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Exploring the experiences of Health Visitors' approach to domestic abuse using 'routine enquiry': a qualitative study

Key points

- Women who experience domestic abuse (DA) report that they would like to be asked by health professionals about the domestic abuse.
- While it is widely recognised that health professionals have an important role in identifying and intervening in domestic abuse, they often struggle to ask women about their experiences of abuse.
- Health visitors occupy an important position in the care of women and children in the community; this has been identified as a priority health setting for the training of staff in domestic abuse and the use of a 'routine enquiry' approach to asking about domestic abuse.
- The findings from this study show that health visitors have a high level of knowledge about domestic abuse. Nonetheless, there was little evidence of disclosure of domestic abuse through a 'routine enquiry' approach.
- The interviewees' experiences suggest that asking about domestic abuse can be impeded for a variety of reasons; from process issues such as not being clear when or how to record the outcomes; to more subtle, relational issues such as the need to build a strong relationship with the woman, the challenge of how to have 'courageous conversations' and the recognition that domestic abuse is a highly complex issue to 'untangle'.
- Factors such as exposure to working with women who have experienced domestic abuse and attendance at Multi Agency Risk Assessment Conferences (MARACs) increase the ability of health visitors to identify and intervene in domestic abuse.

Background

Domestic abuse is widely recognised as a global issue (WHO, 2009) and 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 [or] emotional' (Woodhouse and Dempsey, 2016, p.4). While it is increasingly

understood that domestic abuse can happen in a variety of different intimate relationships: same-sex relationships between parent and child, women against men (Barber, 2008; Donovan and Hester, 2010); the majority of domestic abuse is perpetrated by men against women (WHO, 2013). Research globally tells us that many women who experience domestic abuse are in contact with health care systems long before disclosure but are neither asked about, nor do they disclose, the abuse (García-Moreno et al., 2015). Disclosure of domestic abuse is dependent on a range of complex issues. Nonetheless,

women who experience domestic abuse report that they would like to be asked by health professionals about the domestic abuse, even if they are not at the stage of disclosure at the point of asking (Bradbury-Jones et al., 2014).

Health professionals have an important role in identifying and intervening in domestic abuse, particularly if they work in priority health settings such as primary care, health visiting, midwifery, substance misuse, Accident and Emergency and sexual health services. Research shows that they often struggle to ask women about domestic abuse. A lack of knowledge about domestic abuse, and resulting lack of confidence in dealing with the issue, has been identified as a contributing factor (Lazenbatt et al., 2009; Bacchus et al., 2012).

This research study sought to obtain a better understanding of the experiences of health visitors in identifying and intervening in domestic abuse following initial training on conducting a 'routine enquiry' of abuse.

The study

This study explored the day-to-day experiences of health visitors using a 'routine enquiry' approach to domestic abuse. This means that health visitors ask about the safety and emotional wellbeing of the mother, including domestic abuse, as part of the routine assessment following the birth of a new baby. A 'routine enquiry' approach to domestic abuse has been recommended for use by all health visitors throughout NHS Scotland since 2008 and in response, a programme of training has been rolled-out in Lothian. The research comprised face-to-face interviews with 17 health visitors in NHS Lothian. All of the health visitors identified as white and female, and were aged between 30 and 65. All of the names have been given pseudonyms and any other identifying data has been removed. Data was analysed using Thematic Analysis (Braun and Clarke, 2006). Throughout the research there were difficulties in recruiting participants, due to various reasons, including a severe shortage of health visitors employed in NHS Lothian at the time.

Findings

The majority of health visitors struggled to ask about domestic abuse as part of a 'routine enquiry' approach during an initial assessment post-birth. Two out of seventeen health visitors described experiences of disclosure of domestic abuse following 'routine enquiry'. The majority of the health visitors talked about their experiences of working with women who had disclosed domestic abuse as happening after a police welfare notification form had been received, which was usually following an incidence of domestic violence.

So I suppose, what I'm trying to come to is that, [pause] we are often in the position that we are waiting until we get the child welfare concerns. So routinely I would hope that the routine enquiry had been done by the midwife and if there is a history of domestic violence then they would share that with me. [Janice]

Levels of knowledge about domestic abuse were high and all of the health visitors interviewed had undergone training on domestic abuse and/or gender based violence. Nonetheless, the findings show that health visitors found 'routine enquiry' difficult for several inter-related reasons; these have been termed as 'process' and 'relational'.

Process issues

Process issues were identified as the extent that policy reached practice at front-line level. Despite the high levels of training and knowledge demonstrated by the health visitors around domestic abuse in general, the majority of health visitors were unclear as to whether they were required to ask about domestic abuse, how to ask and how to record it.

There is a huge amount of confusion out there. Should we be doing it [routine enquiry]? Are we doing it? The midwives are doing it. I've no idea. [Sarah]

And when we did the original training, which was to implement the routine enquiry, we did the training, it was very good, there was lots of feedback, there was a steering group set up and yet we have never had any direction from nurse management or, em, you know, the wider things to say that we are implementing routine enquiry, so lots of people don't consider that they have to, don't know that that it is part of our expected practice. [Sarah]

Relational issues

The majority of health visitors discussed relational issues as central to taking a 'routine enquiry' approach to asking about domestic abuse. Relational aspects included the following:

Building strong relationships

All of the health visitors in the study highlighted the importance of developing a good relationship and strong liaison with the woman *before* they could ask about safety and domestic abuse. Trust was seen as central to this relationship. The health visitors were anxious that to ask these difficult questions could threaten the relationship they were building with the woman. There were differences in opinion as to whether a questionnaire 'tool' would be useful or not. There was a general consensus among the participants that to ask at the notification visit was too soon and it would be better to just leave a leaflet then and to ask at the 8 week visit.

Yeah, it's one of these things that is a strange title, a routine enquiry, because it makes it sound as if it is standardised and I think for a while, when it first came in, people thought that to take a standardised approach was to ask the same question but I tend to tailor the questions differently, depending on who I am with and what I've noticed...but it has taken me a long time to feel comfortable, which was silly because we ask people about all sorts of other personal things very easily. [Ann]

It's kind of building up, because when you go in that first visit, you have to actually build up. You can't just go straight in and they are not going to volunteer that on the first visit. Trust is a massive thing. Absolutely. Not just with domestic violence but to drug use to social work, there is such as stigma attached to the social work department that you are that other person and you need time to build that up. That trust. And at times they say that they don't want you in their house but you keep going back and build that up. So on a first visit, I would find it really difficult just to come out with it [asking questions about domestic abuse] as part of a routine question, you know to add in to what I already do on a first visit. [Sharon]

I would feel much more comfortable asking with someone who you have a relationship with. If someone doesn't know and trust you, are they likely to give you the answer? Definitely not. [Morag]

Having 'courageous conversations'

All of the participants recognised 'routine enquiry' as the ability to ask challenging questions but felt ill-equipped to ask these questions. It was widely recognised that to ask these questions is hugely anxiety provoking and made both HVs and women feel uncomfortable. HVs did not feel equipped to have these 'courageous conversations' and many avoided asking these questions directly, choosing rather to ask general questions around safety in the home.

What does routine enquiry even mean? No-one really knows. It really doesn't mean anything. I think it should be called 'how to have courageous conversations', because that is what we do. We need to know how to feel the fear but to do it anyway. [Rose]

Becoming tangled in the complexity

All of the participants recognised that domestic abuse is a highly complex issue to 'untangle'. They understood that DA does not occur alone, but is often entangled in wider issues of mental health, substance misuse, poverty and social isolation. To uncover DA was to become 'entangled' in very complex situations that became resource intensive, stressful and difficult to find effective interventions. This was particularly problematic at a time when resources in the public sector are becoming increasingly constrained.

I just feel that I am a Health Visitor and I'm not an expert in DV neither am I an expert in drug use or substance, I mean I am mental health trained in general, but that was a long time ago...you just get tangled up in it all. It can be just so complicated. [Janice]

Often when we are going in, your main agenda is to be for the sort of health of the child and so the domestic thing can become part of an increasing complex set of things, and we're not seeing the GBV as something that is separate, so if you have a client that has got drug and alcohol problems, mental health problems and problems just caring for the kids and there's chronic neglect, then whether you do a routine enquiry to add to your list to add to a hundred other things or not. [Mary]

It [DA] all just adds another layer. You pick at it on a superficial level, but you can't go any deeper....we are just taking on another element and are so thinly spread as it is. [Wendy]

All of the health visitors in the study recognised that they required additional practical and emotional support, including more regular supervision, in order to effectively work with women who were experiencing DA. While the majority of participants found support from the informal networks provided by colleagues,

they also felt that they would benefit from more formal support from someone who held the role of domestic abuse advisor. The child protection lead was seen as partly holding this role, but there was confusion as to whether the needs of the child, or the mother, were central. The health visitors reported that, at times, these were in conflict with each other and while the health visitors recognised that the needs of the child were their priority, they found this difficult to reconcile with the needs of the woman.

Exposure, experience and attendance at a MARAC

The study found that factors such as exposure to working with women who have experienced domestic abuse and attendance at Multi Agency Risk Assessment Conferences (MARACs) increased the ability of health visitors to identify and intervene in domestic abuse. The participants reported feeling more confident in using a 'routine enquiry' approach as they gained experience in working with women who had experienced DA over time. In addition, health visitors who had been able to sit on a MARAC found this a very positive experience, both in understanding the severity of DA, and also to understand how better to intervene.

Conclusion

This research offers an insight into the experiences of health visitors in their day-to-day work with women following childbirth. While previous research has highlighted a lack of knowledge as an explanation as to why health visitors are reluctant to ask about domestic abuse, this research found that knowledge levels were high. Nonetheless, health visitors still struggled to ask about domestic abuse for a variety of reasons; from process issues such as not being clear when or how to record the outcomes; to more subtle, relational issues such as the need to build a strong liaison with the woman, the challenge of how to have 'courageous conversations' and the recognition that domestic abuse is a highly complex issue to 'untangle'.

The experiences of the study participants highlight the ways in which health visitors are aware that they are invited guests into the homes of women, and that their ability to build a relationship with their clients is paramount to ensuring future access and the ability to do their job. They are reluctant to risk asking questions that might jeopardise that crucial relationship. They are very aware of the challenges of asking women about domestic abuse, especially as it is a

stigmatised area, and felt that this could potentially damage the relationship they are building with the client. It is therefore important that steps are taken at a local and national level to ensure that health visitors are equipped with the skills to ask these 'courageous conversations' within this relational work. In addition, this research recommends that additional support mechanisms be put in place so that health visitors feel supported in this complex work.

Recommendations for policy and practice

- Policies are in place but more clarity is needed around when and how this is implemented in practice.
- HV teams are supported directly by locality and senior managers to facilitate 'routine enquiry' and ensure appropriate levels of support for both staff and families affected.
- Clarification and clear guidance is issued for HV teams on data recording: when to ask about abuse; conducting an evidence based risk assessment and sharing of information.
- HV teams continue to receive appropriate training in line with local and national recommendations on the identification of, and appropriate response to, domestic abuse.
- HVs are offered additional training on ways to have 'courageous conversations' which respect the therapeutic relationship.
- HV caseloads reflect the requirement for additional time and resources to adequately address the highly complex issues associated with domestic abuse.
- Increase opportunities for HVs to participate in a range of initiatives established to support families at high-risk of domestic abuse (MARACs, Domestic Abuse Advocacy workers etc.).

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