

On the next page, you will be asked to generate a code number which will be used to match your responses at different times.

We will not pass on any identifying information in relation to your responses to your surgery, the trainers or anyone else.

Please fill in your answers to each question based on your understanding and confidence today.

We will email you with a request to complete this survey again, on three occasions in total (before, shortly after the training and 3 months later).

The research is commissioned and funded by the Department of Health Policy Research Programme (Bridging the Knowledge and Practice Gap between Domestic Violence and Child Safeguarding: Developing Policy and Training for General Practice, 115/0003). The study is NIHR portfolio adopted, has received ethical approval and R&D approval.

If you have any questions about the study, please contact the lead researcher, Professor Gene Feder by
Telephoning 01173314548, Emailing: gene.feder@bristol.ac.uk
or writing to:

Gene Feder, Professor of Primary Health Care
Centre for Academic Primary Care
School of Social and Community Medicine
University of Bristol, Canynge Hall, 39 Whatley Road
Bristol BS8 2PS

Questionnaire administration

1. Please give yourself a code.

Code: your first two letters of your mother's given name and the day and month of your birth (e.g. your mother's name Maria with your birthday on the 2nd June would be MA0206)

2. What is your gender?

- Female
 Male

3. What is your age?

- under 25
 26-34
 35-44
 45-54
 55-64
 65 and over

4. What is your job title?

- GP
 Practice nurse
 Practice manager
 Other (please specify)

5. How many years of practice you have since professional qualification?

- 0-3 years
 4-9 years
 10-20 years
 20+ years

6. Do you have a named/designated safeguarding role?

- Yes
 No

7. Are you IRIS trained?

- Yes
 No
 I do not know what IRIS is

RESPONDS Training Evaluation Survey, Bristol 05

8. I am completing this questionnaire:

- Before the RESPONDS Training
- Soon after the RESPONDS Training
- 3 months after completing the RESPONDS Training

RESPONDS Training Evaluation Survey, Bristol 05

Managing domestic abuse and child safeguarding in primary care

9. I feel comfortable asking patients about domestic violence and abuse

strongly disagree disagree not sure agree strongly agree

10. I would personally feel confident that I could correctly identify a woman with experience of domestic violence and abuse

strongly disagree disagree not sure agree strongly agree

11. I understand how my own experiences may influence my capacity and willingness to engage with issues of domestic violence and abuse

strongly disagree disagree not sure agree strongly agree

RESPONDS Training Evaluation Survey, Bristol 05

Managing domestic abuse and child safeguarding in primary care

12. If I was to ask every woman who I suspect may be experiencing domestic violence and abuse if she has been abused, I will offend a lot of my patients

strongly disagree disagree not sure agree strongly agree

13. Abused women should leave their partners, whatever the circumstances

strongly disagree disagree not sure agree strongly agree

14. Children witnessing incidents of domestic violence and abuse are at great risk of significant harm

strongly disagree disagree not sure agree strongly agree

15. It is not my place to interfere with how a couple chooses to resolve conflicts

strongly disagree disagree not sure agree strongly agree

RESPONDS Training Evaluation Survey, Bristol 05

Managing domestic abuse and child safeguarding in primary care

16. A woman should expect to be re-abused if she decides not to take appropriate action after being offered help/advice

strongly disagree disagree not sure agree strongly agree

17. It is my responsibility to ask a woman patient if she is experiencing domestic violence and abuse, given appropriate indication

strongly disagree disagree not sure agree strongly agree

18. I feel equipped with strategies to help 'victims' of domestic violence and abuse change their situation

strongly disagree disagree not sure agree strongly agree

19. I would know what to do if a parent disclosed domestic violence and abuse to me

strongly disagree disagree not sure agree strongly agree

Managing domestic abuse and child safeguarding in primary care

20. Primary clinicians should only ask a woman about domestic violence and abuse if they strongly suspect she has experience of domestic violence and abuse

strongly disagree disagree not sure agree strongly agree

21. I feel confident in being able to ensure the safety of children while actively supporting the victim and maintaining an ongoing relationship with the family

strongly disagree disagree not sure agree strongly agree

22. I know how to actively support children and families who live with domestic violence but at the present time do not reach the threshold for a child protection service

strongly disagree disagree not sure agree strongly agree

Managing domestic abuse and child safeguarding in primary care

23. I know when and how to raise the issue of domestic violence and abuse with children

strongly disagree disagree not sure agree strongly agree

24. I feel confident in talking directly to children about their experiences of domestic violence and abuse

strongly disagree disagree not sure agree strongly agree

25. I know how and when it is appropriate to talk to perpetrators about domestic violence and abuse

strongly disagree disagree not sure agree strongly agree

Managing domestic abuse and child safeguarding in primary care

26. I have a good understanding of local information sharing policies for domestic violence and abuse

strongly disagree disagree not sure agree strongly agree

27. I feel confident that I can make an appropriate referral for children of abused patients

strongly disagree disagree not sure agree strongly agree

28. Primary care clinicians should be more involved in identifying domestic violence and abuse cases

strongly disagree disagree not sure agree strongly agree

Managing domestic abuse and child safeguarding in primary care

29. I am comfortable discussing safety issues/plans with abused patients

strongly disagree disagree not sure agree strongly agree

30. Even in ten minutes I can provide help and support for victims of domestic violence and abuse

strongly disagree disagree not sure agree strongly agree

31. I know when, how and where to safely record disclosure and suspicions of domestic violence and abuse

strongly disagree disagree not sure agree strongly agree

Managing domestic abuse and child safeguarding in primary care

32. I can identify the different risks for different family members in families where there is domestic violence and abuse

strongly disagree disagree not sure agree strongly agree

33. I know how to act in order to increase the safety of all family members involved in domestic violence and abuse

strongly disagree disagree not sure agree strongly agree

Managing domestic abuse and child safeguarding in primary care

34. I know how to contact local domestic violence services and what help they can offer children and families

strongly disagree disagree not sure agree strongly agree

35. I can explain to patients what they can expect from children's social services following a referral

strongly disagree disagree not sure agree strongly agree

RESPONDS Training Evaluation Survey, Bristol 05

Follow-up

36. Would you be happy to be contacted by the RESPONDS team for a brief follow-up telephone interview regarding your views on the RESPONDS training?

- Yes
- No

If you answered yes, please give us your name, email address and contact telephone number so that we can arrange an interview with you. (Your name will not be matched with your survey responses.)

RESPONDS Training Evaluation Survey, Bristol 05

Comments (optional)

37. If you have any comments, concerns and/or suggestions you may wish to share with us on any aspects of the RESPONDS training, please use the space below.

Training observation framework

Date: _____ Environment: _____

Actors in the room: Nos. Participants (roles):

Safeguarding lead present?

Ethnicity:

Gender:

Age estimates:

Context

Local issues/specificities/concerns?

Links with local (private) schools? Nos DV Cases?

Anything they are particularly proud of?

(ie recording pol, contacts, team work, training).

Any difficulties (ie safeguarding lead or previous training)?

Delivery

Are issues raised that are not addressed?

Do trainers continue to relate DV and CS?

Are participants invited to reflect on and share experiences?

Timing= rushed? OK?

Manual followed? Which parts?

What works well/could be improved?

Participation/Group

Do they all (gender/age/role) participate?

Are they willing to reflect and share?

Any participants silent? Excluded? Ignored?

Is there debate/clarification by participants?

What works well/could be improved?

Engagement with materials/trainers

How do they respond to the video? Slides? Information?

Do they make or resist links between DV and CS?

Do they trust/dismiss the materials?

Do they trust trainers? Differences between SW/Health?

What materials/who triggers debate?

Any redundant information (know/in place already)?

Comments about quality of materials/trainers

What works well/could be improved?

Content/message

Do they get stuck in particular issues?

Do they trust/resist the message? Believe you can talk to children?

Is there sufficient local content to meet demand?

Is knowledge shared within the practice?

What works well/could be improved?

Evidence of shifts in perspective or learning in the group

Evaluation interview schedule – trainers

Thanks for agreeing to take part in this interview. We would like to record the conversation. It will be transcribed and then the research team will have access to the transcript, but it won't be shared with anyone else outside the team. We will use what you say to help us learn about how to deliver and improve the training. We may write about this in reports and journal articles and we may want to use some quotes from what you say, but in a way that would not identify them. Is that all OK?

Switch on recorder...today's date is.... Your name is ... And do I have your consent to record this?

1. Context

Can you tell me about the training you delivered to refresh our memories?

What were the practices?

What were the differences between them?

Was there anything particularly difficult or pleasantly surprising about any of them?

Well let's look at some of that in a bit more depth and I'll ask you some questions about the training materials, the group dynamics, your role as facilitators and what you think they learned [...add anything additional they mentioned as a specific issue].

2. The materials

What did you think of the training materials?

Did anything work particularly well?

Did anything not work?

What bits did you leave out? Why? Would you leave out the same bits next time?

Is there anything else that you think should have been included?

What parts of the training materials do you think went down well with the training participants?

Do you think there was the right sort of balance between discussing general principles and giving local multi-agency information?

3. Delivery and Dynamics

How do you feel about how your team delivered the training?

What were the difficulties?

Timing? Space? AV equipment?

Who do you feel you worked as a team?

Teamwork, division of labour, tensions?

Did you find it was possible to get the trainees to share their experiences and ideas?

(Prompt: And reflect on their practice?)

Can you give me any examples to illustrate that?

Did everyone participate? Did some people dominate discussions?

(Prompt: who

Do you think they found it worthwhile?

(Prompt: differences between different practices

Do you think they trusted the training materials?

Do you think they trusted you as trainers?

Did there need to be two people delivering the training?

Is there anything that would make it easier to facilitate the training?

4. Content/message/learning

What do you think they learned from the training?

(Prompts: Attitudes towards DV, CS and connections
What to do and confidence to do it
How they see their role
Knowledge and understanding of other agencies' roles and procedures
Knowledge of internal (practice) policy, procedure and expectations
Can you give me any examples to illustrate that?

Did any people or practices resist the message?

Do you think both nurses and GPs benefited equally from this training in general?

If not, why not, and how could this be improved?

Which practices benefited most from this training in your experience?

(prompts: engaging ones or those who had a generally low baseline, etc.)

What else worked well/could be improved?

5. Finishing Off

Did the training event for trainers adequately prepare you for delivering the training?

Prompts: What was good? Missing?

What would you advise someone else who was delivering the training?

Any other comments?

Thanks...

Evaluation interview schedule – training participants

Thanks for agreeing to take part in this interview. We would like to record the conversation. It will be transcribed and then the research team will have access to the transcript, but it won't be shared with anyone else outside the team. We will use what you say to help us learn about how to deliver and improve the training. We may write about this in reports and journal articles and we may want to use some quotes from what you say, but in a way that would not identify them. Is that all OK?

Switch on recorder...today's date is.... Your name is ... And do I have your consent to record this?

Context

6. *Can you tell me about what you remember from the training?*

Who was there? What room were you in?

What did you learn from the training?

What were the key messages?

Was there anything particularly difficult or pleasantly surprising about it?

Well let's look at some of that in a bit more depth and I'll ask you some questions about the training content and how it was delivered and then look at whether you think it has had any impact on your practice.

The materials and delivery

7. What did you think of the training content?

What information was useful?

8. What did you think of how it was delivered?

What did you think of the video?

(Prompt: realistic, emotionally engaging, length, class, ethnicity)

9. Did anything work particularly well? What was the best bit?

Did anything not work? What was the worst part?

10. Do you think there was enough opportunity to reflect on your own experience or share cases with colleagues?

11. Did everyone in the training group take part? If not, how could this be improved?

12. The training was delivered by a multi-agency team (remind that one was a social worker if necessary)
- what would you say were the benefits and drawbacks of this?
(Prompt: what did you think of the social worker input?)
-

Impact/learning

13. Prior to the training, how would you rate you have rated your confidence in dealing with children who have experienced DV? (0-10)
How would you rate this now?
What has changed?
14. Prior to the training, how would you rate you have your knowledge and skills in dealing with children who have experienced DV? (0-10)
How would you rate this now?
What has changed?
15. Has your attitude towards working with domestic violence victims, especially children, altered in any way?
16. When a couple is in conflict – would you get involved?
If so, when and how?
What level of suspicion would you need in order to ask an adult victim whether she is experiencing DV?
Have you had any relevant cases since the training? How did/would you proceed?
Has the training changed your thinking or practice in any way – please give me an example
17. When a child is living in a household where domestic violence is occurring – would you get involved?
If so, when and how?
- Have you talked to a child since you had the training? How did/would you proceed?
 - Has the training changed your thinking or practice in any way – please give me an example
18. Do you feel you have any more strategies for responding to victims of DV than you had before the training?
What sorts of activities might fit within your role?
- (Prompt:
- getting information,
 - providing support,
 - consulting with others, a
 - accessing specialist services,
 - monitoring the situation,
 - referring to safeguarding,

- obtaining feedback about other agency involvement)

19. Has the training had any impact on how you and your colleagues record domestic violence?

20. Has the training had any impact on your work with other agencies?

Prompt (awareness of DV agencies, understanding of social services responses, etc

Finishing Off

21. If you were designing this training what would you change?

Any other comments?

Thanks...

Training evaluation survey

Flow of participants through training evaluation questionnaire survey

Figure 1. Note. Numbers in parentheses denote participants at south first, Midlands, second.

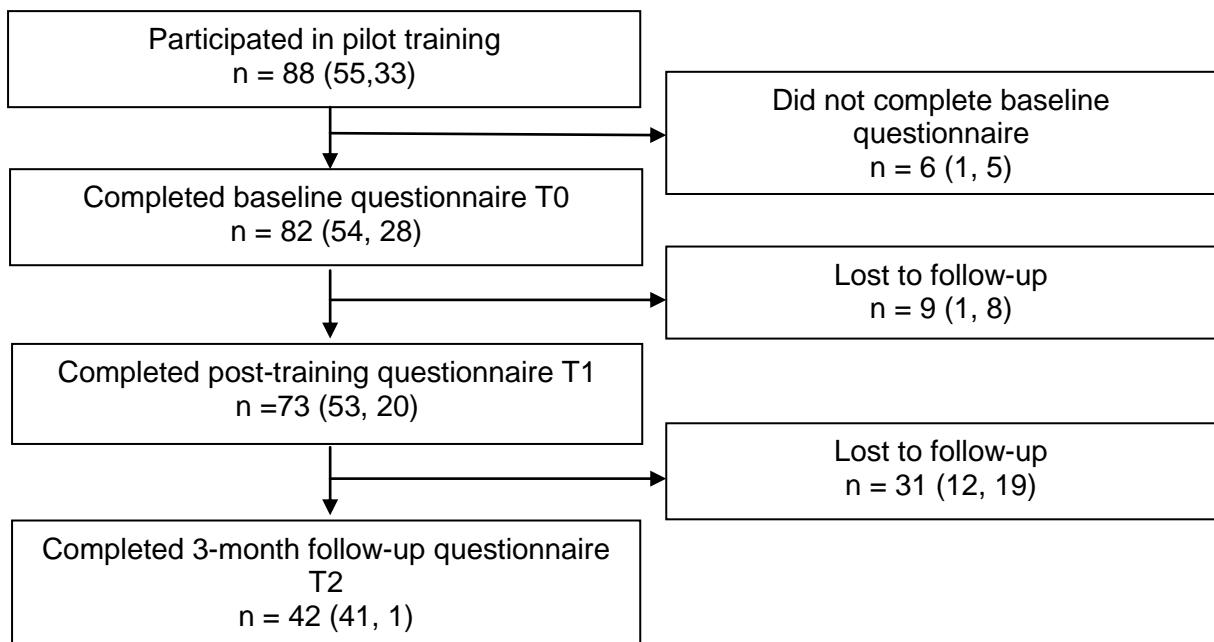


Table 3. Socio-demographic characteristics of training survey participants

Variable	Categories	n (%)			
		T0 (n = 82)	T1 (n = 73)	T2 (n = 42)	p
Gender	Female	55 (67)	51 (70)	33 (79)	0.41
	Male	27 (33)	22 (30)	9 (21)	
Age	<25-34	16 (20)	13 (18)	7 (17)	1.00
	35-44	23 (28)	22 (30)	11 (26)	
	45-54	25 (30)	22 (30)	15 (36)	
	55-64	18 (22)	16 (22)	9 (21)	
Job title	GP	63 (77)	53 (73)	33 (79)	0.94
	Nurse	14 (17)	12 (16)	6 (14)	
	Admin/ manager	2 (2)	4 (6)	1 (2)	
	Other	3 (4)	4 (6)	2 (5)	
Years of practice	0-9	20 (24)	20 (27)	6 (14)	0.46
	10-20	24 (29)	20 (27)	17 (41)	
	>21	38 (46)	33 (45)	19 (45)	
Safeguarding role	No	61 (79)	55 (82)	34 (87)	0.57
	Yes	16 (20)	12 (18)	5 (13)	

Variable	Categories	n (%)			
		T0 (n = 82)	T1 (n = 73)	T2 (n = 42)	p
IRIS trained	No	47 (61)	35 (52)	9 (23)	<0.001
	Yes	30 (39)	32 (48)	30 (77)	
Geographic area	south	54 (66)	53 (73)	41 (98)	<0.001
	Midlands	28 (34)	20 (27)	1 (2)	

Note: Proportions are reported for available data. T0 before training. T1 post-training. T2 3 months post training. p for the Pearson's chi square test.

Table 4. Domestic Violence and Safeguarding Children Scale (DVSC) item means and standard deviations at T0, T1 and T2

Scale item	T0 (n = 82)		T1 (n = 73)		T2 (n = 42)		P
	Mean	SD	Mean	SD	Mean	SD	
1. I feel comfortable asking patients about domestic violence and abuse	3.6	0.9	4.0	0.5	4.0	0.5	<0.001
2. I would personally feel confident that I could correctly identify a woman with experience of domestic violence and abuse	3.1	0.8	3.6	0.6	3.6	0.6	<0.001
3. I understand how my own experiences may influence my capacity and willingness to engage with issues of domestic violence and abuse	3.8	0.8	3.8	0.8	4.1	0.4	0.40
4. If I was to ask every woman who I suspect may be experiencing domestic violence and abuse if she has been abused, I will offend a lot of my patients	2.5	0.9	2.3	0.8	1.9	0.5	0.02
5. Abused women should leave their partners whatever the circumstances	2.6	0.9	2.4	0.9	2.2	0.7	0.002
6. Children witnessing incidents of domestic violence and abuse are at great risk of significant harm	4.4	0.7	4.3	0.9	4.5	0.8	0.53
7. It is not my place to interfere with how a couple chooses to resolve conflicts	2.2	0.9	2.3	0.8	2.1	0.7	0.72
8. A woman should expect to be re-abused if she decides not to take appropriate action after being offered help/advice	2.4	1.0	2.5	1.1	2.0	1.0	0.09
9. It is my responsibility to ask a woman patient if she is experiencing domestic violence and abuse, given appropriate indication	4.2	0.7	4.2	0.7	4.4	0.5	0.84
10. I feel equipped with strategies to help 'victims' of domestic violence and abuse change their situation	3.1	1.1	3.8	0.8	3.9	0.8	<0.001
11. I would know what to do if a parent disclosed domestic violence and abuse to me	3.6	0.9	4.2	0.4	4.2	0.5	<0.001

Scale item	T0 (n = 82)		T1 (n = 73)		T2 (n = 42)		P
	Mean	SD	Mean	SD	Mean	SD	
12. Primary clinicians should only ask a woman about domestic violence and abuse if they strongly suspect she has experience of domestic violence and abuse	2.6	0.9	2.4	0.9	2.0	0.7	0.52
13. I feel confident in being able to ensure the safety of children while actively supporting the victim and maintaining an ongoing relationship with the family	3.0	0.9	3.6	0.7	3.5	0.7	<0.001
14. I know how to actively support children and families who live with domestic violence but at the present time do not reach the threshold for a child protection service	2.6	0.9	3.5	0.8	3.6	0.7	<0.001
15. I know when and how to raise the issue of domestic violence and abuse with children	2.9	0.9	3.8	0.7	3.7	0.6	<0.001
16. I feel confident in talking directly to children about their experiences of domestic violence and abuse	2.6	0.8	3.4	0.7	3.4	0.7	<0.001
17. I know how and when it is appropriate to talk to perpetrators about domestic violence and abuse	2.5	0.9	3.3	0.7	3.3	0.7	<0.001
18. I have a good understanding of local information sharing policies for domestic violence and abuse	3.0	1.0	4.0	0.6	4.0	0.4	<0.001
19. I feel confident that I can make an appropriate referral for children of abused patients	3.5	1.0	3.9	0.8	3.9	0.7	<0.001
20. Primary care clinicians should be more involved in identifying domestic violence and abuse cases	3.8	0.7	4.1	0.6	4.0	0.6	0.03
21. I am comfortable discussing safety issues/plans with abused patients	3.4	0.9	3.9	0.6	3.9	0.5	<0.001
22. Even in ten minutes I can provide help and support for victims of domestic violence and abuse	3.2	1.0	3.7	0.9	4.0	0.7	<0.001
23. I know when, how and where to safely record disclosure and suspicions of domestic violence and abuse	3.2	0.9	3.8	0.6	4.0	0.6	<0.001
24. I can identify the different risks for different family members in families where there is domestic violence and abuse	2.9	0.8	3.6	0.7	3.6	0.7	<0.001
25. I know how to act in order to increase the safety of all family members involved in domestic violence and abuse	3.0	0.7	3.8	0.6	3.8	0.6	<0.001
26. I know how to contact local domestic violence services and	3.5	0.9	4.1	0.5	4.1	0.6	<0.001

Scale item	T0 (n = 82)		T1 (n = 73)		T2 (n = 42)		P
	Mean	SD	Mean	SD	Mean	SD	
what help they can offer children and families							
27. I can explain to patients what they can expect from children's social services following a referral	3.0	0.9	3.6	0.7	3.8	0.7	<0.001
Total score	83.0	12.4	93.7	14.1	92.9	16.8	<0.001
Confidence/self-efficacy sub score	42.0	7.2	48.2	7.7	47.9	9.3	<0.001
Knowledge sub score	49.6	8.2	57.1	9.6	56.8	10.4	<0.001
Beliefs/attitudes sub score	24.6	2.7	24.9	3.4	24.2	4.4	<0.001

Note: Reverse scoring for the following items – 12, 13, 15, 16, 20. T0 before training. T1 post-training. T2 3 months post training.

P-values are for conservative F-tests in the one-way repeated measures ANOVA