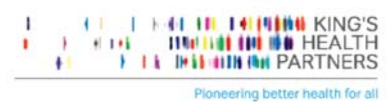
LONDON SCHOOL of HYGIENE &TROPICAL MEDICINE

Health Sector Responses to Domestic Violence:

Promising Intervention Models in Primary and Maternity Health Care Settings in Europe



Project Coordinator
Dr Loraine J. Bacchus, Lecturer, London School of Hygiene & Tropical Medicine/Gender Violence & Health Centre, UK

Partners
Dr Carmen Fernandez, Ministry of Health of CCAA of Castile and León, Spain
Ms Hildegard Hellbernd, SIGNAL, Germany
Dr Sylvie Lo Fo Wong, Radboud University Nijmegen Medical Centre, Netherlands
Dr Leo Pas, DOMUS MEDICA, Belgium
Ms Sirkka Perttu, University of Helsinki Palmenia Centre for Continuing Education, Finland
Ms Tiina Savola, University of Helsinki Palmenia Centre for Continuing Education, Finland

Associate partners
Professor Susan Bewley, Kings Health Partners, United Kingdom
Dr Stanislava Otasevic, Women's Health Promotion Centre, Serbia

Report written by Loraine J. Bacchus, London School of Hygiene & Tropical Medicine

Independent evaluation by Professor Gene Feder, University of Bristol

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Loraine Bacchus

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EXECUTIVE SUMMARY

BACKGROUND

Primary and maternity health care are critical intervention points for women seeking help for domestic violence due to a number of facilitating factors: they offer greater continuity of care compared to other health care settings; opportunities for confidential time and longer appointments with patients; a more predictable workload for health professionals; and a philosophy of care that recognises the social aspects of ill health.

This report represents the findings of a scoping study which explored innovative domestic violence interventions in primary and maternity health care settings in seven European countries: United Kingdom, Germany, Netherlands, Spain, Belgium, Finland and Serbia. These countries were chosen for their expertise in research and practice in the field of domestic violence and health sector interventions. Although this study focussed on interventions involving primary and maternity health care settings, it is recognised that a host of domestic violence interventions exist in other health settings in Europe.

METHODS

In the first phase of the study, a mapping survey was disseminated via project partners to established interventions in each country in order to gain a broad overview of the key components of the intervention. A total of 82 surveys were returned and are presented descriptively by country in each chapter. The 82 surveys relate to 81 interventions that involve large geographical areas, multiple clinics and a range of health professional disciplines. However, as there is no centralised system for collating such information, it was not possible to capture the full range of interventions within these countries.

Following this, case studies were undertaken involving interviews with 37 key personnel from interventions in United Kingdom, Finland, the Netherlands, Spain, Germany and Belgium, These provided a more in-depth exploration of the evolution of the intervention at different stages including: gaining organisational support for the intervention within the health care setting and sensitising health professionals to their role; finding solutions to the challenges of implementing intervention activities; and sustaining the intervention beyond the pilot phase. Interventions were chosen for in-depth study if they targeted women patients and health professionals in primary and/or maternity health care settings; were well established and still functioning; and included a research or formal monitoring. A range of professionals and key stakeholders were interviewed from each intervention to obtain a variety of views.

A two-day end of project workshop was attended by all partners and associates which provided an opportunity to discuss the findings and identify best practice recommendations.

OVERVIEW OF THE CASE STUDY INTERVENTIONS

United Kingdom (London)

MOZAIC Women's Well Being Project is partnership between the maternity and sexual health services of Guy's & St. Thomas NHS Foundation Hospital Trust and the 170 Community Project, a non-governmental organisation offering specialist domestic violence services. Health professionals in maternity and sexual health services receive one-day domestic violence training. Women who disclose domestic violence are offered a referral to MOZAIC. The intervention is underpinned by clinical guidelines developed jointly by the Clinical Governance Committees in the health services and MOZAIC. The MOZAIC office is based in the hospital and consists of a full-time manager, two Independent Domestic Violence Advocates (IDVAs), and a domestic violence trainer/IDVA. As such, the intervention utilises an 'in-reach' approach whereby support is provided to women by one organisation based in the health care setting and therefore easily accessible. A practice development midwife co-trains with the MOZAIC trainer. The IDVAs use a woman-centred approach and work with women at all levels of risk and need for as long as they wish. They provide emotional and practical support and are the link to liaison with a range of services in the community. MOZAIC advocates work closely with the local Multi-Agency Risk Assessment Conference (MARAC) to assist women at high risk. The Hospital Trust has a formalised Clinical Lead for Domestic Violence. The intervention was launched in 2004 and funded by St. Thomas' Charity for three years. The funding included an independent evaluation by a research team at Kings College London which has been published. In 2008 the service received ongoing funding from the local Primary Care Trust. By 2011 MOZAIC had received over 1,000 referrals a survivor's empowerment charity (MOZAIC Voices) was set up. The project was successful in obtaining additional funding for another IDVA to be based at a community-based one stop domestic violence centre, supporting referrals from primary care.

Finland (National)

In 2000 and 2002, as part of two research projects funded by the Ministry of Health and Social Affairs, public health nurses from maternity and child health clinics in 7 municipalities received domestic violence training which included how to ask about domestic violence and respond appropriately. They were also trained to administer a research survey to women which explored experiences of domestic violence. Ongoing support and supervision was provided by the project coordinator during the data collection stage. As a result of these research projects, the first domestic violence guidelines for maternity and child health care professionals were published in 2004, which also included the results of the research. Updated guidelines were published in 2011. After the initial training, there was no reinforcement training or ongoing monitoring activities. Although the initiative did not receive ongoing funding, committed managers and public health nurses at some clinics continued to identify and offer support to women affected by domestic violence.

Netherlands (Rotterdam and Nijmegen)

The Mentor Mothers intervention was implemented in general practice settings in Rotterdam and Nijmegen. The intervention targets mothers with children 18 years or under who are living at home, who are at an early stage of their decision making regarding the domestic violence. General practitioners receive domestic violence training and are trained

to ask direct questions about partner abuse when women present with common risk factors such as depression, injuries or psychosomatic complaints. If a woman accepts a referral to a mentor mother, they will meet once a week for four months (usually in the surgery), although it is possible to extend this. The intervention also utilises an 'in-reach' approach to supporting abused women. The mentors are semi-volunteers as they receive a low salary. In order to be a mentor mother, they must be at least 30 years of age and have children themselves. Mentors work 1 day a week and receive 9 days training which focuses on four areas: (i) cessation/reduction of violence; (ii) children who witness violence; (iii) management of depressive complaints; (iv) and improving the woman's social network and reducing isolation. In Nijmegen, the mentors receive training and weekly coaching from an employee of HERA, a non-governmental organisation and the largest specialist domestic violence organisation in the province which also runs a network of refuges. The intervention in Rotterdam was funded by the Municipalities Health Service and private Trusts and in Nijmegen by the Municipality, the Ministry of Justice and Dutch government healthcare research funding. An evaluation of the intervention is being conducted by a team of researchers at Radboud University, Nijmegen Medical Centre, Department of Primary Care (Gender & Women's Health group).

Spain (Autonomous Community of Castile and León)

Under Spain's Organic Law 1/2004, the governments of all 17 autonomous communities are obliged to address gender violence within the health care system. This case study describes the approach of the autonomous community of Castile and León to the implementation of the *Common Protocol for a Healthcare Response to Gender Violence*, published by the Ministry of Health, Social Affairs and Equality in 2007. A cascade approach to implementation was adopted, initially targeting management teams of Primary Care and Hospitals for awareness raising activities. A multi-disciplinary training team of 35 professionals was established to provide training to Primary Care Teams prioritising doctors, nurses, social workers, midwives and paediatricians. Second priority was emergency services, mental health, gynaecology and midwives in hospitals; and third priority was the remaining health professions and administrative staff. Training was offered at three levels on an annual basis: awareness (initial training), basic (10-20 hours) and advanced (20 hours). Train the trainer courses run for 70 hours and a continuous training program specifically for trainers is maintained. Referral pathways are multi-disciplinary (to other health professionals) and multi-sector (to other organisations in the community). The approach to identification of domestic violence entails asking specific questions routinely (i.e. of all female patients over 14 years of age). Support for health professionals was initially provided by a supervision team with a named contact expert person, although this was not maintained. This was replaced by support from motivated, informal clinical leads and through health professionals' established networks with social workers, the police, refuges and other organisations. Any disclosure of domestic violence is entered in the medical history of the patient's electronic record, and an injury report generated by doctors when a domestic violence is confirmed. The 17 Autonomous Communities develop interventions to detect and respond to domestic violence, though their strategies may be different. However, their Common Protocol for a Healthcare Response to Gender Violence is used as a reference framework. Autonomous communities are required to send their data to the Ministry of Health and Social Policy to publish annual epidemiological surveillance on gender violence and follow-up of the intervention.

Germany (Berlin, Dresden, Dusseldorf, Kiel, Munich, Ennepe-Ruhr-Kreis)

Among many initiatives in Germany addressing DV in primary health care, the study focused on the national pilot project MIGG (Medical Intervention Against Violence) funded by the Federal Ministry of Family, Senior Citizens, Women and Youth (2008-2011). MIGG is the first systematic project to improve health care for patients affected by domestic violence in primary care. It was developed and evaluated in 5 cities. Partners in MIGG include the Institute of Forensic Medicine University of Düsseldorf, as well as SIGNAL e.V. and Gesine (a network for health interventions against DV). The case included two of the partners in MIGG, namely SIGNAL e.V and Gesine, both non-governmental organisations that work closely with primary care health professionals in the MIGG intervention. They also deliver their own domestic violence initiatives independently. They provide a DV intervention program, DV training, develop supporting materials such as guidelines, posters, leaflets and abuse documentation forms. Post-training reinforcement and support activities include multi-professional meetings, annual conferences, GPs quality circles and twice yearly 'train the trainer' meetings. These provide a forum for exchange of good practice and research, case discussion and further training. In essence, they assist health professionals in developing a multi-professional network and links to community support organisations. For example, representatives from women's refuges and other agencies are invited to annual meetings. Gesine also has counsellors and refuges to which health professionals can refer women in need of help. SIGNAL e.V. and Gesine are funded through multiple sources, but primarily by the State and have undertaken research on their work. Attention, Recognition, Action is a domestic violence training intervention based in the Department of Psychotherapy and Psychosomatics at University Hospital Dresden. Training is delivered to staff in the hospital and primary care professionals. Referrals pathways include other health professionals and domestic violence organisations. The project was funded by the Saxony State Ministry for Social and Consumer Protection and included an evaluation of the training intervention.

Belgium (Antwerp and Brussels)

Representatives from four different organisations were chosen for the Belgium case study. The Centres for General Welfare (CAWs) which exist only in the Flemish part of Belgium provide 'first line care' to those with mental health problems, domestic violence victimisation or perpetration, alcohol and drug problems and other social care issues. Clients may be referred by professionals or they may self refer. Under an initiative by the Ministry of Welfare in 2006, 13 of the 26 CAWs received funding to develop domestic violence policy and training.

Domus Medica, a professional organisation for Flemish general practitioners, develop and deliver basic and advanced skills based domestic violence training programmes to general practitioners. They co-train with CAW social workers to enable general practitioners to develop links and facilitate direct referral to CAW. The intervention promotes direct referral to social care, but also has aspects of creating a supportive multi-professional network for GPs. This approach works well in a liberal system such as Belgium, where many general practitioners work in single handed practices on a fee for service basis. Domus Medica offers train the trainer courses to ensure there is a pool of trainers with expertise and also conduct research on the interventions they offer. Initiatives have been funded by the government, the province of Antwerp and the organisations' own resources.

The Child and Family Service (K&G) provide domestic violence training to public health nurses who work with children from birth to 3 years. In addition, a train the trainer course was implemented to create an in-house pool of 24 trainers from K&G.

The MOM (Difficult Moments and Feelings in Pregnancy) is a randomised controlled trial conducted by researchers at Ghent University Hospital and funded by the Scientific Research Foundation (FWO). The study targets pregnant women using a hospital maternity service. Women who agree to participate in a research interview are provided with one of two interventions: a contact card with useful numbers and tips for safety behaviours or standard care. A follow-up is conducted at 12 and 24 months to measure the levels of violence and health outcomes.

KEY FINDINGS

Innovation of practice – initiating the process of change

- Clinical leadership roles for domestic violence are needed during the initial stages of setting up an intervention, even before the introduction of clinical guidelines and training. Convincing busy health professionals that they have a role in addressing domestic violence is not an easy task. Some health professionals will be open and supportive, whilst others will regard it as a problem or a burden to their existing work. Therefore, the first task is to orientate health professionals and other staff in the health care setting to the process of change and innovation and prepare them for new practices. This may include using staff meetings to give short presentations about domestic violence prevalence and health impacts using local data if available; draw attention to national policy and recommendations regarding health sector responses; and providing information about local support organisations.

- The case studies demonstrate that support and endorsement for change is needed at varying levels as part of a top-down and bottom-up approach to implementation. Recognition of violence against women as a public health issue is necessary at State level, through a combination of laws, legislation, national guidelines, action plans and funding. Experienced professionals and NGOs in the field recognised that a "bottom-up only" approach can take years of effort and the intervention runs the risk of disappearing once funding ends. In Spain, it is a legal requirement for health administrations to implement measures to address gender violence and the Common Protocol clearly states that it is health professionals' role to protect and act. At State level, in all 7 countries, there is acknowledgement of violence against women as a public health issue and strategies for addressing it are developed by inter-ministerial task forces. All countries also have National Action Plans to address violence against women which include specific targets for health and social care professionals. Each country also has recommendations for addressing domestic violence in the health sector and endorsements from official health professional governing bodies and Government.

- Whist these are vital steps in the process of change, leadership and support from within the health care setting is also necessary. All the interventions in the case studies highlighted the importance of clinical champions or lead clinicians at all stages of the intervention. These were usually motivated professionals who had attended additional training or were domestic violence trainers themselves. They played an important role in sensitising colleagues to their role in identifying and supporting patients affected by domestic violence, in addition to dealing with resistance within the health care setting. Examples of this type of peer support can be found in all the case studies and involved front line practitioners as well as mid-level managers and clinical directors. Sensitisation activities include: staff meetings, lectures, awareness raising training, posters, making links with domestic violence organisations in the community, discussion of actual domestic violence case stories within the health care setting, as well as day-to-day 'corridor' conversation. This process also encourages ownership of the intervention by health professionals.

- Clinical champions acted as role models, but many had assumed this role voluntarily without funding and/or organisational support. Good practice can be found in some countries, where these roles were funded and/or formally recognised as being part of the health professional's remit. For example, in the MOZAIC intervention in the UK, the Hospital Trust has a lead clinician for domestic violence and adult safe-guarding. In Belgium, some Centres for General Well Being (CAW) are funded through a government initiative to have one social worker lead on the development of domestic violence policy and training. In Germany, the SIGNAL e.V. coordination team receives funding from regional government for promoting and supporting intervention programmes in different healthcare settings. For example, the SIGNAL e.V. coordination team meet with the coordinators of all five hospitals in Berlin which have domestic violence interventions programmes, four times a year to provide support to the intervention and monitor quality. A group of 13 nurses from different departments at Charité University Hospital (which involves 3 hospitals in Berlin) formed a working group which meets every three months during work hours to discuss progress on intervention activities. The working group is supported by the Director of Nursing. In Spain, the leaders of all the autonomous communities received funding to attend awareness raising training and advice on implementation. Informal clinical champions can be found In Mentor Mother intervention in the Netherlands, which was supported by committed general practitioners; the training intervention in maternity and child health clinics in Finland which was supported by clinic managers; and in Attention, Recognition Action intervention in Germany which was led by a psychotherapist/psychiatrist.

- Clinical leadership roles should be formalised through task description of their roles and responsibilities, supported by health management and funded on an ongoing basis to avoid intervention atrophy. Funding is particularly important in health care systems where many general practitioners still work in single handed practices and/or on a fee for service basis (e.g. Belgium, Netherlands/Germany). However, in any health care system, relying solely on motivated 'volunteer' health professionals is not sustainable in the long-term. They may not always be available due to competing tasks and there is a risk that intervention activities stop altogether once

they move on. Expertise may also be needed at different geographical levels depending on the country, its health care system, size of the population and available specialist domestic violence services.

Adapting to the challenges of implementation

- The interventions in the case studies reported similar struggles in very different contexts; e.g. with regards to the organisation and funding of health care systems, the presence and power of survivor movements, the availability of community resources such as the refuges, perpetrator programmes and other specialist domestic violence organisations. Some of the common challenges identified include:

  - Difficulties motivating health professionals to attend the initial domestic violence training, particularly in countries where many general practitioners work in single handed practices and/or on a fee for service basis.

  - Providing support for health professionals after the initial training and sustaining training activities.

  - Loss of leadership roles when clinicians move to other jobs or have less time to devote to the intervention in the context of competing tasks.

  - The need for funded and properly coordinated multi-agency partnerships and clear referral pathways.

  - Lack of clarity around information sharing and confidentiality between different organisations (e.g. police, healthcare, non-governmental organisations).

  - Lack of funding for training activities.

  - Lack of funding for research, evaluation and monitoring of interventions.

  - The reluctance of some health professionals to ask about domestic violence even after receiving training.

- Within the case study interventions a number of innovative approaches to dealing with some of these issues were described. In Belgium and Germany where general practitioners tend to work in single handed practices, training is provided out of office hours. In the Netherlands, each year family physicians need 40 Continuing Medical Education (CME) points in order to stay registered as a family practitioner. Training is accredited and provided during and outside office hours. In Serbia, each year primary care providers are required to obtain 24 points in order to maintain their medical license. Those who attend the training programmes in Serbia receive 6 points. In Spain, health professionals who wish to attend a ‘train the trainer’ course are freed from their work and are paid expenses. Spain, Belgium, Netherlands,

Germany and Serbia create pools of local trainers through their 'train the trainer' initiatives. In the UK, midwives have to attend a certain number of study days each year to maintain their registration. In the MOZAIC intervention, domestic violence is offered as one of the midwives study days.

- Post-training support is provided through a number of mechanisms. In the UK and Netherlands, health professionals have a formalised partnership and direct referral pathway to domestic violence advocates and mentor mothers who provide support to women. Health professionals are also able to discuss their concerns with the domestic violence trainers linked to the intervention programmes. In Belgium and Germany, the lead organisations providing the training have created opportunities for health professionals to meet each other at annual conferences, and quality circles. These are used to provide additional training, provide opportunities for health professionals to share experiences of dealing cases of domestic violence, and establish links with representatives from community organisations.

- The presence and strength of formalised multi-agency partnerships varied across the countries. Multi-agency Domestic Violence Fora and Multi-Agency Risk Assessment Conferences (MARAC) that deal with high risk cases of domestic violence are well established in the UK, but less developed in the other countries. The case studies revealed diverse ways of working with other organisations. In Belgium, the process of multi-agency work began with the development of consensus guidelines for identifying and responding to domestic violence and by co-training general practitioners and social workers. In the UK and Netherlands, advocates and mentor mothers work closely with health professionals and act as the link to liaison with other community organisations. In Germany, NGO organisations create networks and meeting opportunities for general practitioners working in single handed practices. In Spain, the Netherlands Primary Health Care Centres and public health nurses in Finland work closely with professionals from other disciplines, for example by referring women to social workers or mental health professionals in the health centres, as well as community organisations. However, it was highlighted during discussions at the end of project workshop, that formalised multi-agency working at a policy level is more challenging. It requires proper coordination, funding, recognition of the power positions, but also the deeply engrained cultural differences, agendas and approaches to work across the different agencies.

- The case studies and mapping surveys revealed that approaches to the identification of domestic violence varied by country, health care setting and patient group. Of the 81 interventions in the mapping survey, 62 reported that routine enquiry of female patients was a component of the intervention and 28 also reported routine enquiry with male patients (except Spain and the Netherlands). In the case study interviews as well as in the mapping surveys interpretations of routine enquiry for domestic violence (i.e. asking all women whether or not there are risk factors) varied greatly across interventions. Approaches to the identification of domestic violence included: asking all women using a recognised screening tool; asking women who attend with known risk markers (e.g. injuries, depression, drug/alcohol problems); or asking all women attending for antenatal care and at certain child care check-ups. The case

study interviews demonstrated that whilst some health professionals are very confident about discussing domestic violence and try to ask in a systematic manner, others need more support and are likely to adapt their approach according to the situation in order to increase their own comfort. Examples include: asking women to complete a screening form and then discussing their answers; asking more general questions about stress or dealing with relationship problems; asking about domestic violence when the clinic is less busy; or asking women once they have a more established patient/provider relationship Developing good communication skills for identifying and responding to domestic violence requires more than one training session. Experiential learning and opportunities for obtaining feedback on skills are necessary. This may involve observing an experienced heath professional making an enquiry with a patient, or being observed in clinical practice with time to discuss afterwards.

- Different referral pathways were described in the case study interventions. In the UK and Netherlands, women are referred by the health professional directly to a domestic violence advocate or lay worker from a partner organisation. In Belgium general practitioners are expected to refer women directly to social workers at the local Centres for Wellbeing. In Spain, Finland and some of the interventions in Germany, health professionals play a greater role in supporting women affected by domestic violence, by working closely with other professionals as well as community organisations. In the mapping survey, of the 81 interventions that involved action by a health professional, 70 reported offering information to the patient and 57 reported making an assisted referral (i.e. calling an organisation or professional on behalf of the patient). Referral pathways included: domestic violence organisations (65); another health professional (40); a social worker (46); the police (49); mental health services (8) and domestic violence advocacy based in the health care setting (2).

Sustaining the intervention

- Domestic violence interventions evolve as problems emerge and solutions are tested. Roles and responsibilities shift and change, and ideological differences may emerge in interventions that involve partnerships between organisations. Health professionals require feedback about how well the intervention is working, as well as a forum for sharing problems, highlighting incidents of harm, and discussing solutions. Since health care organisations are not expected to deal with domestic violence in isolation, discussions should take place within a multi-disciplinary and multi-agency context wherever possible.

- There were many examples of good practice across the case studies in relation to feedback mechanisms. In the UK, MOZAIC advocates attend social work and internal staff meetings in the hospital to update health professionals on the number and types of cases that are being referred, share success stores, advertise their training, as well as provide feedback on an individual basis. Advocates also have limited access to women's electronic medical records in order to alert midwives and doctors to the fact that a woman is receiving help from MOZAIC and that it may not be safe

to discharge her from the postnatal ward. They also publish an electronic newsletter and have a website. In Belgium, Domus Medica host meetings for social services and professionals who have undertaken the train the trainer course. This helps to maintain motivation levels and is an opportunity for professionals to discuss new ways of dealing with problems. SIGNAL e.V. has funding to meet with their train the trainer pool at least twice yearly as a forum for exchange and to discuss the results of the training evaluations and research results. The Mentor Mother intervention in the Netherlands has recently implemented a train the trainer pool of professionals as a method for ensuring sustainability.

- During the end of project workshop partners highlighted a need for women survivors to participate in the feedback mechanism. In the UK, MOZAIC launched a survivor's group called MOZAIC Voices at the House of Commons in 2011 which involves current and former clients. MOZAIC Voices has charitable status, engages in fund raising activities to raise awareness about domestic violence and survivors have been consulted about decisions relating to the service and research plans. In the Netherlands, all women referred to MeMoSA have an exit interview which provides insights that are fed back into the intervention.

- Train the trainer approaches were reported in the case study interventions for Germany, Belgium and Spain. Train the trainer courses are also available in Serbia and have recently been implemented in the Mentor Mothers intervention in the Netherlands. The results of the mapping survey found that of the 81 interventions that include a training component for health professionals, 37 also deliver train the trainer courses. Establishing a local pool of trainers is one method for ensuring sustainability of the intervention, but in order to maintain sufficient numbers, the courses need to recruit on a regular basis and fund health professionals' time and expenses.

- Domestic violence training for health professionals also needs to be offered on a regular basis in order to sustain the intervention. The mapping surveys showed that the length of basic domestic violence training courses offered ranged from 1 hour to 4 days and the frequency with which they were offered ranged from rolling programmes throughout the year, to training delivered five years ago.

- Feeding back the evidence of the process of implementation and outcomes of the intervention helps to create ownership of the intervention by health professionals, an important step in sustaining the intervention. Of the 81 interventions described in the mapping survey 30 reported that there was an associated formal research component. However, if we include the 13 autonomous communities of Spain who completed a mapping survey this figure increases to 39 interventions as the autonomous communities are required to submit data on gender violence to the Ministry of Health and Social Policy. All the interventions in the case studies face ongoing challenges in trying to secure funding and studies demonstrating benefit to women, children and health professionals as well as cost effectiveness are needed to convince funders.

GOOD PRACTICE RECOMMENDATIONS

- Domestic violence training should be part of the undergraduate curriculum, postgraduate curriculum and continuing professional development for all health professionals.

- Within the health care setting, training needs to be delivered on a regular basis to ensure all new health professionals are included. Reinforcement training, feedback mechanisms and support for health professionals post training are also needed to maintain a 'domestic violence aware' culture and to ensure continuous quality improvement.

- Practical training in the identification of domestic violence and communication skills should continue after the initial training session. Experiential learning approaches should be considered. Health professionals need to practice their skills in real clinical situations and obtain feedback and support. Communication with patients about domestic violence is an ongoing learning process

- A mix of incentive schemes may be needed to motivate health professionals to engage in training activities, such as accreditation, contribution of points to renewal of medical license, reimbursement of expenses, offering training during and outside of working hours, as well as offering free training.

- NGOs that take a lead role in designing and delivering training programmes, coordinating post-training support to health professionals and providing direct support to women must be funded for their work.

- Including community support organisations in the training of health professionals provides opportunities for developing multi-agency partnerships and enables all those involved to develop a greater understanding of each other's roles in supporting families affected by domestic violence.

- Interventions that involve 'in-reach' approaches (i.e. casework by specialist domestic violence advocates, lay advocates or social workers linked to the health care setting) are well suited to maternity and primary health care centres. Although these intervention models require more financial resourcing, women can readily access the service. Furthermore, health professionals feel more comfortable dealing with domestic violence, knowing that there is a direct referral pathway. In-reach approaches require strong multi-agency partnerships.

- Implementation of domestic violence interventions requires both a top-down and bottom-up approach. Domestic violence must be acknowledged at State level as a serious public health issue, with action plans that include funded measures for health care professionals. Demonstrable high-level support for the intervention is also needed within the health care organisation.

- Leadership roles and key reference persons within the health care setting are needed at all stages of the intervention, from gaining organisational support and staff acceptance, to sustaining the intervention. These should be formalised through task description of roles and responsibilities, supported by management and funded on an ongoing basis to avoid intervention atrophy.

- Interventions need a system for documenting the implementation process. This should include the organisational context and personnel; practices that work well; problems that occur; and adaptations to the intervention model. There must also be a system for feeding back this 'evidence' to health professionals (e.g. using the evidence in the training of health professionals and through internal meetings). Systems are also needed for recording the care process and outcomes for women affected by domestic violence. Guidelines and operational procedures underpinning the intervention should be updated to reflect changes to the intervention. This helps to create ownership of the intervention by health professionals. This is best achieved within a multi-disciplinary and multi-sector context and should include the views of women who have used the intervention.

- Interventions should be tailored to women's individual needs. Some women will require intense advocacy support and/or counselling. However, others will benefit from early interventions which assist them in developing a supportive network, reduce their isolation and enhance their understanding of the risks and use of safety behaviours.

- Formal research and evaluation are essential to demonstrating the implementation process and outcomes of the intervention. It is essential for securing further funding and should include a feedback mechanism to health professionals involved in administering the intervention and local stakeholders. It is important for funders and policy makers to know whether an intervention works, but also how, when and why it works. Research should demonstrate feasibility and acceptability. Country level data is needed to convince funders, policy makers and health care professions.

- Future intervention studies should consider how to include measures of harm as well as benefit, the impact on children and vulnerable women. This includes those with physical disabilities, visual or hearing impairments, mental health disorders, intellectual disabilities, older women, refugee and asylum seekers, prisoners, trafficked women, and women with drug and/or alcohol abuse problems.

- There should be a centralised system for collating information about domestic violence interventions based in health care settings to facilitate mapping of services and for identifying gaps in service provision.

- Health professionals use different approaches to the identification of domestic violence. Studies assessing the application of these approaches in different health care settings and target groups are needed.

- Health care setting in which domestic violence intervention research is sparse include: mental health, accident and emergency, reproductive and sexual health (including abortion) and social services.

Background

Domestic violence is one of the most pervasive forms of violence against women, which results in significant morbidity and mortality. Across Europe, national prevalence surveys show the lifetime prevalence of domestic violence to be between 4% and 30% (Martinez & Schrottle 2006). Primary and maternity health care settings have been identified as critical entry points for women seeking help for domestic violence. Health practitioners in these settings are in particularly propitious positions to facilitate supportive relationships before, during and after women disclose domestic violence. Importantly, practitioners may be a woman's first or only contact with a professional who can provide information and support. They have the potential to detect and address injuries and illnesses related to domestic violence in sensitive and confidential ways. There is greater potential for successfully embedding interventions within these health care settings due to a number of facilitating factors: (i) the continuity of care (ii) opportunities for confidentiality (iii) the focus on patient and family centred rather than process driven care (iv) a more predictable workload (v) longer consultations (vi) and a philosophy of care which recognises the social aspect of health. For these reasons, the Daphne project focussed on interventions to address domestic violence in maternity and primary care health settings. However, since research suggests that women who experience domestic violence are more likely to have gynaecological problems, sexually transmitted infections, unwanted pregnancies or elective terminations, it seems prudent to expand the health care settings to include other services attended by women including early pregnancy units, sexual health services, abortion services and inpatient and outpatient gynaecology in future interventions and research.

There is limited research and evaluation from European countries on health sector interventions for domestic violence. In addition, there is no centralised system for collating information on established domestic violence interventions in healthcare systems across Europe, perhaps with the exception of Spain (see Spain Case Study). Most of the research evidence on such interventions comes from North America, although there is a published trial from the UK (Feder et al. 2011). It is not clear how these interventions might be replicated or adapted in Europe, where health systems vary. Furthermore, there are differences between countries with regards to the national policy context and legislation regarding gender violence, civil society resources, specialist NGOs and criminal remedies.

The most recent systematic review on interventions to address domestic violence in different health care settings found that there is insufficient research evidence to implement a screening programme for domestic violence in health services. Although the authors acknowledge that it may be inappropriate to judge a policy of routine enquiry for domestic violence using National Screening Committee criteria, since women report many benefits of being asked about domestic violence during health consultations (Feder et al. 2009). The review also reports that the evidence for the effectiveness of advocacy is growing, particularly for women who have actively sought help or are in a refuge. Interventions involving collaboration between primary or maternity health care services and specialist domestic violence advocacy organisations are already popular in the UK and similar models can also be found in other European countries such as the Netherlands. In Europe, there are some published studies that have evaluated domestic violence interventions in primary and maternity health care settings and further details of these are

provided in the following chapters (Bacchus et al. 2007; Bacchus et al 2010. Torres Vitolas et al. 2010; Feder et al. 2011; de Deken et al. 2010a, 2010b; Lo Fo Wong et al. 2006, 2007, 2008; Perttu 2004; Perttu & Kaselitz 2006).

There has been much debate amongst health practitioners, academics and professional bodies about how to successfully integrate domestic violence interventions into well-established organisational cultures in the health sector and ensure sustainability. The development and delivery of domestic violence training programmes for health professionals requires significant resourcing. However, this initial investment in training may be lost unless there are additional resources to support health professionals in addressing domestic violence in clinical practice beyond the training. This includes having strong partnerships between health care services and the community organisations that provide support to women and children, as well as formalised and accessible expertise in the form of domestic violence coordinators or lead clinicians. At present in Europe, a range of promising domestic violence interventions are being implemented in maternity and primary care settings. However, there is currently no forum to share and consider emerging research, good practice and protocols. Partners from seven European countries (United Kingdom, Finland, Spain, Germany, the Netherlands, Serbia, and Belgium) are currently implementing promising health sector interventions. These vary in important ways, for example, by: the referral and assistance networks established; forms of interpersonal violence addressed; types of healthcare practitioner targeted for training; approaches to delivering training and identifying women affected by abuse; and types of support offered to women who disclose abuse. These varying approaches raise different challenges for implementation and sustainability of the interventions. A collaborative forum for discussion and information exchange will provide a unique opportunity to learn more about how to effectively integrate responses to domestic violence into health service provision and and to address some of the challenges encountered.

The proposed project emerged from a recognised gap in knowledge about the range of domestic violence intervention models currently based in maternity and primary care health settings in Europe. To improve health sector strategies in this area, there is a clear need for facilitated communication and collaboration. All partners have extensive experience of implementing and evaluating domestic violence interventions in these settings. Partners were carefully selected to represent a range of interventions in the seven countries. In preparation for this project, detailed information was gathered from each project partner, which highlighted important variations in intervention models, including intervention aims, health professionals targeted, approaches to training and identification of domestic violence, and delivery mechanisms.

A mapping survey of European intervention models and in-depth case studies of six interventions elicited detailed information about different setting-specific models and to offer recommendations for good practice. The project has set up a web site for health professionals, academics, policy makers and women's NGOs delivering domestic violence interventions within the health sector. The web site facilitates sharing of protocols, training materials, risk assessment and screening tools, as well as research on health sector interventions for domestic violence. As the first comparative study of domestic violence

interventions across Europe, the innovative nature of this project will enable us to offer key lessons for future policy and practice.

Aims and objectives

This report presents the findings of a two-year study exploring domestic violence interventions in primary care and maternity care in seven European countries. This is a descriptive study of an area in which there has been a paucity of research. The overarching aims of the project were to conduct a scoping and mapping exercise to identify established domestic violence interventions in primary and maternity care in the following countries: United Kingdom, Germany, The Netherlands, Spain, Belgium, Finland and Serbia. Case studies were conducted in the following countries: United Kingdom, Germany, The Netherlands, Spain, Belgium and Finland. Due to EU regulations it was not possible to conduct a case study in Serbia. The case studies consisted of interviews with collaborating partners and key personnel from one or more established health sector interventions in each country, chosen by the collaborating partner.

The seven countries were chosen for their established research and practice in the area of domestic violence and for their links with each other. All partners are experts within their countries on domestic violence and health sector interventions and were able to facilitate the coordinator in disseminating the mapping survey and identifying key personnel for qualitative interviews in the case studies.

Specific objectives

1. Identify and describe the key components of different models for delivering domestic violence interventions in primary and maternity health care settings in seven European countries.

2. To draw out key learning points about best practice and what challenges are encountered with regards to implementation and sustainability of interventions.

3. Establish an internet site for health professionals, policy makers, non-governmental organisations and academics to improve the exchange of knowledge and resources; and to foster better practice and policy strategies, as well as research collaborations within Europe.

4. To hold an end of project workshop in London for all partners and associates to discuss the findings and agree on good practice recommendations.

Methods

Web based mapping survey

A survey was developed in collaboration with partners to map established domestic violence interventions based in primary or maternity health care settings in each country. This included multi-health sector initiative that target primary or maternity care

professionals. The survey aimed to gain a broad overview of the intervention and its components including: the health care settings in which the interventions were based; the types of health care professionals and patients targeted within the intervention; geographical coverage; multi-agency collaborations and funding issues; policies and guidelines on domestic violence; domestic violence training; routine enquiry for domestic violence; documentation of domestic violence; referral systems and resources for victims; and research and evaluation of interventions.

The survey was translated into the languages of the seven countries and reviewed by partners. The survey was available as an internet link and a Word document. Each partner acted as an informant for their country or region and was responsible for disseminating the survey and sending out reminder emails. The survey was completed by one person in each intervention that had played a significant role in the design or implementation of the intervention and/or had sufficient knowledge about the intervention in order to answer the majority of the questions. Descriptive data from the survey will be presented for each country. It should be acknowledged that the mapping survey did not capture the full range of domestic violence interventions in primary and maternity care settings in these countries, as there is no centralised system for collating such information. It was not possible to calculate a response rate for all countries. The sampling strategy involved each partner contacting known individuals associated with interventions that met the eligibility criteria.

Definitions of terms in the mapping survey

As health care systems across the six countries differ, the following definitions were developed for purposes of the survey to ensure that it captured all relevant interventions.

Domestic violence
Domestic violence is defined as any behaviour within an intimate relationship that causes physical, psychological or sexual harm to those in the relationship (Krug WHO 2002). In this project the focus was on women victims of domestic violence, although questions about other client groups targeted by the intervention were included in the survey (e.g. children, male patients).

Primary care
Primary care refers to health services that a patient receives on first contact with the health care system, before being referred elsewhere, for example, to more specialist health services in a hospital. This can include seeing a general practitioner (or family physician/doctor), practice nurse, family planning advisor, social worker, or counsellor in a general practice surgery or healthcare centre. It can also include midwives, obstetricians, gynaecologists and health visitors who work in primary care settings. This can include private practice and public practice.

Maternity care
Maternity care refers to the care of women during pregnancy, childbirth and postpartum by midwives, general practitioners, or doctors (usually consultant obstetricians or gynaecologists) based in primary care settings (e.g. general practice surgeries or health centres) OR in hospitals.

Multi-sector initiatives that target primary or maternity care
The survey also targeted multi-sector initiatives that targeted primary or maternity care. For example, interventions that involved social care and primary care working together.

Domestic violence Intervention
The intervention must be currently running and may include *any* of the following components: domestic violence training, routine enquiry for domestic violence, documentation of domestic violence, referral of patients who disclose domestic violence to other professionals or community organisations. If you have more than one intervention project that is part of a larger national initiative, but they are implemented in very different ways (e.g. between two geographical areas) please complete separate surveys for each intervention.

Qualitative interviews

Qualitative interviews (in-person or telephone) were conducted with partners and other key personnel involved in established health sector interventions to address domestic violence in the following countries: United Kingdom, Germany, the Netherlands, Spain, Belgium and Finland. Partners were responsible for selecting potential respondents to interview and assisting in arranging field trips or telephone interviews. Interventions were chosen for in-depth study if they targeted women patients and health professionals in primary and/or maternity health care settings; were well established and still functioning; and included a research or formal monitoring component. Respondents included a range of health and social care professionals, managers and personnel from non-governmental organisations working for or in collaboration with various health care settings. Further details about the interviewees can be found in the results chapters for each country.

The interviews explored in more depth a range of issues including: the national policy context in which health sector interventions to address domestic violence emerged; individuals and organisations that were highly influential in developing interventions; key components of the intervention and target groups; practices that work well; challenges encountered; key roles, responsibilities and partnerships that underpin and sustain the intervention; funding issues; and research and evaluation. Interviews were transcribed verbatim. Interviews conducted with a translator present were transcribed by independent translators. Data were stored Word. The researcher (LB) was responsible for reading and eliciting key themes arising from the interviews.

End of project workshop

A one and a half day workshop was convened in London on the 3rd and 4th of November 2011 by the project coordinator at the London School of Hygiene & Tropical Medicine, to which all partners and associates were invited. The objectives of the workshop were as follows:

1. To discuss with partners the best practice recommendations taking into account the variation in context and intervention approaches.

2. To agree with partners the function, content and maintenance of the project website.

3. To agree with partners final outputs from the project including the final report, publicity leaflets with key results and submission of a joint publication to a European journal.

4. To identify gaps in European research on health sector interventions to address gender violence and discuss future studies.

Ethics

The project received approval from the London School of Hygiene & Tropical Medicine Ethics Committee on the 26th July 2010 (Reference: 5750).

All research participants in the qualitative interviews were be provided with a Participant Information Sheet and Consent Form which they were asked to sign if they agreed to be interviewed. Interviews were digitally recorded with participants' consent and transcribed. Translators were used for participants who preferred to use their first language. The interviews conducted with a translator present were subsequently transcribed by independent translators. All results from the in-depth interviews were written up anonymously. Intellectual property will be protected when developing the web-based European network. Any material, including the final briefing paper will be published without identifying details from any specific participant and in accordance with copyrights and applicable declarations of consent.

Outputs

Final report

The results from each country (United Kingdom, Finland, The Netherlands, Spain, Germany, Belgium and Serbia) are presented in the following chapters. For each country the chapter will be divided in the following way:

- A brief description of the health care system in the country
- A brief overview of domestic violence policy as it relates to the response of the health care system
- Results of the mapping survey of domestic violence interventions in primary and maternity health care settings
- Results of the case study interviews (with the exception of Serbia)
- Key learning points

Publicity brochure with key results and recommendations

Apart from the main report, a set professionally designed set of briefing notes containing the key findings and good practice recommendations was produced in the main language of each country.

Development of the DIVERHSE web site (Domestic & Interpersonal Violence: Effecting Responses in the Health Sector in Europe)

The research process and information collected from the surveys and case studies facilitated the development of an internet resource for health professionals, researchers, NGOs and other practitioners involved in delivering domestic violence interventions in health care settings and for advocates working to improve policies and practice. A consultant was contracted to develop an informational and resource web-site which contains: 1) publicly available project documentation and results 2) clinical guidelines, protocols and training programmes; 3) tools for identifying and documenting domestic violence, and risk assessment tools; and 4) references to/or pdf copies of published research reports and papers. The website will also contain an 'Events' page to announce relevant European-wide and international events or conferences and funding opportunities. The website will be hosted externally by the web designer and supported for three years after the end of the Daphne project with input from the Project Coordinator. This will allow sufficient time to obtain additional funding, ensure that information and resources from other European countries can be included and to develop other aspects of the website.
http://diverhse.eu
http://diverhse.org

References

Bacchus L, Bewley S, Aston G, Torres Vitolas C, Jordan P, Murray SF. (2010) Evaluation of a UK domestic violence intervention in maternity and sexual health services. *Reproductive Health Matters*, 18(36): 147-157.

Bacchus L, Aston G, Torres Vitolas C, Jordan P, Murray S. (2007) *A theory-based evaluation of a multi-agency domestic violence service based in maternity and genitourinary medicine services at Guy's & St. Thomas' NHS Foundation Trust.* London: Kings College London (Accessed 18th August 2011).
http://www.kcl.ac.uk/schools/nursing/research/themes/women/projects/maternal/domesticviolence.html

De Deken L, Pas L, Hillemans K, Cornelis E, Van Royen P. (2010a) Detectie van partnergeweld. Een aanbeveling voor de huisarts (Detection of partner violence. A recommendation for the general practitioner) Huisarts Nu (GP Now) 39(3), S1-63 (Accessed 18th August 2011).
http://www.domusmedica.be/kwaliteit/aanbevelingen/overzicht/partnergeweld.html

De Deken L, Pas L, Hillemans K, Cornelis E, (2010b) De huisarts in contact met partnergeweld. een evidence based werkmodel. Huisarts Nu; 39(9):339-345 (Accessed 18th August 2011).
http://www.domusmedica.be/images/stories/huisartsnuarchief/h39_09_04_partnergeweld.pdf

Feder G, Ramsay J, Dunne D, Rose M, Arsene C, Norman R, Kuntze S, Spencer A, Bacchus L, Hague G, Warburton A, Taket A. (2009) How far does screening women for domestic (partner) violence in different health-care settings meet criteria for a screening programme? Systematic reviews of nine UK National Screening Committee criteria. *Health Technology Assessment*, 13(16): 1-136 (Accessed 18th August 2011).
http://www.hta.ac.uk/1501

Feder G, Agnew Davies R, Baird K, Dunne D, Eldridge S, Griffiths C, Gergory A, Howell A, Johnson M, Ramsay J, Rutterford C, Sharp D. (2011) Identification and Referral to Improve Safety (IRIS) of women experiencing domestic violence with a primary care training and support programme: a cluster randomised controlled trial. *The Lancet*, 378: 1788-1795.

Lo Fo Wong S, Wester F, Mol SSL, Lagro-Janssen TLM. (2006b) Increased awareness of intimate partner abuse after training: a randomised controlled trial. *British Journal of General Practice*, 56: 249-257.

Lo Fo Wong S, Wester F, Mol S, Lagro-Janssen T. (2007) “I am not frustrated anymore”. Family doctors evaluation of a comprehensive training on partner abuse. *Patient Education and Counselling*, 66: 129-137.

Lo Fo Wong S, Wester F, Mol S, Romkens R, Hezemans D, Lagro-Janssen T. (2008) Talking matters: abused women’s views on disclosure of partner abuse to the family doctor and its role in handling the abuse situation. *Patient Education and Counselling*, 70: 386-394.

Martinez M, Schrottle M. (2006) *State of European research on the prevalence of interpersonal violence and its impact on health and human rights*. Germany: Coordination and Action on Human Rights, Universitiy of Osnabrueck, 2006 (Accessed 18th August 2011).
http://www.cahrv.uni-osnabrueck.de/reddot/CAHRVreportPrevalence(1).pdf

Perttu S. (2004) *Intimate partner violence against women and its screening at the maternity and child health clinic*. Reports of the Ministry of Social Affairs and Health (Accessed 18th August 2011). http://pre20090115.stm.fi/pr1104480484516/passthru.pdf

Perttu S, Kaselitz V. (2006) *Addressing intimate partner violence. Guidelines for health professionals in maternity and child health care* (Accessed 18th August 2011).
http://www.hyvan.helsinki.fi/daphne/

Torres Vitolas C, Bacchus L, Aston G. (2010) A comparison of the training needs of maternity and sexual health professionals in a London teaching hospital with regards to routine enquiry for domestic abuse. *Public Health*. 124(8): 472-478.

Study 1: United Kingdom

Description of the UK health sector

The National Health Service (NHS) is the shared name of three of the four publicly funded healthcare systems in the United Kingdom. The English NHS is officially called the National Health Service. The others are NHS Scotland, NHS Wales and Health and Social Care in Northern Ireland (HSC rather than NHS). Each system operates independently and is politically accountable to the relevant governments: Scottish Government, Welsh Government, Northern Ireland Executive and the UK Government (for the English NHS).

The NHS is funded primarily through the general taxation system and provide healthcare to anyone normally legally resident in the United Kingdom, with almost all services being "free at the point of use" for anyone legitimately fully-registered with the system (i.e. in possession of an NHS number) including not only UK citizens, but also legal emigrants. The NHS also provides free emergency-based are to all people within UK borders regardless of their legal status or national origin.

The population in the UK was 62.3 million in mid 2010 (an increase of 0.8% on the previous year).

Further information about the NHS can be found at (Accessed 18th August 2011):
http://en.wikipedia.org/wiki/National_Health_Service

For further information about the UK population can be found at (Accessed 30th January 2012):
http://en.wikipedia.org/wiki/List_of_countries_by_population

NHS Primary Care Trust (PCT)
Primary health care refers to health services that a patient receives on first contact with the health care system, before being referred elsewhere, for example, to more specialist health services in a hospital. Primary care refers to services provided by GP surgeries, dental practices, community pharmacies and high street optometrists. Around 90% of people's first contact with the NHS is with these services. Other health professionals that may be based at GP surgeries include counsellors, practice nurses, or social workers.

An NHS Primary Care Trust (PCT) is a type of NHS Trust and part of the National Health Service in England. There are around 150 PCTs in England. However, they are due to be abolished in 2013. PCTs commission primary, community and secondary care from providers. PCTs are responsible for spending around 80% of the total NHS budget. PCTs have their own budgets and set their own priorities, within the overriding priorities and budgets set by the relevant Strategic Health Authority and the Department of Health. They provide funding for general practitioners and medical prescriptions; they also commission hospital and mental health services from appropriate NHS trusts or from the private sector. However, in July 2010 the Government announced plans to abolish PCTS by 2013.

General Practice
General practice is for most people the first and most commonly used point of access to the NHS with nearly 300 million general practice consultations a year according to the Department of Health in 2008. Practice size has increased in the last decade and the workforce has grown and the range of services offered has expanded. Current government policy aims to improve access and choice for patients and to enable greater self-management of people with long-term conditions, to expand the role of GPs in areas such as health promotion, and to improve quality of care. In England the vast majority of the population are registered with a general practice. There are around 8,230 practices in England and they range in size from single handed practices to multi-partner practices employing several nurses and other clinical staff. The number of single handed practices has decreased considerably (around 28%) as older GPs have retired. There are also GPs with special interests that provide services such as dermatology, care for older people, care for those with epilepsy and respiratory medicine. A fairly new development has been plans to encourage GPs to come together in larger centres (polyclinics) which will house GP practices alongside other primary, community and outpatient services. These polyclinics will provide a one-stop-shop to those with long term conditions.

Before 2004, most GPs in England were employed under a nationally negotiated General Medical Services contract. The GPs as individuals were contracted and paid for each piece of work carried out and on the basis of the number of patients registered with them. However, from the 1st of April 2004, a new GMS contract was agreed and it is now the practice that is contracted by the Primary Care Trust (PCT) rather than the individual GP. The contract provides a 'global sum' which is determined by linking the amount paid to a practice to the needs of its registered patients (Kings Fund, 2009).

Further information about primary health care can be found at (Accessed 18th August 2011):
http://www.dh.gov.uk/en/Healthcare/Primarycare/index.htm
http://en.wikipedia.org/wiki/NHS_primary_care_trust

Maternity healthcare
In the UK, maternity healthcare refers to the care of women during pregnancy, childbirth and postpartum by midwives, general practitioners, or doctors (usually consultant obstetricians or gynaecologists) based in primary care settings (e.g. general practice surgeries or health centres) and in hospitals. The first contact with the health service for most pregnant women is a visit to their general practitioner when they are between seven and eight weeks pregnant. Although not all women go to their general practitioner and some may see a midwife first. At first contact, women are referred or given an appointment for an initial assessment, commonly referred to as the 'booking appointment'. This is normally carried out by a midwife and involves a detailed assessment of the woman's physical, social and clinical history so that the rest of her antenatal care can be planned appropriately and any potential problems identified at an early stage. The booking appointment should be made by 12 weeks, although this is partly dependent on women making early contact with health services as soon as they suspect they are pregnant.

Nearly all women (99%) see a midwife for some or all of their antenatal checks and 60% (usually those with high risk pregnancies) see a hospital doctor (consultant obstetrician) one or more times. The National Institute for Health and Clinical Excellence (NICE) has recommended the appropriate number of appointments for women with a healthy pregnancy, with more for first-time mothers than those who have already had a baby. NICE recommend 10 appointments for a first-time mother who gives birth at term and 7 for women who have already had a baby (NICE, 2008). The setting in which women receive antenatal care varies, but can include a health centre, GP surgery or hospital Trust. Women with high risk pregnancies require specialist services provided by hospital Trusts.

Further information about maternity services can be found at (Accessed 18th August 2011):

National Institute for Health and Clinical Excellence, Antenatal care: Routine care for the healthy pregnant woman, guideline CG6, 2003, updated to guideline 62, March 2008
http://www.cqc.org.uk/_db/_documents/Towards_better_births_200807221338.pdf

References

Kings Fund (2009) Briefing. General practice in England: An overview. London: The Kings Fund. Available online at (Accessed 24th October 2011):
http://www.kingsfund.org.uk/publications/briefings/general_practice_in.html

Domestic violence policy context in the UK

Historically, there have been a number of policy and legislation documents that are of relevance to the development of health sector interventions to address domestic violence in the UK spanning ten years. However, for the purposes of this report, only the most current and documents are outlined in this section.

In 2005 the UK Department of Health published a handbook for health professional in which it recommended that "*all [National Health] Trusts should be working towards routine enquiry and providing women with information about domestic abuse support services. It is important to take the initiative and be proactive*" (Department of Health, 2005). The handbook recommends that the implementation strategy must be underpinned by clear guidelines, training for health professionals, systems for documentation of abuse disclosed, clear referral pathways for women and robust clinical supervision (pp.88-105). In addition to the handbook, the Department of Health funded a number of regional "train the trainer" sessions in 2005, where senior midwifery leaders and educationalists were able to share expertise. Additionally, a number of Emerging Practice workshops were conducted across the country to prepare maternity services for the changes in practice that were expected following publication of the handbook. The Department of Health and the Home Office ran a series of Strategic Breakfasts for PCT chief executives and senior regional and local authority staff to strengthen partnership work on domestic violence (Mann, 2007). Although there has been much progress since the publication of the handbook, the implementation of such interventions has been piecemeal in countries of the UK.

In May 2009, the UK Department of Health established a taskforce, led by Professor George Alberti, to look at what health services could to do prevent violence against women and girls, and to provide more effective services to identify and support victims. The taskforce consisted of four sub-groups: domestic violence (including the impact on children); sexual violence against women; sexual abuse against children; and harmful traditional practices (e.g. female genital mutilation, forced marriage, trafficking of women). Members of the independent taskforce included eminent academics and health professionals working on the issue, chief executives, commissioners and policy makers of NHS Trusts, representatives from national health professional governing bodies such as the Royal Colleges, as well as representatives and advocates from women's organisations that support women and children affected by domestic violence. In March 2010 the taskforce published 23 recommendations (HM Government, 2010). This included, amongst others, the need for:

- Appropriate basic training and education for all staff.
- Primary Care Trusts (PCTs) and NHS Trusts to work in partnership with other agencies to ensure that appropriate services are available to victims of violence and abuse.
- Every NHS organisation to have a single designated person to advise on appropriate services and referral pathways for victims of violence and abuse, as well as providing advice in cases where the patient is at imminent risk.
- Every NHS organisation to have policies specifically for staff who are victims of domestic and sexual violence, as well as clear referral pathways for staff to access support.
- NHS organisations to ensure that information relating to violence and abuse against women and children is treated confidentially and shared in a responsible manner.
- Consistent and practical standards for collating data on violence and abuse against women and children to underpin the analysis of quality, outcomes and performance management by commissioners, NHS and third sector providers.
- Commissioners/PCTs with their partners in Local Strategic Partnership should ensure that appropriately funded and staffed services are put in place along locally agreed care pathways.
- NHS organisations should ensure that there is sustained and formalised coordination of the local response to violence against women and children through a local Violence Against Women and Children Board. NHS organisations should participate fully in local multi-agency fora, such as Multi-Agency Risk Assessment Conferences (MARACS) that deal with high risk cases.
- PCTs and NHS Trusts should nominate local 'violence against women and children' leads supported by the Violence Against Women and Children Board, to work with victims and the NHS to drive change and improve outcomes.

Following on from this, In March 2011, the government launched the Call to End Violence Against Women and Girls Action Plan which contained 88 actions under four key areas (HM Government, 2011):

- To prevent violence from happening by challenging the attitudes and behaviours which foster it and intervening early where possible to prevent it.
- To provide adequate levels of support where violence does occur.
- To work in partnership to obtain the best outcome for victims and their families.
- To take action to reduce the risk to women and girls who are victims of these crimes and ensure that perpetrators are brought to justice.

In order to achieve these goals, the government has committed £28 million towards funding specialist services over the next four years, improving the response to rape, training and early intervention programmes and new powers and better support for victims.

In 2011, the Department of Health produced guidelines to support health commissioners, focussing on primary care, mental health services, maternity and sexual health services, to improve commissioning of services for women and children who experience violence or abuse. The guidance suggests outcomes measures, includes case study examples and advice on how to include the needs of victims of violence in Joint Strategic Needs Assessments (Department of Health, 2011).

More recently, the National Institute for Clinical Excellence have commissioned a series of systematic reviews to inform the development of domestic violence guidelines for health and social care professionals and third sector organisations (i.e. voluntary/non-governmental).

References

Department of Health (2005) Responding to domestic abuse: a handbook for health professionals (Accessed 18th August 2011)
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4126161

HM Government (2010) Call to end violence against women and girls (Accessed 18th August 2011)
http://www.homeoffice.gov.uk/publications/crime/call-end-violence-women-girls/vawg-paper?view=Binary

HM Government (2011) Call to end violence against women and girls: action plan (Accessed 18th August 2011)
http://www.homeoffice.gov.uk/publications/crime/call-end-violence-women-girls/vawg-action-plan?view=Binary

Department of Health (2011) Commissioning services for women and children who are victims of violence or abuse. A guide for health commissioners (Accessed 18th August 2011) http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_125938.pdf

Results from the UK mapping survey

Dissemination

There is no central system in for collating information on health sector interventions to address domestic violence in the UK. The Daphne project coordinator (Loraine Bacchus) was responsible for contacting key individuals within the UK to assist with dissemination of the mapping survey. The survey was sent to the following organisations as well as individuals known to the coordinator for their involvement in the development and/or evaluation of health sector interventions to address domestic violence in primary and/or maternity care. It should be acknowledged that some interventions meeting the eligibility criteria may not have been captured by the mapping survey.

- Members of the HEVAN Forum (Health Ending Violence and Abuse Now)
  HEVAN is a national organisation for health professionals, academics, policy makers, advocates and non-governmental organisations working in the field of domestic violence.

- Professor Joyce Kenkre, University of Glamorgan and Chief Nursing Officer for Wales in the Welsh Assembly Government.

- Katie Cosgrove, National Programme Manager, Directorate of Healthcare, Policy and Strategy, Scottish Government.

- Clare McFeely, Research Manager, National Gender Based Violence and Health Programme, Directorate of Healthcare, Policy and Strategy, Scottish Government.

- Professor Helen Lester, Chair of the Society for Academic Primary Care (SAPC) and Chair of the Royal College of General Practitioners (RCGP). The SAPC and RCGP are partners for the development and dissemination of primary care research.

- Professor Amanda Howe, Honorary Secretary, Royal College of General Practitioners (RCGP)

A number of email requests were sent to the Royal College of Obstetricians and Gynaecologists in order to ensure wide coverage of maternity care services, although no response was received.

Respondents
Since a snowballing technique was used to disseminate the mapping survey, including email lists, it is not known precisely how many surveys were disseminated and it was not possible for calculate a response rate. However, a total of 15 surveys were returned. It was possible for respondents to select multiple answers for some questions.

Intervention settings
Respondents reported that Interventions targeted multiple healthcare settings including: primary care (5); maternity care services (11); multi-health sector initiatives that include maternity or primary care (4); genitourinary medicine (1); gynaecology (1); and accident and emergency (1).

Health professionals targeted in the interventions included: general practitioners (6); midwives (11); nurses (5); health visitors (4); obstetricians (4); gynaecologists (2); doctors, nurses and health advisors in genitourinary medicine (1); and maternity support workers (1). All 15 respondents indicated that the female patients were the target population for the interventions, although 3 respondents indicated that male patients were also recipients of the intervention. These were based in genitourinary medicine, accident and emergency (in multi-sector initiatives that included maternity and primary care interventions). Further detail about each intervention is provided in the following table.

Table 1.1 Coordination, funding and location of domestic violence interventions in the UK
Note: Names of interventions given may be descriptive rather than official names

Name and length of the intervention	Professionals targeted in the intervention	Coordinating organisation and geographical location	Funding source
Maternity Pathway (9 years)	Midwives	Leeds teaching hospital fulfilling Service Level Agreement with Leeds Primary Care Trust Leeds, England	Part of the Service Level Agreement with Leeds Primary Care Trust who commissions maternity services
Unnamed intervention (5 years)	Midwives; obstetricians	Calderdale and Huddersfield NHS Foundation Trust Calderdale and Huddersfield, England	Calderdale and Huddersfield NHS Foundation Trust
Routine screening (5 years)	Midwives	Midwifery managers and leaders at James Paget University Hospital Great Yarmouth, Norfolk, Lowestoft, Suffolk England	NHS Trust
MOZAIC Women's Well-Being Project (5½ years)	Midwives; obstetricians; maternity support workers; gynaecologists; genitourinary medicine staff (nurses/doctors/health advisors)	Partnership between Guy's & St. Thomas NHS Foundation Trust and the 170 Community Project (an NGO) London, England	Lambeth Primary Care Trust
IRIS (Identification and Referral to Improve Safety) (3 years)	General practitioners; nurses; health visitors	Bristol University London, England	The Health Foundation
PATHway Project (20 months)	Midwives; nurses; obstetricians; gynaecologists	Partnership between Manchester City Council and St. Mary's Manchester, England	NHS Manchester
Standing Together Against Domestic Violence (maternity services) (1 year)	General practitioners	Standing Together London, England	Primary Care Trust
Standing Together Against Domestic Violence (primary health care) (1 year)	Midwives	Standing Together London, England	Primary Care Trust

Name and length of the intervention	Professionals targeted in the intervention	Coordinating organisation and geographical location	Funding source
Bristol Pregnancy Domestic Violence Programme (5 years)	Midwives	Partnership between University of West England and Bristol NHS Trust Bristol, England	Department of Health (original evaluation); Avon Primary Care Research Collaboration (current evaluation)
WORTH Services (6 years)	General practitioners; midwives; nurses; health visitors; obstetricians; gynaecologists;	West Sussex County Council - Community Safety Unit on behalf of Community Safety Partnership West Sussex, England	West Sussex Country Council (local government)
Routine enquiry (4 years)	Midwives	NHS Scotland Edinburgh, Scotland	Government
National Gender based Violence and Health Programme (not specified)	Midwives; nurses; health visitors	National Gender Based Violence and Health Team, Scottish Government Scotland	Scottish Government
Unnamed (length not specified)	General practitioners; midwives; obstetricians	Mid Staffordhsire NHS Foundation Trust Staffordshire, England	Hospital Trust
Refuge Accommodation and Peripatetic Housing Support (30 years)	General practitioners; health visitors	Rhondda Women's Aid Rhondda, Wales	Welsh Assembly (Welsh Government) via the Supporting People Housing Team
Unnamed (18 years)	General practitioners	New Pathways (NGO specialising in supporting victims of rape and sexual abuse) Merthyr Tydfil, Wales	Not specified

Collaborative partnerships and funding

Amongst the 15 respondents, 6 reported that the coordinating (or leading) organisation in the intervention was the NHS; 3 reported coordination via partnerships between the NHS and local government or the voluntary sector; 4 were coordinated solely by voluntary sector organisations; and 2 by local or national government. With regards to funding for the interventions, amongst the 14 respondents that answered, 9 received funding directly from the NHS; 4 from the government; and 1 from an independent charity.

Policies on domestic violence

Fourteen respondents reported that the intervention had a policy that provides guidance to health professionals about how to respond to patients affected by domestic violence. This included policies developed specifically for the intervention (9) and policies based on the national guidelines (5). One respondent did not know whether the intervention had a policy. Amongst the 14 respondents who reported the existence of an intervention policy, all stated that the policy recommended routine enquiry for and documentation of domestic violence, and referral pathways for patients affected by abuse. 13 respondents stated that the policy provided guidance on how to assess the safety of the patient and any children or vulnerable adults who may be affected by domestic violence; as well as guidance on confidentiality and information sharing.

Domestic violence training

Of the 15 respondents, 14 indicated that domestic violence training was provided to health professionals. Training was provided by a range of people including a domestic violence trainer from outside the healthcare service (11); health professionals (8); staff from local women's organisations (1); and jointly by health professionals and domestic violence trainers (1).

Table 1.2 Professionals targeted for training

Professional group	**Training provided (N)**	**Training mandatory (N)**
Nurses	6	3
General practitioners	3	1
Midwives	12	8
Health visitors	4	2
Psychologists/counsellors	3	1
Gynaecologists	4	1
Obstetricians	5	1
Social workers	1	1
Reception/clerical/administration	5	0
Maternity support workers	1	1
Sexual health practitioners	1	0

Table 1.3 Content of domestic violence training

Content of domestic violence training	Yes (N)	No (N)	Don't Know (N)
Routine enquiry for domestic violence	12	2	1
How to document domestic violence	12	1	2
How to refer patients who disclose domestic violence	14	0	1
How to assess the safety of the patient	12	1	2
How to deal with issues of confidentiality and information sharing	13	0	2

Three of the 15 respondents reported that the intervention offered 'train the trainer' courses. Other respondents reported that additional training was offered to key clinicians in the healthcare setting to enable them to become 'in-house' experts to which other staff could contact for advice. Respondents gave quite detailed answers regarding the frequency and length of the training and these are tabled in the following pages.

Table 1.4 Frequency and length of domestic violence training interventions in the UK

Name and geographical location of intervention	Frequency of training	Length of training
Maternity Pathway, Leeds England	Annually for the past three years to all midwives at all levels (including the Head of Midwifery and the Senior Team)	The input has been one hour in length.
Unnamed, Calderdale and Huddersfield, England	Introductory training is run bi-monthly and professionals only have to attend once. There is also a bi-monthly update day focusing on domestic violence, substance misuse, mental health and teenage pregnancy and professionals have to attend this on a 3 yearly basis.	One full day initially, then a 2 hour session within the update training.
Routine Screening, London England.	Once a year.	Mandatory training is 40 minutes once per year. Supplemented by domestic abuse educator 1 day course as required.
MOZAIC Women's Wellbeing Project, London England	At induction for all staff at the hospital Trust. With regards to Women's Services, it is offered annually for midwives and maternity support workers and 3 times a year for obstetricians.	1 hour minimum, 1 day - optional

Name and geographical location of intervention	**Frequency of training**	**Length of training**
IRIS (Identification and Referral to Improve Safety), London England	Training is delivered at the beginning of the intervention to both the clinician and reception/administration teams. Every 2-3 months the DV trainer ('IRIS advocate-educator') will go to individual practice meetings to provide refresher info on DV and to discuss patient referrals from the practices. This provides the opportunity for the practice teams to gain further and on-going DV information. A practice champion (a lead person at each practice) is identified and they receive a further 2 hour training session Refresher sessions are offered to practices each year and one-off info sessions for new staff and locums.	Two 2 hour training sessions for the clinical team (the 2nd session to be delivered within 6 weeks of the 1st session) One hour training session for the reception/admin team
PATHway Project, Manchester England	This is a two year project and the worker undertakes snap shot training with all maternity staff, which supplements the training on routine enquiry provided by the Consultant Midwife.	Training is brief and does not differentiate between different staff
Standing Together Against Domestic Violence, London England (primary care)	Main staff attended a one-day training session, 2 champions at each site were invited to attend a follow up half day session. One practice was able to send two, the other none. In addition I visit the surgeries regularly to update them on DV and inform those who didn't attend the training what they can do about DV.	Main staff attended a one-day training session, 2 champions at each site were invited to attend a follow up half day session. One practice was able to send two, the other none. In addition I visit the surgeries regularly to update them on DV and inform those who didn't attend the training what they can do about DV.
Standing Together Against Domestic Violence, London England	1 day training session with a half day session as a follow up 2 months later.	1.5 days in total.

Name and geographical location of intervention	Frequency of training	Length of training
Bristol Pregnancy Domestic Violence Programme, Bristol	Training day runs 4 times a year. One whole day for new staff and 1/2 day yearly updates for staff who have already undergone the training day.	Training day runs 4 x a year a whole day for new staff and 1/2 day yearly updates for staff who have already undergone the training day.
WORTH Services, West Sussex England	One full day training for up to 25 people - monthly 1:1 coaching sessions as required.	One full day and up to 2 hours 1:1 coaching
Routine Enquiry, Edinburgh Scotland	Varies widely - not enough.	Varies widely, not enough
National Gender Based Violence and Health Programme, Scotland	This training has been introduced relatively recently. At present there are no further sessions planned however, boards recognise that this is required. Ongoing support is provided through managers, supervision and peer support. Managers are encouraged to discuss domestic abuse and routine enquiry at team meetings and 1-2-1 supervision.	One full day training is delivered although in some areas this has been condensed to half a day when workers have recently attended alternative domestic abuse training.
Unnamed, Staffordshire England	Sessions are held monthly staff are allocated to attend Trainers are staff of Women's Aid and Independent Domestic Violence Advocates (IDVAs).	Length is variable
Refuge Accommodation and Peripatetic Housing Support, Rhondda Women's Aid Wales	Levels 1 - 3 Domestic abuse awareness raising Programme of training provided throughout the year	Varies from 1 day to 10 days (attended weekly) Longer accredited courses are available via the university.
Unnamed, Merthyr Tydfil Wales	Unknown	Unknown

Approaches to routine enquiry for domestic violence

Of the 15 respondents, 14 indicated that the intervention model involved routine enquiry for domestic violence. All of these reported that female patients were being asked about domestic violence and 2 reported that male patients were also asked (in genitourinary medicine and accident and emergency).

For 8 respondents whose interventions were based in maternity services, routine enquiry involved asking all pregnant women about domestic violence at some point during their antenatal care. For 2 respondents whose interventions were based in primary care (general practice), the term 'clinical enquiry' was used which referred to asking patients attending with certain clinical indicators (e.g. depression).

Nine of the 14 respondents stated that there were systems within the intervention to monitor and audit the extent of routine enquiry for domestic violence and this was usually by means of paper or electronic patient records.

Documentation of domestic violence

Respondents indicated that within the intervention, health professionals were advised to document the following information:

Table 1.5 Documentation of domestic violence

Information documented	Yes (N)	No (N)	DK (N)
Whether or not the patient was asked about domestic violence	12	1	2
Whether or not the patient disclosed domestic violence	14	0	1
Name of the perpetrator	8	4	3
Relationship of the perpetrator to the patient	12	1	2
A description of the types of abuse experienced	12	1	2
A description of any recent incident of abuse	11	1	3
A description of the types and location of injuries	12	1	2
A body map picture indicating location of injuries	9	3	3
Whether referral information was offered to the patient	12	1	2
Whether the patient accepted the referral information	11	2	2
Indication of any action taken by the patient	9	4	2
Whether there are any children in the household	13	0	2
An assessment of the safety of the patient and any children	11	2	2

Referral pathways

Of the 15 respondents, 12 reported that they offered information about support and organisations to patients that disclosed domestic violence. In addition, 11 also said that the health professional assists by contacting the organisation on behalf of the patient. One respondent mentioned making written referrals.

Table 1.6 Referral pathways

Referral sources	(N)
Domestic violence organisation in the community	11
Another health professional	7
Social worker	7
Police	8
Others - MOZAIC advocacy service in the hospital - Independent Domestic Violence Advocate in the maternity clinic - WORTH services	3 1 1 1

Evaluation

Respondents were asked whether the intervention included a formal research or evaluation component and to provide details of any reports or publications. Eight respondents reported a research component.

Table 1.7 Evaluation of domestic violence interventions in the UK

Name, geographical location and length of Intervention	Evaluation activity
Maternity Pathway (9 years) Leeds, England	No formal research, but participants of the domestic violence training course are invited to complete an evaluation form.
Unnamed intervention (5 years) Calderdale and Huddersfield	No
Routine screening (5 years) Great Yarmouth, Norfolk, Lowestoft, Suffolk, England	No
MOZAIC Women's Well-Being Project (5½ years) London, England	Included a formal 3 year evaluation. Bacchus L, Aston G, Torres Vitolas C, Jordan P, Murray S. (2007) *A theory-based evaluation of a multi-agency domestic violence service based in maternity and genitourinary medicine services at Guy's & St. Thomas' NHS Foundation Trust.* London: Kings College London. Bacchus L, Bewley S, Aston G, Torres Vitolas C, Jordan P, Murray SF. (2010) Evaluation of a UK domestic violence intervention in maternity and sexual health services. *Reproductive Health Matters*, 18(36): 147-157. Torres Vitolas C, Bacchus L, Aston G. (2010) A comparison of the training needs of maternity and sexual health professionals in a London teaching hospital with regards to routine enquiry for domestic abuse. *Public Health*. 124(8): 472-478.

IRIS (Identification and Referral to Improve Safety) (3 years) London, England	Includes formal research: Gregory A, Ramsay J, Agnew-Davies R, Baird K, Devine A, Dunne D, Eldridge S, Howell A, Johnson M, Rutterford, Sharp D, Feder G. (2010) Primary care Identification and Referral to Improve Safety of women experiencing domestic violence (IRIS): protocol for a pragmatic cluster randomised control trial. *BMC Public Health*, 10(54). Johnson M. (2010) 'Herding cats': the experiences of domestic violence advocates engaging with primary care providers. Domestic Abuse Quarterly, Women's Aid Federation of England. Feder G, Agnew Davies R, Baird K, Dunne D, Eldridge S, Griffiths C, Gergory A, Howell A, Johnson M, Ramsay J, Rutterford C, Sharp D. (2011) Identification and Referral to Improve Safety (IRIS) of women experiencing domestic violence with a primary care training and support programme: a cluster randomised controlled trial. *The Lancet*, 378: 1788-1795.
PATHway Project (20 months) Manchester, England	Included an evaluation, not specified further.
Standing Together Against Domestic Violence (maternity services) (1 year) London, England	An informal evaluation of the project, through monthly project reports to the funder and learning papers at the end of the project.
Standing Together Against Domestic Violence (primary health care) (1 year) London, England	An informal evaluation of the project, through monthly project reports to the funder and learning papers at the end of the project.
Bristol Pregnancy Domestic Violence Programme (5 years) Bristol, England	Includes formal research conducted by the University of Bristol: Salmon D, Baird K, Price S, Murphy S. (2004) *An evaluation of the Bristol Pregnancy and Domestic Violence Programme to promote the introduction of routine antenatal enquiry for domestic violence at North Bristol NHS Trust*. Bristol: University of the West of England, Faculty of Health and Social Care. Baird K, Salmon D, Price S. (2005) Learning from the Bristol pregnancy and domestic violence programme. *British Journal of Midwifery* 13: 692–96. Price S, Baird K, Salmon D. (2005) Asking the question: antenatal domestic violence. *Practising Midwife* 8: 21–25.

WORTH Services (6 years) West Sussex, England	Safety in Numbers. A multi-site evaluation of Independent Domestic Violence Advisor services (2009). London: CAADA http://www.caada.org.uk/Research/Safety_in_Numbers_full_report.pdf CAADA Insights (in process)
Routine enquiry (4 years) Edinburgh, Scotland	Lazenbatt, A., Taylor, J. & Cree, L. (2009) A healthy settings framework: an evaluation and comparison of midwives' responses to addressing domestic violence. Midwifery, 25, 622-636.
National Gender based Violence (GBV) and Health Programme (length of intervention not specified) Scotland	The National GBV & Health Team is co-ordinating the evaluation. Currently in process.
Unnamed (length not specified) Staffordshire, England	Not known.
Refuge Accommodation and Peripatetic Housing Support (30 years) Rhondda, Wales	Yes, not specified further. www.welshwomensaid.org.uk
Unnamed (18 years) Merthyr Tydfil, Wales	No.

UK case study: MOZAIC Women's Wellbeing Project

Historical context

The MOZAIC Women's Well Being Project is a partnership between the maternity and sexual health services of Guy's & St. Thomas' NHS Foundation Trust, a teaching hospital in London, and the 170 Community Project, a non-governmental organisation which also runs a domestic violence project. The hospital serves the local boroughs of Lambeth and Southwark in London. Based on the Greater London Authority statistics (2011), the mid-2010 population figures for these boroughs are: Lambeth (284,500); Southwark (287,000); and Lewisham (266,500)

For further information on population figures for Lambeth, Southwark and Lewisham (Accessed 30th January 2012):

Greater London Authority (2011)
http://www.london.gov.uk/sites/default/files/Update%2011-2011%20Mid-2010%20population%20estimates.pdf

The intervention consisted of the following components:

- Clinical guidelines for dealing with domestic violence in maternity and sexual health services.
- One day domestic violence training for health professionals in maternity and sexual health services to enable them to carry out routine enquiry for domestic violence, documentation and referral to MOZAIC.
- Referral to MOZAIC Women's Well Being Service, an on-site domestic violence advocacy service for women.
- A range of publicity materials such as leaflets, posters and contact cards which promoted self-referrals to MOZAIC.
- Information for male patients using the sexual health service about national organisations that provide support to male victims and perpetrators of domestic violence.

MOZAIC was officially launched in April 2004 and an independent evaluation of the service was completed in September 2007. Since then MOZAIC has continued to attract funding and expand its portfolio of services for women and children affected by domestic violence. This particular intervention was chosen from the UK as there has already been a rigorous evaluation (see publications below). Furthermore, sufficient time has passed to enable the intervention to become fully embedded within the health service and the local community. The Daphne project provided a unique opportunity to understand the factors that influenced and ensured its successful continuation.

Previous research and evaluation

MOZAIC was independently evaluated by a team of researchers at Kings College London (Florence Nightingale School of Nursing & Midwifery). The briefing paper and full evaluation report was published in 2007 and are available on the internet at:

Bacchus L, Aston G, Torres Vitolas C, Jordan P, Murray S. (2007) *A theory-based evaluation of a multi-agency domestic violence service based in maternity and genitourinary medicine services at Guy's & St. Thomas' NHS Foundation Trust.* London: Kings College London (Accessed 18th August 2011).
http://www.kcl.ac.uk/schools/nursing/research/themes/women/projects/maternal/domesticviolence.html

In addition, the following papers have been published:

Bacchus L, Bewley S, Aston G, Torres Vitolas C, Jordan P, Murray SF. (2010) Evaluation of a UK domestic violence intervention in maternity and sexual health services. *Reproductive Health Matters*, 18(36): 147-157.

Torres Vitolas C, Bacchus L, Aston G. (2010) A comparison of the training needs of maternity and sexual health professionals in a London teaching hospital with regards to routine enquiry for domestic abuse. *Public Health*. 124(8): 472-478.

The intervention and its evaluation was funded by St. Thomas' Charity for three years (2004 to 2007) after which time it received funding from the Primary Care Trust. The Henry Smith City Parochial Foundation, an independent organisation that support initiatives that help to tackle issues arising from poverty in London, was successfully approached by the Domestic Violence Lead at St. Thomas' Hospital and Victim Support (a local/national charity for victims of crime) to obtain funding for a further violence project in accident and emergency.

The previous model of MOZAIC (2004 to 2007)

During its inception, the intervention model consisted of the following personnel:

- An informal clinical lead for domestic violence within the hospital Trust.
- Unfunded clinical 'champions' for domestic violence in the maternity and sexual health services.
- An external specialist domestic violence trainer employed by the hospital Trust.
- A part-time midwife co-trainer from the hospital Trust.
- Three domestic violence advocates.
- Management and supervision of the domestic violence advocates through the 170 Community Project, although not physically based in the hospital.

A key feature underpinning the intervention model was the idea of 'in-reach' by a specialist domestic violence advocacy service from the community who were based in their own office within the hospital setting. MOZAIC advocates were employed and managed by the 170 Community Project. MOZAIC was easily accessible to women attending health appointments in the maternity and sexual health services. The advocates were also a source of advice and support to health professionals who were dealing with patients affected by domestic violence or were themselves affected by the issue.

MOZAIC utilised a "woman-centred approach" to advocacy in which the woman is encouraged to take a lead role in decisions relating to her situation. This required the advocates to build on the woman's ongoing analyses of the risks that she and her children faced and to craft a range of options that would enhance their safety. MOZAIC worked with women at different levels of risk and at different stages of decision making for as long as they wished to be involved with the service. The advocates were the link to liaison with a range of voluntary and statutory agencies within the local community from which women needed assistance. The work entailed assisting women to obtain a range of community resources such as housing, refuge accommodation (safe houses), welfare benefits, educational opportunities, child care, solicitors (for injunctions and non-molestation orders), the police, and counselling services for the woman and her children. For other women, the work simply involved listening and providing emotional support. The advocates were required to develop strong partnerships with a range of local organisations and have an in-depth knowledge of local policies and current legislation with regards to women's rights and entitlements.

During the initial stages, MOZAIC worked with many complex cases of domestic violence, including a significant number of women who had no recourse to public funds due to their immigration status and/or suffering with depression. Due to the intense nature of their case work with women, the advocates had less time to engage in policy or system-level advocacy. For example, lobbying and taking collective issues forward with the purpose of making policy changes, or promoting the service within the hospital Trust. Whenever possible, the advocates attended local multi-agency domestic violence meetings or local MPs for support on particular "stuck" cases.

The hospital Trust (a statutory organisation) and the 170 Community Project (a non-governmental organisation) had very different management styles, authority structures, operating procedures, and policies for dealing with domestic violence and child protection issues. Therefore, time was needed for the organisations to develop a joint vision and harmonise their strategies and policies for dealing with domestic violence. The newly recruited MOZAIC advocates came from a variety of backgrounds and were not previous employees of either organisation. This facilitated the process of developing an innovative advocacy service that was not constrained by philosophical differences between the organisations. However, time was needed for each organisation within the partnership to clarify appropriate roles and responsibilities of various personnel in the intervention, develop an understanding of each other's decision making processes, identify any constraints on accountability, agree joint aims, and develop sound feedback mechanisms within and between the two organisations with regards to the intervention.

More in-depth findings about the MOZAIC advocacy model can be found in the full report (Bacchus et al. 2007)

The current model of MOZAIC 2011

The partnership between the 170 Community Project and Guy's & St. Thomas' NHS Foundation Trust has continued, although the management structure and personnel have changed over the years. The MOZAIC manager, domestic violence advocates and the trainer are employed and managed by the 170 Community Project and its management committee. However, the 170 Community Project have supported MOZAIC's independence in developing the service in the hospital. MOZAIC is currently funded by the local Primary Care Trust (PCT).

In its current format the intervention model consists of the following personnel:

- A formal (i.e. formerly recognised role in job description) clinical lead for domestic violence within the hospital Trust, who is also responsible for child protection and adult safeguarding. As a senior midwifery practitioner, the clinical lead had also been involved in setting up supporting MOZAIC.

- A number of unfunded clinical 'champions' for domestic violence in the maternity and sexual health services.

- A domestic violence trainer who is also a part-time Independent Domestic Violence Advocate (IDVA) employed by the 170 Community Project.

- A practice development midwife who co-trains from the maternity service.

- Two full time Independent Domestic Violence Advocates (IDVAs) employed by the 170 Community Project.

- One full-time manager of MOZAIC, employed by the 170 Community Project and based in MOZAIC office at the hospital.

- An Independent Domestic Violence Advocate (IDVA) and trainer based at the Gaia Centre, a multi-agency staffed advice centre in the borough of Lambeth for women experiencing domestic violence. There are a number of different voluntary and statutory sector agencies based at the Centre and this IDVA attends the Gaia Centre for MOZAIC.

- The project also receives ad hoc administrative support and advocacy support from social work trainees doing work placements.

Findings from the qualitative interviews: 4 years post evaluation

Sample

For the Daphne project a small focus group was held with three individuals. Two of these had historical and current knowledge of MOZAIC and a newer member of staff who joined MOZAIC post-evaluation. In addition, an individual interview was conducted with a new member of staff who joined MOZAIC post-evaluation. The interviews explored participants' views on the events, people, policies and organisational changes that contributed to the intervention achieving stability beyond the initial evaluation.

- A midwife who has been clinical lead for domestic violence within the hospital Trust for the last 2 years, but involved with the MOZAIC intervention for 7 years in total.
- A consultant obstetrician who was the previous clinical lead for domestic violence within the hospital Trust and co-principal investigator on the evaluation of the intervention for 7 years in total. She is still involved in supporting MOZAIC.

- The current manager of the MOZAIC Women's Well Being Service for the last 2 years who was previously a domestic violence advocate with MOZAIC.

An in-person individual interview was conducted with a new member of staff who joined MOZAIC post-evaluation:

- The domestic violence trainer/Independent Domestic Violence Advocate with MOZAIC for the last 2 years.

Management structures: stabilising MOZAIC

On completion of the evaluation, there was uncertainty about future funding and MOZAIC was experiencing rapid staff turnover. Previously, the MOZAIC advocates were managed by one of the advice workers at the 170 Community Project in Lewisham. This required both the manager and the advocates to travel between the hospital and the Community Project, which made day-to-day trouble shooting and management more challenging. In addition, the manager of MOZAIC also had a dual role as advice worker at the 170 Project which created a workload that was untenable in the long-term. One of the recommendations from the evaluation report was need for "*a full-time project manager whose roles and responsibilities are clearly defined within the project*".

The recruitment of a full-time manager of MOZAIC based at the hospital helped to stabilise the service. In addition to day-to-day management of the project and support of the advocacy workers, the manager is responsible for fundraising, grant writing, policy and community development and system-level advocacy within the hospital Trust. Since a key function of the manager's role is to attend meetings in the hospital and local community, this allows the advocates more time to engage in individual case work with women.

> *"It looks a bit different in terms of the structure because one of the things that came out of the evaluation was a need for a management structure. Because we had that in-reach that was a bit far away from 170 Community Project….So that's how we*

changed to having a managerial role that stabilised staff turnover which I think was very critical to its internal stability. I think now in terms of total number of advocates we have grown a bit". [Previous Clinical Lead for Domestic Violence]

"I think the stability has been the main feature in terms of how the service has grown." [MOZAIC Manager]

The current manager of MOZAIC is also the Chair of the local multi-agency domestic violence forum in Lambeth, which is where the hospital is based. This has strengthened the partnerships that MOZAIC has with other local organisations.

"The other critical issue is that you [speaking directly to the MOZAIC Manger] are now Chair of Lambeth Domestic Violence Forum. So I think that means you're in a very key networking place, that you know the 170 Project over in Deptford and you and I [referring to current and previous clinical leads for DV] we didn't have that central place that you and MOZAIC have now got." [Previous Clinical Lead for Domestic Violence]

System-level advocacy: embedding MOZAIC within the hospital Trust

Another recommendation from the final evaluation of MOZAIC was the need for advocates to have "*some protected time to engage in policy-level advocacy*" that would enable them to take forward the issues that were arising from their most complex cases. This includes attention to publicity campaigns, enhancing multi-agency links and local policy development. A balance was needed between individual case work and community development and system-level advocacy. This was challenging during the first three years of MOZAIC which were dedicated to developing the service, operational policies, doing individual case work with women and day-to-day trouble shooting.

MOZAIC began to have a broader influence on policies once they had been running for some time and had become embedded within the hospital Trust and the local community. The recruitment of a full-time, on-site manager for the advocates was an essential part of this process. It allowed for more strategic planning of MOZAIC such as setting priorities with the available resources, applying for further funding, expanding the services offered to women and children and identifying areas that needed further research.

"We spend most of our time doing institutional advocacy and trust me, that means things have changed slowly, but things have changed....speaking to other professionals, trying to get them to see all the safety issues and risk factors and now I feel that's changed a lot" [MOZAIC Manager]

During the interviews it became apparent that there had been a significant shift in perceptions about and attitudes towards MOZAIC within the hospital Trust. During the first eighteen months of the intervention there was resistance from some staff within the maternity and sexual health services. This partly stemmed from their uncertainty about how to work closely with advocates from such an ideologically different organisation to the NHS, as well as concerns about the domestic violence training and routine enquiry, opening up

Pandora's Box and creating more work. Seven years on and MOZAIC is regarded by many as an essential service within the hospital Trust for women and children affected by domestic violence. Furthermore, health professionals have come to appreciate the benefits of having an on-site specialist service that actually reduces the burden on their work.

> *"They're very much known within the [hospital] Trust, they got to take notice of the adult safeguarding agenda and the Chief Nurse is saying we've got to carry on with the service, so that's a massive change in position"* [Current Clinical Lead for Domestic Violence]

A key event which helped to raise the profile of MOZAIC within the hospital Trust and local community was the MOZAIC Plus Strategy event. Key stakeholders were invited including representatives from the Primary Care Trust, health professionals and local statutory and voluntary organisations such as social services, the police, and domestic violence agencies. As a result of this event, MOZAIC eventually received funding from the Primary Care Trust. As mentioned in the section on the context of health care in the UK, Primary Care Trusts commission services in primary care and acute settings (i.e. hospitals).

> *"There was an event about producing a MOZAIC Plus Strategy and we started looking forward. I think although what we hoped for didn't come out of it, a lot of the connections were made"* [Previous Clinical Lead for Domestic Violence]

> *"Yes, I think a lot of work came out of that. I think a lot more people became aware of us and people became interested."* [Current Clinical Lead for Domestic Violence]

The other role within MOZAIC which has facilitated the process of embedding the service is the domestic violence trainer who has a dual role as an advocate, but with a smaller case load of clients compared with the full-time advocates. In addition to providing training to health professionals within maternity and sexual health services at the hospital, she has extended the training to other departments.

> *"I have a lesser caseload because I do the training so I try and maintain 15 or under clients at any one time. The rest of the time I'm doing training, so developing training packages and providing them to the hospital. There will be days when I attend staff meetings on the departments and wards."* [MOZAIC Domestic Violence Trainer/Advocate]

The training and advocacy activities that MOZAIC workers engage in has resulted in closer working relationships with health professionals in different hospital departments.

> *"In terms of getting actual referrals there are a lot more consultants [doctors] that make referrals, and from other departments as well, like dermatology now. I'd say 8 or 9 referrals from them. Like now we're on a first name basis with them."* [MOZAIC Manager]

> *"I get referrals from all over the [hospital] Trust, of all sorts and then we work on them."* [Current Clinical Lead for Domestic Violence]

Towards the end of the evaluation of MOZAIC, there were changes in staff within the sexual health service. The initial clinical champion in sexual health (a Consultant Physician) left the hospital Trust and intervention activities, such as training, routine enquiry and referrals began to dwindle. However, another doctor with an interest in domestic and sexual violence took on the role of clinical champion and MOZAIC began to attend staff meetings to re-introduce themselves and re-build their connections with the sexual health service. One of the findings from the evaluation of MOZAIC was that the intervention needed to be adapted to the sexual health service in terms of the content and style of the domestic violence training and the nature of the patient-provider relationship which is brief and intermittent (Bacchus et al. 2010). Therefore, it was important to obtain staff views on how they wanted to work with MOZAIC.

> *"We also let them have a buy-in in terms of the referral pathways as it just didn't suit their style of working. [Doctor A] he had this fantastic idea of making sure that referrals could just be done on line and I was like well that's a bit….and he was saying well give me a chance, let me put something together and he did. What happened with piloting that, it kind of made that department feel like they were involved and had a buy-in as well."* [MOZAIC Manager]

> *"So just keeping that link in….and feeding back to [sexual health staff] and letting them know because a lot of the time in that department patients go once and then they don't go back. And so just letting them know oh she's alright and we're still working with that person."* [MOZAIC Manager]

This renewed relationship with the sexual health service has also led to published research collaboration with MOZAIC involving a survey on sexual violence in female patients attending the clinics and ongoing research with male patients. Within the maternity and sexual health settings, there is a commitment to generating new knowledge and the service, teaching and research components continue to flourish.

Community development: establishing strong partnerships

A natural development arising from individual case work with women and the domestic violence training has been the pursuit of strong collaborative relationships with other agencies in the local community. This has enhanced individual work with women, but also increased the number of referrals that MOZAIC receive outside the hospital Trust.

> *"There are much more legal connections [referring to solicitors] and they're more established than they used to be."* [Previous Clinical Lead for Domestic Violence]

> *"The police are emailing now about anything and they speak to MOZAIC. So we can catch women very early in the pregnancy if they get assaulted."* [Current Clinical Lead for Domestic Violence]

> *"Because what's happened is there's much more awareness [hospital] Trust wide in terms of the service existing, which has led to more outside referrals from the Trust. It's also had an impact on the type of service we deliver as well in terms of engaging*

outside agencies and getting them on board and getting them to have an understanding of what our role is" [MOZAIC Manager]

"I do a lot of ad hoc training in the community. So I've done a full study day for Lambeth Housing, a full study day for SLAM [South London and Maudsley NHS Foundation Trust] and then some shorter sort of one hour, two hour meetings with GP surgeries and sometimes SARC [Sexual Assault Referral Centres]." [MOZAIC Domestic Violence Trainer/Advocate]

MOZAIC convened meetings with Government Ministers and key civil servants, as well as Professor George Alberti (Chair of the Department of Health Taskforce on Violence Against Women and Girls). MOZAIC were also cited as a beacon by the Department of Health and given as exemplar as an 'in-house' domestic violence service in the Violence Against Women and Girls Strategy for its links with healthcare and the local community. Close proximity to and connections with people in positions of authority regarding policy making and funding decisions has been an important feature in raising the profile of MOZAIC and ensuring its long-term sustainability.

"People have begun to recognise that we're very valuable I think and it's partly because Ministers keep turning up to visit." [Previous Clinical Lead for Domestic Violence]

"George Alberti who was leading on VAWG strategy, he's a non-executive member of Kings College Hospital. So he's very determined to push a local agenda about violence in the health services and get it all singing all dancing as a sort of beacon borough." [Previous Clinical Lead for Domestic Violence]

"But I think the one big trip with what happened, was I went to the ends of the earth to find the person in the Home Office, do you remember we went up to meet them? That opened a lot of doors. It was just like a whole door opened and then they invited us to meet them." [Current Clinical Lead for Domestic Violence]

At the time of writing this report, MOZAIC have one year of funding left from the Primary Care Trust (PCT). In 2012/13 Strategic Health Authorities and PCTs will be abolished and local councils that will have responsibility for the public health budget and will be required to appoint a local director of public health. Finding long-term funding for domestic violence services in health care settings continues to be a struggle in the UK. Both MOZAIC's Manager and the Trust Clinical Lead for Domestic Violence are involved in fundraising activities. In addition to finding ongoing funding for the core activities of MOZAIC, there are also plans to find funds for a women's counsellor as this appears to be a service that is lacking in the community due to long waiting lists.

"There are two people in commissioning who are the safeguarding nurses, who I've already started tapping up on it and they're already keen on MOZAIC….So we've started work." [Current Clinical Lead for Domestic Violence]

"We've got local government into partnership so we were able to get some funding from the Home Office for an IDVA [Independent Domestic Violence Advocate] who is managed by MOZAIC, it is like a satellite IDVA based at the Gaia Centre which is a Lambeth One Stop Shop." [MOZAIC Manager]

Professional and personal development of domestic violence advocates

The nature of domestic violence advocacy work is complex and potentially dangerous for the recipients and those providing the service. In the UK, the professionalization of the advocacy sector has occurred in response to the need for organisational and occupational standards that outline the parameters and expectations of advocates; accountability and transparency; due attention to safety and harm reduction; consistency and quality of service; as well as ensuring that advocates are supported personally and professionally. Two organisations that have taken the lead on developing national service and occupational standards for advocates working with women victims are Coordinated Action Against Domestic Abuse (CAADA) and Women's Aid Federation of England (WAFE). Both offer intensive accredited training programmes. These are run by highly qualified and experienced practitioners and trainers within the domestic and sexual violence field.

Further information about CAADA and WAFE training programmes can be found at (Accessed 18th August 2011):
http://www.caada.org.uk/training/IDVAtraining.htm
http://www.womensaid.org.uk/landing_page.asp?section=000100010027

One of the recommendations of MOZAIC evaluation was to "*assist in the continuing professional development of advocacy workers, using internal structures for regularly assessing the training needs of staff*" (pp.290). This recommendation was implemented as a priority once staff turnover had ceased. All MOZAIC staff were funded to attend training with CAADA who run an intensive and accredited training programme for Independent Domestic Violence Advocates (IDVAs). IDVAs typically work with high risk cases of domestic violence and the course provides them with the necessary tools to identify and manage risk and provide appropriate interventions. IDVAs also work closely with local Multi-Agency Risk Assessment Conferences (MARACS) where representative from different organisations come together to discuss serious cases of domestic violence where there is imminent risk. The professionalization of the advocates has led to a greater acceptance amongst health professionals of the advocates and a respect for skills needed to carry out advocacy work. MOZAIC advocates are also using CAADA recommended risk assessment tools with their clients, which was also a recommendation from the evaluation.

"We have been developing advocates in terms of all being CAADA trained. The field has professionalised and everyone has been through CAADA. It's a kind of legitimacy professionalization." [Previous Clinical Lead for Domestic Violence]

"Especially when you're working in the NHS, they like you to have some sort of certificate to say that you can do this, that or the other." [Current Clinical Lead for Domestic Violence]

Advocacy: managing high risk and maintaining a survivor led focus

Despite being CAADA trained as IDVAs, the model of advocacy provided by MOZAIC has not departed from its original philosophy of being woman centred. The advocates continue to work with women at all levels of risk and at different stages of decision making. This approach lends itself well to hospital based maternity services, as pregnant women are in frequent contact with their community or hospital based midwife, and are required to attend some antenatal appointments at the hospital (e.g. scans). Therefore, the advocates have time to develop a trusting relationship with women over many months and are able to monitor over the whole pregnancy and beyond delivery any changes in their situation, such as increased risk or mental health issues. Furthermore, they can work closely with health professionals involved in the women's care. In the following discussion, the focus group reflect on the current model of advocacy:

> *"I think before it was a bit more loose in terms of it was much more focussed on the emotional side. I think now there's a more holistic way of doing advocacy. So we get an assortment of referrals, it's not always just the high risk referrals."* [MOZAIC Manager]

> *"There are some women with old issues that come back to us."* [Current Clinical Lead for Domestic Violence]

> *"It's going back to the old times of being case workers as opposed to just being advocates dealing with high risk issues and crisis interventions. Because typically an Independent Domestic Violence Advocate is all about dealing with the crisis. Whereas for MOZAIC, I think that's what makes us unique. It's kind of all the things in between that a woman wants support with."* [MOZAIC Manager]

> *"And that maybe a health service issue around continuity which comes from the pregnancy, there's a long period of time, which I think, it can't come out of an Accident and Emergency project. It could come out of primary care because it has the same long-term philosophy."* [Previous Clinical Lead for Domestic Violence]

There were attempts to run a survivor's group in the early phase of MOZAIC, but this never developed into a regular group. It was difficult to find available space in the hospital to undertake group work and MOZAIC was experiencing staff turnover. Once MOZAIC achieved stability, there was time to revisit the survivor's group and make it a formal part of the service. MOZAIC Voices was launched at the House of Commons in May 2011. The launch of the survivor's group has also increased referrals to the service from agencies in the community.

> *"It's established as its own charity, it has its own charitable registration, its own bank account, its own management committee. Along with that, now I'm running a support group once a week for survivors who have gone through our service. To then access that as well and build their self-esteem, safety planning, understanding healthy relationships and all of that."* [MOZAIC Domestic Violence Trainer/Advocate]

"When I started, Voices was already there and women were participating in the groups. It was something that the previous advocates were passionate about. It was smaller and more ad hoc, but it was always part of MOZAIC. What we tried to do was put a bit more balance into it. So it's not just open to women who have already been through the whole crisis and are now kind of turning their lives around. We tried to make it accessible to everybody, so for the older clients, the newer clients and the ones in the middle. It's very exciting. Oh we just got our charity number as well." [MOZAIC Manager]

Procedures to reduce the potential for harm

The evaluation of MOZAIC highlighted a number of unintended incidents of harm and adverse events. These mainly related to lack of confidentiality and inappropriate information sharing, as well as issues around documentation of domestic violence by health professionals in the maternity service where women keep their patient records and relinquish them on the postnatal ward (Bacchus et al. 2010). Although a separate system for confidential documentation was set up, this was hardly used. The most severe incidents of harm involved a woman being assaulted by her partner after he read a midwife's documentation about the domestic violence and the help she was receiving in the hand-held patient record. In another case, a recently delivered woman was discharged from the postnatal ward to her abuser despite written notes that she was receiving support from MOZAIC and should not be discharged as accommodation was being arranged after the weekend.

The evaluation recommended that "*systems for coding and documentation of domestic violence be reviewed within the maternity setting with regards to issues of confidentiality, safety, communication between health professionals, and methods of auditing the practice of routine enquiry for domestic violence.*" (Bacchus et al. 2010; Bacchus et al. 2007). There have been significant changes to how the MOZAIC advocates are able to communicate concerns they have about a woman to health professionals in the maternity service. This now includes limited access to women's electronic medical records:

"I think the key to it working [referring to MOZAIC] is that you need a service in the hospital, you need the hospital to be supportive. Um you know the fact that we have access to Healthware…we have our own password [referring to the computerised maternity records system]. We can't alter their actual medical records obviously, but what we can do is put alerts on. All the advocates have Criminal Records Bureau checks and we've got our hospital Trust badges and we just went and had some training and got a username and now we can access it. It's really wonderful, we can find out women's details when the referral information is incomplete like name, date of birth. We can notify professionals that we're working with them. So we'll put an alert saying MOZAIC working with client and our extension number and a contact name. Or if we're really worried we can say please notify us next time the woman comes, that kind of stuff. Or when she gives birth." [MOZAIC Domestic Violence Trainer/Advocate]

Another factor which has also helped to reduce the potential for harm is the strengthened partnership between MOZAIC and the hospital over the years, which has improved information sharing and communication. Comments from the interviews demonstrate how well integrated MOZAIC have become within the hospital.

> *"The hospital is incredibly supportive and we're so embedded in everything they do. You know everybody knows us, we can swipe through with our ID cards. I think that's really nice that they all know us and are supportive of what we do. That makes our work so much more effective."* [MOZAIC Domestic Violence Trainer/Advocate]

Adapting domestic violence training

Domestic violence training was a mandatory study day for midwives when the intervention was initially set up. However, this is no longer the case although midwives are strongly encouraged to attend. As in the previous model, training is still delivered as a one-day session and on a rolling basis. However, the blanket approach to training has been replaced:

> *"We have updated the training because the statistics were quite out of date. We've added a lot of further media so we show some films in the sessions now. And basically we change it every three months based on the evaluations. So sometimes we'll add more about routine enquiry if that's what they were requesting, do more role playing or whatever."* [MOZAIC Domestic Violence Trainer/Advocate]

Due to lack of time it has not been possible for the trainer to develop and offer a modular training programme in addition to basic one day training. For example, there are plans to eventually offer short modules on special topics such as the legal aspects of domestic violence.

Ongoing monitoring and evaluation

Although there has not been another independent evaluation of MOZAIC since 2007, they use a number of informal methods to obtain feedback about the intervention. This includes auditing of maternity records to evaluate routine enquiry, post-training evaluations after sessions and talking to women using the service.

> *"Well I'm on the fourth go of the audit of routine enquiry….at the clinic we've now got a simple system where they just photocopy page whatever it is of the maternity notes [with the hidden domestic violence code], collect a hundred and we say oh the rate has gone up. The last time we did it was two years ago actually so I was thinking it would be time to get someone to do it again because at that stage it was still only 65% of women."* [Previous Clinical Lead for Domestic Violence] Note: the rate of routine enquiry during the evaluation rose from 15% to 47% in one year.

> *"On a day-to-day basis it would be us working with the hospital. Because we're linked with them so well, we see how they're doing and whether they're writing notes [documenting] properly. Also I think from the women we work with, that's where we'll learn whether it's working or not because they'll tell us how they were asked*

[about domestic violence], they tell us good experiences and bad. I definitely make sure I feed that into the training." [Domestic Violence Trainer/Advocate]

MOZAIC replaced the excel database they were using for entering client information with a recognised software package for advocacy called Paloma. This has enabled them to collect data on clients and produce reports and statistics for funding applications.

"We had that whole crisis of not knowing where the funding was going to come from and it was just a way of making sure that people saw the need for the service and we were able to give them some figures. When we put the [bid] to the Home Office, I know that statistics that I was able to provide with Paloma, that's what stood us apart from some of the other services....They were only able to choose one service in each of their boroughs that they were going to support and we were chosen. It's based on the standard of the statistics that I was able to produce." [MOZAIC Manager]

Key learning points

- The MOZAIC intervention model (in-reach and intensive case work by a voluntary sector specialist domestic violence organisation) lends itself well to hospital based maternity services and can be expanded to other departments in the hospital such as sexual health services. It may also be adapted to primary care settings such as GP surgeries and health centres, although advocacy may need to be provided by 'floating' advocates that serve a number of surgeries/health centres in a local area.

- Maternity care is also an opportune time to catch women experiencing domestic violence at a very vulnerable stage when support is more likely to be accepted. Given the complexity of cases that were seen by MOZAIC (e.g. women suffering with depression, drug/alcohol abuse and women with insecure immigration status) it is likely that an intensive intervention with the potential for long-term case work is more likely to be beneficial.

- The MOZAIC intervention model is resource intensive in terms of set-up costs, funding staffing and time needed to develop and implement the different components such as guidelines, domestic violence training, building links with local community organisations and the hospital, and providing advocacy. Although it was not possible during the initial funding period, with hindsight, it would have been beneficial to dedicate more time to fully developing the MOZAIC intervention model.

- However, it should be recognised that it is not possible to anticipate all the potential challenges that can occur as a result of collaboration between very different organisations. MOZAIC was about planting a seed in an organisation that was resistant to change. It took time to gain support from the higher echelons within the hospital Trust which has now helped to embed the intervention model. Both organisations were willing to maintain focus on the woman centred approach and continue despite the setbacks.

- The intervention model should be underpinned by clearly defined roles and responsibilities regarding the partnership which should be documented in service agreements, contracts and job descriptions. Good feedback mechanisms are needed within and between the organisations.

- Each organisation within the partnership needs to be clear about each other's decision making processes. Staff accountability and line management issues need to be clarified from the outset (e.g. what type of management, support and supervision will each organisation contribute to the role of domestic violence trainer, the advocates and the nominal clinical leads?). However, even with these clarifications at the beginning, differences in organisational style and approaches to dealing with issues are likely to arise as the service inevitably develops and changes. During the evaluation of the MOZAIC intervention, planned away days brought intense involvement and focus on the staff as people and enhanced understandings about each other and the organisations. The successful evaluation and the MOZAIC Plus

Event (post evaluation) also had a hidden impact on relations. These shared events brought about mutual respect and a desire to continue the service.

- It took considerable time (years) and effort for MOZAIC to become embedded within the hospital Trust. A strong collaborative partnership was essential to this process. There must be a willingness to work together through the ideological and structural differences of a large bureaucratic institution like the NHS and a small voluntary sector organisation. Allowing the time to develop internal relationships is fundamental to the development of trust within these types of partnership. In turn, this has a huge impact on issues such as sharing resources, developing joint policies, accountability, managing risk, and ultimately the service to women and children. Although these issues are likely to be a feature of any partnership work, the difficulties may be enhanced in the domestic violence field as the intervention itself deals with the issue of damaged and abusive relationships, as well as abuse of power.

- In the MOZAIC intervention model, each organisation brought different skills and resources to the table. In any partnership, it is important to establish what these are from the outset so that partners can agree a set of guiding principles which include appropriate roles and responsibilities; identification of any constraints on accountability; and discussion about how ideological and operational differences between the organisations will be dealt with.

- The MOZAIC intervention model has benefitted from the strong connections it has established with a range of local voluntary and statutory organisations that provide support to women and children affected by domestic violence. Having a Clinical Lead for Domestic Violence in the hospital Trust and a full-time, onsite manager for MOZAIC has been crucial to developing more strategic partnerships to secure ongoing funding (e.g. with the Multi-Agency Domestic Violence Forum, Lambeth Local Authority, key stakeholders within local and national government).

- Primary research and continuing monitoring must be built into all funding applications for domestic violence interventions. However, expectations about the scale of the research and anticipated outcome measures must be proportionate to the funds available. Ongoing monitoring of detection of domestic violence and referral to support services can be achieved through regular audits of patient records. Such evidence is also needed to ensure that the work of support services for women and children is funded.

Study 2: Finland

Description of health sector in Finland

Finland is divided into six provinces, each of them headed by a Regional State Administrative Agency which is led by a Governor. These agencies are responsible for guidance and supervision of the social welfare and health sector in their respective provinces.

The responsibility for organising health care in Finland lies with approximately 330 municipalities across the country. Municipalities can provide health care services independently or jointly with neighbouring municipalities in join municipal boards which maintain a joint health centre. Municipalities can buy in health care services from other municipalities, non-governmental organisations or the private sector.

Approximately 5.4 million people reside in Finland, with the majority living in Southern Finland. It is the eighth largest country in Europe in terms of area and the most sparsely populated country in the European Union. Around one million residents live in Greater Helsinki, which includes: Helsinki, Espoo, Kauniainen and Vantaa.

Specialised medical care
Residents of municipalities can book appointments in a health centre by themselves. However, access to specialised medical care requires a referral from a health care centre physician or private practitioner for non-emergency cases. For the organisation of specialised medical care, Finland is divided into 20 hospital districts. Five of them are University hospital districts. HUS, in the Hospital District of Helsinki and Uusimaa, is the largest of these. One hospital district can have several hospitals.

Hospitals provide what is known as specialised care (outpatient or inpatient). Hospital districts are formed by municipalities, which consist of a hospital and other specialised units. Each municipality belongs to one of the hospital districts. Health services are funded mainly by municipalities from taxes. Public health care is supplemented by private health care. The national system of health insurance reimburses the client for part of the charges for private health care.

Primary health care
Public primary health care is the responsibility of health centres. As mentioned earlier, municipalities have their own health centre or form joint municipal boards with health centres serving the participating municipalities. One health centre can have several units and wards for inpatient care.

Municipal health centre services include physical examinations, dental health, medical care, ambulance services, school and student health care and other basic services. Maternity and child health clinics come under primary health care in Finland and are provided in health centres. Maternity and child health clinic services in Finland are ‘universal services’ which means that a doctor’s check-up at maternity and child health clinic is free of charge. However, if a patient wishes to visit a doctor in the main health centre (for a non-pregnancy related issue) they may be required to pay a single or annual payment for an appointment.

A fee may also be charged for an emergency visit to the health centre on the weekend or over bank holidays. Almost all pregnant women have a check-up at the maternity clinic in the first trimester of pregnancy and this is a condition for receiving the maternity grant. It is recommended that an expectant mother with a normal pregnancy should attend 11 to 15 times, including appointments with a public health nurse and a doctor. Child health clinics monitor and support the development of under-school age children. It is recommended that the child health clinics arrange 16 check-ups, five of which are appointments with a doctor and a public health nurse. Approximately half of the check-ups are for under-one year olds. Public health nurses carry out a home visit before and after the woman delivers, and at other times if needed.

Further information about the health care system in Finland can be found at (Accessed 18th August 2011):
http://www.stm.fi/en/social_and_health_services/health_services

For further information about the population of Finland can be found at (Accessed 30th January 2012):
http://en.wikipedia.org/wiki/List_of_countries_by_population

Domestic violence policy context in Finland

The Ministry of Social Affairs and Health has been the main Government department that has activated programmes to address violence against Women in Finland. The first Finnish *National Programme for Prevention of Violence against Women and Prostitution* started in 1998 and continued for five years. This was conducted by the National Research and Development Centre for Welfare and Health (STAKES) which was an expert agency in the field of social welfare and healthcare. After organisational restructuring in 2009, the new organisation is called the National Institute for Health and Welfare (THL). A number of handbooks, reports, briefing papers and studies were published from this programme. The programme included a research project conducted between 2000 and 2002 on screening for intimate partner violence at maternity and child health clinics in seven municipalities. As a result of the research project a screening tool was developed (Perttu, 2004). A handbook for maternity and child health clinics for the prevention of intimate partner violence was published in 2004 by the Ministry of Social Affairs and Health (Perttu, 2004). The Ministry of Social Affairs and Health recommended that all women should be asked about partner violence: at the maternity clinic at least once during the first six months of pregnancy and at the child health clinic at the latest at the half-year-check-up of the baby and after that, at the yearly check-ups (Perttu, 2004).

With regards to maternity care, in 2006, "*Addressing intimate partner violence. Guidelines for health professionals in maternity and child health care*" was published as a result of a Daphne funded project "Good practice in screening of victims of violence in intimate partnerships in maternity and child health services" (2005/2006). It presents a model for identifying partner violence in maternity and child health clinics using a screening tool (Perttu & Kaselitz, 2006).

Domestic and sexual violence training in Finland has been patchy with many professional groups receiving training on a one-off basis and usually as part of other training activities. The need for further training is also highlighted in the document "Recognise, Protect and Act" (2008). It recommends that social and health care staff offering primary or specialised care must be aware of the feature of domestic violence, and have internal procedures and practices for recognising the signs of violence, raising the issue and referring patients to the appropriate sources of help. Furthermore, it states that employers should support social and health care staff in obtaining supplementary and continuing training.

In connection with the adoption of the Action Plan for Gender Equality 2008-2011, the Finnish Government took the decision on the 17th July 2008 to initiate a cross-sector National Action Plan to Reduce Violence Against Women between 2010 and 2015 (Ministry of Social Affairs and Health, 2010). This is an inter-ministerial Action Plan prepared by the Ministry of the Interior, the Ministry of Justice, the Ministry of Social Affairs and Health, and the Ministry of Foreign Affairs. The process was coordinated by the National Institute for Health and Welfare (THL) on behalf of the Ministry of Social Affairs and Health. There have been calls to the Finnish government to put into effect a National Action Plan, as there has been no national programme in Finland since the 1998-2002 project for the Prevention of Violence Against Women and Prostitution. A key action within the Action Plan (2010-2015) relates to "*Strengthening the identification and intervention in violence*". Implementation of the National Action Plan is coordinated and monitored on a monthly basis by a cross-working group on the prevention of interpersonal and domestic violence, appointed by the Ministry of Social Affairs and Health. Represented on this working group are the Ministry of Social Affairs and Health; the Ministry of Justice; the Ministry of Foreign Affairs; the Ministry of the Interior Migration Department; the National Police Board and the National Board of Education.

One of the actions within the current National Plan relating to health professionals is to strengthen the identification of and intervention in to violence. It recommends that health care services begin to routinely ask questions about domestic violence, especially in maternity and child health clinics and in school and student health care. A number of special tools have been developed for health services for identifying adult victims of domestic violence, assessing their needs and referring to sources of help. For example, the Regional State Administrative Agency of Southern Finland has developed a standardised form, which is also available in electronic format, for reviewing patients admitted to health centres and hospitals for physical injuries resulting from abuse (PAKE). Training in the use of this form has started. A form for recording violence has also been incorporated in to the social welfare client information system. The form allows social welfare staff to ask clients about violence they have experienced or perpetrated and record these cases into the information system.

Within the National Action Plan (2010 to 2015) the following proposals are included which are due to be rolled out between 2011 and 2012:

- Domestic violence and sexual violence training to be part of the curriculum for all medical students (GPs, gynaecologists, urologists and psychiatrists) at both the basic and supplementary training stage.

- Training and guidance for emergency health care staff in the use of the assessment tool for physical injuries resulting from violence (PAKE) and data to be entered into the electronic patient records.
- Review and complement existing guidelines for school and student welfare regarding the identification and prevention of domestic violence and sexual violence, as well recommendations for how to refer patients.
- Provide training in screening for domestic violence at maternity and child health clinics.
- Include screening for violence during client contact in social and health care services and integrate as part of the electronic client information system.

References:

Ministry of Social Affairs and Health (2010) *Action Plan to Reduce Violence Against Women* (Accessed 18th August 2011)
http://www.stm.fi/c/document_library/get_file?folderId=2765155&name=DLFE-14813.pdf

Ministry of Social Affairs and Health (2008) *Recognise, Protect and Act* (Accessed 18th August 2011).
http://webapps01.un.org/vawdatabase/uploads/Finland%20-%20recommendations%20local%20services%202008.pdf

National Report. Gender Violence in Finland. From the Perspective of Women. University of OULU (Accessed 18th August 2011).
http://www.surt.org/gvei/docs/national_report_finland_def.pdf

Perttu S. (2004) *Intimate partner violence against women and its screening at the maternity and child health clinic*. Reports of the Ministry of Social Affairs and Health. (Accessed 18th August 2011)
http://pre20090115.stm.fi/pr1104480484516/passthru.pdf

Perttu S, Kaselitz V. (2006) *Addressing intimate partner violence. Guidelines for health professionals in maternity and child health care.* (Accessed 18th August 2011)
http://www.hyvan.helsinki.fi/daphne/

Results from the Finland mapping survey

Dissemination
The mapping survey was disseminated by the Finnish partners (Sirkka Perttu and Tiina Savola) to 17 people in 8 municipalities in which there were established domestic violence interventions based in primary and/or maternity health care settings. There is no central system in Finland for collating information on all domestic violence interventions based in health care settings. The Finnish partners contacted individuals known to them who were currently working in health based (primary and/or maternity care) domestic violence interventions. However, it should be acknowledged that such interventions may exist in other municipalities that were not captured by the survey.

Respondents
A total of 12 (67%) surveys were returned. It was possible for respondents to select multiple answers for some questions.

Amongst the 12 surveys returned, 7 were from public health nurses, 2 from head/charge nurses, 2 from doctors and 1 from a student nurse.

Geographical location of the interventions
Of the 12 interventions, 3 were based in Porvoo, 2 in Ulvila, 3 in Vantaa, 1 in Kante-Hame, 1 in Sastamala, 1 in Jyvaskyla and 1 joint municipal board of Forssa district (Forssa, Tammela, Jokioinen, Humppila and Ypaja).

Intervention settings
Respondents reported that the interventions targeted multiple health care settings including: primary care (8); maternity care services (7); children's health services (5); and multi-health sector intervention that include primary and/or maternity care (2).

A range of health professionals were targeted in the 12 interventions including: public health nurses (8); general practitioners (7); nurses (4); social workers (4); and paediatric doctors (2). Other professionals mentioned included: youth work, education and the police (2); oral health (1); practical/auxiliary nurses (1); porters of the health care centre (1) and family health workers (1).

All 12 respondents indicated that female patients were the target population for the interventions and 7 mentioned male patients. Since most of the respondents were from maternity and child health clinics, a number of other recipients were mentioned including: children (5); fathers (2); and elderly patients (1). Based on 8 responses, the length of time that the interventions had been running ranged from 18 months to 8 years.

Table 2.1 Coordination, funding and location of the domestic violence interventions in Finland
Note: some names of interventions given are descriptions of the interventions rather than official names

Name and length of intervention	Professionals targeted in the intervention	Coordinating organisation and geographical location	Funding source
No official name (3 years & 3 months)	General practitioners; nurses; auxiliary nurses	Attendo MedOne Oy (primary health care organisation) Vantaa	City of Vantaa
No official name (length of intervention not given)	General practitioners; nurses	Coordinator not specified Vantaa	Funder not specified
Health Emergency Care (4 years)	General practitioners; nurses; auxiliary nurses; porters	Attendo MedOne Oy (Primary health care organisation) Vantaa	Attendo MedOne Ltd is responsible for the costs.
Intervention model in maternity and child care clinics (8 years & 2 months)	Public health nurses	The City of Porvoo, Social and Health Centre Porvoo	No financing (own resources)
Palve (12 years)	General practitioners; nurses; public health nurses; obstetricians; gynaecologists; social workers; early childhood education services; police; youth work	Health service in Porvoo Porvoo	Funder not specifed
Mitta täys (5 years)	General practitioners; public health nurses; obstetricians; social workers; youth work; education; police	Primary health care Porvoo	Self financed
Intimate partner violence in maternal and child health clinics (5 years & 2 months)	Public health nurses; social workers; family health clinic worker	Administration of join social and health care in Pori (Primary health care organisation) Ulvila	Self financed
Family violence screening and referral to treatment (5 years)	Public health nurses; social workers	Administration of joint social and health care in Pori (Primary health care organisation) Ulvila	Funder not specified
Intervention in maternity care (6 years & 2 months)	Public health nurses	FSTKY Neuvola Maternity Clinic Kanta-Häme	Not funded

Name and length of intervention	Professionals targeted in the intervention	Coordinating organisation and geographical location	Funding source
Kaste Project (commence in 2000, end date not given)	General practitioners; public health nurses; social workers; oral health practitioners	Health care organisation Jyväskylä	Funder not specified
RAP Kansio First Aid and Examination in Rape (1 year & 6 months)	General practitioners; nurses	Coordinator not specified Sastamala	Funder not specified
Intimate partner violence screening in maternal and child health clinics (6 years & 2 months)	Public health nurses	FSTKY Primary Health Care Joint municipal board of Forssa district Forssa, Tammela, Jokioinen, Humppila, Ypäjä	FSTKY Primary Health Care

Policies on domestic violence

Ten respondents reported that the intervention had a policy that provides guidance to health professionals about how to respond to patients affected by domestic violence. This included policies developed specifically for the intervention (7); policies based on the national guidelines (2) and a policy specific to the region (1).

Of the ten respondents who answered, all of them said that they policy recommended routine enquiry for and documentation of domestic violence and 9 said that it contained guidance on how to refer patients who disclose domestic violence.

Of the 9 respondents who answered, 6 reported that the policy contained guidance on how to assess the safety of the patient and any children or vulnerable adults who may be affected, and 6 said that it included guidance on confidentiality and information sharing.

Domestic violence training

Of the 12 respondents, 11 said that domestic violence training was provided to health professionals. Of the 10 respondents that answered, 7 said that training was provided by a domestic violence trainer from outside the health care service and 5 said that training was provided by a health professional. Nine respondents said that the training was not mandatory for any health professionals. Two respondents said that "train the trainer" courses were not provided and 10 respondents said did not know.

Table 2.2 Professionals targeted for training

Professional group	Training provided (N)	Training Mandatory (N)
Nurses	6	2
General practitioners	6	0
Midwives	1	0
Public health nurses	8	1
Psychologists/counsellors	3	0
Paediatric doctors	3	0
Social workers	6	0
Receptionists/clerical workers/practice assistants	1	1
Practical nurses/auxiliary nurses	1	1
Porters	1	0
Family health workers	1	0

Table 2.3 Content of domestic violence training

Content of domestic violence training	Yes (N)	No (N)	DK (N)
Routine enquiry for domestic violence	9	1	2
How to document domestic violence	9	1	2
How to refer patients who disclose domestic violence	10	0	2
How to assess the safety of the patient	4	1	7
How to deal with issues of confidentiality and information sharing	5	2	5

Table 2.4 Frequency and length of domestic violence training in Finland

Coordinating organisation and geographical location	Professionals targeted in the intervention	Frequency of training	Length of training
Attendo MedOne Oy (primary health care organisation) Vantaa	General practitioners; nurses; auxiliary nurses	Training provided at least once a year. New employees trained to use PAKE form and how to photograph injuries.	1½ hours
Coordinator not specified Vantaa	General practitioners; nurses	1 to 2 times a year	1 to 2 hours
Attendo MedOne Oy (Primary health care organisation) Vantaa	General practitioners; nurses; auxiliary nurses; porters	New employees are trained to use PAKE form. Training is organised twice a year internal training.	Approximately 4 hours, emphasis is on the PAKE form.
The City of Porvoo, Social and Health Centre Porvoo	Public health nurses	Once a year	1 day
Health service in Porvoo Porvoo	General practitioners; nurses; public health nurses; obstetricians; gynaecologists; social workers; early childhood education services; police; youth work	Once a year	1 day
Primary health care Porvoo	General practitioners; public health nurses; obstetricians; social workers; youth work; education; police	Rarely	Half a day
Administration of join social and health care in Pori (Primary health care organisation) Ulvila	Public health nurses; social workers; family health clinic worker	Training was given 5 years ago	Not specified
Administration of joint social and health care in Pori (Primary health care organisation) Ulvila	Public health nurses; social workers	Training offered during implementation of the intervention	Not specified

Coordinating organisation and geographical location	Professionals targeted in the intervention	Frequency of training	Length of training
FSTKY Neuvola Maternity Clinic Kanta-Häme	Public health nurses	Rolling programme of training	Not specified
Health care organisation Jyväskylä	General practitioners; public health nurses; social workers; oral health practitioners	Training in the Spring and Autumn	Not specified
Coordinator not specified Sastamala	General practitioners; nurses	Not specified	Not specified
FSTKY Primary Health Care Forssa Health District: Forssa, Tammela, Jokioinen, Humppila, Ypäjä	Public health nurses	No regular training, but there is usually something available every year	A few hours

Approaches to routine enquiry for domestic violence

Ten respondents stated that routine enquiry for domestic violence was part of the intervention. All of these reported that female patients were being asked about domestic violence and 3 indicated that male patients were also asked. When asked to define routine enquiry for domestic violence the following answers were obtained. This demonstrates that some approaches to the identification of domestic violence do not fit the definition of routine enquiry, which involves asking all women about violence whether or not there are risk factors.

- N=5 Asking every woman who attends the maternity and child health clinic when the child is 5 months old
- N=4 Ask if domestic violence is suspected/if injuries/ask at certain clinic visits
- N=1 Ask all pregnant women during the first trimester

Five of the 10 interventions had no form of monitoring or auditing of routine enquiry for domestic violence. Two reported auditing using patient records and 3 stated that they did not know if routine enquiry was monitored.

Documentation of domestic violence

Respondents indicated that within the intervention, health professionals were advised to document the following information:

Table 2.5 Documentation of domestic violence

Information documented	Yes (N)	No (N)	DK (N)
Whether or not the patient was asked about domestic violence	8	3	1
Whether or not the patient disclosed domestic violence	10	1	1
Name of the perpetrator	7	3	2
Relationship of the perpetrator to the patient	10	0	2
A description of the types of abuse experienced	9	0	3
A description of any recent incident of abuse	10	0	2
A description of the types and location of injuries	9	0	3
A body map picture indicating location of injuries	6	3	3
Whether referral information was offered to the patient	8	0	4
Whether the patient accepted the referral information	7	2	3
Indication of any action taken by the patient	4	1	7
Whether there are any children in the household	10	0	2
An assessment of the safety of the patient and any children	9	0	3

Referral pathways

Of the 10 respondents that answered questions about referral systems, 5 said that they referred patients to specialist domestic violence organisations in the community, 7 to another health professional, 6 to a social worker, and 4 to the police. Nine respondents said that they gave referral information to the patient and 7 said that the health professional contacted the organisation on behalf of the patient.

Evaluation
None of the 12 respondents reported the inclusion of a research component.

Finland case study: Maternity and child health clinics

Historical context and previous research

The Ministry of Social Affairs and Health have recommended that maternity clinics ask about domestic violence at least once during the first two trimesters of pregnancy, and at child health clinics, no later than the child's six-month check-up and subsequently at the child's annual check-ups (Perttu, 2004).

Between 1998 and 2002, the Ministry of Social Affairs and Health funded research under its STAKES Programme for the Prevention of Prostitution and Violence against Women. This involved exploring a suitable method for identifying, addressing and discussing domestic violence with women using maternity and child health clinics. As part of this programme, two surveys of women attending prenatal care and mother-child clinics were conducted. In the first survey of 1020 women conducted in 2000, 17.9% reported experiencing physical or sexual violence, or threats in their current relationship. Of the 99 women who participated in a further in-depth interview, 77.3% of these reported being victimised during pregnancy and 17% said that the violence had started in pregnancy. Around 17% of these 99 women had sought help from a health centre. (Perttu, 2004).

In a second survey conducted in 2002 with 510 women attending prenatal and mother-child clinics, 11% of women reported that they had experienced physical or sexual violence, or threats of violence at some point in their pregnancy (Perttu & Kaselitz, 2006).

Pilot screening projects, funded under previous Daphne programmes, were implemented in Finland in two settings in 2005: an obstetrics and gynaecology department in the university hospital in Helsinki and in a number of maternity and child health clinics in Vihti. This was underpinned by training of midwives. Of the 87 women screened in the hospital, 9% reported some form of partner violence. All but one woman felt positive about being asked about domestic violence. One of the main findings from the hospital clinic, was that many women were not asked about domestic violence as they were accompanied by partners or children. Many of the women using the gynaecology and obstetrics department were experiencing complications during pregnancy and partners are encouraged to attend check-ups.

With regards to the screening implemented in six different maternity and child health clinics in Vihti, 87 women were screened and 8% reported some form of partner violence. Midwives at the clinic noted three barriers to screening: lack of time, the presence of the partner, and feeling uncomfortable repeating questions about domestic violence after a year if there had been no disclosure of violence at the beginning.

References

Perttu Sirkka 2004. Intimate partner violence against women and its screening at the maternity and child health clinic. Reports of the Ministry of Social Affairs and Health (Accessed 18th August 2011). http://pre20090115.stm.fi/pr1104480484516/passthru.pdf

Perttu S. & Kaselitz V. (2006) *Addressing intimate partner violence. Guidelines for health professionals in maternity and child health care*. Finland: University of Helsinki, Palmenia Centre for Continuing Education (Accessed 18th August 2011).
http://www.hyvan.helsinki.fi/daphne/results.php

http://www.coe.int/t/pace/campaign/stopviolence/Source/guidelines_for_health_professionals_maternity_child_health_care_en.pdf

Findings from the qualitative interviews

Sample
For the Daphne project five in-person interviews were conducted with health professionals in Järvenpaa (2011 population of 38,674) and Jyväskyla (2011 population of 130,974). These participants were chosen as they were recipients of domestic violence training in previous projects funded by the Ministry of Social Affairs and for their continued efforts in maintaining changes in practice. The interviews explored participants' views on the challenges of sustaining changes in clinical practice beyond the initial training period, as well as their feelings about a new government initiative to include men in the process of screening for domestic violence in maternity and child health clinics.

- The manager (6 years) in Child and Family Services in Jarvenpaa. This includes maternity and child health clinics, as well as school and student health in Jarvenpaa.

- A public health nurse at a maternity and child health clinic in the Child and Family Services in Jarvenpaa, who has been a public health nurse for 30 years.

- The manager (5 years) of Child and Family Services in Jyvaskyla.

- A public health nurse at a maternity and child health clinic in Jyvaskyla, who has been a public health nurse for 24 years.

- A domestic violence project manager (19 years) who is also the Finnish partner in the Daphne project. The project manager is an expert in the field of gender violence in Finland and based at the University of Helsinki. She has coordinated domestic violence projects and training initiatives across Finland. She was also involved in producing research reports and handbooks on violence against women for the National Research and Development Centre for Welfare and Health.

Adapting 'screening' for domestic violence in maternity and child health clinics
As part of a previous projects funded by the Ministry of Social Affairs in 2000 and 2002, the public health nurses interviewed had received domestic violence training. This included awareness raising, how to ask about domestic violence, how to document a disclosure and refer women to appropriate sources of help. As a result of these projects, the first guidelines for health professionals in maternity and child health care clinics were published (Perttu, 2004) which included a screening form (Intimate Partner Violence Screening in Maternity and Child Health Clinics) which was developed based on interviews and the Abuse Assessment Screen (McFarlane et al. 1992). For those interviewed, the training was

delivered almost ten years ago, although the nurses interviewed reported that they continued to enquire about domestic violence in a less systematic manner and had adapted their approach to identification. Over the years they departed from the screening tool and had made adaptations that they felt more comfortable with.

> *"Yes every one of the nurses used the screening formula, but they ask parents between themselves how they tried to solve their domestic problems and how they argued and do they fight at home. It is like how do you usually solve problems and conflicts at home?"* [Manager, Health Services Jarvenpaa]

In Finland women attend routine antenatal appointments with public health nurses at health centres and continue to have regular contact with them until their child reaches school age (i.e. 6 years). The role of the public health nurse in Finland is similar to that of a midwife or health visitor in the UK. The nurses interviewed said that they knew some of the women very well as they had provided maternity and child for all their children. The continuity and long-term nature of the care provides ample opportunities for public health nurses to pick up on common indicators of domestic violence, ask questions and provide ongoing support and referrals.

> *"Another question that isn't there [on the original screening tool] is 'are you afraid in your partnership?' That one we ask. After that, if something comes up, we have these [additional] questions. From what I have discussed with the nurses, they feel that they would rather deal with these matters by discussion. We have so much interaction in this work that we are using this interaction with women"* [Manager, Health Services Jyvaskyla]

One of the public health nurses interviewed reported that she preferred to ask mothers to complete the screening tool themselves after having an initial appointment to become acquainted. The woman's responses would then be discussed in more depth during the appointment and the tool was simply a way of initiating this.

> *"Yes, I have a habit of getting the mother to think with me. I don't give the questionnaire until she comes here and we meet and chat. She fills it in herself. After that I go through it with her and I ask 'what is this you wrote?'. I ask about every question, then I add another, I clarify if there is psychological violence and how the spouse behaves when they have an argument."* [Public Health Nurse, Jyvaskyla]

The Finnish maternity and child care system regard the family as the client and therefore partners are encouraged to attend all check-ups with the woman. Although the training emphasised the need to ask the woman separately from her partner, the nurses interviewed had different points of view about this. Given the potential safety issues that can arise from asking the couple together about abuse in the relationship, the following quote highlights the need for clear guidelines and reinforcement training.

> *"I will ask both at the same time so I can observe from their interaction, but normally nothing comes out. I have never experienced any [danger] and nobody has behaved badly I have told them at the clinic that all families are asked these questions. The*

position of a public health nurse is such that they are allowed to ask all kinds of questions. You start thinking if I am able to sort out absolutely everything. But our position is like a trusted friend so we are hardly ever accused of asking unnecessary questions." [Public Health Nurse, Jarvenpaa]

"A lot of the times the questioning is left out as father always come along. So if something comes up it may worsen the situation." [Public Health Nurse, Jarvenpaa]

Identified referral pathways

An essential component of any health care intervention to address domestic violence is a clear referral pathway, with services that specialise in supporting victims and perpetrators of domestic violence. This is in addition to the range of statutory services that women may access such as the police, housing, legal services, housing and social services. In Jarvenpaa and Jyvaskyla, which are small towns in Finland, there are very few specialist domestic violence organisations and referrals tend to be within the health centre to other health professionals. However, it is not known whether these professionals have special training in dealing with clients or families affected by domestic violence.

"We have two family therapists and a psychologist and then we have psychiatric nurses and social workers. Many of the families get an appointment with the therapist and they work with the family. We live here, which is very small and I don't know if there are women's groups. The church perhaps has some groups….but in Helsinki there are a few groups but the distance is a bit long to go. Those who need help the most, they don't have the capability to go there, they are too tired for that." [Manager, Health Services Jarvenpaa]

With regards to support for perpetrators of domestic violence, one public health nurse mentioned Miessakit in Jarvenpaa, which is a non-governmental organisation that specialises in mental, psychological and social support for men in Finland. The organisation runs a help line for men who use violence against their partners, and offers individual and group work with men. However, special services for male perpetrators exist in only a few municipalities and many are private organisations. In each municipality there are family guidance centres and one possible solution to the lack of services for victims and perpetrators might involve 'skilling up' therapists at these centres. The Mobile Crisis Centre appears to be the key domestic violence service for women in Jyvaskyla. In the following excerpts the health manager in Jyvaskyla discusses some of the issues around referral pathways.

"We will refer [women] to the health centre and then Mobile, the crisis centre. But there was a bit of uncertainty about whether their activity will continue or not. They deal with other crises too, but it has been a place for us which in these acute matters has been a possibility." [Manager, Health Services Jyvaskyla]

"Some of our younger public health nurses, if they don't know the care pathway they are a bit worried about using this [screening form] and there is no training." [Manager, Health Services Jyvaskyla]

"This was raised [in discussions] with the City or even a bigger area. Some people thought that we can't use this questioning if the care pathway is not known. The reason why practice [of questioning] is slightly obsolete with us, is that the municipality [Palokka] joined [the City] two years ago, but we continued as our own health centre and it took time to find out which social workers were in our area." [Manager, Health Services Jyvaskyla]

One of the proposed actions under the 2010 National Action Plan to Reduce Violence Against Women is to ensure there are specialised services for victims of violence including an extensive network of shelters for women.

Factors affecting sustainability of the intervention

A number of issues affected sustainability of the training intervention in these clinics over the years. This included the need for: additional training and reinforcement activities for existing staff as well as training for new public health nurses joining the clinics; identified local services to which abused women and perpetrators of abuse could be referred to; systems for monitoring the practice of enquiry for domestic violence; regional domestic violence leads with expertise on the issue to coordinate work; and clinical guidelines that clearly outline the role of the public nurse. To their credit, the managers of the clinics went to great lengths to maintain the changes in clinical practice, for example, enabling staff to attend domestic violence training whenever it became available and attending regional working groups on domestic violence. However, it was a struggle as they both had extensive work remits and domestic violence had to compete against other issues.

"I think the responsibility is shared. Because I am responsible for this unit and the social workers have their own chief and the therapists have their chief. [The three of us] work quite close to the clients. All the health nurses discuss our work. I take care of the decisions…about what we really do." [Manager, Health Services Jarvenpaa]

"Until now I have been in charge, but it has been in children's shoes [idiom meaning in small measure] because I have such a broad job description. I was in a regional family violence working group, but I was still partly doing clinical work. And then I also have school healthcare and occupational health care from the human resource side of things, so there is very little time for me to do this development work" [Manager, Health Services Jyvaskyla]

"The care pathway would always be permanent and it would be updated, but also ongoing training for the employees so that you could have new ways of working…I still see it as important that there is training available to bring up the issue and do deal with it and that the care pathway is clear and everybody knows who to contact and how to proceed. Cooperation is important and there should be a responsible person in the hospital for the whole region. But physically just here [referring to the clinic] there is no need." [Public Health Nurse, Jyvaskyla]

The establishment of regional service units providing special expertise in the prevention of violence is one of the proposed measures within the 2010 National Action Plan to Reduce

Violence Against Women. These will be implemented between 2013 and 2015. In addition, there are plans to establish multi-professional coordination groups for domestic violence, and cross-sectoral coordination groups for domestic violence in each municipality or joint municipality partnership.

Domestic violence training has been ad hoc since the initial programme. All interviewees identified a need for further training including basic training for new public health nurses, as well as further training to enhance communication skills.

> *"Training so that you could again go through the signs [of domestic violence] from the mother, the little clues, that you would be sensitised to and also go through the skills of bringing up the issue so that they become stronger, that kind of training. And they don't need to be long, even a day's training will motivate them to bring it up."* [Public Health Nurse, Jyvaskyla]

> *"I want to know how to discuss and solve the problem with the family because we know that there are not so many places you can go and talk about it."* [Public Health Nurse, Jarvenpaa]

In Jyvaskyla there was an identified need for more formal support and supervision for public health nurses.

> *"Currently this is a shortcoming because we don't have guidance [counselling] for employees….it's workmate, colleagues, we are always asking for job guidance. It is so difficult to deal with yourself when it happens, you should be able to talk it through."* [Public Health Nurse, Jyvaskyla]

However, in Jarvenpaa public health nurses work closely with the family therapists at the health centre and can get support from them even if they have not referred a case of domestic violence.

> *"With the difficult cases, the nurses and family therapists sit down together and try to find solutions to the cases which are not really clients of those therapists. So they get some supervision from the therapists themselves."* [Manager, Health Services Jarvenpaa]

<u>Future developments in maternity and child care clinics</u>

On the 1st January 2011 a new Decree for welfare clinic services was establiahed. Under this new decree, the whole family is regarded as the 'client' in the maternity and child health clinics. In practice this means that all services offered by these clinics have to be inclusive of men. According to Finnish health policy, men should be encouraged to participate in the check-ups during pregnancy and child bearing years. This has raised questions about whether men need to be asked about experiences of family violence, both victimisation and perpetration. A new project called RutiiNiksi (2011-2013) will take into account the Decree for welfare clinic services when developing a new tool for routine enquiry for partner violence. The project is run jointly by the National Institute for Health and Welfare (THL) and

the University of Helsinki/Palmenia. The project is funded by the Ministry of Social Affairs and Health, Finland.

> *"We have a national project developing a new took because the law [referring to the new Decree] has changed. In maternity and child health clinics they have to take into account the whole family, also the man. That's why we have to think of a new tool. This is a three year national project."* [Domestic Violence Project Manager, Helsinki]

> *"If there is a violent man, we don't know how he will react to these questions."* [Manager, Health Services Jyvaskyla]

> *"Here we may have a problem because bringing up violence in a relationship would demand that you could meet the mother alone and the situation is easier and the mother is able to answer. So I find it a bit problematic in the future that the spouse is always there. I will not have the opportunity to ask…So then we should probably arrange visits so that we ask that sometimes the father comes alone for instance to the baby clinic and in the mother's [maternity] clinics we ask that the mother comes on her own. We will just have to ask for separate visits."* [Public Health Nurse, Jyvaskyla]

The health centres in Finland already have an electronic client information system that is suitable for documentation of domestic violence, information sharing between health professionals and auditing of routine enquiry. The system has separate pages in the electronic records for the mother, the child and the father. All health professionals in the health centre (e.g. public health nurses from the maternity and child health clinic, and doctors and nurses from the main health centre) can access the record and share information. If a woman attends the maternity or child clinic with injuries, it is usual practice for the public health nurse to refer the woman to a doctor in the health centre for documentation.

Key learning points for best practice

- Within the organisation of maternity and child health care in Finland, public health nurses are the main health professional group that provide care to pregnant women and children under school age. There are opportunities for continuity of care, potentially over many years and therefore, public health nurses should be targeted for training initiatives that promote identification of domestic violence. Such training should be mandatory for public health nurses and offered on an ongoing basis to ensure that newly qualified nurses are involved. Public health nurses should also be provided with opportunities to access further training.

- Health managers should ensure that health professionals have protected time to attend domestic violence training.

- Demonstrable commitment to is needed from the management of primary health care organisations in all aspects of the development, implementation, evaluation and sustainability of the domestic violence intervention.

- In small towns where specialised domestic violence services are lacking, referrals are often made to other primary care health professionals in the health centres. Therefore, family therapists, doctors, and health centre nurses, and school and student nurses should be targeted for domestic violence training. Outside of primary care, social workers and the police should also be invited to training.

- The Finnish case study highlighted that the initial investment in training was almost lost after many years. Interventions are difficult to sustain over time if they are not underpinned by clear guidelines, identified referral pathways for victims and perpetrators, ongoing domestic violence training, reinforcement activities, and support and supervision for staff. Training cannot occur in isolation, but must be part of a system-based approach.

- During domestic violence training, it is important to seek the views of public health nurses to explore further how they currently ask about domestic violence and what types of assessment tools or questions they prefer to use. In the Finnish case study, the public health nurses used the screening tool developed in 2004 (Perttu, 2004), but adapted it in a number of ways. There needs to be greater focus on developing good communication skills with women as well as questioning approaches.

- It is essential that the practice of routine enquiry for domestic violence in maternity and child health clinics is reviewed, given the new government decree that promotes the inclusion of fathers in the process of questioning for domestic violence in maternity and child care clinics. There are likely to be safety issues associated with this practice and therefore caution is warranted. Furthermore, reliable and validated tools for asking male patients about domestic violence (experience and perpetration of) are currently lacking. Further research is required on this issue.

- Maternity and child health clinics in Finland have an efficient system for electronic patient records and sharing of vital information between health professionals within the same health care centre. Prompts and questions about domestic violence as well as facilities for documenting disclosure and/or injuries should be incorporated in to the current system

- There needs to be identified experts on domestic violence at a regional and at municipality level to coordinate domestic violence initiatives and ensure that information is filtered down at a local level to health service managers in all municipalities.

- There is also a need for a system of ongoing monitoring and evaluation of intervention practices.

- Domestic violence training, identification of domestic violence and guidelines should be a part of the welfare strategy of the municipalities.

References

McFarlane J, Parker B, Soeken K, Bullock L. (1992) Assessing for abuse during pregnancy. Severity and frequency of injuries and associated entry into prenatal care. *The Journal of the American Medical Association*, 23: 3176-3178.

Study 3: The Netherlands

Description of health sector in the Netherlands

Since the new Health Insurance Act in January 2006, all residents of the Netherlands are required to take out a health insurance policy. The system is private health insurance with social conditions. Private insurance companies are obliged to offer a core universal package for essential curative primary care, which includes: services by GPs, hospitals, medical specialists and obstetricians; hospital stays; dental care up to the age of 18; various medicinal appliances and prescription medicines; prenatal care; patient transport (e.g. ambulance); and paramedical care. This must be offered at a fixed premium to everyone regardless of their age or health status. It is illegal in the Netherlands for insurers to refuse any application for health insurance or to impose special conditions. The system is financed through taxes paid by employers to a fund controlled by the health regulator (50%); the government (5%); and the insured person who pays the remaining 45% directly to the insurance company. The population of the Netherlands, based on November 2011 estimates, is 16,727 255.

Primary healthcare
In the Netherlands there is a clear boundary between primary and secondary care. General practitioners (GPs) in the Netherlands are considered the 'gatekeepers' to secondary care. Therefore, patients do not initially have access to hospital care, but must be referred to specialist treatment by their general practitioners. Most GPs work in single or group private practice, although more primary health care centres with employed GPs are emerging.

Maternity care
In maternity care, the primary care provider and gatekeeper is a midwife, although some GPs in rural areas still provide some care during pregnancy and childbirth. Most primary care midwives work in group practices and are jointly responsible for their clients. Healthy women with uncomplicated pregnancies will usually only see a midwife and they can freely choose whether to give birth at home, in a hospital or a birth centre where they will be attended to by their own midwife or GP, without supervision from a gynaecologist. Women with complicated pregnancies requiring specialist care must consult a gynaecologist in secondary care. Women may be referred from primary to secondary care at any point during pregnancy if complications arise. After delivery, care is provided by midwives, sometimes GPs and maternity care assistants (MCAs) unless the woman and/or her baby is hospitalised and a gynaecologist and/or neonatologist is responsible.

Further information about the health care system in the Netherlands can be found at (Accessed 18th August 2011):
http://en.wikipedia.org/wiki/Healthcare_in_the_Netherlands

Further information about the population in the Netherlands can be found at (Accessed 30th January 2012):
http://en.wikipedia.org/wiki/List_of_countries_by_population

Domestic violence policy context in the Netherlands

Government initiatives for tackling domestic violence has been a fairly new development in the Netherlands compared to other European countries. In 2000, the Ministry of Justice stated that a stronger impulse by central government was necessary to intensify the approach to domestic violence. Consequently, the national project "*Preventing and Combating Domestic Violence*" was initiated under the direction of the Ministry of Justice 2002-2008. This was an inter-ministerial action involving the four Ministries of Justice, of the Interior and Kingdom Relations, of Health, Welfare and Sports, of Social Affairs, Employment and Education, and Culture and Science. Representatives from different implementing organisations contributed to the final report, "*Private violence – public issue*". The government proposed fifty measures to address domestic violence. However, the role of health care services in tackling domestic violence is given a cursory mention in relation to the need for training.

In the Netherlands, the major sources of funding for domestic violence interventions come from central government, local government and the health insurance companies. Research by Lo Fo Wong and colleagues (2006a; 2006b; 2007; 2008) on domestic violence training programmes for general practitioners had a major impact on interventions involving physicians in Rotterdam and Nijmegen. Local government in these cities funded the Mentor Mothers interventions that form the basis of the Netherlands case study. This body of research has also generated greater interest from the Ministry of Health, which convened a committee of experts in order to produce domestic violence guidelines for health professionals and this was completed in 2009.

Further information about domestic violence policy in the Netherlands can be found at (Accessed 18th August 2011):

http://www.cbo.nl/thema/Richtlijnen/Overzicht-richtlijnen/Geestelijke-gezondheidszorg/

http://www.cbo.nl/Downloads/849/rl_fhg_09.pdf

Results from the Netherlands mapping survey

Dissemination

The mapping survey was disseminated by the Netherlands partner (Dr Sylvie Lo Fo Wong) to one named clinician or researcher in 7 established interventions in primary and/or maternity care settings in the Netherlands. There is no central system in the Netherlands for collating information on all domestic violence interventions based in health care settings. The Netherlands partner contacted individuals known to her who were currently working in health based (primary and/or maternity care) domestic violence interventions. However, it should be recognised that the survey may not have captured all interventions of this type.

Respondents

A total of 6 of the 7 surveys were returned. It was possible for respondents to select multiple answers for some questions.

Amongst the 6 surveys returned, 1 was from a GP/Research Fellow; 1 from a PhD candidate; 1 from a trainee GP/doctoral candidate; 1 from a trainee GP/researcher; 1 from a Researcher (sociologist); and 1 from a midwife/medical anthropologist.

Intervention settings

Respondents reported that the interventions targeted multiple health care settings including: general practice (3); maternity care services (2); private obstetric care (1); and multi-health sector intervention that include primary and/or maternity care (3).

Health professionals targeted in the interventions included: general practitioners (3); midwives (2); nurses (1); and obstetricians (1).

All 6 respondents indicated that female patients were the target population for the interventions. Based on 8 responses, the length of time that the interventions had been running ranged from 18 months to 8 years.

Table 3.1 Coordination, funding and location of domestic violence interventions in the Netherlands

Name of intervention	Professionals targeted in intervention	Coordinating organisation & geographical location	Funding sources
Mentor Mothers (3 years)	General practitioners	Rotterdam	Municipalities Health Services Rotterdam and two private Trusts.
PreCare (7 years including pilot phase)	Nurses	Tilburg, Rotterdam, Purmerend, Zaanstad, Breda, Lelystad/Dronten, Zwolle, Den Bosch, Amsterdam, Barnveld, Ede, Nijkerk, Renswoude, Scherpenzeel, Wageningen, Venlo, Rijswijk, Leidschendam, Voorburg, Leidschendam, Iepenburg, 8th part of The Haguecity	Intervention funded by youth health care organisations. Research funded by ZonMw (Dutch government healthcare research funding).
Mentor Mothers (8 months, commenced January 2011)	General practitioners	Nijmegen	Municipality Nijmegen, ZonMw (Dutch government healthcare research funding) and the Ministry of Justice
Screening Instrument ALPHA-NL (3 years)	Midwives; obstetricians	Zaan Region, Waterland, Amsterdam, East Netherlands, Helmond	Municipalities in the areas of the intervention with regards to Centre for Youth and Family and Societal Support Law.
Implementation of screening for domestic violence in maternity care (4 years)	Midwives	Nationally in 89 maternity care practices	Intervention funded by the concerning youth health care organisations. Research funded by ZonMw (a Dutch research organisation)
Feel the ViBe – Web based intervention for young people whose mothers are attending the Mentor Mother programme in Nijmegen ((5 months, commenced in March 2011)	General practitioners	Nijmegen	Fund for Victim Support

Policies on domestic violence

Of the 6 interventions, 4 had a policy developed specifically for the intervention and 1 had a policy based on the national guidelines. No policy has been developed for the forthcoming web based intervention as the intended recipients are young people. With reference to the

5 interventions that involve action by health professionals, the following are included in the intervention guidelines:

Table 3.2 Domestic violence policy recommendations

Does the policy?	Yes (N)	No (N)
Recommend routine enquiry for domestic violence	5	0
Provide guidance on documentation of domestic violence	2	3
Provide guidance on how to refer patients who disclose domestic violence	5	0
Provide guidance on how to assess the safety of the patient and any children or vulnerable adults who may be affected by domestic violence?	3	2
Provide guidance on confidentiality and information sharing?	4	1

Domestic violence training

With the exception of the web based intervention which is not relevant to this section, all 5 respondents reported that the intervention involved domestic violence training for health professionals. Health professionals targeted for training include: nurses (1); GPs (2); midwives (3); gynaecologists (1); obstetricians (1); receptionists/clerical workers/practice assistants (1); physiotherapists (1); mentor mothers (1) and youth health care professionals (1). Training is mandatory in three of the interventions. In the Mentor Mothers projects based in Rotterdam and Nijmegen training is mandatory for mentor mothers and GPS; in ALPHA-NL training is mandatory for midwives and obstetricians. None of the interventions offer “train the trainer” courses.

Three respondents said that training was provided by a domestic violence trainer from outside the healthcare setting who is not a health professional, 2 reported that training was provided by a health care professional and 1 reported training by both.

Table 3.3 Frequency and length of domestic violence training interventions in the Netherlands

Intervention	Frequency of training	Length of training
Mentor Mothers (MeMoSA) Rotterdam	Training provided once to GPs participating in the mentor project. Some midwives, physiotherapists and doctor's assistants trained, but they did not participate in MeMoSA	1 day (6.5 hours)
PreCare	PreCare nurses are offered multiple training courses before they are allowed to implement the intervention.	Basic training for 3 hours a day (for 4 days). Note: PreCare nurses screen women with certain risk factors who are at an increased risk of abusing their child. The training covers a range of topics, including domestic violence.
Mentor Mothers Nijmegen	Training provided once to GPs and mentor mothers involved in the project.	GPs: 1 evening (3 hours) Mentor mothers: 9 days
Screening Instrument ALPHA-NL	One obligatory training day for midwives participating in ALPHA-NL. Multi-sector meetings to improve inter-agency cooperation.	6 hours accredited
Implementation of screening for domestic violence in maternity care	During implementation of the project, 19 training sessions were provided for a total of 238 midwives from 89 different practices.	"Two parts of the day" note: equivalent to a few hours

Of the 5 respondents who described interventions involving action by health professionals, all of them stated that the training included routine enquiry for domestic violence and how to refer patients who disclose domestic violence. With the exception of the Mentor Mother project in Nijmegen, all respondents reported that the training included documentation of domestic violence, how to assess the safety of the patient and how to deal with issues of confidentiality and information sharing.

Approaches to routine enquiry for domestic violence

Four of the five respondents who described interventions involving action by health professionals described their approach to the identification of domestic violence. In the mentor mother interventions in Rotterdam and Nijmegen, routine enquiry is defined as asking women direct questions about domestic violence only if they present with certain clinical symptoms. In ALPA-NL routine enquiry for domestic violence involves asking all women who are 20 weeks pregnant about domestic violence, and then again mid pregnancy. In the maternity screening project, midwives are trained to ask all pregnant women about domestic violence on three occasions (the first or second visit, after week 30 and after the baby is born). In PreCare, women who are under 26 years of age, have a low

educational level and are less than 28 weeks pregnant with their first child, are screened for a range of risk factors that put them at risk for abusing their child, including domestic violence. Apart from experiencing current domestic violence, other risk factors include: having little or no support; a history of violence or abuse; psychological problems; financial problems; being unemployed; housing problems; alcohol problems, smoking or using drugs during pregnancy; and having a non-realistic approach to motherhood. Therefore, it can be seen that interpretations of routine enquiry for domestic violence (i.e. asking all women whether or not there are risk factors) varied across interventions.

Of the five respondents, 2 reported auditing of routine enquiry for domestic violence using the midwives medical records (AlPHA-NL) and a research survey completed by midwives and sent back to the research team (Domestic violence screening in maternity care project).

Documentation of domestic violence

All 6 respondents answered questions on documentation of domestic violence within their interventions.

Table 3.4 Documentation of domestic violence

Information documented	**Yes (N)**	**No (N)**	**DK (N)**
Whether or not the patient was asked about domestic violence	3	1	2
Whether or not the patient disclosed domestic violence	3	1	2
Name of the perpetrator	2	3	1
Relationship of the perpetrator to the patient	4	0	2
A description of the types of abuse experienced	4	0	2
A description of any recent incident of abuse	2	1	3
A description of the types and location of injuries	3	1	2
A body map picture indicating location of injuries	1	3	2
Whether referral information was offered to the patient	3	1	2
Whether the patient accepted the referral information	3	1	2
Indication of any action taken by the patient	3	1	2
Whether there are any children in the household	4	0	2
An assessment of the safety of the patient and any children	3	1	2

Referral pathways

Of the 6 respondents, 5 said that they referred patients to specialist domestic violence organisations in the community, 4 to another health professional, 5 to a social worker, and 3 to the police. Four respondents said that they gave referral information to the patient and 4 said that the health professional contacted the organisation on behalf of the patient.

Evaluation

Respondents were asked whether the intervention included a research component and to provide details of any reports or publications. All six respondents reported that the intervention included research.

Table 3.5 Evaluation of domestic violence interventions in the Netherlands

Intervention	Evaluation activity
Mentor Mothers (MeMoSA) Rotterdam	Includes a research component – results yet to be published.
PreCare	Includes a research component. Mejdoubi. J. et al. (2009) First draft results of PreCare. *Journal of Youth Care*. Graaf I, Riper H. (2006) *Care for mother and child. Programme PreCare: home visits by a nurse during pregnancy and first two years of the child. Evaluation research*. Utrecht: Trimbos Institute. Kooijman K, Coeverden SV, Struijf A et al. (2008) PreCare: parenting support from pregnancy to toddler stage. *Journal of Youth Care*, 3(60) Oudhof M, Prinsen B. (2007) *Care for PreCare. Evaluation research amongst youth health care nurses*. Utrecht: Netherlands Jeugdinstituut/VU medisch centrum/Evean JGZ.
Mentor Mothers Nijmegen	Includes a research component. Study protocol published: Loeffen MJW, Lo Fo Wong S, Wester FPJF, Laurant MGH, Lagro-Janssen ALM. (2011) Implementing mentor mothers in family practice to support abused mothers: study protocol. *BMC Family Practice*, 12: 113. Data collection on study outcomes still in process.
Screening Instrument ALPHA-NL	Includes an evaluation by TNO – an independent Dutch Research Organisation, no further details provided
Implementation of screening for domestic violence in maternity care	Includes a research component – project report and two papers in progress for a midwifery journal. No further details provided.

Feel the ViBe, a web based intervention for young people whose mothers are attending the Mentor Mother programme in Nijmegen (commenced in March 2011) http://www.feel-the-vibe.nl/	Includes a research component, study in progress.

Netherlands case study: MeMoSA (Mentor Mothers)

Historical context and previous research

The Mentor Mother intervention also known as MeMoSA (Mentor Moeders voor Steun en Advies) based in Rotterdam and Nijmegen was chosen for the Netherlands. The intervention is unique in its approach to supporting women with young children experiencing domestic violence who are at an early stage of their decision making and who may not be ready to leave the home (Loeffen et al. 2011). Mentor Mothers provides an interesting contrast to traditional models of domestic violence advocacy, such as the one described in the UK case study. Furthermore it is less resource intensive as it is time limited and utilises trained volunteers. The intervention is being evaluated and the results will be available in the near future.

The origins of the Mentor Mother Advocacy model for supporting women experiencing domestic violence can be traced back to the US (McFarlane & Wiist, 1997). The model was developed for pregnant abused women and based on prior research on advocacy programmes for abused women leaving shelters and home visitation programmes to improve outcomes for pregnant women. Within this model, advocacy was offered by mentor mothers who lived in the project's service area. They provided weekly social support, education and assisted women with referrals to other community resources. Women were initially identified as experiencing abuse by nurses at public health clinics who were trained to screen routinely for domestic violence at the first antenatal appointment. The success of the intervention was based on contact success with women by mentor mothers, number and type of advocacy contacts and number and type of referrals made.

This model was later adapted by Australian researchers who were also developing an intervention model which involved peer support and home visitation strategies, both of which have been shown to reduce maternal postnatal depression. The intervention known as MOSAIC (Mothers' Advocates In the Community) involved social support, advocacy and antenatal mentoring with the aim of reducing partner violence and improving women's physical and emotional well being. MOSAIC was based in primary care because of the lack of research on effective interventions in this health care setting. This intervention reported a difference in the mean abuse scores at follow-up in the intervention group compared with the control group (Taft et al. 2011). In the Netherlands, the research group, led by the Netherlands partner in this Daphne project, adapted the intervention model from the MOSAIC intervention in Melbourne, Australia. This included shorter guidance and support, focused training with mentor mothers with regards to parenting skills, coping with depression, safety planning, and developing a social network and support. In the Netherlands they enrolled mothers with children ≤ 18 yrs at home, whereas MOSAIC was for pregnant women and mothers with children ≤ 5 yrs.

The Netherlands partner within this Daphne project has undertaken research and published a number of studies on domestic violence training in general practice settings. This includes an exploration of GPs knowledge, attitudes and practices regarding domestic violence (Lo Fo Wong et al. 2006a); a randomised control trial to test whether awareness of domestic violence and active questioning increase after attending a focus group and training,

compared to focus group only (Lo Fo Wong et al. 2006b; Lo Fo Wong et al. 2007); and women's views and experiences of disclosing domestic violence to a general practitioner (Lo Fo Wong et al. 2008). As a result of the training, GPs reported being more alert to the signs and symptoms of domestic violence and felt more confident about raising the issue with patients. They also showed a preference for the use of role plays to practice consultation and communications skills (Lo Fo Wong et al. 2007). In a randomised controlled trial comparing full training of GPs, with focus group discussion and a third control group found that one and a half day training session for GPs increases awareness and identification of partner abuse in female patients by up to 4.5 times, whilst active questioning about abuse increased six times. The study also found that focus group discussion alone doubled the rate of active questioning for domestic violence, suggesting that discussion with peers can make GPs more alert to the issue (Lo Fo Wong et al. 2006b). Interviews conducted with women who had disclosed abuse to a trained GP indicated that the GP's openness and communication skills were important factors in encouraging them to talk about the abuse (Lo Fo Wong et al. 2008). More recently, this research group has published a waiting room survey of female patients in general practice who are part of the MeMoSA (Mentor Mother) intervention in Rotterdam which found that 30% of women in attending GPs practices had ever experienced intimate partner violence. The study also found a significant association between experiences of intimate partner violence and depression with more than trhee quarters of depressed women having a history of partner violence (Prosman et al. 2011).

Mentor Mothers intervention in the Netherlands

As a result of this body of work, the research team developed an adapted Mentor Mother intervention which was implemented in general practice settings in two areas of The Netherlands: Rotterdam and Nijmegen. The intervention targets abused women identified in general practice settings, many of whom who are at a very early stage of decision making regarding the domestic violence. GPs are trained to ask direct questions when they see common risk markers for domestic violence (e.g. depression, psycho-somatic complaints, injuries etc). If a woman accepts help, the GP will make a referral to the mentor mother programme.

The intervention is time limited and mentor mothers see women once a week for four months, although an assessment is made at the end to determine whether it is an appropriate time to end the support. In exceptional cases it is possible for mentoring to be extended for an additional month to prepare the woman for the end of the intervention. Mentor mothers receive nine days of training which covers four areas: (i) reduction of violence; (ii) children who witness violence; (iii) management of depressive complaints; (iv) and improving the woman's social network. The training includes theory, information giving and practical exercises such as role plays using actors as simulation patients. The training manual for mentor mothers was developed by Dr GertJans Prosman, a psychologist and researcher in Gender & Women's Health at Radboud University Nijmegen Medical Centre. The minimum age to be a mentor mother is 30 years and they must also be mothers themselves. They are employed for 1 to 2 days as a mentor mothers and are paid a low salary so that they are considered semi-volunteers. As such, it is recommended that mentor mothers work a maximum of 1 to 2 days per week and attend monthly coaching sessions.

The mentors come from a variety of educational and career backgrounds, including students from higher education looking for practical experience, whilst others come from social work or youth work. In general they are usually educated to just below Higher Education (HBO) in the Netherlands, otherwise known as “middle-level applied education” which is orientated towards vocational training and lasts four years.

The first Mentor Mother intervention (MeMoSA) was developed and studied in Rotterdam in 2007, involving 42 GPs (corresponding to 27 full-time GPs) and 63 women. The evaluation results are currently being written up for publication. The second Mentor Mother intervention in Nijmegen began in January 2011 and is being independently evaluated by Lo Fo Wong and colleagues at Radboud University in Nijmegen Medical Centre. The project will involve approximately 86 GPs at 40 practices and aims to recruit 35 women in one year to the mentor intervention.

The study protocol for the Mentor Mother intervention in Nijmegen and further details of the evaluation approach can be found elsewhere (Loeffen et al. 2011).

Local domestic violence policy context: Rotterdam and Nijmegen

This section describes the local policy context in which the Mentor Mothers intervention was developed. In the Netherlands central government has funded 35 large cities to develop domestic violence strategies, as it is more efficient to do this from a large city than in all the municipalities, of which there are approximately 400. Local policy making is undertaken by the city council (i.e. local government). Rotterdam and Nijmegen are run by a city council and the Municipal Executive Committee which comprises a Mayor and a number of Aldermen. The city council is the highest civil administration and consists of members representing different political parties. In Rotterdam there are 45 members who represent eight political parties and in Nijmegen 39 members who represent eleven political parties. These members are democratically elected by citizens of Rotterdam and Nijmegen and are responsible for defining the scope of municipal policy and monitoring the execution of tasks by the bench of the Mayor and the Aldermen.

Nijmegen city council receives two million Euros a year from central government to implement its domestic violence strategies. The budget is allocated to four areas: providing refuges (which makes up half the budget); prevention such as training for GPs (which constitutes the smallest share of the budget); care (i.e. mentor mothers project); safety (i.e. perpetrator’s programmes); and coordination of involved organisations such as the police, healthcare, education etc. Nijmegen city council currently funds the new Mentor Mothers project implemented in GP settings in January 2011.

GGD Rotterdam is a public health service covering 18 municipalities in Rotterdam and surrounding areas. It monitors and promotes the health of inhabitants residing in the municipalities. GGD develops and implements policies under the direction of local government on a range of health and social care issues. The GGD has five key areas and domestic violence fits within the broader remit of “personal orientated care” which also includes the addictions and mental health. In 2007 the Health Care Inspectorate, an organisation which promotes public health through enforcement of quality health services,

prevention measures and medical produces, undertook some research and discovered that child abuse and domestic violence were receiving very little attention in the health care system. They recommended that policies and systems for reporting domestic violence and child abuse were put in place. In Rotterdam there are twelve hospitals working together to write a policy for dealing with child abuse and domestic violence. As a result of this, the hospitals use risk assessment tools and work more closely with child abuse coordinators, the GGD, the police and childcare system. With regards to GP's involvement in addressing domestic violence, once again this has occurred largely as a result of research conducted by Lo Fo Wong and colleagues. GGD Rotterdam funded the first Mentor Mothers (MeMoSA) intervention in 2007.

The GGD in Rotterdam have published an approach to dealing with domestic violence and a code of conduct for reporting domestic violence and child abuse. These are applicable to all health and social care agencies and other municipal services. Three key objectives within the approach are:

(i) Early detection and reporting: achieved through improving the skills of professionals such as doctors, teachers, social workers and other professionals so that they recognise the signs of abuse. Advice and reporting of child abuse through the AMK (Child Abuse Counselling and Reporting Centre) and domestic violence through the ASHG (Domestic Violence Advice and Counselling Centre).

(ii) A well-coordinated network of professionals: through multi-agency networks known as LTHGs (Local Domestic Violence Teams)

(iii) Attention to prevention: through the development of a various programmes aimed specifically at children and young people.

The Code of Conduct is a generic step-by-step guide for professionals from various institutions for dealing with cases of domestic violence and child abuse.

Further information about local domestic violence policy can be found at:

Rotterdam's approach to domestic violence (Accessed 18th August 2011).
http://www.envisvictimsupport.eu/?p=417

The Rotterdam Code of Conduct for Reporting Domestic Violence and Child Abuse (Accessed 18th August 2011).
http://www.envisvictimsupport.eu/?p=588

http://www.envisvictimsupport.eu/wp-content/uploads/2009/03/rotterdams-approach-to-domestic-violence.pdf

Nijmegen's Code of Conduct for Reporting Domestic Violence (Accessed 18th August 2011).
http://www.rijksoverheid.nl/onderwerpen/huiselijk-geweld/hulp-bieden/meldcode

Nijmegen city council, domestic violence information (Accessed 18th August 2011).
http://www2.nijmegen.nl/wonen/zorgwelzijn/maatschappelijke_opvang/huiselijk_geweld

References

Loeffen MJW, Lo Fo Wong S, Wester FPJF, Laurant MGH, Lagro-Janssen ALM. (2011) Implementing mentor mothers in family practice to support abused mothers: study protocol. *BMC Family Practice*, 12: 113.

Lo Fo Wong S, de Jonge A, Wester F, Mol SSL, Romkens RR, Lagro-Janssen T. (2006a) Discussing partner abuse: does doctor's gender really matter? *Family Practice*, 23: 578-586.

Lo Fo Wong S, Wester F, Mol SSL, Lagro-Janssen TLM. (2006b) Increased awareness of intimate partner abuse after training: a randomised controlled trial. *British Journal of General Practice*, 56: 249-257.

Lo Fo Wong S, Wester F, Mol S, Lagro-Janssen T. (2007) "I am not frustrated aymore". Family doctors evaluation of a comprehensive training on partner abuse. *Patient Education and Counselling*, 66: 129-137.

Lo Fo Wong S, Wester F, Mol S, Romkens R, Hezemans D, Lagro-Janssen T. (2008) Talking matters: abused women's views on disclosure of partner abuse to the family doctor and its role in handling the abuse situation. *Patient Education and Counselling*, 70: 386-394.

McFarlane J, Wiist W. (1997) Preventing abuse to pregnant women: implementation of a "Mentor Mother" advocacy model. *Journal of Community Health Nursing*, 14: 237-249.

Prosman GJ, Jansen S, Lo Fo Wong S, Lagro-Janssen A. (2011) Prevalence of intimate partner violence among migrant and native women attending general practice and the association between intimate partner violence and depression. *Family Practice*, 28: 267-271.

Taft AJ, Small R, Hegarty KL, Watson LF, Gold L, Lumley JA. (2011) Mothers' Advocates In the Community (MOSAIC) – non-professional mentor support to reduce intimate partner violence and depression in others: a cluster randomised trial in primary care. *BMC Public Health*, 11:178.

Findings from the qualitative interviews

Sample

Eight participants were chosen as they were involved in the Mentor Mother intervention in a variety of roles (e.g. funders, health professionals, Mentor Mothers, and research), thus providing different perspectives of the intervention. Interviewees were selected from the Nijmegen and Rotterdam Mentor Mother interventions. The population in Nijmegen and Rotterdam according to 2011 statistics is 736,107 and 616,003 respectively. The interviews explored participants' views on the intervention components, and how the intervention works, the role of the Mentor Mother, factors that have supported the success of the intervention, as well as the challenges encountered in trying to achieve sustainability.

- A policy advisor (19 months) for Nijmegen City Council (i.e. local government) with responsibility for advising the mayor and municipal executives on a range of policies

including domestic violence and involved in the funding decision of the Mentor Mothers intervention.

- A domestic violence policy advisor for the GGD Rotterdam (4 years) involved in the funding decision of Mentor Mothers (MeMoSA) Rotterdam. GGD is a public health service covering 18 municipalities in Rotterdam. It monitors and promotes the health of inhabitants residing in the municipalities. GGD develops and implements policies under the direction of local government on a range of health and social care issues.

- The former general programme manager for the domestic violence programme in Rotterdam (for the last 5 years, but retiring) based at GGD Rotterdam and also involved in the funding decision of Mentor Mothers (MeMoSA) Rotterdam.

- A Mentor Mother for the MeMoSA intervention project in Rotterdam (3 years).

- A Coordinator of the Mentor Mothers project in Nijmegen for 1 year and also working for HERA (the largest specialist domestic violence organisation in Nijmegen) for 12 years.

- A trainee GP/psychologist and PhD student on the evaluation of the Mentor Mothers Project in Nijmegen (1 year).

- A GP (31 years) and research fellow (10 years) responsible for developing the Mentor Mothers project and evaluation in Rotterdam and Nijmegen.

- A GP (12 years) who received domestic violence training as part of the Mentor Mother (MeMoSA) project in Rotterdam which began in 2007.

“A low threshold intervention”

Everyone interviewed referred to the Mentor Mother intervention as being a “*low threshold intervention*”. It targets women with young children and/or recently delivered women. It is considered low threshold because it is easy for women to access via a referral from their general practitioner whom they have regular contact with. In addition, women are not required to visit a service in order to get support because the mentor mother can arrange to visit them at home, at their GP’s office, or somewhere safe and convenient in their local community.

> *“The GP in Holland is really low threshold to go there because everybody has their own family practitioner. Most of the time you know your GP your whole life so you have some confidence in him. They will tell them about partner violence, about their problems….they can be provided with the mentor mother which is really low threshold as well because she’s not some health care worker in some big building. She’s also a woman. And because it goes through the GP, it’s easily available.”* [Mentor Mother Coordinator]

"We feel that it's more accessible because general practitioners identify the violence and they offer the abused mother the opportunity to go to a mentor mother. So we think that this step is very small. It's not a great step to go to a mentor mother. Because the mentor mothers are semi-professional, they're not really professional people, but are close to the mothers because they are mothers themselves. And they can contact very quickly, so within a week there is contact between the mother and the mentor mother. So no waiting lists." [Trainee GP]

Based on the key informant interviews, it would appear that women who use the mentor mother programme tend to be those who are not ready to leave their partner, may not have sought help previously, or conversely they may have engaged with some services in the past, but not satisfied with the help offered. Many of the women who use the mentor intervention are isolated at home and looking after young children. They may also suffer with depression, making it difficult for them to engage with routine health care for themselves and their children.

"….experience from Rotterdam shows that the mentoring mostly attracts women who are not ready [to leave] yet, because they are also not ready for regular health care. They are not yet ready to share it with another, to leave, to share it with their partner so they just keep it a secret." [Coordinator of Mentor Mothers]

<u>*The mentor mother as the "professional friend"*</u>

Mentor mothers were described as developing a "*professional friendship*" with women, whilst focussing on key four areas in a time limited intervention: (i) reduction of violence; (ii) children who witness violence; (iii) management of depressive complaints; (iv) and improving the woman's social network. From the initial intake meeting with the mentor mother, the woman defines the goals she wishes to work on during four-month period. It is made very clear to the woman at the first meeting that contact is once a week for four months. However, the mentor mother will make an assessment in the final month about whether it is safe and appropriate to terminate contact or an additional month is required. Women's goals vary greatly and may include doing volunteer work, accessing further education, visiting the local community centre, doing sport, or finding assistance with childcare. Other goals may involve assisting the woman in accessing health care for her own depression or counselling for her children. By reducing the woman's isolation and assisting her in developing her own social support network, it is anticipated that in the future she will be more amenable to seeking help for the domestic violence and consider other options. Unlike traditional domestic violence advocacy models that involve long-term case work with a focus on risk assessment and the provision services, the mentor mothers work with women at a very early stage of their decision making.

"I like to think of myself as a professional friend. When I meet with women we talk about their situation and I ask them about what they want to do, their goals. It's not about what I want, it's about what they want to do. They must take responsibility. I try to empower women and increase their social network. Some of them are so isolated, they don't see their family or friends. There are lots of issues with

depression. Then there are some that do see their family, but it's the family that's keeping them trapped in the abuse situation." [Mentor Mother]

"…It's a critical point a lot of people say. They want to empower the woman because they are so early in their process of change, so they are really early in their readiness to change. They want to empower these women so that they are at least more open for help." [Mentor Mother Coordinator]

Women are also educated about the effects of witnessing domestic violence on children and how to be alert for signs of escalating violence so that they are aware of what steps to take in order to ensure their safety and the safety of their children. In general partners are not aware that the woman is receiving support from a mentor and in some cases he is no longer in the home. However, there is always a possibility that a partner may notice that the woman has developed more social contacts and activities, which in itself may trigger more abuse. Therefore, the mentor mother will discuss safety issues at home and assist each woman in developing a safety plan should she need to leave in an emergency. One component of the mentor training is 'reduction of violence' which includes recognition of unsafe situations, safety behaviours, communication skills in threatening situations and safety planning.

They can help them and educate them especially regarding the children because most of these women don't really want to admit what it does to the children. And talking to someone who will not judge you really helps." [GP/Research Fellow]

Since the mentors receive only 9 days training prior to the job, there is a focus on mentoring safely. Mentor mothers receive ongoing monthly coaching. If there are any concerns about the safety of the woman and her children then the mentor is obliged to inform the woman's GP and/or a social worker.

"I had one woman who I could not get [access] to her because of the abuse. She was not contacting me out of fear. She was being physically abused every week, every week he was raping her. Her daughter was there and so she was witnessing all this. In the end I had to tell her that I must think of her daughter and the childcare organisation told her that they would remove her daughter. That was a difficult situation, sometimes I still think about it." [Mentor Mother]

In the first mentor mother intervention based in Rotterdam, women were mainly seen at home or sometimes in public spaces such as cafes, restaurants and supermarkets. Also in Rotterdam there was the opportunity of a private room in GP practices. An important change to the Nijmegen intervention was to offer women the opportunity to meet with the mentor in the general practice office which is a safe, neutral environment. All general practitioners were agreeable to this.

Sustainability of the intervention

Interviewees identified a need for lead professionals with expertise, who may or may not be health professionals, to coordinate the work on domestic violence in primary care. Although

clinical champions for domestic violence were essential during the initial stages of setting up an intervention, it would be unfair to expect them to take on additional activities to ensure that changes continue. As one GP highlighted, after the initial training and the end of the evaluation of the mentor intervention in Rotterdam, it was easy to forget to ask about domestic violence or forget to refer to a mentor mother. The links become broken unless there are reinforcement activities. This may involve short training updates, or simply meetings between the mentors/trainers and GPs to provide feedback about existing referrals or discuss difficult cases. Organising larger meetings may be more difficult since most GPs in the Netherlands work in single handed practices.

> *"The problem is in the Netherlands most practices are private. Therefore, the only one that would be responsible for domestic violence would be the person who owns the practice. I did not succeed in getting a coordinating person in the larger practices because we have some health care centres, but not many. There are five in this whole area."* [GP/Research Fellow]

Some GPs with an interest in the issue of domestic violence accumulate a lot of experience and knowledge as a result of dealing with different cases and become informal leads or support for less experienced colleagues. However, it would be unrealistic to expect a few committed GPs to support other colleagues in the long-term.

> *"In the hospitals they have a coordinator for child abuse, not for domestic violence. So they are just starting to think that domestic violence is also a serious issue. [They would be responsible for] training for all new personnel because you might train them today, but in two years there might be new people. Also secretaries, nurses, assistants, that's the first thing. Second thing is there might be a central person to consult whenever doctors need advice. So they might have patients they have questions about. Nowadays they call on me….from all over the city!"* [GP]

> *"I'm already focussed on domestic violence so I'm not the average GP. So I know more than my colleagues, because some come to me to ask where I can send that person. So I have my network, my social network. If I have a case of child abuse or domestic violence, I know who to phone and who I have to send the woman to. And I always get feedback because I want to know if she really got there. And if the woman doesn't go to that appointment, they'll email me. So I know that next time a woman comes to me, I can talk about it with her. So my colleagues in the neighbourhood know that I'm focussed on it….er yes maybe they think I am the lead person."* [GP]

Domestic violence training also needs to be ongoing, but of course requires identified and reliable funding.

> *"We are about 400 GPs in this city, those who haven't work with the mentors they don't know about them. So the point is that they really need training every three or four years."* [GP/Research Fellow]

> *"There has to be enough GPs [trained] and they have to refer. At the start of the project in January we sent them a newsletter and we'll do that every few months. We*

> *think it's very important to keep reminding them about the project because intimate partner violence is not something they think about every day. We have made posters for all the waiting rooms and all general practitioners received a file with the registration forms and the protocol so we hope that will remind them of the project"* [Trainee GP and PhD student on evaluation of MeMoSA]

Partnerships and funding

The original mentor mother programme was based in the south of Rotterdam and funded by GGD Rotterdam, a public health body. Radboud University Medical Centre Nijmegen was also funded by the GGD to undertaken an independent evaluation, which is currently being written up. At the end of the funding period ownership of the mentor programme was transferred from the GGD to a youth mental healthcare organisation (Flexus Jeugplein) with funding that meant a reduction in the number of mentor mothers, from seven to three.

One of the learning points from the Rotterdam experienced was the need for the intervention to be situated within an appropriate organisation. The organisation must have expertise on domestic violence in order to oversee the day-to-day work of the mentor mothers and provide adequate training and support.

> *"Well we used to be under the GGD, but they gave our funding to Flexus who now manage us. Flexus is a youth care organisation and they don't have a lot of experience with domestic violence. For them the child is the client so they are very child focussed. We also have to get the child's consent to do the mentoring. We work with the woman and through her we are helping the child. They eventually will want us to work with the whole family including the abuser and that's going to be very unsafe."* [Mentor Mother]

The new mentor mothers programme in Nijmegen works together with HERA, the largest specialist domestic violence organisation in the province which also runs a network of refuges. The Radboud University hires a HERA prevention employee for training, coaching and coordinating of the mentor mothers. The mentors are trained by a mentor mother coordinator at the Radboud University by a HERA employee using the original training manual produced for the Rotterdam project and receive ongoing coaching and support. The mentor mother coordinator also has support and supervision through HERA. The other advantage of being linked to HERA is that if a mentor mother encounters a woman who wishes to leave her partner, the case can be transferred to a HERA worker.

> *"….the point is that it [mentor mothers] has to be incorporated into an organisation. In Nijmegen it will be better. The social work organisation possibly will have all these mentor mothers working for them because they are in all the health centres. They have many more health centres in Nijmegen. Nijmegen is different from Rotterdam, we have more private GP practice in Rotterdam which makes it difficult to embed."* [GP/Research Fellow]

"If a woman during the project decides to leave her home, so for example, go to a shelter, then the mentoring mother stops and things are being provided further, for example, by HERA. But then it's HERA not the mentor." [Mentor Mother Coordinator]

Policy advisors involved in the funding of the mentor mothers intervention were asked to discuss what made the intervention fundable. During the interviews it was emphasised that government funding for all social interventions will decrease in the coming years up to 2015. Therefore, it is important that new initiatives link in with a number of local government policy objectives, not just domestic violence, and that they demonstrate that they are of benefit to the recipients. The notion of a "low threshold" intervention that was accessible to women, in addition to attention to the safety and well being of the children as a key feature of the mentor's role made the intervention more appealing to funders.

"Well we're looking for some sort of effect and best practice methods. We're also looking for interventions that are sort of within a structure of chain approach, where there is good screening and identification for the intervention….[by structure] I mean that's when we are helping a child within some sort of intervention. The parents also have to be involved with it" [General Programme Manager for Domestic Violence, Rotterdam]

"Well um the prevention of children who are witnessing domestic violence. We fund it because it helps intergenerational violence." [Domestic Violence Policy Advisor, Rotterdam]

"We get a lot of requests [for funding]….and I think that one of the reasons that we did this project is because it is essential. This [intervention] has a low door step [low threshold], it's very easy for someone to go to their general practitioner and then after some consultations they finally start talking about the problem. That's where this project was perfect and also I know it's well organised and scientifically tested. So those were the reasons and specifically because it was close to families." [Policy Advisor, Nijmegen City Council]

"Well the cross cutting perspective is very important because we have to look at people as a system and it's very important if there's domestic violence, but if there's an addiction it's important we being these two perspectives together. But it has to be simple. Well for instance the Mentor Mother project is also a good example. The GP knows about a wide area of problems. Okay this person has a problem with depression, for instance, and domestic violence. Well they know there to find help for the domestic violence and depression and the mentor can make a few calls…." [Policy Advisor, Nijmegen City Council]

During the interviews, participants defined success of the intervention in varying ways. For example, increasing referrals to the mentors by GPs; seeing the women increase their social network or take up paid or volunteer work; improved parenting skills; a reduction or cessation of violence and the family remaining intact; and increased safety. Funders recognised that it can take a couple of years for a project to mature and demonstrate positive results and that some intermediate outcomes are not easy to capture.

“Good question! We don’t always know if it works. For example, empowerment of women, there is no very good national research on that.” [Domestic Violence Policy Advisor, Rotterdam]

“The research on the outcomes, you cannot always use them immediately.” [i.e. some positive outcomes only appear after some time has passed]. [General Programme Manager for Domestic Violence, Rotterdam]

Key learning points

- The mentor mother model (in-reach and brief intervention by a mentor mother) lends itself well to primary care settings such as GP surgeries. It may also be suitable for health care contexts in which midwives or public health nurses are the primary carers of pregnant and postnatal women.

- The mentor mother intervention is described as a low threshold intervention because it is easily accessible to women via their GP and visits by the mentor mother can take place in the GP surgery, the woman’s home (if safe) or the local community centre.

- The intervention targets women with young children and/or recently delivered women experiencing domestic violence. Women most likely to benefit from the intervention tend to be at an early stage in their decision making process and therefore may have no immediate plans to leave their abuser.

- Whilst the safety of the mother and her children is paramount, mentoring activities are based around four key ideas: (i) reduction of violence; (ii) children who witness violence; (iii) management of depressive complaints; (iv) and improving the woman’s social network. The goal is to reduce women’s isolation and assist them in developing a social network that may be a support mechanism in any future help seeking activities.

- The mentor mother intervention model is less resource intensive in terms of funding when compared to traditional models of domestic violence advocacy which involve intense case work and continuous risk assessment. The mentor mothers are semi-volunteers (i.e. paid a small wage) from the local community who attend a nine-day training course. Ongoing supervision is available and their time commitment is one to two days a week for four months per client. The mentor mothers have a collective agreement contract, with all the benefits, although at a lower scale than their training requires (i.e. semi-volunteer). This is to ensure commitment to the job as experience has shown that unpaid volunteers are not always reliable.

- Training of health professionals *is* resource intensive in terms of time and funding. In order to sustain the intervention, training must be offered as a rolling programme to ensure that new health professionals are involved. Existing trained staff will also require reinforcement activities (additional training or meetings with the trainer to discuss difficult cases) to ensure that the referrals to the mentor programme

continue. As with any health sector intervention, the training must be underpinned by guidelines outlining exactly what is expected of health professionals when responding to a patient who is experiencing domestic violence.

- A pool of accredited domestic violence trainers is needed in order to ensure the quality of the training. In the Netherlands GPs work in private practice and therefore "train the trainer" initiatives are more difficult to implement.
- As more GPs become sensitised to the issue of domestic violence as a result of training, it will be necessary to have lead professionals to coordinate training and provide ongoing support to health professionals.

- Funders need to ensure that the mentor mothers are housed by an appropriate organisation with expertise in domestic violence and coaching and support of those working with abused women. This is essential since the mentor mothers are semi-volunteers from a variety of backgrounds and receive brief training when compared to other models of advocacy that have been documented in the research literature. It is important that they have access to expert advice and support when dealing with complex and/or high risk cases. In addition, a specialist domestic violence organisation will have established links with a range of community organisations that the mentor may need to facilitate access to.

- If the mentor mother intervention proliferates in the Netherlands, it may be necessary to consider the development of further accredited training for mentors, over and above the basic training. As their role potentially evolves, it may be necessary for them to acquire additional skills.

- Time is needed for GPs (and other referring health professionals) to become professionally acquainted with the mentor mothers. Feedback mechanisms are needed to strengthen the partnership and generate more referrals. Furthermore, funding for the mentor mother intervention must continue as part of this system based intervention, as without it, GPs are unlikely to enquire about domestic violence.

- The mentor mother interventions in Rotterdam and Nijmegen are the first of its kind in Europe and offer a new approach to advocacy for women with children who may not be ready to leave their abuser and at a very early stage of decision making. The evaluation findings will be important for informing the development of similar interventions in other European countries.

Study 4: Spain

Description of the health sector in Spain

Spain is politically organised at two main levels of government: the central government of Spain and the governments of the 17 Autonomous Communities, plus two Autonomous Cities. Therefore, the Autonomous Communities have a fairly high level of self-government and are responsible for the administration of schools, universities, health, social services, culture, urban and rural development and, in some cases, policing.

The legal framework for the current Spanish National Health System is the General Health Act 14/1986. The key principles of this act were:

- Public funding with universal, free health services at time of use
- Devolution of health affairs to the Autonomous Communities
- Provision of holistic health care, aiming to achieve high quality with proper evaluation and control
- Inclusion of different public health structures and services in a National Health System (NHS)

As a result of this Act the financing of the health system was transformed from an insurance-orientated system to a system financed by taxes, with almost universal coverage with free access to health care. Governance of the health system was decentralised to all 17 autonomous communities in 2002.

Within the central government, the Ministry of Health and Consumer Affairs assumes responsibility for general organisation and coordination, and basic legislation on health; international health, and relations and agreements relating to it; legislation on pharmaceutical products, and undergraduate and graduate training. The 17 autonomous communities in Spain hold planning powers and organise their own health services in their regions. The General Health Act of 1986 also created the Inter-territorial Council of the Spanish National Health Service (CISNS) which comprises representatives from the autonomous communities and the state and promotes cohesion of the system. Health policy making power in Spain lies at a regional level, with health authorities and regional health governments playing a central role. All autonomous communities have drawn up a health map with territorial subdivisions (health areas and zones). Each health area is responsible for the management of facilities, benefits and health service programmes within its geographical limits (Duran et al. 2006).

Primary healthcare
Primary Care is arranged at Health Centres, where multi-disciplinary teams provide health services to people and the community. Working alone is restricted to the private sector. General practitioners are the first point of contact between the population and the health system and are the gatekeepers to specialised care.

Specialised care
Specialised care is provided by medical specialists which may be in-patient hospital care or out-patient consultation at specialist centres and at day hospitals. It includes diagnosis, therapy, rehabilitation and certain preventive care. Referral to specialised care is undertaken by a primary care physician.

Maternity care
The care programme for pregnant women is developed in a coordinated manner between Primary Care (the GP and the Primary Care midwife) and the hospital gynaecologist and midwife. There are joint-action protocols that define the roles to be played by the different professionals involved in the process. The G.P. refers the patient. The initial assessment is made at the time of the first consultation by the G.P. and the Primary Care midwife. The protocol is applied and the standard tests are requested. In the case of high-risk pregnancies, there is a referral to the hospital obstetrics service and there the woman is monitored by the midwife and the hospital gynaecologist. In the case of normal pregnancies, the protocol establishes the visits to be made in Primary Care and when the woman is to be seen by the obstetrician, when the ultrasound scanning is carried out, etc Preparation for delivery (obstetrical psycho-prophylaxis and maternal education) is always carried out at the health centre by the Primary Care midwife. Late in the pregnancy the visits to the obstetrician become more frequent, up to the time of delivery. Home visits to women who have recently given birth and to newly-born infants are made by the Primary Care midwife and sometimes by the paediatric nurse. There are some differences between the pregnancy monitoring protocols of the various Autonomous Communities.

Spain has 46,196,278 in habitants according to the 2012 estimates.

Further information about health care in Spain can be found at (Accessed 18th August 2011):
http://en.wikipedia.org/wiki/Spanish_National_Health_System

For further information about the population in Spain can be found at (Accessed 30th January 2012):
http://en.wikipedia.org/wiki/List_of_countries_by_population

References
Duran, A, Lara, JL, van Waveren M. (2006) *Health systems in transition. Spain health system review*. European Observatory on Health Systems and Policies, vol 8(4) (Accessed 18th August 2011).
http://www.euro.who.int/__data/assets/pdf_file/0005/96386/E89491.pdf

Domestic violence policy context in Spain

As in many other European countries, the women's movement in Spain has played a key role in lobbying and campaigning for changes in policy at State level and in highlighting gender violence as a human rights issue. However, Government actions for addressing gender violence generally and within the context of healthcare are a fairly recent development in Spain, occurring within the last seven years. A defining moment was the Organic Law 1/2004 on Comprehensive Protection Measures against Gender Violence which came into action on the 28th December 2004. This was the first time that the term gender violence was used in legislation thereby recognising that multiple forms of violence against women was a consequence of gender inequality.

Compared to the other European countries, Spain has the most systemised and standardised approach to implementing domestic violence interventions in health care settings. Under Spain's Organic Law 1/2004, the governments of all the autonomous communities are obliged to address gender violence within the health care system as part of its portfolio of health services. As the Spain case study will highlight, the hierarchical management structures within the health care system, coupled with the top-down and bottom-up approach to implementing the Common Protocol, have been important factors in embedding domestic violence interventions within the system. Spain also has a rigorous data capture system for monitoring the implementation of interventions in the autonomous communities and cities with autonomous status.

In 2004 the National Health System Inter-territorial Council created a Commission Against Gender Violence which was chaired by the Healthcare Secretary General and formed by the NHS's Quality Agency Directorate General, representatives of each Autonomous Community, the Equality Policies General Secretariat, the Women's Institute and the Observatory on Women's Health. Under the Organic Act 1/2004 for the Comprehensive Protection Against Gender Violence, the Commission is obliged to provide technical support and direct the planning of the health care measures. Under the Act, the Commission is also responsible for issuing an annual Gender Violence Report which provides an overview of strategies and implementation of programmes in the 17 autonomous communities and cities with autonomous status. The data for the annual reports is obtained from the medical history of the electronic patient record and the grievous bodily harm (GBH) report which is in written format (i.e. injury reports by medical doctors). Some of the autonomous communities have started to computerise the GBH report to avoid double counting.

The "*Common Protocol for a Healthcare Response to Gender Violence*" was published by the Ministry of Health and Consumer Affairs in 2007 as a result of the Commission's Taskforce in charge of Protocols and Health care Action Guides for Addressing Gender Violence. The protocol is not limited to domestic violence, but includes "*any form of ill-treatment inflicted on women over 14 years of age, regardless of whom the aggressor may be*", although the actions focus primarily on violence from a current or former intimate partner (Ministry of Health and Consumer Affairs, 2007). The protocol aims to establish a standardised guideline for the National Health System, for early detection, assessment and action in cases of gender violence. Key recommendations for the prevention of gender violence in the health care system include:

- The inclusion of early detection and comprehensive care in health professionals' ongoing training

- Conducting multi-disciplinary clinical sessions to discuss actual cases of domestic violence being dealt with in the health care centre or service

- Conducting joint sessions with other professionals and institutions

- Making available publicity information (leaflets and posters) on domestic violence informing women that health care professionals can provide support

- Including gender awareness in the activities of Education for Health and in Maternal Education groups

- Cooperation with community groups through workshops and conferences on the role of health care in addressing domestic violence

The protocol from the Ministry recommends that direct questions should be asked when a woman presents with certain indicators of abuse. However, some of the autonomous communities have decided to implement systematic questioning of all female patients over 14 years of age, regardless of whether risk factors are present. Each autonomous community adapts the common protocol to its own context and contains information on local statutory and non-governmental organisations.

In Spain there is a systematic approach to collecting data on all cases of gender violence detected within the health care system. As mentioned earlier there are two sources of data: the patient's medical history in the electronic record and injury reports that are generated by doctors. This has resulted in a surveillance system which allows the Commission to publish data on the extent and nature of the abuse by level of care (e.g. primary and specialised care). Furthermore, epidemiological surveillance is carried out on gender violence, as well as the monitoring of training activities and number of trained health professionals. In 2009, the rate of gender violence cases detected in the Spanish National Health System was 93.7 cases per 100,000 women aged 14 or over (based on the medical history) and 114.5 cases (based on the Grievous Bodily Harm Report). The number of cases detected in primary care is higher, regardless of information sources, compared to specialised care. This may be due to a greater implementation of training programmes in primary care, but also a consequence of abused women's most direct access to health care being primary care. Intimate partner violence accounts for the highest proportion of cases. In 2009, 10, 940 health professionals from primary care had received training in gender violence compared to 2,547 professionals in specialised care (Ministry of Health and Social Policy, 2009).

References

Ministry of Health and Consumer Affairs (2007) *Common protocol for a healthcare response to gender violence*. Available on line at (Accessed 24th August 2011):
http://www.msc.es/organizacion/sns/planCalidadSNS/pdf/equidad/commonProtocol.pdf

Ministry of Health and Social Policy, Spain. Reports, studies and research (2009) *Gender Violence 2007 Report.* Available on line at (Accessed 24th August 2011):
http://www.msps.es/en/buscador/home.jsp

Ministry of Health and Social Policy, Spain. Reports, studies and research (2010) *Gender Violence 2008 Report*. Available on line at (Accessed 24th August 2011):
http://www.mspsi.gob.es/organizacion/sns/planCalidadSNS/pdf/equidad/informeViolenciaGenero2008/genderViolence2008Report.pdf

Ministry of Health, Social Policy and Equality. Reports, studies and research (2011) *Gender Violence 2009 Report.* Available on line at (Accessed 24th August 2011):
http://www.mspsi.gob.es/organizacion/sns/planCalidadSNS/pdf/equidad/informeViolenciaGenero2009/genderViolence2009Report.pdf

Results from Spain mapping survey

Dissemination
There are 17 autonomous communities in Spain. The Spanish partner (Dr Carmen Fernandez Alonso) disseminated the mapping survey to 18 individuals from the 17 autonomous communities who have responsibility for programmes on gender violence.

Respondents
A total of 13 (76.5%) surveys were returned representing 12 autonomous communities. It was possible for respondents to select multiple answers for some questions. Of these, 5 surveys were from lead coordinators or health professionals and 8 were from key people within the government of the autonomous communities.

Table 4.1 Geographical location of domestic violence interventions in Spain

Name of intervention (length of time since inception)	Location
Health care in gender violence (3 years)	Autonomous Community of Balearic Islands
Guidelines for responding to gender violence in the domestic setting (6½ years)	Autonomous Community the Canary Islands
Training in domestic violence, questioning on Gender Violence, Referral to other health professionals (2 years)	Town of Aranda de Duero in the province of Burgos (in the Autonomous Community of Castille and León)
Regional strategy for health actions against gender violence (6 years)	Autonomous Community of Madrid
Training for the prevention, diagnosis and treatment of gender violence (6 years)	Autonomous Community of Aragon
Training in domestic violence (6 years)	Chartered Community of Navarre
Health responses to violence against women (8 years)	Autonomous Community of la Rioja
Programme for the detection and treatment of women victims of gender violence (intervention: 4 years/train the trainers: 7 years)	Autonomous Community of Castille and León
Protocol for health sector responses to abuse (5 years & 3 months)	Autonomous Community of Cantabria
Guidelines for detection and treatment of domestic violence in primary care (3 years)	Autonomous Community of the region of Murcia
Andalusia guidelines for healthcare response to domestic violence (length of intervention not specified)	Autonomous Community of Andalusia
Training of health professionals (2 years)	Autonomous Community of Extrem adura
Protocol for the approach to male violence within the fame work of health in Catalunya (length of intervention not specified)	Autonomous Community of Catalonia (i.e. Cataluyna)

Intervention settings
Respondents reported that the interventions targeted multiple health care settings including: primary care (11); maternity services (9); multi-health sector initiatives that include maternity or primary care (7); emergency services (2); mental health services (3); and speciality care (1).

Health professionals targeted in the interventions included: general practitioners (12); midwives (12); nurses (12); obstetricians (9); gynaecologists (9); social workers (10); mental health professionals (4); paediatricians (4); accident & emergency staff (1); trauma (1); physiotherapists (2); administrative teams (1); and residents in family medicine (1).

All 13 respondents indicated that female patients were the target population for the interventions and 1 respondent also mentioned male patients. Based on 11 responses, the length of time that the interventions had been running ranged from 2 to 8 years.

Collaborative partnerships and funding
Twelve respondents reported that the coordinating or lead organisation was a health organisation and 1 reported that the autonomous government was the coordinator. With regards to funding, 12 respondents reported that the intervention was funded by the Department of Health in their autonomous community and 1 respondent reported the autonomous government.

Policies on domestic violence
Of the 13 respondents, 4 reported that they had a policy developed specifically for the intervention and 6 had a based on the national guidelines.

Table 4.2 Domestic violence policy recommendations

Does the policy?	**Yes (N)**	**No (N)**
Recommend routine enquiry for domestic violence	10	3
Provide guidance on documentation of domestic violence	12	1
Provide guidance on how to refer patients who disclose domestic violence	13	0
Provide guidance on how to assess the safety of the patient and any children or vulnerable adults who may be affected by domestic violence?	12	1
Provide guidance on confidentiality and information sharing?	13	0

Domestic violence training
All 13 respondents reported that the intervention involved domestic violence training for health professionals. Health professionals targeted for training included: nurses (12); general practitioners (12); midwives (12); psychologists/counsellors (10); gynaecologists (11); obstetricians (11); social workers (11); reception, clerical workers or practice assistants (7); physiotherapists (2); medical internal residents (2) and primary care paediatricians (2).

Only 2 respondents reported that domestic violence training was mandatory in the autonomous communities of Castile and León and the Balearic Islands for primary care professionals: nurses (2); general practitioners (2); midwives (2); and social workers (2); and

it was voluntary for mental health professionals (psychologists/psychiatrists) (1) gynaecologists (1); obstetricians (1); clerical workers and practice assistants (1).

Four respondents said that training was provided by a domestic violence trainer from outside the healthcare setting who is not a health professional, and 9 reported that training was provided by a health care professional. In addition, 4 respondents said that multi-disciplinary training was offered involving health professionals disciplines other than their own such as social work, psychiatry, or teams involving health professionals and non-health professionals. One respondent said that training was provided by the National School of Health.

Eleven respondents reported that the intervention included 'train the trainer' courses. Trainers are usually health professionals who have attended the basic training who meet certain criteria including: prior training in domestic violence; ability and interest in teaching; and a commitment to train other health professionals in the autonomous community. There is usually a pool of domestic trainers in each autonomous community.

Table 4.3 Content of domestic violence training

Did the training include the following?	**Yes (N)**	**No (N)**	**DK (N)**
Routine enquiry for domestic violence	11	2	0
How to document domestic violence	12	1	0
How to refer patients who disclose domestic violence	13	0	0
How to assess the safety of the patient	12	0	1
How to deal with issues of confidentiality and information sharing	12	1	0

The following tables contain information on the frequency and length of domestic violence training programmes offered in each intervention.

Table 4.4 Frequency and length of domestic violence training in Spain

Intervention name and geographical location	Professionals targeted in the intervention	Frequency of training	Length of training
Health Care in Gender Violence Autonomous Community of Balearic Islands	General practitioners; midwives; nurses; obstetricians; gynaecologists; social workers	Every three years.	There are two lines of training: brief courses for increasing awareness (6 hours), and advanced training. They are undertaken during working hours.
Guidelines for responding to gender violence in the domestic setting Canary Islands	General practitioners; midwives; nurses; primary care paediatricians	45 professionals in primary care were formed in 2004 through the "training of female and male trainers" programme. They subsequently trained the staff at the health centres, reaching approximately 90% the personnel in the seven health regions (islands). Subsequent training has been included in continuing education programmes in each primary care administration unit.	Training of (female) trainers: 1 month. Workshops in health centres: 18-20 hours. Workshops for specialization in any aspect (e.g. clinical interview): 7 hours. Workshop about the guidelines: 14 hours. Workshop of trainers recycling: 1 week. The offer for training is very flexible so it can cover every specific need.
Training in domestic violence, questioning on Gender Violence, Referral to other health professionals Town of Aranda de Duero in the province of Burgos (in the Autonomous Community of Castille and León)	General practitioners; midwives; nurses; obstetricians; gynaecologists	Annually.	Workshops of 2 to 3 days.

Intervention name	Professionals targeted in the intervention	Frequency of training	Length of training
Regional strategy for health actions against gender violence Autonomous Community of Madrid	General practitioners; midwives; nurses; obstetricians; gynaecologists; social workers; accident & emergency staff; paediatricians; mental health staff	There is an offer for training every year that includes training addressed to the primary care network, hospitals, and A&E units. It is voluntary, although in the case of the primary care setting, it has become a priority to train 20% of the teams annually.	The training aimed at primary care centres has duration of 10 hours. There is a complementary course of study cases addressed to professionals who have already completed the basic course. Training for A&E units, obstetrics and gynaecology services, and the outpatient emergency network takes also 10 hours. This offer is complemented by other courses and workshops aimed at deepening on this problem, with duration set to 25-30 hours per course or workshop.
Training for the prevention, diagnosis and treatment of gender violence Autonomous Community of Aragon	General practitioners; midwives; nurses; obstetricians; gynaecologists; social workers; medical internal residency (MIR) trainees in family medicine	Training courses are offered each year aiming to reach 100% of health professionals	Varies with the course offered. Clinical sessions are 2 hours and there are also 20-hour courses
Training in domestic violence Chartered Community of Navarre	Mental health professionals	Annually regardless of professional group	Sessions of 12 hours Sessions of 20 hours
Health responses to violence against women Autonomous Community of la Roja	General practitioners; midwives; nurses; obstetricians; gynaecologists; social workers; mental health professionals	Two courses (20 hours) are held annually as part of the course syllabus or continuing education for health professionals; there are also awareness sessions in the Health Centres.	The courses include 20 hours of teaching.

Intervention name	Professionals targeted in the intervention	Frequency of training	Length of training
Programme for the detection and treatment of women victims of gender violence Autonomous Community of Castile and León	General practitioners; midwives; nurses; obstetricians; gynaecologists; social workers; physiotherapists; paediatricians	There are three levels: 1) Awareness (initial training) 2) Basic Training 3) Advanced Training These activities are covered in the annual programme for continuing education and are evaluated and included as an objective in the annual administrative plan for each primary-care management.	There are guidelines for the content and duration of training programmes set by the Department of Health, but these are adapted to conditions and situation of the Autonomous Community where the where the intervention will be applied taking into account regional priorities and feasibility criteria. Priorities have been established, offering training activities annually aiming to ensure that most of the staff receives the awareness training and primary care professionals at least the basic training. It is recommended that basic activities last for about 10-20 hours. For emergency services personnel the duration is 6 hours. Advanced training activities are covered in over 20 hours. Instructor training: 70 hours. The activities include training in interviewing and communications skills.
Protocol for health sector responses to abuse Autonomous Community of Cantabria	General practitioners; midwives; nurses; social workers; physiotherapists; paediatricians	We have designed a basic level of training currently given to newly recruited professionals, and for the last two years there has been an advanced course that focuses primarily on communication skills.	We have designed a basic level of training currently given to newly recruited professionals, and for the last two years there has been an advanced course that focus primarily on communication skills. Current levels are the aforementioned basic and advanced; there is currently no re-certification in domestic violence management training.

Intervention name	Professionals targeted in the intervention	Frequency of training	Length of training
Guidelines for detection and treatment of domestic violence in primary care Autonomous Community of the region of Murcia	General practitioners; midwives; nurses; obstetricians; gynaecologists; social workers	Annually, there are a series of training activities as part of the Comprehensive Plan for Training on Gender Violence in the Region of Murcia.	It is flexible. The Comprehensive Plan for Training has a formative itinerary structure so that some professionals are trained in two years and some in one year.
Andalusia guidelines for healthcare response to domestic violence Autonomous Community of Andalusia	General practitioners; midwives; nurses; obstetricians; gynaecologists; social workers;	Training is offered to centres upon request. There are also targets to meet depending on the agreements with the organization.	It depends on the type of training: - Awareness courses: 1 to 4 hours. - Basic training: 20 hours or more. - Train the trainer: 75-hour course.
Training of health professionals Autonomous Community of Extremadura	General practitioners; midwives; nurses; gynaecologists; social workers; mental health staff; administrative personnel	We are developing a basic training programme.	Minimum 20 hours.
Protocol for the approach to male violence within the fame work of health in Catalunya Autonomous Community of Catalonia (i.e. Cataluyna)	General practitioners; midwives; nurses; obstetricians; gynaecologists; social workers	Did not specify	Did not specify

Of the 13 respondents, 10 said that the intervention includes routine enquiry for domestic violence of women older than 14 years of age. The approach to the identification of domestic violence varied across the interventions and did not always involve routine enquiry (i.e. asking all women about violence whether or not there are risk factors). Eight reported that routine enquiry for domestic violence is monitored using the patient records.

Table 4.5 Approaches to the identification of domestic violence within interventions

Name of intervention and geographic location	**Approach to identification of domestic violence**
Health care in gender violence, Autonomous Community of Balearic Islands	Questions similar to "How are things at home?" are asked of female patients that present with certain symptoms; the Delgado test is used for an assessment of suspected cases.
Training in domestic violence questioning on gender violence, referral to other health professionals, Town of Aranda de Duero in the province of Burgos (in the Autonomous Community of Castille and León)	1. Have you been hit, kicked, punched, or have you received any other kind of injury in the last year? If the answer is yes, who did it? 2. Do you feel safe in your current relationship? 3. Do you feel not safe in the present because of a previous relationship?
Regional strategy for health actions against gender violence, Autonomous Community of Madrid	Use of questions recommended by the national Guidelines to detect violence in anyone who attends to a medical consultation.
Training for the prevention, diagnosis and treatment of gender violence Autonomous Community of Aragon	Asking questions during the medical interview forpatients that present with certain physical or psychological symptoms.
Training in domestic violence, Autonomous Community of Navarre	Questions for the detection of Gender Violence are asked of all women who have suspicious symptoms or signs that are described in the Common Protocol.
Programme for the detection and treatment of women victims of gender violence, Castile and León	Questions are asked routinely of all females over 14 years of age visiting Primary Care for any reason, whether they are suffering ill-treatment. Facilitation questions are advisable. It is recommended to ask questions once every 3 years.
Protocol for health sector responses to abuse Autonomous Community of Cantabria	It means asking questions in a non-standardized, but appropriate way (with an introductory narrative, in a direct way, with indirect questioning, etc.) to all women over 14 years attending primary care services.
Guidelines for the detection and treatment of domestic violence in primary care Autonomous Community of Murcia	Questions for patients who present with certain symptoms; questions for patients who attend certain visits such as first prenatal visit or a health check.

Training of health professionals, Autonomous Community of Andalusia	There are questions for patients that present with certain symptoms.
Guidelines for responding to gender violence in the domestic setting, Autonomous Community of Canary Islands	Detection questions that are asked of all women at a time that is considered most appropriate, with priority given to those that present with indicators.

Documentation of domestic violence

Spain has a standardised way of collating data on cases of gender violence using the electronic patient records (medical history) and doctor's reports of injuries (Grievous Bodily Harm Report). This is described further in the case study.

Table 4.6 Documentation of domestic violence

Information documented	**Yes (N)**	**No (N)**	**DK (N)**
Whether or not the patient was asked about domestic violence	11	0	2
Whether or not the patient disclosed domestic violence	12	0	1
Name of the perpetrator	2	8	3
Relationship of the perpetrator to the patient	12	0	1
A description of the types of abuse experienced	12	0	1
A description of any recent incident of abuse	12	0	1
A description of the types and location of injuries	12	0	1
A body map picture indicating location of injuries	11	1	1
Whether referral information was offered to the patient	12	0	1
Whether the patient accepted the referral information	11	0	2
Indication of any action taken by the patient	9	3	1
Whether there are any children in the household	12	0	1
An assessment of the safety of the patient and any children	11	0	2

Referral pathways

Of the 12 respondents that answered, 10 said that they referred patients to specialist domestic violence organisations in the community, 4 to another health professional, 12 to a social worker, and 4 to the police. Eleven respondents said that they gave referral information to the patient and 8 said that the health professional contacted the organisation on behalf of the patient. One respondent said that they encourage the woman to make direct contact with the organisation herself.

Evaluation

Respondents were asked whether the intervention included a research component and to provide details of any reports or publications. All autonomous communities in Spain have an electronic health information system and all disclosures of domestic violence are entered in the patient's electronic medical history. They are required to submit data to the Ministry of Health, Social Affairs and Equality who collate it and produce the annual Gender Violence reports. However, 4 respondents reported formal research evaluations.

Table 4.7 Evaluation of domestic violence interventions in Spain

Name of intervention (length of time since inception) and geographical location	Evaluation activity
Health care in gender violence (3 years) Autonomous Community of Balearic Islands	Number of cases detected by centres and hospitals as part of routine monitoring, no formal evaluation
Guidelines for responding to gender violence in the domestic setting (6½ years) Autonomous Community of Canary islands	Currently conducting an investigation, no results at present
Training in domestic violence, questioning on Gender Violence, Referral to other health professionals (2 years) Town of Aranda de Duero in the province of Burgos (in the Autonomous Community of Castille and León)	No formal evaluation included
Regional strategy for health actions against gender violence (6 years) Autonomous Community of Madrid	Two assessments led by the Director General of Primary Care: Evaluación intermedia de la Formación Continuada a profesionales de Atención Primaria sobre Violencia de Pareja hacia las Mujeres (available on line) Interim evaluation of continuing education on partner violence against women for primary care professionals Status of the support guidelines to address partner violence against women in primary care in the community of Madrid (in preparation)
Training for the prevention, diagnosis and treatment of gender violence (6 years) Autonomous Community of Aragon	A qualitative study was conducted to evaluate the care provided by the healthcare system and social assistance to women victims of domestic violence – no further details provided
Training in domestic violence (6 years) Chartered Community of Navarre	Not known

Health responses to violence against women (8 years) Autonomous Community of la Rioja	There are two evaluation reports: one to the sub-committee of the La Rioja Observatory of Gender Violence and the other to the National Health System Annual reports on the web page of the La Rioja Government (www.larioja.org), La Rioja Health Service (www.riojasalud.es) and the Department of Health and Citizenship (www.msps.es)
Programme for the detection and treatment of women victims of gender violence (intervention: 4 years/train the trainers: 7 years) Autonomous Community of Castille and León	Data collected on: number of people screened; cases detected; cases reported to a legal service; age of the woman; country of origin of woman; and pregnancy status. The Medical Director submits the data to those responsible for the services portfolio in the Regional Health Administration.
Protocol for health sector responses to abuse (5 years & 3 months) Autonomous Community of Cantabria	As an integrated intervention within a priority area of the projects on women's health, the first plan 2004-2007 was included in a qualitative assessment. The Cantabrian Health Service evaluates coverage and some technical norms of the services for abuse every year.
Guidelines for detection and treatment of domestic violence in primary care (3 years) Autonomous Community of the region of Murcia	Directorate General for Health Care Services in the Murcia Health Service is responsible for evaluation data.
Andalusia guidelines for healthcare response to domestic violence (length of intervention not specified) Autonomous Community of Andalusia	Not known
Training of health professionals (2 years) Autonomous Community of Extremadura	Committee for the Evaluation of Services Portfolio
Protocol for the approach to male violence within the fame work of health in Catalunya (length of intervention not specified) Autonomous Community of Catalonia (i.e. Cataluyna)	Not known

Spain case study: Implementation of the Common Protocol for a Healthcare Response to Gender Violence in Castile and León

Historical context and previous research

There are 2,510,849 inhabitants in the autonomous community of Castile and León. The population is distributed over 2,248 towns, of which 87% have less than 1,000 inhabitants. 44% of the population lives in towns of less than 10,000 inhabitants and 12% in towns with less than 500 inhabitants. There are 246 health centres and 3,661 local surgeries. Below are the numbers of different types of health professionals working in Castile and León:

- Doctors (including paediatricians): 3,240
- MIR (doctors in speciality training): 367
- Nurses: 2,620
- Social workers: 83
- Midwives: 165
- Physiotherapists: 139
- Nursing auxiliaries: 259
- Hygienists: 63
- Dentists: 78

Initial gender violence training commenced in 2004-2006. In 2007, a Gender Violence Training Plan commenced (2007-2011) for the Community of Castile and Léon. In 2007, a multi-disciplinary training team comprised of 35 professionals from the 11 health areas was set up. In 2007 the pilot project was developed at 22 Health Centres of the Gender Violence Detection and Attention to Victims Service. In 2008 the Gender Violence Detection and Attention to Victims Service was implemented in primary care at all the Health Centres of Castile and Leon (246 Health Centres).

The multi-disciplinary training team provided basic training to the Primary Care Teams as well as advanced training to health professionals that wanted to become trainers ("train the trainer"). A tiered approach was taken to training health professionals with the highest priority being staff in the Primary Care Teams such as doctors, nurses, social workers, midwives and paediatricians. The second priority was emergency services, mental health, gynaecology and midwives in hospitals. The third priority was other professionals assisting in reception areas (e.g. receptionists, administrators etc).

With regards to primary-care health professionals, the target population of the training was 7,159 of the 9,046 persons comprising the primary care staff. Between 2006 and 2009, 5,544 primary-care professionals received some kind of gender violence training. With regards to specialised care (i.e. hospital centres) and emergency services, the target population for the training was 7,292 of the 26,282 (total hospital staff). Between 2006 and 2009, 994 health professionals specialising in care and/or from the emergency services received some kind of Gender Violence training.

During the execution stages, the following action was taken:

- Information and awareness activities targeted at the Primary Care and Hospitals management teams
- The Gender Violence Detection and Attention to Victims Service was defined
- The protocol was set up with provisions for care and assessment criteria
- The protocol was approved
- Pilot tests were carried out at 22 health centres in 2007
- Implementation at 22 health centres in 2007
- Implementation at 246 Primary Care health centres in 11 areas of the Autonomous Communities
- The inclusion of gender violence as an objective in the Annual Management Resolutions (for the purposes of covering and monitoring by area / individual)
- There is quarterly monitoring and an annual assessment.

With regard to the process of assessment of gender violence against women over 14 years of age, the data obtained for the period 2008 to March, 2011 show that questions about gender violence were asked of 138,556 women, which amount to 12.46% of the female inhabitants of Castile and León in this age group. Of this percentage, 2,282 (1.65%) new cases of gender violence were detected.

Factors that facilitated the development of training and the setting up of the Department for the Detection and Attention to Gender Violence include: providing adequate cover for health professionals to attend training sessions; holding short workshops and clinical sessions for resolving cases during working hours; the inclusion of gender violence within the priority institutional objectives; development of a long-term gender violence training programme; introduction of new formats for training including on line training; creation of a team of trainers; and a support and supervision team with a named and contactable person (although this was not maintained). However, despite commitment and institutional support from the State and the autonomous government, there were still challenges including: resistance to training from some professionals as well as a lack of awareness of their role in addressing gender violence; difficulties in implementing data management system; sufficient substitution of health professionals to enable them to attend training courses in 2010 and 2011; as well as heavy workloads making participation in training difficult.

More detailed data about training activities and detection rates for Castile and León can be found in the 2009 Gender Violence Report (Ministry of Health and Social Policy, 2011).

Source: Fernandez Alonso C. Presentation to the technical workshop held on 15th March 2011 – *Setting up the process of detection and attention to gender violence in the portfolio of primary care services in Castile and León*.

Findings from the qualitative interviews

Sample

Six in-person interviews were conducted with individuals in various parts of Castile and León. In order to maximise diversity, the Daphne partner (Carmen Fernandez Alonso) chose different types of health professionals working in primary or maternity care settings in which the Ministry's Common Protocol for a Health Care Response to Gender Violence had been implemented (e.g. training, identification of domestic violence and recording of cases using the electronic records). At a more strategic level interviews were conducted with two higher level managers in the Department of Health in the autonomous communities of Madrid and Castile and León. The interviews explored participants' experiences of implementing the intervention, factors that have supported the success of the intervention, as well as the challenges encountered including sustainability issues.

- Programme Coordinator, Observatory of Women's Health (6 years) based at the Ministry of Health in Madrid. The Observatory of Women's Health coordinates the annual reports on gender violence which provide an overview of implementation of programmes in all 17 autonomous communities.

- The Head of the Social and Health Coordination Service responsible for Gender Violence at the General Directorate for Planning, Coordination, Quality and Training of the Ministry of Health of Castile and León (4 years in this Service and 8 in the Regional Health Management Training Service) and one of the Daphne collaborators in this project. Responsible for coordination of all gender-violence training and assisting in dealing with gender violence in primary care in Castile and León.

- A family doctor (practicing for 31 years) based at a primary health care centre in Segovia. The domestic violence intervention has been running for 3 years.

- A nurse (practicing for 20 years) at based at a primary health care centre in Salamanca. The domestic violence intervention has been running for 4 years.

- A consultant doctor and Head of Obstetrics and Gynaecology (5 years) in a hospital in Burgos. The domestic violence intervention has been running for 2 years.

- A midwife (practicing for 20 years) based at a primary health care centre in Valladolid. The domestic violence intervention has been running for 3 years.

Top-down and bottom-up approach to systems change

In Spain, addressing gender violence within the health care system is not simply a recommendation in a government guideline. It is also legal regulation, since the Organic Law 1/2004 on Comprehensive Protection Measures against Gender Violence explicitly mentions the involvement of Health Care Administrations in Public Authorities' cooperation plans to combat gender violence. Interviewees described a top-down approach to implementation, targeting managers at a high level within health care administration. The annual management plan includes all the objectives for the health centre and the area, and also

includes objectives for gender violence such as the training activities. During the initial phase, the Ministry of Health, through the Women's Health Observatory, promoted and established a training programme intended for leaders of the autonomous communities. Compared to other countries in this project, this approach seems to be the most successful for ensuring widespread implementation of the Common Protocol and fostering institutional support.

> *"The most important thing is institutional support including a training strategy, training of managers, intermediate ranks, professionals and basically all levels. For this, it is imperative to have the involvement of the managing teams so there is a strong institutional support. Before we started implementing the programme in the [health] centres, we worked closely with the managing teams. We have a strong hierarchical structure that you may not have in England. We tried to get the managing teams involved in the programme so that the regional teams in the different areas also got involved. They basically didn't have any other option given that at the highest hierarchies it had been manifested already that this programme was an institutional objective. It's not that we tried to convince them. We were implementing the Law on Gender Violence and the norms that it contained that had to be carried out in all the [autonomous] communities"* [Head of the Directorate for Social Health Care, Valladolid]

> *"The Ministry, since 2009 put some economic resources to help the autonomous communities on this question of training health professionals. In 2009 the Ministry put four million Euros to all 17 autonomous communities."* [Programme Coordinator, Observatory of Women's Health]

Approach to the identification of domestic violence

In Spain, the recommendation from the Ministry of Health for the whole state is included in the Common Protocol (a consensual protocol and hence includes the minimum standards) which should be followed by all the health services in the autonomous communities. The recommendations are:

(i) When doing the clinical history taking, ask all women the exploratory questions stemming from the psychosocial approach. For example: *How are things at home? How is the relationship with your partner and family?* Sometimes these general questions facilitate the disclosure of an abusive relationship.

(ii) Additionally, it is recommended that the health professionals conduct an active exploration when there are indicators of abuse. In these cases, it is recommended that they ask directly about the presence of abuse using direct questions suggested in the Common Protocol.

However, the protocol can be adapted by each of the autonomous communities to its own context. Following on from this, some health centres in Castile and León have decided to recommend systematic enquiry of every woman above 14 years of age that attends the service. This is also the case in other autonomous communities such as Cantabria. In some

areas of Castile and León they also use specific questionnaires (e.g. Comunidad Balear, Comunidad Valenciana, etc.).

The health professionals interviewed described their roles in very different ways, but usually with reference to the Common Protocol for Gender Violence, using terms such as "early detection, prevention and assessment of vital risk:

> *"Early detection of gender violence and intervention in positive cases."* [Primary Care Doctor, Segovia]

> *"….Asking about domestic violence to all the women aged 14 years old or older that come to our service and responding accordingly….Prevention of domestic violence with the teenagers from the different schools in the area. Between 12 and 14 years old every year. We do so in the context of a sexual health training programme."* [Primary Care Nurse, Salamanca]

> *"All pregnant women have to be systematically questioned about gender violence. It's not systematically done for those women that come for other services like cervical cancer screening. Sometimes they have already been asked by their primary physicians, but we also target them when we detect risk factors."* [Primary Care Midwife, Valladolid]

Although the health professionals interviewed were trained to ask about domestic violence using a standard questionnaire format or specific questions, some had adapted this over the years to a more conversational style. This implies that the communication skills should be an important feature of domestic violence training programmes.

> *"I have memorised the questionnaire over the years and because I have systematised it, the questions come easily. I am used to asking open questions. Something like a spiral interview. I start asking very general questions and the, depending on what the woman tells me, I become more specific about what I ask. If there's any indication of abuse in what the woman tells me, I keep asking."* [Primary Care Doctor, Segovia]
> *"I follow the universal questionnaire. I found it very useful at the beginning and I based my own questions on it. Once one asks the questions many times, one can then do it more instinctively."* [Primary Care Nurse, Salamanca]

It was acknowledged that questioning was not always systematic and that other factors such as work load, time, staff confidence and commitment played a role. The following comment demonstrates that although screening for gender violence is considered part of routine care, it still takes second place during busy clinics due to the time it may take to deal with a disclosure sensitively.

> *"I try to question all of them. I try, but it depends on the day and the patient load. I also have to ask them about smoking, alcohol consumption, their last pap smear and so on. But there are always days when it is not possible, because I what I cannot do is let the cat out of the bag and tell the woman ok see you another day."* [referring to lack of time to deal with disclosure]. [Primary Care Doctor, Segovia].

Monitoring of routine enquiry and incentive schemes

Each of the 17 autonomous communities has its own health care information system in which health professionals are required to enter information about disclosures of domestic violence in the patient's medical history. The data is sent to the Ministry of Health and Social Policy who collate it and produce the annual Gender Violence Reports. There are two sources of information for obtaining data on gender violence: the electronic medical history and the doctor's report when a patient has injuries, also known as the Grievous Bodily Harm report (GBH). The GBH report is a paper report, but some communities have begun to computerise them to avoid double counting cases of domestic violence when data is sent to the Ministry for the annual reports.

> *You can record [gender violence] in the medical history, but when there are some injuries, the doctor uses the injuries document. So you have to search to get the different data. There are two main complications. There's the fact that you can record these indicators twice, once in the electronic system and again in the injury report. One you get them all together you cannot find if they are from the same woman so there are duplicates. And the other problem is that each autonomous community has adapted the codes for gender violence as they want to."* [Programme Coordinator, Observatory on Women's Health]

In Castile and León, and some other autonomous communities in Spain, targets are set in relation to the percentage of women that should be 'screened' for domestic violence. The Ministry of Health offer small financial incentives to health centres that meet or exceed these targets. Although this has helped to increase the rate of routine enquiry for domestic violence amongst health professionals, signing up to the targets is voluntary and not all the autonomous communities use this strategy.

> *"Since domestic violence was included in the targets, enquiry is done more frequently…It was a percentage of women in our quota. Each of us has approximately 1,800 people in our quota…I think that the minimum of the centre was about 6% of those women, which we have exceeded. I think we had reached 20%."* [Primary Care Nurse, Salamanca]

> *"We have annual targets and if we want to reach them, we sign an agreement. It is part of the budget [referring to the annual management plan]. If targets are met, some money is paid for productivity of the health centre. If there is funding coming from the Ministry, then there is a larger budget for training"* [Primary Care Doctor, Segovia]

In Spain it is mandatory for health professionals to report domestic violence to a judge. However, this is not done systematically, but on a case by case basis since mandatory reporting without protective measures can place a woman at greater risk of harm from the perpetrator.

Support for health professionals and lead roles

Interviewees were asked to describe support systems that were in place for health professionals dealing with domestic violence. Some referred to named health professionals, whilst others felt that support was obtained through coordinated efforts and referred to their networks with social workers, the police, shelters and other organisations. One respondent noted that health centres with access to a lead professional were more active in training and screening activities compared to those without.

> *"There has been no institutional support, but CFA has been a very important person. When we started planning the activities we were wondering who knew about domestic violence in Castile and Leόn and she was the perfect person. She has definitely been a great guidance for all of this."* [Head of Obstetrics & Gynaecology, Burgos]

> *"I sometimes refer [women] to the Centre for Equality because there are complex cases that I cannot deal with in my position. Some women have many other related issues. Domestic violence usually doesn't present isolated from other problems. I also refer them to social services if they can make use of them because of socioeconomic difficulties. There are also people with mental health related issues like depression."* [Primary Care Midwife, Valladolid]

> *"There is always a person that is responsible for domestic violence and other services in each region. But it certainly is noticeably beneficial when there is a person leading the activities who was not appointed as an obligation [referring to clinical champions]. It would be very good if there were more of these people. We have many [health] centres in our community and it is evident [in terms of implementing intervention activities] when one of the centres has a leader and another does not."* [Head of the Directorate for Social Health Care, Valladolid]

Interviewees were also able to access support through health professionals who had assumed informal lead roles for gender violence. These were usually health professionals who had attended additional training on gender violence and related topics. However, there was a recognised need for more formalised lead roles for domestic violence, as there are for other areas of the health services portfolio. It was suggested that lead professionals could be responsible for following up cases of domestic violence after the initial detection and providing feedback to the referring professional, as well as establishing links with all the relevant organisations in the province (health area) that can provide support. Lead professionals for gender violence supported colleagues around issues that arose in daily practice after the initial training. However, one of the difficulties with having informal leads was the gap they left when moving on to other jobs.

> *"I was the coordinator of activities. Coordinating? Almost everything, it's complicated. It implied keeping the people in motion. It was not just organising….Back then the most important matter was generating networks for intervening if a case of domestic violence was detected."* [Head of Obstetrics & Gynaecology, Burgos]

"There is a responsible person in the management. When we first became part of the group of trainers, there were only four of us. The first two people were a medical doctor, [X] and me. And now she [X] is responsible for domestic violence in the management…It's because she was working for the management already and she was a trainer so she became responsible. She deals with specific problems, if there is any problem with the protocol or if there is any doubt of how to act, then they call her. If they can't communicate with her, they call us instead." [Primary Care Nurse, Salamanca]

"[I do] almost everything…keeping people in motion. It was not just organising. Back then the most important matter was generating networks for intervening if a case of domestic violence was detected. There was a system available in the private sector, but we wanted to be able to provide care for domestic violence victims in primary care, mental health services and with the help of social works. I have previous training in related social and health areas. I was trained in sexology and was working as part of these services and the different areas started to get intermixed. So I started having a personal motivation to initiate the activities for domestic violence…I left [to start a new job] seven months after we were approved and now people don't do it because I was the kind of person to address these concerns" [Head of Obstetrics & Gynaecology, Burgos]

"There is a midwife that volunteers in an association that works on gender violence, but more than being a leader, she just keeps us informed about the activities they have. So she doesn't have a formal lead role. [Having a lead role] at health centre level, I think it is not necessary. I think this role would be more useful at a higher level. Because we have many groups but they are a bit uncoordinated. It would be very useful to have someone doing a long-term follow-up of the women that were referred." [Primary Care Midwife, Valladolid]

Sustainability of domestic violence training

In Castile and León, training of health professionals has been sustained through the implementation of a "train the trainer" programme. For primary care, domestic violence training is mandatory (in practice), but its level of development has not been the same in all the provinces. Training is made available during working hours to ensure maximum attendance by health professionals. The basic training is 10 to 20 hours, which is organised into a 6-hour introductory session, then additional 2-hour clinical sessions in the health centres to allow professionals to accumulate the 10-20 hours necessary. The Ministry recommends that basic training should be 10-20 hours. However each autonomous community adapts the training to their own needs and situation. Financial support from Central Government was given to all 17 autonomous communities for implementation of training programmes. However, once an intervention is successfully implemented, then the autonomous community absorbs the costs. As reported in the annual Gender Violence reports, the implementation of training has been most successful in primary care health. As part of the training plan in Castile and León, a pool of 35 trainers was set up and distributed in the different areas. A smaller team that supported the trainers and also dealt with complex disclosures of domestic violence was also created. As a rule, the trainers are usually

health professionals who volunteer to become trainers within their own autonomous community, although their attendance at the course is subsidised. Training activities are monitored in all the autonomous communities, for example, in terms of the types of training and the number of hours, and health care level in which training has taken place (e.g. primary care, specialised care, emergency care).

> *"I have attended training and I also give training at the Midwives Teaching Centre where I teach anthropology. Because gender is a subject that is included in the syllabus and gender is basically the origins of the violence. I can actually talk to them about the origins of gender violence and the cultural issues associated with it."* [Primary Care Midwife, Valladolid]

> *"They [health professionals] have done the basic and advanced training, they're motivated with it and people who have trained them already know that they have good communication skills and all that, so they propose the train the trainer course to them. Then after that, each community has a pool of trainers and they only train within their community."* [Programme Coordinator, Observatory of Women's Health]

> *"I asked [for training]. We were chosen to receive training and I attended. Now we provide training to all the centres. So the group of trainers has been going to all the centres after the management made domestic violence training mandatory."* [Primary Care Nurse, Salamanca]

Positive aspects of domestic violence training

All of the health professionals interviewed were also involved in coordinating or delivering domestic violence training. When asked to describe the most useful aspects of the basic training, some mentioned the practical parts of the workshop involving questioning approaches or dealing with difficult scenarios. Others had an interest in the theoretical underpinnings of domestic violence such as masculinities and gender or the health consequences of domestic violence.

> *"The workshops have been the most useful part, especially those with practical information. The part on awareness was only the first phase and maybe the midwives are already sensitised to domestic violence so there's no need to focus on raising awareness in this specific group. So it was the workshops when all the doubts on how to deal with specific situations could be answered."* [Head of Obstetrics & Gynaecology, Burgos]

> *"For me [the best part of the training] was about how to ask the questions. That was the most important thing because the referrals are very easy to do. Because domestic violence is such a complex and difficult problem, it's not detecting but how to communicate with them, approach them."* [Primary Care Midwife, Valladolid]

> *"First of all increasing my awareness because I didn't really know about the extent of the problem. I didn't have any idea of what the women were dealing with and what could be causing it. And we tended to blame them because they refused to get out of*

that situation. That was the part I had more clarification about. And then of course the different interventions for domestic violence." [Primary Care Nurse, Salamanca]

The future of interventions in health care settings

There was the recognition that health professionals cannot deal with domestic violence in isolation and that early intervention and prevention efforts are needed to compliment services for victims. Furthermore, it was felt that there was still much more work to be done in terms of changing the way health professionals view domestic violence. As long as it is regarded as a social problem that is difficult to deal with in clinical practice, instead of the potential cause of symptoms that women present with, detection rates will remain low.

"There is still a great need to change the way of thinking of the health professionals, both males and females. When the way of thinking changes and domestic violence becomes one of the differential diagnoses, then a woman victim of domestic violence who attends the health centre complaining about a headache will be detected." [Family Doctor, Segovia]

"If there is no parallel intervention in society, for example, schools educating about gender inequalities, no matter how many women we try to detect, there will still be many others suffering from years of abuse. Some of them will lose the opportunity for complete recover." [Family Doctor, Segovia]

"I think we should focus on prevention, not only with campaigns on equality, but with a wider spectrum of interventions. I've been identifying more and more negative stereotypes amongst young people. We should definitely start intervening with teenagers. Another group that should be targeted are young girls from immigrant families." [Primary Care Midwife, Valladolid]

Key learning points

- Addressing gender violence within the health care system is legal regulation in Spain according to the Organic Law 1/2004 on Comprehensive Protection Measures against Gender Violence.

- During the sensitisation phase, Intervention activities such as domestic violence awareness training targeted managers within the health care administration and were sponsored by the Ministry of Health, Social Policy and Equality. This ensured that there was acceptance within the health care system at a senior and strategic level.

- Commitment and institutional support for gender violence initiatives in the health care system comes from the State and the autonomous governments. However, clinical champions, usually motivated health professionals who attended train the trainer courses, assumed formal and informal lead roles. This bilateral top-down and bottom-up approach has been crucial to sustaining the intervention. It also helps to ensure that key messages about the important role of health professionals in addressing domestic violence permeate the organisation at all levels.

- Domestic violence training has been sustained through 'train the trainer' initiatives, which means that each autonomous community has its own pool of trainers. Trainers are usually health professionals from the autonomous community who have undertaken additional training and have an interest in gender violence and teaching. In some autonomous communities domestic violence training is mandatory in primary care settings. There is also participation in the training by non-health professionals.

- Professional leads for domestic violence are needed to ensure that health professionals are fully engaged in intervention activities such as training and screening for domestic violence. They are a key source of support following the initial training, for example, to provide advice with complex cases of domestic violence. Furthermore, they are able to establish links with organisations in the local community that may be involved in assisting with cases of domestic violence.

- Targets for domestic violence screening exist in health centres in some autonomous communities and are linked to financial incentives from their managements.

- Spain has implemented a fairly rigorous system for monitoring indicators of gender violence and training activities. Each autonomous community has its own health care information system. Disclosures of gender violence, including domestic violence are entered into the patient's medical history. Each year health centres are required to send their data to the Women's Health Observatory (an office at the Ministry of Health) which is published in the Gender Violence Reports.

Study 5: Germany

Description of the health sector in Germany

The German health care system is decentralised with private practice physicians providing ambulatory care and independent, mainly non-profit hospitals providing the majority of inpatient care. In Germany, about 90% of the population is covered by a Statutory Health Insurance (SHI) plan which is compulsory for people earning up to around €48,000 per year. The remaining 10%, who are high income workers, are not required to be covered. However, they may remain in the publicly-financed scheme if they wish and they can purchase private insurance, or they can be uninsured. The SHI scheme is operated by over 1,000 public or private sickness funds. The SHI package includes: preventive services; mental health care; dental care; prescription drugs; medical aids; rehabilitation; and sick leave compensation. Long-term care is covered by a separate insurance scheme which has been mandatory for the whole population since 1995. The SHI is financed through the contribution of employers and the insured. The contribution depends on the employees' income. The generally applicable contribution rate for SHI is 15%, with the employer paying 7% and the employee paying 8% (Busse & Riesberg, 2004).

Primary and secondary ambulatory care

Ambulatory health care is mainly provided by for-profit providers, including physicians, dentists, pharmacists, physiotherapists, speech and language therapists, occupational therapists, podologists and technical professionals. Acute care and long term care are commonly provided by non-profit or for-profit providers employing nurses, assistant nurses, elderly caretakers, social workers and administrative staff. In Germany, family physicians are not gatekeepers. Patients are free to choose physicians, psychotherapists, dentists, pharmacists and nursing care providers. They may also choose other health professionals, although access to reimbursed care is available only with a referral from a physician. In 2003 there were 304,100 active physicians in Germany, of which 132,400 worked in ambulatory care. Of these, a minority of 6,600 practised only for private patients, whilst 117,600 worked as SHI-affiliated physicians and 8,200 as salaried physicians. The majority of physicians in Germany have single handed practices and only 25% share a practice. The practice premises, equipment and personnel are financed by the physicians. Single practices are the dominant form of ambulatory physician care in Germany. Ambulatory physicians working in single handed practices offer almost all medical specialities, for example, psychiatry, neurology, paediatrics, gynaecology, obstetrics and so on. However, poly-clinic type ambulatory care centres with employed physicians have been allowed since 2004 (Busse & Riesberg, 2004). Since the beginning of 2010 1,454 ambulatory care centres have been established with 8,610 physicians.

Maternity care

When pregnancy is suspected women visit a gynaecologist. She can also go to a midwife. All pregnant women are given a mother's passport (*Mutterpass*). The *Mutterpass* records the immediate details of the pregnancy, birth and the mother's health. Almost all prenatal examinations can be done by midwives or doctors. The only exception is the ultrasound examination which must be done by a gynaecologist. Every pregnant woman is entitled to

ten or more antenatal examinations on recommendation by the gynaecologist. These are reimbursed by the health insurance companies. Under the terms of German health insurance twelve advice sessions with a midwife (*Hebamme*) are paid for during pregnancy as well as the costs of aftercare for up to eight weeks following the birth. Daily visits by a midwife until the baby is ten days old are also covered.

Secondary and tertiary hospital care

In Germany hospitals provide in-patient and outpatient care. Hospitals are mainly non-profit and both public and private. Patients have free choice of hospitals if they are referred for inpatient care. Hospitals are mainly staffed by salaried doctors. Senior doctors may also treat privately-insured patients on a free-for-service basis. Doctors in hospitals are generally not allowed to treat outpatients, although there are exceptions, for example if the necessary care cannot be provided on an outpatient basis by specialists in private practice. Since 2004, hospitals can also provide some highly specialised services on an outpatient basis.

The population of Germany according to 2011 statistics is 81,768,000.

Further information about health care in Germany can be found at (Accessed 18th August 2011):

http://en.wikipedia.org/wiki/Health_in_Germany

http://berlin.angloinfo.com/countries/germany/birth.asp

http://ec.europa.eu/youreurope/citizens/health/index_en.htm

Further information about the population of Germany can be found at: (Accessed 30th January 2012)

http://en.wikipedia.org/wiki/List_of_countries_by_population

References

Busse R, Riesberg A. (2004) *Health care systems in transition: Germany*. Copenhagen, WHO Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies, vol 6(9) (Accessed 18th August 2011).
http://www.euro.who.int/__data/assets/pdf_file/0018/80703/E85472.pdf

Domestic violence policy context in Germany

In Germany, the First Action Plan to Combat Violence Against Women was managed by the Federal Ministry for Family Affairs, Senior Citizens, Women and Youth 1999 to 2006). Two expert steering committees were established on trafficking of women and domestic violence which consisting of representatives of the Lander (16 Federal States of Germany), communities, non-governmental organisations and members of the responsible ministries. All measures announced 1999 were implemented by September 2004. It is within this document that the need to improve the response of health care services to abused women is mentioned. The Action Plan also mentions the Berlin pilot project, S.I.G.N.A.L, which explored the prevalence and health effects of domestic violence in women attending the accident and emergency department at Charité University Hospital (Federal Ministry for Family Affairs, Senior Citizens, Women and Youth, 1999).

In 2000, the European Women's Health Network (EWHNET) published a women's health report for Germany. This seminal report funded by the Ministry for Family and Women's Affairs, was the first to highlight the adverse health consequences of violence for women and girls (Wieners & Hellbernd, 2000). It also described a pilot domestic violence training intervention for health professionals called S.I.G.N.A.L which was based in the accident and emergency department at Benjamin Franklin University Hospital (now Charité Hospital) in Berlin.

The German Ministry for Family, Senior Citizens, Women and Youth financed the Federal Coordination Women's Health (BKF) from 2002 and 2005 for health professionals and advocacy experts to elaborate strategies for better health care for victimized women. Following on from this, German federal countries developed their own action plans and alliances against domestic violence. Regional coordination was performed by different professional groups with the aim to involve the health care sector (Hellbernd & Brzank, 2008).

In September 2007, the Federal Government published the second Action Plan II to Combat Violence Against Women containing more than 130 measures to be financed from the Federal budget. The second Action Plan specifically mentions *"activating the health care field, mainly the medical profession, for the protection of affected women"* and lowering the threshold so that women have easy access to support systems. It also includes measures to address the needs of migrant women and disable women who are victims of violence (Federal Ministry for Family Affairs, Senior Citizens, Women and Youth, 2007).

There are now numerous guidelines and recommendations for dealing with domestic violence published between 2002 and 2008 by medical associations and ministries in nearly all federal states in Germany. In 2008, the Robert Koch Institute (which is a central Federal institution responsible for disease control and prevention) published "*Violence and Health Consequences: With Special Consideration of Domestic Violence Against Women*" which includes best practice recommendations (Hornberg et al, 2008). In 2010, the German Association of Obstetricians and Gynaecologists (DGGG) published guidelines and recommendations for responding to domestic violence. (www.dggg.de)

A "*Nationales Zentrum Frühe Hilfen*" (National Centre for Prevention of Neglect and Maltreatment in Early Childhood) was founded 2006 as a result of violent attacks against newborn and young children in the Federal Republic of Germany (http://www.fruehehilfen.de). Support and assistance is available for children up to 3 years and parents who are in difficult situations, and domestic violence is considered a risk factor. In 2010, a multi-professional conference "Domestic violence and early childhood" was organised by the Centre (NZFH) and further information can be found at: http://www.fruehehilfen.de/wissen/materialien/publikationen/publikation/titel/fruehe-hilfen-bei-haeuslicher-gewalt/

There is also a multi-professional network for violence during pregnancy which is a collaboration between a women's counselling centre, a group of gynaecologists, a midwife, a lawyer, a practitioner in psychotherapeutic medicine and a planned parenthood organisation which advises women during pregnancy and after birth, as well as women who are considering an abortion or who have problems with a past abortion. The network offer support to women in the Cologne area and also organise education and awareness programmes. Further information is available at: http://www.schwanger-und-gewalt.de/netzwerk.html

References

Federal Ministry for Family Affairs, Senior Citizens, Women and Youth (1999) *Action plan of the Federal Government to combat violence against women* (Accessed 18th August 2011). http://webapps01.un.org/vawdatabase/searchDetail.action?measureId=22046&baseHREF=country&baseHREFId=549

Federal Ministry for Family Affairs, Senior Citizens, Women and Youth (2007) *Second Action plan of the Federal Government to combat violence against women*. (Accessed 18th August 2011).
http://webapps01.un.org/vawdatabase/searchDetail.action?measureId=22053&baseHREF=country&baseHREFId=549

Hellbernd H, Brzank P. (2008) Domestic violence against women: Health care needs and the S.I.G.N.A.L Intervention Programme. European Women's Health Network (EWHNET) documentation of the 2008 conference. In: (eds) Lasch V, Sonntag U, Mascewsky-Schnieder U. *Equity in access to health promotion, treatment and care for all European Women*. Kassel University Press, pp.119-140. (Accessed 18th August 2011).
http://www.uni-kassel.de/upress/online/frei/978-3-89958-740-1.volltext.frei.pdf

Hornberg C, Schröttle M, Bohne S, Khelaifat N, Pauli A. (2008) Violence and health consequences: with special consideration of domestic violence against women. Robert Koch Institute, Berlin, Germany. (Accessed 18th August 2011).
http://www.rki.de/cln_151/nn_216470/EN/Content/Health__Reporting/GBEDownloadsT/gewalt,templateId=raw,property=publicationFile.pdf/gewalt.pdf

Results from German mapping survey

Dissemination
The mapping survey was disseminated by the German partner (Hilde Hellbernd) to one person in 4 established domestic violence intervention projects that target primary and/or maternity care settings in Germany: SIGNAL e.V.; Gesine; Attenion, Recognition, Action; and MIGG. There is no central system in Germany for collating information on domestic violence interventions based in health care settings. The German partner contacted known individuals currently working in health based (primary and/or maternity care) domestic violence interventions. However, it should be acknowledged that other domestic violence interventions may exist in Germany that were not captured by the survey.

Respondents
All 4 respondents completed the survey. It was possible for respondents to select multiple answers for some questions. Of these, 2 surveys were from medical doctors, 1 from a health scientist/ project coordinator, and 1 from a social education worker.

Intervention settings
Respondents reported that the interventions targeted multiple health care settings including: primary care (4); maternity services (3); private obstetric care (1); private care (1); multi-health sector initiatives that include primary or maternity care (2); and addictions services and family planning centres (1).

Health professionals targeted in the interventions included: general practitioners (4); midwives (2); nurses (2); gynaecologists or obstetricians (4); social workers (1); physiotherapists (1); specialist doctors in other fields e.g. paediatricians, orthopaedics etc (1). The following table provides more detail on each intervention.

All 4 respondents indicated that female patients were the target population for the interventions and 2 respondents also mentioned male patients.

Table 5.1 Coordination, funding and location of domestic violence interventions in Germany

Name of intervention and length of time since inception	Professionals targeted in the intervention	Coordinating organisation	Geographical location	Funder
Gesine (7 years)	General practitioners; midwives; nurses; gynaecologists; social workers; orthopaedic doctors; dentists; paediatricians; health insurance personnel	Gesine, non-governmental organisation	Ennepe-Ruhr-Kreis in North Rhein Westphalia	Ashoka (donations); contributions from the State; local council; and from North Rhein Westphalia State sporadically.
SIGNAL e.V./MIGG (SIGNAL e.V. 11 years/MIGG 3 years)	General practitioners; gynaecologists	SIGNAL e.V. a non-governmental organisation	Berlin	MIGG Funding 3 years: Federal Ministry for Family Affairs, Senior Citizens, Women and Youth (FMFSWY). Funding of association SIGNAL e.V. since 2010: Berlin Senate of Health
Attention, Recognition, Action (3 years)	General practitioners; midwives; nurses; gynaecologists; social workers; physiotherapists	University Medical Centre	Dresden	Saxony State Ministry for Social and Consumer Protection.
MIGG (3 years)	General practitioners; gynaecologists	Federal Ministry for Family Affairs, Senior Citizens, Women and Youth (FMFSWY) and Institute for Forensic Medicine at the University Clinic Dusseldorf	Dusseldorf, Kiel, Munich	MIGG Funding 3 years: Federal Ministry for Family, Senior Citizens, Women and Youth and the Medical Centre's own resources.

Notes: SIGNAL e.V. association is a non-profit organisation with staff from health care, women's shelters, counselling and public health research. It offers training on domestic violence for health care professionals, advice to managers on implementation of interventions and resource materials.
MIGG Medical Intervention Project Against Violence (coordinated by SIGNAL e.V., GESINE and the Institute of Forensic Medicine at University Hospital Dusseldorf).

Policies on domestic violence

Of the 4 respondents, all reported that they had a policy developed specifically for the intervention and 1 had a policy based on the 'national guidelines'. In addition SIGNAL e.V. have their own operating guidelines and MIGG modified existing international guidelines on best practice. In Germany there are no national guidelines for responding to domestic violence within the health care system, but there are recommendations in each of the 16 Federal States which correspond with international guidelines and intervention standards. Furthermore, the guidelines are not compulsory in nature.

Within the policy, all but one intervention (MIGG) recommended routine enquiry for domestic violence. All respondents reported that the guidelines provided guidance on: documentation of domestic violence; how to refer patients who disclose domestic violence how to assess the safety of the patient and any children or vulnerable adults who may be affected by domestic violence; and confidentiality and information sharing.

Domestic violence training

All 4 respondents reported that the intervention involved domestic violence training for health professionals. Health professionals targeted for training include: nurses (2); doctors (4); midwives (2); psychologists/counsellors (3); gynaecologists or obstetricians (3); social workers (1); and reception, clerical workers or practice assistants (4). Two respondents (Action, Attention, Recognition and MIGG in Dusseldorf, Kiel and Munich) reported that domestic violence training was not mandatory for any staff. Two respondents said that training was provided by a domestic violence trainer from outside the healthcare setting who is not a health professional, and 3 by a health care professional. All the interventions, with the exception of Gesine, offer 'train the trainer' courses.

Table 5.2 Frequency and length of domestic violence training in Germany

Intervention name and geographical location	Professionals targeted in the intervention	Frequency of training	Length of training
Gesine Ennepe-Ruhr-Kreis in North Rhein Westphalia	General practitioners; midwives; nurses; gynaecologists; social workers; orthopaedic doctors; dentists; paediatricians; health insurance personnel	20 times a year	Foundation training: 6 hours Documentation training: 2 hours Expansion module: 30 minutes to 4 hours
SIGNAL e.V./MIGG Berlin	General practitioners; gynaecologists	Basic training and further training modules offered every 3 months	Foundation training: 5 hours Supplementary training: 2 to 3 hours
Attention, Recognition, Action Dresden	General practitioners; midwives; nurses; gynaecologists; social workers; physiotherapists	Once a year	Basic training: 2 sessions of 3.5 hours in length Medical assistants get 1 session lasting 3 hours
MIGG Dusseldorf, Kiel, Munich	General practitioners; gynaecologists	1 to 2 doctors round tables every two weeks; specialist subject day for professional groups once a year.	Varies: from 20 minutes to 4 hours to 1 day. Doctors get less than nurses

All 4 respondents reported that the domestic violence training included: routine enquiry for domestic violence; how to document a disclosure of domestic violence; how to refer patients who disclose domestic violence; how to assess the safety of the patient; and how to deal with issues of confidentiality and information sharing.

Routine enquiry for domestic violence in the intervention

All 4 respondents said that the intervention includes routine enquiry for domestic violence of female and male patients. All the interventions with the exception of one (Attention, Recognition, Action) reported monitoring of routine enquiry using standardised documentation forms.

Table 5.3 Approach to the identification of domestic violence within interventions

Name of intervention	Approach to the identification of domestic violence
Gesine	Encourages routine enquiry of all women patients and provides examples of tools during training, but allows health professionals to develop their own approach
SIGNAL e.V./MIGG (Berlin)	Active approach to questioning patients using screening instruments such as HITS or HARK.
Attention, Recognition, Action	To respond to all patients.
MIGG (Dusseldorf, Kiel, Munich)	Training discussed use of screening instruments HARK and HITS and also presents the advantages and disadvantages of screening. However, approach to screening (e.g. specifying which consultations to ask etc) was overlooked.

Documentation of domestic violence

All the intervention projects developed their own documentation forms for disclosures of domestic violence. Within the interventions health professionals are advised to document the following:

Table 5.4 Documentation of domestic violence

Information documented	Yes (N)	No (N)	DK (N)
Whether or not the patient was asked about domestic violence	1	2	0
Whether or not the patient disclosed domestic violence	4	0	0
Name of the perpetrator	3	1	0
Relationship of the perpetrator to the patient	4	0	0
A description of the types of abuse experienced	4	0	0
A description of any recent incident of abuse	3	1	0
A description of the types and location of injuries	4	0	0
A body map picture indicating location of injuries	4	0	0
Whether referral information was offered to the patient	3	0	1
Whether the patient accepted the referral information	1	2	1
Indication of any action taken by the patient	2	1	1
Whether there are any children in the household	3	1	0
An assessment of the safety of the patient and any children	3	1	0

Referral pathways

All 4 respondents said that health professionals refer patients to specialist domestic violence organisations in the community and also to other health professionals. Three respondents said that patients are sometimes referred to the police; and 3 to mental health services. All respondents said that they gave referral information to the patient and 3 said that the health professional contacted the organisation on behalf of the patient.

Evaluation

Respondents were asked whether the intervention included a research component and to provide details of any reports or publications. Three respondents reported the inclusion of research.

Table 5.5 Evaluation of domestic violence interventions in Germany

Intervention name and geographical location	**Evaluation activity**
Gesine Ennepe-Ruhr-Kreis in North Rhein Westphalia	No formal evaluation or research conducted. Feedback from trained health professionals who attend network meetings and conferences is obtained through self-report surveys.
SIGNAL e.V./MIGG Berlin	MIGG includes a research component supported by the Society for Women and Gender Research. Further information can be found at: www.signal-intervention.de
Attention, Recognition, Action Dresden	Includes a research component. Article published in the Journal for Evidence, Training, Quality Health (JETQH) Epple et al. 2010
MIGG Dusseldorf, Kiel, Munich	Includes a research component, results will be available in 2012.

German case study: ‘SIGNAL e.V.’, ‘MIGG’, ‘GESINE’ and ‘Attention, Recognition, Action’

Historical context and previous research

Three of the domestic violence interventions described in the mapping survey were chosen for the case study interviews: SIGNAL e.V.; MIGG Berlin; Gesine Network; and Attention, Recognition, Action. MIGG is a collaborative project between two of the above organisations; SIGNAL e.V., Gesine and a third organisation, the Institute for Forensic Medicine University Dusseldorf. Due to their close collaboration on the MIGG intervention, the case study included SIGNAL e.V. and the Gesine Network. Attention, Recognition, Action was chosen for its unique approach to targeting both health professionals based in the mental health services of a University Hospital and also primary care doctors.

The association SIGNAL e.V.

SIGNAL e.V. is a non profit organisation founded in 2002. The organisation is an interdisciplinary cooperation project with staff and facilities drawn from health care, women’s shelter and counselling centres and public health research. It offers further training and lectures for employees in the health care field, advice and counselling for health care professionals and program managers on implementation of intervention programmes and creates supporting material. Further activities are public relations work, seminars at medical university and nursing schools and ‘train-the-trainer’ seminars as well as networking to improve the links between institutions involved in health care and women’s support and counselling centres. SIGNAL e.V. is responsible for providing the S.I.G.N.A.L intervention mentioned above as it was developed by a member of the association SIGNAL e.V. Since 2010 the organisation has received funding for a coordination team from the Berlin Senate for Health, Environment and Consumer Protection. The SIGNAL coordination team is active in the following areas: implementation and development of the intervention programmes in various health care settings; support for hospital programmes; promoting legal documentation of domestic violence; and introducing the topic of domestic violence and sexual violence in the education of health care professionals.

S.I.G.N.A.L Intervention

S.I.G.N.A.L was the first hospital based domestic violence intervention in Germany. S.I.G.N.A.L was developed in 1999 for the area of medical care and targeted health professionals in accident and emergency. The intervention was developed by a member of the association SIGNAL e.V. (Angelika May). The project was a collaborative partnership between staff at the Benjamin Franklin University Hospital, which is part of the Charité University Hospital and staff from women’s domestic violence shelter projects. The S.I.G.N.A.L intervention is a German acronym for the following steps:

- **S**prechen (speak to) the patient about violence and signal your willingness.
- **I**nterview (interview) the patient using specific simple questions.
- **G**ründlich (thoroughly) examine old and new injuries at various stages of healing that can be indications of domestic violence.

- **N**otieren (note down) and document all findings and statements that can be used as evidence in court.
- **A**bklären (clarify) the current need for protection.
- **L**eitfaden (brochures) should be offered to the victim containing emergency phone numbers and support services.

The intervention was implemented and evaluated between 2000 and 2003 and funded by the Federal Ministry for Family Affairs, Senior Citizens, Women and Youth and carried out by the Institute for Health Sciences at the Technical University in Berlin. It provided the first German data on the prevalence of domestic violence and health impacts in female patients attending the accident and emergency department.

A training programme was developed for various staff members in the hospital and guidelines for responding to patients affected by domestic violence were developed. Staff found the training helpful in raising their awareness of the issue and also having resources about local counselling programmes and shelters to which they could refer women. During the SIGNAL evaluation, a cross-sectional survey on the prevalence of domestic violence in women aged 18 to 60 attending accident and emergency was conducted in 2002. Of 806 women who completed the survey, 36.6% reported at least one episode of domestic violence after the age of 16 and 4.6% had experienced this in the past year. In addition, 1.5% of women came to accident and emergency for treatment of injuries caused by violence. Over half (57%) of women who had experienced at least one episode of domestic violence in their lifetime reported health consequences. Over two thirds (67%) of women said that they would discuss domestic violence with their doctor, but only 8% indicated that they had ever been asked about domestic violence by a health professionals. About 45% of the women who had experienced domestic violence said that they would have liked their doctor to ask them about violence. The study concluded that accident and emergency was an important first point of contact for women experiencing domestic violence to receive support and referral to community organisations. The report includes guidelines for health care staff and recommendations on implementing an intervention programme against domestic violence in accident and emergency departments (Hellbernd, Brzank, Wieners et al. 2004)

Gesine Network

Gesine network for health and intervention against domestic violence was founded in 2004 by Marion Steffens and others. Gesine was the first domestic violence intervention in Germany to target general practitioners beginning in the Ennepe-Ruhr Kreis district and was designed to be replicable in other regions. As GPs in Germany tend to work in single handed practices, it is difficult to establish a system based response to domestic violence. Gesine encourages GPs to become network members by providing them with the knowledge and tools to respond to patients experiencing domestic violence and connecting them to a reliable referral system. Gesine creates a link between local organisations that support women affected by domestic violence, such as shelters and counselling centres, and health care professionals. The network is based upon a set of expectations that members must adhere to including: signalling openness to the issue by displaying posters in waiting rooms and women’s toilets, attending training and a minimum number of meetings a year,

responding to patients without judgement and referring them to the relevant organisations for support. Gesine also provide documentation templates on how to legally document injuries caused by domestic violence. In return for adhering to the set of expectations, health professionals receive ongoing support from Gesine after the initial training programme. This is done on an individual level and through a series of annual conferences and bi-annual multi-professional meetings (quality circles) where complex cases can be discussed and further training undertaken. Furthermore, Gesine provide health professionals with the necessary materials including information leaflets and contact cards on domestic violence and sources of help for patients, guidelines and abuse documentation forms. The first Gesine network reaches approximately 200 health professionals a year through conferences and meetings. Frauen helfen Frauen is the primary support organisation in the region for women. Prior to the Gesine network, health professionals did not refer women to this organisation. However, after implementation of the network 20% of all referrals to Frauen helfen Frauen come from doctors.

MIGG

MIGG (Medical Intervention Against Violence) was a national pilot project funded by the Federal Ministry of Family, Senior Citizens, Women and Youth between 2008 and 2011 to improve health care for patients affected by domestic violence in primary care. The pilot project was implemented and tested in five regions in Germany, each with 20-25 medical practices consisting mainly of general practitioners and gynaecology surgeries. The project was coordinated by SIGNAL e.V. in Berlin, the Gesine network in Ennepe-Ruhr-Kreis and the Institute of Forensic Medicine at the University Hospital Dusseldorf with further locations in Munich and Kiel. The project was independently evaluated by the Institute for Women and Gender Research (GSF) in Frankfurt.

Domestic violence training was provided by SIGNAL e.V. the Gesine network and the Institute for Forensic Medicine in Dusseldorf. Nationwide, more than 125 physicians participated in the pilot project. Domestic violence training by SIGNAL e.V. comprised a basic module (5 hours), a module for legal documentation of injuries (3 hours) and subject specific modules dealing with issues such as disabilities (2-3 hours). In addition, reinforcement activities were put in place which consisted of quality circles (regular exchange with medical colleagues and case reviews) and an annual interdisciplinary conference. The intervention established links with women's shelters and counselling centres and the Institute of Forensic Medicine at Charité University Hospital. Patient information leaflets about domestic violence and training materials and tools for health professionals were developed for the intervention.

A snapshot patient survey on partner violence was implemented in 10 of the participating medical practices (3 GPs, 3 gynaecological surgeries and 3 GPs with a focus on addiction treatment) in Berlin. A quantitative and qualitative survey of physicians was completed by 19 doctors 12 to 18 months after training. The snapshot survey with 517 patients (70% women and 30% men) found a high level of violence for women between the ages of 18 and 65. More than half (56%) of the 269 female patients reported having experienced emotional, physical or sexual violence during their lifetime. The evaluation of the domestic violence training showed increased sensitivity and more confidence amongst physicians in

dealing with cases of domestic violence. Aspects of the training that were positively favoured by physicians include the interactive components using case studies, role play and the integration of the entire practice team in the training. The SIGNAL documentation form for injuries was welcomed by physicians as a method for legal documentation. Physicians also appreciated the materials produced for the project including the contact card with emergency numbers (Hellbernd, 2011). As a result of this pilot project, a training curriculum and a guide to implementing domestic violence intervention programmes will be published in 2012.

Attention, Recognition, Action

Attention, Recognition, Action is a domestic violence training intervention based in the Department of Psychotherapy and Psychosomatics at University Hospital Dresden. The training programme targets hospital doctors, nursing staff, midwives, and psychotherapists, in addition to, primary care doctors. The intervention created by a psychotherapist/psychiatrist who worked with ministers in the government of the region of Saxonia who formed a commission against domestic violence. The University Hospital Dresden and the Institute of Forensic Medicine were funded by the Saxony State Ministry for Social and Consumer Protection to develop domestic violence guidelines for doctors and implement training.

Prior to training a baseline survey was sent to health professionals working in outpatient clinical settings in Dresden and Chemnitz and inpatients departments of the Medical University of Dresden in Saxony. 1,072 (23%) of 4,886 surveys were returned. This survey found that 70% of doctors reported that they did not know about the medical guidelines for victims of domestic violence and 91% of all participants were reported that they did not know the main advisory centre for victims. Overall, 84% said that they would participate in training. After the baseline survey, 913 health professionals attended a multi-professional training programme which lasted 30 to 60 minutes. Eighteen months after the baseline survey, a re-assessment survey was administered. This was sent to doctors, nursing staff, midwives and psychotherapists in Dresden and a comparable city without a training programme. In total, 781 (16%) returned the survey. Amongst the 129 training participants who answered the second survey, 94% said that they were satisfied with the training and 84% said that they could apply what they learned in clinical practice. Training participants had significantly more contact with domestic violence victims compared with non-trained health professionals. Overall, the training appeared to improve knowledge and awareness of the issue. However, only 38% reported using the medical guidelines and 30% reported using the documentation form.

References

Hellbernd H, Brzank P, Wieners K, Maschewsky-Schneider U. (2004) *Domestic violence against women: health care. The S.I.G.N.A.L Intervention Project*. Evaluation Fact Sheet. (Accessed on 18th August 2011):
http://www.signal-intervention.de/download/SIGNAL_fact%20sheet%20engl..pdf

Hellbernd H. (2011) *Medical Intervention Against Violence (MIGG)*. Presentation at: Interventions on Intimate Partner Violence in Primary Care, May 2011, Radboud University Nijmegen Medical Centre, Women's Studies Medical Science, Holland.

Epple F, Croy I, Schellong J. (2011) Domestic violence in patients – underestimated by medical staff. Self-report data from medical staff of outpatient clinical setting in Dresden and Chemnitz and of the inpatient departments of the Medical University of Dresden in Saxony, Germany. *Z. Evid. Fortbild. Qual. Gesundh. wesen* (ZEFQ) 105: 452–458.

Findings from the qualitative interviews

Sample

The Daphne partner (Hilde Hellbernd) selected different types of health professionals working in single handed practices (primary care) and hospitals (maternity and mental health) who were involved in well established domestic violence interventions. The interviews explored participants' experiences of implementing the intervention, factors that supported the success of the intervention, challenges encountered (particularly in relation to sustainability issues) and solutions tested. A decision was made to include both SIGNAL e.V. and the Gesine network in the German case study, as both organisations worked collaboratively in setting up and delivering the MIGG intervention. The intervention Attention, Recognition, Action was included although it was based in the mental health services of a hospital because it also targeted doctors in primary care for domestic violence training. Nine in-person interviews were conducted with the following individuals:

- Coordinator/Social Education Worker (Social Pedagogue) for the Gesine Network in Ennepe-Ruhr County (7 years at Gesine, but working in the field of domestic violence for 25 years). Ennepe-Ruhr County is a small rural town in Western Germany. Gesine network for health and intervention against domestic violence is a non-governmental organisation that was founded in 2004. Gesine develops and delivers domestic violence training programmes for health professionals; provides a range of materials on domestic violence including leaflets, documentation forms and guidelines; offers ongoing support after training by hosting meetings bi-annually and conferences annually for health professionals to discuss cases of domestic violence; and creates a link between local organisations that support victims of domestic violence and health care professionals; and creation of a women's support centre that offers a counselling service.

- Coordinator/social scientist also working for the Gesine Network in Schwelm (7 years at Gesine, but 20 years working in the field of domestic violence.

- A general practitioner (5 years in practice) working in a single practice in Köpenick and was involved in the MIGG intervention.

- A general practitioner/psychotherapist (40 years in practice) working in a single practice in Berlin, Schöneberg who was involved In the SIGNAL e.V. intervention (3 years). Trained as a psychotherapist and specialising in psychotherapy for the addictions and psychosexual issues.

- A gynaecologist (15 years in practice) working in a single practice in Berlin and involved in the MIGG intervention (3 years).

- Joint interview with two nurses (in practice for 32 and 39 years respectively) at Charité Hospital, the largest university hospital in Germany and Europe. Both nurses have been coordinators for 3 years in the SIGNAL domestic violence intervention which was implemented at the hospital in 2005.

- A psychiatrist/psychotherapist (24 years in practice) based at a Clinic and Polyclinic for Psychotherapy and Psychosomatics at a University Medical Centre in Dresden. Attention, Recognition, Action is a domestic violence training intervention that was implemented at the clinic in 2008.

- The Coordinator of SIGNAL e.V. (1 year) and Coordinator of SIGNAL/MIGG (3 years). However the coordinator has been a member of the association SIGNAL e.V. since 2002. SIGNAL e.V. is a non-governmental organisation founded in 2002 currently funded since 2010 by the Senate for Health, Environment and Consumer Protection. SIGNAL develops and delivers intervention programmes in health care settings for nursing and medical staff. This includes training, materials for intervention and prevention, and special events.

Approaches to identification of domestic violence

All of the interventions studied (SIGNAL, MIGG, Gesine, Attention, Recognition, Action) include routine enquiry for domestic violence in their training programmes and suggest tools and questions that health professionals can use in practice. Role plays were mentioned as methods used during training to give health professionals practice of asking direct questions. Although routinely asking all patients about domestic violence is encouraged during training, it is only mandatory for nurses at Charité University Hospital involved in the SIGNAL intervention. Interviewees described a process of finding their own comfort level with questioning approaches and trying to determine the best moment to ask. Role plays on routine enquiry alone may not provide health professionals with the confidence they need to initiate discussions about abuse. Training programmes should include basic communication and counselling skills for dealing with difficult subjects.

> *"No [I don't ask all new female patients about domestic violence]. When a new patient comes, I need to get to know them first before I ask this question. Then I would ask does your husband hit you? I ask them directly, I don't necessarily use the words domestic violence, it's a little abstract. So I ask the directly and use words like hit or beaten."* [General Practitioner/Psychotherapist, Schöneberg]

> *"So not all women are asked, some women just come straight out with it and say I have been beaten or they come in accompanied by the police and then you know. There are, of course, women who initially don't speak about it at all and you suspect something so you ask them, and at that point everyone has their own method. It was covered in the training how you should ask, but then you develop your own way. Everyone has their own personality and each approaches it differently. Some are always open and direct, still others try to come at it from a different angle. I don't know, it depends on the woman, it's difficult to say. How they behave, how they are"* [Nurse Coordinator, SIGNAL]

> *"The older patients directly speak about the illnesses of their husbands. The younger patients it is more difficult you have to ask them directly. We directly ask every new patient who comes to this GP practice if they had any experience of violence in relationships."* [General Practitioner, Köpenick]

"They can choose what fits them best. We do support routine enquiry, for example, during pregnancy and special situations. But they have to do in their own way because it wouldn't do any good if they would try to follow a questionnaire that is not their language or way of talking to people." [Coordinator, Gesine]

Routine enquiry for domestic violence in single handed practices managed by one GP or gynaecologist is difficult to sustain. Strategies for managing time constraints are likely to be common as the following quote suggests:

"I try to ask indirectly if they have any problems or stress within the family and with her husband to find out if there is some kind of violence. I think perhaps that's not enough, but I don't have more time to try. If I realise she doesn't want to talk about it I just say if you want to talk with me you can just come again or we can talk after office hours, but within office hours there's not a lot of time to talk about problems very deeply." [Gynaecologist, Berlin]

When discussing the challenges of dealing with domestic violence, many of the health professionals interviewed described their frustration at seeing the same women return with injuries or other complaints resulting from the violence, as well as the lack of time they have to discuss domestic violence. Gesine have developed a new concept for their domestic violence training which re-frames health professionals' primary motivation for asking about domestic violence.

"Well we have a method, but we start our first training in the autumn so we have to see how it works. We focus on the fact that this communication has a target and that this target is not to change the woman, but to motivate her to look at her situation. There is a special technique for how you can do it in ten minutes. So you can learn this type of technique, what do you start with and how do you focus on this topic and how to you end this conversation." [Coordinator, Gesine]

<u>Sustaining domestic violence training</u>

Since the majority of general practitioners and gynaecologists work in single handed practices, it is not cost effective to conduct domestic violence training in clinical settings. Instead doctors are invited to attend pre-arranged training sessions. SIGNAL e.V. intervention provides domestic violence training through the association SIGNAL e.V. which consists of a small pool of ten trainers from women's groups and other organisations (statutory and non-governmental). The trainers are paid directly by the health care services that request training. For this reason, it has been difficult to engage doctors in a two-day training session as they are more expensive to cover compared to nurses.

"Yes [training] is mandatory for nursing staff, but not for physicians because physicians are more expensive. They won't get paid to participate in a two-day training. They have to look for a substitution because other doctors have to cover their work if they participate. So a lot of extra hours and doctors are more expensive than nurses. We could convince the Director of the Board of Nursing, but the Medical

Board is more difficult to convince that it's very important" [Coordinator, SIGNAL/MIGG]

The MIGG project set up an advisory board which included women's groups and prosecutors, but also key supportive individuals from the associations of gynaecologists, family doctors, and forensic medicine who attended bi-annual meetings. This was an important step towards engaging more doctors in the training as a decision was made to put aside one hour for domestic violence in a mandatory training day for family physicians. Another outcome of the advisory board was the implementation of a quality circle (or peer group meeting) on domestic violence. Quality circle meetings are considered the best way to reach doctors for domestic violence training and particularly those in single handed practices. The meetings are a familiar method for doctors to discuss a range of topics including medical issues and use case studies or summarised data as the basis for discussion.

"There was just one [quality circle] on domestic violence. It is quite a challenge to continue though. We had a discussion after the end of MIGG and the medical association don't have the resources to do this and there should be some paid organisations or coordinators to try to organise this and this may be included in some of our tasks." [Coordinator, SIGNAL/MIGG]

The Gesine experience was similar in the sense that doctors were keen to attend quality circles on domestic violence, but they did not want to be responsible for organising or leading them as they felt that they lacked expertise. Train the trainer methods have been utilised in all the interventions in order to sustain training using health professionals from a range of disciplines. In addition, doctors obtain credits for attending domestic violence training, although currently no credit system exists for nurses. Gesine offer training on the weekend and evenings when doctors can attend in their own time, as they lose fees by attending during office hours.

"We are not doing the training by ourselves. We just do the basic training on the topic of domestic violence, networking and communications skills. And it's also certified of course. They are obliged to get 50 credit points a year and they get 8 credits for doing the domestic violence training. We have therapists, legal medicine, psychiatrists and so on doing domestic violence training on their own topics. So we work together and collaborate with different medical professions." [Coordinator, Gesine]

Health professionals were asked what parts of the domestic violence training they found most beneficial for clinical practice. Communication techniques with patients, recognising the indicators of domestic violence, understanding psychological violence and its impact, and opportunities for sharing experiences with other health professionals were commonly cited during interviews.

"We talked in small groups and it helped to find the right words to use to approach the subject." [General Practitioner, Schöneberg]

"I have to be honest they did a lot of role plays and personally I have a problem with them. What I found helpful were these recordings that they brought along." [referring to an audio tape about a case of a nurse that was killed by her partner] [Nurse Coordinator, SIGNAL]

"To see how other doctors work and how they cope with these patients and all these doctors have the same difficulty in asking. It's not so easy because you are fearful of the reaction which might come, but for every doctor it was the same. So it was quite interesting to see gynaecologists who are probably more involved with violence in relationships, how they react or how they get in contact with the patient." [General Practitioner, Köpenick]

Attention, Recognition, Action, an intervention based in the mental health services of the University Medical Centre in Dresden, took a pragmatic approach to training which lasted twenty minutes to four hours depending on what time clinicians had available. The psychiatrist/psychotherapist who developed the intervention made direct contact with clinic directors and offered to go and train in the clinics. When doctors were invited to attend training outside their clinic, very few attended. In addition, having a doctor make the initial approach and provide the training proved to be a successful strategy for gaining cooperation.

Support for health professionals

In Germany, the majority of general practitioners and speciality doctors work in solo practices. This makes it difficult to implement a systems change intervention that involves a top down approach to organisational change or having lead professionals to provide expertise and coordinate intervention activities. With regards to the MIGG and Gesine interventions which target general practitioners and gynaecologists in single handed practices, post training support is provided on an individual level by the organisations responsible for coordinating the interventions and through a series of multi-professional meetings during the year. In addition, local organisations that assist women and children affected by domestic violence attend meetings to provide an overview of what they do and network with health professionals. Health professionals bring individual cases to the conferences to discuss and they also receive ad hoc training. General practitioners and gynaecologists seem to benefit more from having opportunities to share actual cases of domestic violence they are dealing with. One gynaecologist interviewed said that the meetings were useful because it was reassuring to learn that other doctors encounter the same difficulties in asking patients about domestic violence and responding to disclosures.

"…We have two different kinds of meetings. First we have these doctor's conferences and we've got these network meetings. The medical doctor's conferences are more um, we have these case discussions. For example, about how often did they ask women [about domestic violence] and what did they think about it, and what are their expectations and stuff like that. And they always get a little training at these meetings. So we train them whenever we can get them" [Coordinator, Gesine Network]

"These network meetings, they are a bit more informal, a bit more on the activity of the participants. So it's really about networking. So that means in every session one person talks about their organisation and what they are doing on the topic of violence against women, so that others can get an idea of how they work and who they can refer women to." [Coordinator, Gesine Network]

"We have support with MIGG where we have this meeting with other GPs and gynaecologists who are also participating in the project and we've got some information material. But mostly in this meeting we speak about the patients, about the case reports which we share, which shows us how to cope or how to react in such a situation." [General Practitioner, MIGG]

"I think it would help if we had another [quality] circle with GPs to listen to their experiences. I think this is the most helpful thing….to stay in contact and get into the mindset of the problem." [General Practitioner, Köpenick]

Nurses working in emergency care and maternity at Charité Hospital involved in the SIGNAL e.V. intervention formed a working group that meet every three months to monitor progress on domestic violence training activities, documentation of injuries, discuss complex cases and ensure that domestic violence remains a priority issue. At Charité there are 13 nurse coordinators for domestic violence from departments across the hospital. There is support for the intervention from the Director of Nursing who attends a yearly meeting with nursing staff and the SIGNAL coordinators. Although nurses who join the working group are volunteers with an interest in the topic and attend in their free time, they are paid for the extra hours they work. SIGNAL nurse coordinators from Charité also participate in a task force coordinated by SIGNAL e.V. which includes all accident and emergency departments in Berlin which work with the SIGNAL intervention programme.

"We say whenever you have any questions ask SIGNAL. We can also supply them with another module of training if there is a need. We also have contact with the Director of Nursing once a year and all nursing, leading staff and doctors were invited to talk about their ideas." [Coordinator, SIGNAL/MIGG]

"We have this working group where we meet, all the different parts of the hospital in the different districts, there are three. So we meet every three months and everything is reviewed and organised, but there is also a bit of support at the time, when you talk about things, you feel you can unload them." [Nurse Coordinator, SIGNAL]

"This working group has grown so positively. Colleagues are more sensitive to [domestic violence] and they are more ready to go into this whole issue whereas they previously refused. Doctors are more away of it and are prepared to fill in these documentation forms. The more time that passes, the more support we have from above. For example, [the Director of Nursing] supported us from the beginning and said that if we wanted to be in the working group she was prepared to underwrite that as overtime. That is also important." [Nurse Coordinator, SIGNAL]

In the intervention called Attention, Recognition, Action which is based in the Department of Psychotherapy and Psychosomatics at University Hospital Dresden, domestic violence training is offered to doctors, nursing staff, midwives and psychotherapists. In this intervention the lead professional is a psychiatrist/psychotherapist who developed the guidelines, training programme and evaluation of the training. As recognised leads in the intervention, her team were available to respond to calls from health professionals were in need of advice about a domestic violence case. In addition, materials for responding to domestic violence were placed on line and in waiting rooms.

> *"We started an intranet so it was easy [for health professionals] to find the documents. Then we put our information material in places in the outpatient treatment and emergency rooms and we responded by telephone. With the training, the question was easier to ask I think. I think now they associated my name with domestic violence. It started as extra work, totally extra work, but because there were project assistants I can delegate, but it will be very difficult when the project ends [referring to end of funding]."* [Psychiatrist/psychotherapist, Attention, Recognition, Action]

Challenges and successes

Interviewees were asked to discuss the challenges and successes of the domestic violence interventions. The challenges described by health professionals relate mainly to their experiences of dealing with patients affected by domestic violence. Lack of time, the presence of partners or other family members, the reluctance of patients to accept help are just some of the issues mentioned.

> *"There are those who come and disclose and then disappear. They are not capable of accepting help. They feel ashamed, fearful, if they tell someone it will only get a lot worse, become marginalised. This is hard. They come but don't want to take the next step."* [General Practitioner, Schoenberg]

> *"The difficulties? Well the reaction of the patient. If you're asking them directly about violence in their relationship they are a bit upset, some of them."* [General Practitioner, Köpenick]

> *"It's difficult if the woman is not alone in our office, it's hard to talk about it if the husband is inside the waiting room or the grandmother or the mother-in-law, they don't want to talk about it. So I think that is the biggest problem I have. I try to send the husband out or the others who come, but if she doesn't speak German very well it's kind of difficult."* [Gynaecologist, Berlin]

> *"The majority of patients who come to us [in accident and emergency] we don't see again. So we have some patients who we have really supported or women for whom we have suggested going to a refuge and where we simply hope they take this advice and that they leave their husband. But there are many that just go back."* [Nurse Coordinator, SIGNAL]

"Partly you are angry, when you think God we're made such an effort! This is perhaps the third or fourth time here already, always the same women go back to the wife beater. On the other hand we have been taught, which always helps a bit, that there are women who put up with it year in and year out and then suddenly after ten years make break to leave their husband. When I hear something like that it renews my hope." [Nurse Coordinator, SIGNAL]

With regards to the coordinators of the interventions, the main challenges highlighted relate mainly to funding issues, lack of time and gaining the interest of doctors for training. SIGNAL e.V. is funded by the Senate on a year to year basis, whilst Gesine are funded by Ashoka (a charity), contributions from the State and local council, although the coordinators spend a great deal of their time in fund raising activities. Attention, Recognition, Action are funded until the end of 2011 and ongoing funding is unlikely unless they can formulate a new proposal that includes children.

"There should be continuing funding, because if we don't continue then everything will go. Because with these [post training] surveys we did, it was direct, there was a very high effect, with only one training. Even with half an hour training there was a big effect, but it will fade and you will have to do the course again. We have to change the topic to children as the partner in government has changed from the woman's officer to the children's officer. What we will do is put a lot of emphasis on children in the domestic violence project just to continue what we have done." [Psychiatrist/Psychotherapist, Attention, Recognition, Action]

With regards to the successes of the interventions, health professionals tended to focus on positive outcomes (or stepping stones) with individual women they had worked with, their increased confidence in asking about domestic violence, and developing networks with local organisations and other health professionals.

"More networking in the whole city. The doctors say to the patients you can go to that advisory centre and the women who work in the advisory centre say, we have some referrals from that doctor." [Psychiatrist/Psychotherapist, Attention, Recognition, Action]

"An important step is that they overcome the shame of explaining what is happening …to express themselves." [General Practitioner/Psychotherapists, Schoenberg]

The coordinators measured success in terms of the numbers of health professionals who received training or were still utilising network meetings, and increased referral rates to the women's counselling groups and shelters,

"Well the success is that there are so many activities. We have guidelines in every Federal State. We really have a lot of material, but I see there is still a lot of work to do. I think there are only 10 or maybe 20 hospitals in the whole of Germany that are really working intervention projects." [Coordinator, SIGNAL]

"For me success is that 80 people and organisations, so that would mean hundreds of people, took the topic of health consequences of domestic violence on board and acted on it. Success is that they are still coming to network meetings, they come to the annual conferences. That's success and then the referral rate rose to a very high level. Recently we got to know from our clients that they see a difference between an trained doctor and an untrained doctor [from a survey with female clients]. [Coordinator, Gesine]

Key learning points

- In Germany primary care is predominantly provided by general practitioners and speciality doctors working in single handed practices. Therefore, it is difficult to implement a system based approach to domestic violence interventions that involves organisational support from managers and peer support from other health professionals. The Gesine and MIGG experience demonstrate that the creation of networks can be successful in generating a supportive structure in which doctors can obtain training, materials such as leaflets and abuse documentation forms, as well as ongoing advice and support from the coordinating organisation and regular meetings with other health professionals to share experiences and gain peer support (e.g. quality circles and conference). Through network meetings doctors are able to establish links with women's refuges and counselling groups who also attend the meetings. However, within this approach, it is less likely that clinical leads with expertise on domestic violence will emerge and there is some dependence on the coordinating organisations to maintain the momentum of the intervention.

- The hospital based domestic violence interventions (SIGNAL and Attention, Recognition, Action) are underpinned by a system change approach. This involves engaging and gaining the cooperation of clinical directors to implement training, clinical guidelines and working groups. Within this approach it is possible to have clinical leads with expertise in domestic violence, who may also be responsible for coordinating activities in the clinical setting, for example, the working group of 13 nurse coordinators at Charité University Hospital involved in the SIGNAL intervention.

- Domestic violence training programmes should include a component on basic communication and counselling skills to provide health professionals with the confidence to approach patients. Role plays demonstrating routine enquiry may not be sufficient. Health professionals described a process of finding their own comfort level with questioning and determining the most appropriate moment to ask patients about domestic violence.

- In the interventions domestic violence training is accredited and doctors receive credits for attending. However, no such system is in place for nursing staff. Doctors are more expensive to train, in terms of finding cover for clinics, which has resulted in fewer doctors being able to attend.

- Domestic violence training activities need to be funded. This includes offering free training to GPs (as many work in single-handed practices) and offering financial incentives to GPs who require extra time when dealing with a patient affected by domestic violence and providing legal documentation. NGOs that design and deliver training programmes, produce supporting materials such as leaflets, abuse documentation forms for clinics, and post-training support, must be funded for their work.

- Although three of the four interventions in this case study included research, there is a need for ongoing and robust monitoring of intervention activities including attendance at training, rates of routine enquiry for domestic violence, referral to women's organisations, and documentation of injuries. This may be more challenging to achieve in primary care settings where GPs and speciality doctors work in solo practices. Ongoing monitoring requires a standardised approach and a responsible lead person to coordinate it.

Study 6: Belgium

Belgium is a Federal State with a parliamentary form of government. There are three levels of government – federal, regional and community. Regional and community parliament are also based on elections. There are three regions in Belgium: the French speaking Walloon region, the Dutch speaking Flemish region and the bi-lingual Brussels-Capital. The Federal State is responsible for health care, Justice and inner affairs (including police). The regions are responsible for territorial matters such as transport, housing and economic development and the environment. The three linguistic communities based on language and culture, are the Flemish, French and German communities. The French and Flemish communities share responsibility for Brussels. Each region and community has a government and a council which is a legislative body. These communities are responsible for policy areas such as education, social support and cultural affairs. After regions and communities, the country is further subdivided into ten provinces and over 589 local authorities. It is at this level at which the strategy for tackling violence (including domestic violence) has been coordinated since 1990 by provincial coordinators. Each province has a capital town where the provincial authorities are located.

Description of the health sector in Belgium

The Belgian health care system is underpinned by principles of equal access and freedom of choice with a compulsory health insurance which covers the whole population and has a broad benefits package. The Belgian health care system is organised on a federal, community and regional level. Health care policy is shared between the federal government and the Flemish, French and German speaking Ministries responsible for Health and Social Welfare. The federal government is responsible for regulating and financing the compulsory health insurance; determining accreditation criteria, financing hospitals; legislation covering professional qualifications; and registration of pharmaceuticals and their price control. The regional and community governments are responsible for education, health promotion, child health services; home care, some of the hospital accreditation standards and financing of some hospital investment (Corens, 2007)

Belgium's health care system has been based on a compulsory health insurance scheme since 1945. Premiums are fixed at different levels according to the social security sector, and are pooled in a common pot of funding from which they are distributed on the basis of need. In order to benefit, a person must join a health insurance fund for which an employer's certificate is required, as both employer and employee contribute to the cost. People are free to choose their own insurer. Insurance will not cover 100 per cent of medical bills and typical reimbursement is between half to three quarters. People who are not members of the health insurance scheme are covered by the public municipal welfare centres in each local municipality that can meet the costs of medical care (European Observatory on Health Care Systems, 2000). In Flanders, welfare provision (e.g. Centres for General Wellbeing CAW, childcare) and mental health care are also provided by institutions sponsored and recognised by the Flemish Ministry.

Primary and secondary ambulatory care

Primary health care can be defined as the first point of contact for an individual with the health care system. Delivery of health care in Belgium is mainly private and based on the principles of independent medical practice. Most doctors work as independent self employed health professionals. Medical specialists can work in hospitals and/or on an ambulatory basis in private practice. Most general practitioners (GPs) work in private practice. Independent medical practitioners are remunerated mainly via fee-for-service payment and patients are free to choose their own doctor as there is no obligatory referral system in Belgium (Corens, 2007). However, there are increasing contributions as incentives for accreditation and electronic records keeping in primary care. First line mental health care is provided in some practices, but direct access to community supported centres is available.

In Belgium patients can visit GPs or they can visit a specialist in the hospital or in a poly clinic. Many GPs operate in single handed practices, frequently without any staff except a medical secretary. However, there have been a growing number of integrated health care practices which operate with a multi-disciplinary team with a number of GPs, administrative reception staff, nurses, a physiotherapist and psychotherapist. Patients are free to choose a doctor to contact, can change their doctor at any time and can even see several doctors at a time (European Observatory on Health Care Systems, 2000).

Hospital care

In Belgium there are two types of hospital: general hospitals and psychiatric hospitals. General hospitals are further divided into acute hospitals, geriatric hospitals and specialist hospitals which deal with conditions such as palliative care, chronic diseases, and neurological disorders. Some general hospitals do provide psychiatric services, but on a short-term basis. People can choose which hospital they attend and hospitals are obliged to accept all patients. There is no referral system from primary care, although it is usually the general practitioner or specialist doctor who decides to send the patient to a hospital (European Observatory on Health Care Systems, 2000).

Maternity care

Maternity care can vary in Belgium, but in the first instance a woman will visit her general practitioner. In the Flemish community the GP will play a more or less active role in antenatal care, while women mainly choose to be assisted by a gynaecologist or obstetrician in private practice. In the French community, antenatal care is predominantly provided by a gynaecologist or obstetrician working in the private or public sector. Women without health insurance are entitled to maternity care and payment comes from the Public Social Welfare Centre (CPAS/OMCW), of which there is one in every municipality. Midwives are located mainly in hospitals, linked to maternity care units. However, in the Flemish Community some centres for midwifery work in close collaboration with general practice. Some multidisciplinary group practices in primary care involve a midwife, but in general this is rare.

In the Flemish Community, Child and Family (Kind en Gezin or K&G) an independent agency under the responsibility of the Flemish Minister of Public Health is responsible for the organisation of preventive health care for children. Nursing and medical staff provide free

vaccinations and examine the child. In the French community, the Birth and Childhood Organisation Office (Office de la Naissance et de l'Enfance or ONE) which is under the responsibility of the Ministry of Culture and Social Affairs of the French Community, provides antenatal services and care for children up to the age of six (Corens, 2007)

The population in Belgium based on 2010 statistics is 10,839,905.

Further information about the population in Belgium can be found at (Accessed 30th January 2012):
http://en.wikipedia.org/wiki/List_of_countries_by_population

References

Corens D. (2007) Health system review: Belgium. *Health Systems in Transition*, 9(2): 1-172. (Accessed 18th August 2011).
http://www.euro.who.int/__data/assets/pdf_file/0007/96442/E90059.pdf

European Observatory on Health Care Systems (2000) *Health care systems in transition: Belgium*. (Accessed 18th August 2011).
http://www.euro.who.int/__data/assets/pdf_file/0003/75126/E71203.pdf

Domestic violence policy context in Belgium

There have been three national action plans to combat violence against women in Belgium. The National Action Plan to combat violence against women was created to coordinate policies on violence between the different ministries and levels of society involved in regulation and action. The 2001 to 2003 action plan included domestic violence, sexual violence, violence and work and human trafficking. Following on from this the 2004 to 2007 national action plan focussed only on partner violence. The federal government made a decision to include all forms of gender violence in the 2008 to 2009 national action plan. The current national action plan (2010 to 2014) contains specific objectives and operational plans involving the health care system under objective 3: "*Prevent and Detect Partner Violence*". This includes developing initial training and professional development for professionals working in the fields of prevention, education and health and social care sectors in order to enable them to identify domestic violence and respond appropriately. Advanced courses were organised for key hospital staff who already attended the basic training provided in 2009 and 18 hospitals were targeted for awareness raising training in 2010.

In the Flemish Community pathways and protocols have been developed for mental health in collaboration with social services under coordination in districts of the provinces. Such protocols have also been developed on the Flemish side in 2005 and form the basis of training initiatives in primary care coordinated between the Flemish College of General Practitioners and the French. In preparation for this, primary care guidelines were developed for domestic violence and are further being prepared for child abuse and elderly abuse.

Between 2010 and 2012 in the French community there are plans to map and describe current training initiatives and implement training for teachers/specialist teachers, professionals from the centres of Psycho-Medico, nurses, social workers, psychologists, and early childhood professionals to equip them with the skills to identify domestic violence and intervene appropriately.

The National Action Plan to Combat Intimate Partner Violence and Other Forms of Domestic Violence 2010 – 2014 (Accessed 18th August 2011).
http://igvm-iefh.belgium.be/nl/binaries/NAP_Engels_tcm336-133536.pdf

Currently there are no specific official multidisciplinary Flemish or French guidelines on intimate partner violence for social care, mental care and the health sector. However, there is a general practice recommendation which was developed by Domus Medica (Accessed 18th August 2011).
http://www.domusmedica.be/kwaliteit/aanbevelingen/overzicht/partnergeweld.html

In Belgium, most of the published research on domestic violence interventions and health is in Dutch or French.

Results from Belgium mapping survey

Dissemination

The mapping survey was disseminated by the Belgium partners, Leo Pas and Ester Cornelis from Domus Medica, to one person in 56 established domestic violence intervention centres that target primary and/or maternity care settings in the Flemish Community in Belgium. Amongst those who received a request to complete the survey were: provincial family violence coordinators in Flanders (6); all Centres for General Welfare (CAW) in Flanders (27); hospitals (4); Confidential Centres for Child Abuse (6); clearing house for self-help (1); Flemish Women's Council (1); Movement Against Violence (1); Institute of Paediatrics (1); Pupil Guidance Centre (1); Child and Family Services (1); Flemish Scientific Association for Youth Health Care (1); Flemish Reporting Point for Elderly Abuse (1); Flemish Community Education Council (1); Women's Shelter (1); Advocate (1); and a therapist in aggression counselling (1). In Belgium, primary health care relates to all services where there is direct access by patients without the need for a referral. This includes the child and family centres and (Kind en Gezin) and the Centres for General Wellbeing (CAW). As such, the Belgium study aimed to cover all direct access primary care services providing care to families affected by domestic violence. In addition, CAW work jointly with Domus Medica to provide training to GPs. GPS are encouraged to refer patients affected by domestic violence to CAW, some of which have specialist domestic violence social workers.

The Flemish partner in this project proposed to the Federal Steering Committee of training in primary care to disseminate the survey in the French Community. A French translation of the survey was developed to encourage participation. However, it was not possible to implement the Daphne mapping survey in the French Community, as it potentially conflicted with a similar initiative they were undertaking around the same time.

Respondents

Twenty-six (46%) Flemish respondents completed the survey, reporting on 25 intervention projects. It was possible for respondents to select multiple answers for some survey questions.

Amongst the 24 respondents who gave their job title, surveys were received from social workers (4); a general practitioner (1); psychologists/psychotherapists (5); a gynaecologist (1); coordinators (4); a criminologist (1); a remedial teacher (1); an intra-family violence worker (1); employee client care/care providers (2); a team officer (1); a head of department (1); and a PhD student.

For further clarification, the 25 intervention projects described were promoted by 19 collaborative teams which can be divided in to three distinct groups:

- 13 Social services teams (Centres for Wellbeing, CAW) described their involvement in promoting their primary care provisions for family violence in 15 projects. Activities described are mainly promotion of adequate care by the CAW teams through training of new staff as well as quality assurance through staff meetings and case discussions (12/13). About half of these CAW (7/13) also described activities promoting interventions outside their own centers: three centers describe their

activities with their target client group (i.e. the public coming to ambulatory care center or in refuge center) and some to justice and police.

- Two research teams and one provincial coordinator for violence described 5 pilot projects in health care. Three are situated at Gent University (2) and Ghent University Hospital (1) and two in the General Practice Research Department of Domus Medica (Flanders and Belgium). One of these interventions (Interactive Case Management described as a pilot project) involves teams of the CAW as providing support for problems identified in general practice (GP oriented action in Antwerp , Flanders), the other intervention involves GP trainers working together with CAW trainers.

- Finally attention to partner violence in child care was described by the central preventive child care coordination center for the whole of Flanders (Kinden en Gezine or K&G), while 2 (of the 6 regionally situated) Flemish Child Abuse or ”children’s confidence centers” described their internal training and external intervention offer.

Intervention settings
Twenty-six respondents reported on 25 interventions targeting multiple health care settings including: general practice (4); maternity (1); private care (3); health care facilities that provide primary and obstetric care (2); Centre for General Well Being Work, CAW (13); preventive care (1); voluntary outpatient care (1); assistants (1); hospital wide (1); police (1); refuge (1); government wide (1).

With regards to the 19 collaborating centres mentioned earlier, 17 perform their own staff training. Six of the 19 described interventions oriented towards different professional groups. This multidisciplinary orientation of the promotion of interventions was performed through CAW (social services), the U-Gent university team and a child abuse center.

Table 6.1 Health professionals targeted in the intervention

Target group	**N within the 25 interventions**	**N within the 19 collaborating teams**
Public authorities	6	6
GPs	6	2
Social workers	2	2
Midwives	4	3
Nurses	4	2
Second line obstetric care	4	2
Gynaecologists	5	2
Social assistants	15	12
Total	**25**	**19**

The majority of teams (14 of the 19) indicated that in addition to primary and maternity care, the interventions also targeted professional groups outside of these settings including police (2), lawyers (1); mediators (1); teachers/educators (3); psychologists (3) and

psychiatrists (1). All 25 interventions indicated that female patients were the target population and 22 also mentioned male patients.

Table 6.2 Coordination, funding and location of domestic violence interventions in Belgium
Note: some names of interventions given by respondents are more descriptive than official names

Name and length of intervention	Professionals targeted in the intervention	Coordinating organisation and geographical location	Funding source
Psycho-social counselling, legal assistance, mediation family affairs, gynaecological consultation (4 years)	GPs; midwives; nurses; obstetricians; gynaecologists; social workers; psychologists; lawyers	CAW (Centre for General Well Being Work) Brussels (Etterbeek, Jette, Central)	Flemish Government under General Well Being Work
Intra-family violence counselling (5 years)	Social workers; psychologists; childcare workers; educators	CAW (Centre for General Well Being Work) Mid West Flanders (17 municipalities)	Flemish Government under General Well Being Work
Couple counselling (8 years)	Social workers	CAW (Centre for General Well Being Work) South East Flanders	Flemish Government under General Well Being Work
No name given (5 years)	General practitioners; social workers; police	CAW (Centre for General Well Being Work) Delta, District Halle-Vilvoorde	Flemish Government under General Well Being Work
Intra-family violence (date not given)	"Population" (not specified further)	Executives of CAW (Centre for General Well Being Work) Bruges	Flemish Government under General Well Being Work
Refuge (15 years)	Social workers	CAW (Centre for General Well Being Work) The Kempen	Flemish Government under General Well Being Work
Partner violence, couple counselling (7 years)	Clients (i.e. recipients of counselling)	CAW (Centre for General Well Being Work) Fishery Country East Flanders, Region Ghent-Eeklo	County East Flanders, Ministry of Flemish Community , Department for Well Being and Public Health
Treat and support intra-family violence (7 years)	Social workers	CAW (Centre for General Well Being Work) Antwerp	Flemish Government under General Well Being Work

Name and length of intervention	Professionals targeted in the intervention	Coordinating organisation and geographical location	Funding source
Educational care providers (4 years)	Social workers	CAW (Centre for General Well Being Work) Antwerp (Berchem)	Flemish Government under General Wellbeing Work
Intra-family violence (6 years)	Social workers; psychologists	CAW (Centre for General Well Being Work) Limburg	CAW (Centre for General Well Being Work) Sonar/County Limburg European Project
No name given (length of intervention not given)	Social workers	CAW (Centre for General Well Being Work) Boeschout	Flemish Government and private donors
Counselling/guidance (1 year)	Social workers	CAW (Centre for General Well Being Work) Region Vilvoorde	Flemish Community under General Well Being Work
No name given (length of intervention not given)	Social workers	CAW The Well Being House, Mechelen	Flemish Community General Well Being Work
No name given (5 years)	Social workers	CAW (Centre for General Well Being Work) Jurisdiction Leper and Veurne	Flemish community General Well Being Work
No name given/no year given	Nurses; education consultants	Child and Family (Kind en Gezin) Flanders	Flemish Government
No name given (7 years)	Social workers; educationalists	Child and Family Service (Kind en Gezin) Antwerp	Flemish Community and own funding through existing resources
Care provision in child abuse (35 years)	Care providers and non-care providers (not specified)	Confidentiality Centre for Child Abuse Antwerp	Flemish Government, county, city and public centre for social well-being (OCMW)
Intake of signals (13 years)	Social workers; child abuse counsellors; psychologists	Confidential Centre Child Abuse East Flanders	Flemish Community

Name and length of intervention	Professionals targeted in the intervention	Coordinating organisation and geographical location	Funding source
Disclosure of child abuse, emergency intervention, care provision and coordination of aid (23 years for the child abuse centre	General practitioners; midwives; nurses; district nurses; obstetricians; gynaecologists; social workers	Confidential Centre for Child Abuse County Limburg	Flemish Community
Project interactive case management intra-family violence (1 year) Web based ICM Project	General practitioners	Domus Medica Antwerp	County Antwerp
Training for intimate partner violence (2 years)	General practitioners;	Domus Medica (Flemish community) and Centre Academic General Medicine Free University of Brussels (French Community)	Federal Government, Public Health and Safety of the Food Chain
Interactive case management intra-family violence (2 years) Federal training project	General practitioners	Domus Medica Antwerp	Province Antwerp/Domus Medica/Institute for Gender Equality
Domestic violence training and referral to care provision (5 years)	General practitioners; social workers; police	Domus Medica/ CAW (Centre for General Well Being Work) Brussels-Halle-Vilvoorde	Federal Community
MOM -Difficult Moments and Feelings (1 year)	Midwives; obstetricians; gynaecologists;	University of Ghent Flanders	Scientific Research Foundation (FWO)
Intra-family violence in hospital context (5 months)	General practitioners; midwives; nurses; obstetricians; gynaecologists; social workers; hospital personnel in general	International Centre for Reproductive Health (ICRH) University of Ghent East Flanders, West Flanders, Limburg, Flemish-Brabant and Antwerp	Federal Government Service of Public Health and Security of the Alimentary Chain
Protocol for the immediate admittance of victims of violence to the Academic Hospital (UZ) Ghent (7 years)	Midwives; social workers; emergency physicians; paediatricians; psychiatrists	Academic Hospital, University of Ghent Ghent	None given

Policies on domestic violence
Of the 26 respondents, 19 reported that they had a policy developed specifically for their interventions and 5 had a policy embedded in the 'national guidelines' (referring to GP guidelines developed by two GP associations – French and Flemish which are used nationally) and 2 did not specify how guidelines were developed.

The policy included the following actions and guidance: routine enquiry for domestic violence (21); documentation of domestic violence (21); how to refer patients who disclose domestic violence (25); how to assess the safety of the patient and any children or vulnerable adults who may be affected by domestic violence (25); confidentiality and information sharing (24).

Domestic violence training
All 26 respondents reported that the 25 interventions involved domestic violence training for health professionals. Health professionals and other organisations targeted for training include: nurses (5); general practitioners (7); midwives (3); district or social nurses (2); psychologists/psychotherapists (14); gynaecologists (3); obstetricians (2); social workers (19); receptionists/administrative staff/practice assistants (4); hospital wide (1); emergency physicians (1); police (3); criminologists (1); educators (2); refuge staff (1); lawyers and mediators (1).

Sixteen of the 26 respondents said that domestic violence training was not mandatory for any staff. The remaining 10 respondents said that domestic violence training was mandatory nurses (2); psychologists/psychotherapists (3); gynaecologists (1); obstetricians (1) and social workers (8). Other professionals for which training was mandatory include: educators (2); all new employees (1); children's workers (1); emergency physicians (1) and lawyers and mediators (1).

Ten respondents said that training was provided by a domestic violence trainer from outside the healthcare setting who was not a health professional, and 16 reported that training was provided by a health care professional. Training was also provided by multi-disciplinary teams including GPs with social workers or psychologists (3); research team evaluating the intervention (2); and workers from CAW - Centre for General Well Being (2). Thirteen respondents said that the intervention offered 'train the trainer' courses. The training content in the 25 interventions projects and Centres for General Well Being are described in table 6.3.

Table 6.3 Domestic violence training content by intervention and Centres for General Well Being (CAW)

Content	N of 25 intervention projects	N of 15 CAW projects
Routine enquiry for domestic violence	19	12
How to document a disclosure of domestic violence	21	12
How to refer patients who disclose domestic violence	23	14
How to assess the safety of the patient	24	14
How to deal with issues of confidentiality and information sharing	25	15

Table 6.4 Frequency and length of domestic violence training interventions in Belgium

Coordinating organisation and geographical location	Professionals targeted in the intervention	Frequency of training	Length of training
CAW (Centre for General Well Being Work) Brussels (Etterbeek, Jette, Central)	General practitioners; midwives; nurses; gynaecologists; social workers; psychologists	Not specified	Basic education; 2 days For counselling department; 3 days
CAW (Centre for General Well Being Work) Mid West Flanders (17 municipalities)	Social workers; psychologists; childcare workers; educators	2 to 3 times a year	At least half a day
CAW (Centre for General Well Being Work) South East Flanders	Social workers	Annually a training course is organised for new employees. Quarterly there is peer supervision for all departments.	Training for new employees is 1 day and the peer supervision is 4 half days per year
CAW (Centre for General Well Being Work) Delta, District Halle-Vilvoorde	General practitioners; social workers; police	Annual basic training for social workers at Centre for General Well Being (CAW). Training of physicians on request	CAW social workers: 3 days Physicians: 2 hours Police: varies
Executives of CAW (Centre for General Well Being Work) Bruges	Population (not specified further)	Annually	Various parts of the day
CAW (Centre for General Well Being Work) The Kempen	Social workers	More than once a year	Varies from 1 to 3 days
CAW (Centre for General Well Being Work) Fishery Country East Flanders, Region Ghent-Eeklo	Clients	Some organised on demand and others on a regular basis	Depends on demand
CAW (Centre for General Well Being Work) Antwerp	Social workers	Currently a series of 3 four-hour sessions running. Follow-up sessions are voluntary.	4 hours

Coordinating organisation and geographical location	Professionals targeted in the intervention	Frequency of training	Length of training
CAW (Centre for General Well Being Work) Antwerp (Berchem)	Social workers	All new employees are trained.	Basic training (not specified) followed by coaching and peer supervision
CAW (Centre for General Well Being Work) Limburg	Social workers; psychologists	Training on dealing with aggression offered once to all staff. Employees of Intra-Family Violence provided with specific study days.	Every 6 weeks, there are internal peer supervisions for employees of Intra-Family Violence.
CAW (Centre for General Well Being Work) Boeschout	Social workers	4.5 days for the entire staff at Centre for General Well Being (CAW)	4.5 days. Each week a one-hour meeting based on case studies
CAW (Centre for General Well Being Work) Region Vilvoorde	Social workers	Via internal general education and supervision (not specified). Staff also able to access external training.	3 days for internal and half a day for external training
CAW The Well Being House, Mechelen	Social workers	Not specified	Not specified
CAW (Centre for General Well Being Work) Jurisdiction Leper and Veurne	Social workers	Annually	Depends on the aim of the training
Child and Family (Kind en Gezin) Flanders	District nurses; educational consultants	2 times a year	2.5 days prosecution service
Child and Family Service Antwerp	Social workers; educationalists	Not specified	2.5 days Day 1: recognition of family violence Day 2: Hand over of this knowledge to others Half a day by prosecution officer on role of prosecution service

Coordinating organisation and geographical location	Professionals targeted in the intervention	Frequency of training	Length of training
Confidentiality Centre for Child Abuse Antwerp	Care providers and non-care providers (not specified further)	Employees are offered 5 external and 5 internal general educational days a year	Not specified
Confidential Centre Child Abuse East Flanders	Social workers; child abuse counsellors; psychologists	Continuous courses on child abuse for all employees according to supply and demand of employees and/or the service	Not specified
Confidential Centre for Child Abuse, County Limburg	General practitioners: midwives; nurses; district nurses; obstetricians; gynaecologists; social workers; professionals and non-professionals	Training of all new employees, plus existing employees attend regular study days. Use of feedback and discussion via team meetings for additional support	New employees: 3 days Supervision: about 6 sessions a year Peer supervision: weekly in team Individual coaching can be done daily
Domus Medica Antwerp	General practitioners (Project Interactive Case Management Intra Family Violence 1 year intervention/web based ICM project)	Self study of the GP guidelines and pathways promoted. Training can be requested	1.5 to 2 hours
Domus Medica (Flemish community) and Centre Academic General Medicine Free University of Brussels (French Community)	General practitioners (Training for intimate partner violence 2 year intervention)	On request by locals physician's association	Two types of training offered: 1) sensitisation training 2) 2) In-depth training for those interested 1.5 to 2 hours
Domus Medica Antwerp	General practitioners (Training on partner violence 2 year intervention – Federal training project)	On request by locals physician's association	One part of the day (either morning, afternoon or evening)
Domus Medica/ CAW (Centre for General Well Being Work) Brussels-Halle-Vilvoorde	General practitioners; social workers; police (Domestic violence training and referral 1 year intervention)	On request	About 2 hours

Coordinating organisation and geographical location	**Professionals targeted in the intervention**	**Frequency of training**	**Length of training**
University of Ghent Flanders	Midwives; obstetricians; gynaecologists;	Not specified	Not specified
International Centre for Reproductive Health (ICRH) University of Ghent East Flanders, West Flanders, Limburg, Flemish-Brabant and Antwerp	Midwives; nurses; obstetricians; gynaecologists; social workers; hospital personnel in general	Not specified	Basic training: 3 hours Follow-up education: 24 hours Protocol guidance: 8 hours
Academic Hospital, University of Ghent Ghent	Midwives; obstetricians	Every 6 months to a year. In principle every new cohort of emergency physicians, assistants in gynaecology etc	Several hours for physicians and assistants

Routine enquiry for domestic violence in the intervention
17 respondents said that the intervention includes routine enquiry for domestic violence of female (18) and male patients (16). Eleven respondents said that there was no monitoring or auditing of routine enquiry for domestic violence. Of the 8 respondents who answered the question on monitoring of routine enquiry, 1 respondent said that patient records were reviewed to monitor routine enquiry and 7 said that other methods for auditing were conducted including: file review; notes of interviews and case studies; and checks at team meetings. Of the 17 respondents, 8 reported that the approach to routine enquiry involved asking questions about domestic violence when patients presented with injuries, symptoms, or behaviours consistent with experiences of abuse; 6 said that routine enquiry involved asking all patients whether or not there were indicators; and in 3 cases it was not clear what the approach entailed.

Table 6.5 Documentation of domestic violence
In the intervention health professionals are advised to document the following:

Information documented	**Yes (N)**	**No (N)**	**Don't Know (N)**
Whether or not the patient was asked about domestic violence	13	12	1
Whether or not the patient disclosed domestic violence	22	3	1
Name of the perpetrator	8	14	3
Relationship of the perpetrator to the patient	24	1	1
A description of the types of abuse experienced	21	3	2
A description of any recent incident of abuse	19	6	1
A description of the types and location of injuries	11	14	1
A body map picture indicating location of injuries	7	18	1
Whether referral information was offered to the patient	21	3	2
Whether the patient accepted the referral information	19	5	2
Indication of any action taken by the patient	20	4	2
Whether there are any children in the household	24	1	1
An assessment of the safety of the patient and any children	24	1	1

Referral pathways
Twenty-four respondents said that professionals refer patients to specialist domestic violence organisations in the community and 10 also refer to other health professionals. Ten respondents said that they sometimes refer patients to social workers and 20 refer to the police. Other services that patients are referred to include mental health centre (3) and psychologists/psychiatrists (2).

Twenty-four respondents said that they offer referral information to patients that disclose domestic violence and 20 said that the health professionals contact the organisation on behalf of the patient.

Evaluation

Respondents were asked whether the intervention included a research component and to provide details of any reports or publications. Seven respondents reported the inclusion informal evaluation methods through team meetings and case discussion. Eight respondents reported the inclusion of formal research.

Table 6.6 Evaluation of domestic violence interventions in Belgium

Name of intervention	Coordinating organisation and geographical location	Evaluation activity
Psycho-social counselling, legal assistance, mediation family affairs, gynaecological consultation (4 years)	CAW (Centre for General Well Being Work) Brussels (Etterbeek, Jette, Central)	No formal research – informal evaluation through team meetings, intervision and cooperation with other services
Intra-family violence counselling (5 years)	CAW (Centre for General Well Being Work) Mid West Flanders (17 municipalities)	No formal research – care provider consultation with respective client
Couple counselling (8 years)	CAW (Centre for General Well Being Work) South East Flanders	No formal research - self-evaluation appraisals and evaluation interviews with capacity officer. Year Journals Centre for General Well Being work
No name given (5 years)	CAW (Centre for General Well Being Work) Delta, District Halle-Vilvoorde	Not known
Intra-family violence (date not given)	Executives of CAW (Centre for General Well Being Work) Bruges	No formal research, informal evaluation through team officer
Refuge (15 years)	CAW (Centre for General Well Being Work) The Kempen	No formal research – evaluation during team meetings
Partner violence, couple counselling (7 years)	CAW (Centre for General Well Being Work) Fishery Country East Flanders, Region Ghent-Eeklo	Answered ‘yes’, but no details provided

Name of intervention	Coordinating organisation and geographical location	Evaluation activity
Treat and support intra-family violence (7 years)	CAW (Centre for General Well Being Work) Antwerp	Not known
Educational care providers (4 years)	CAW (Centre for General Well Being Work) Antwerp (Berchem)	Answered 'yes', but no details provided
Intra-family violence (6 years)	CAW (Centre for General Well Being Work) Limburg	Interventions in Intra-Family Violence are evaluated, but interventions in Relationship and Well Being are not.
No name given (length of intervention not given)	CAW (Centre for General Well Being Work) Boeschout	No
Counselling/guidance (1 year)	CAW (Centre for General Well Being Work) Region Vilvoorde	Evaluation via the registration system and via management of personal files after authorisation by the person involved
No name given (length of intervention not given)	CAW The Well Being House Mechelen	No
No name given (5 years)	CAW (Centre for General Well Being Work) Jurisdiction Leper and Veurne	No
No name given/no year given	Child and Family (Kind en Gezin) Flanders	No
No name given (7 years)	Child and Family Service (Kind en Gezin) Antwerp	Not known
Care provision in child abuse (35 years)	Confidentiality Centre for Child Abuse Antwerp	Year journal located on www.vkantwerpen.be
Intake of signals (13 years)	Confidential Centre Child Abuse East Flanders	No formal research – informal evaluation through team meetings

Name of intervention	Coordinating organisation and geographical location	Evaluation activity
Disclosure of child abuse, emergency intervention, care provision and coordination of aid (23 years for the child abuse centre	Confidential Centre for Child Abuse County Limburg	No formal research – evaluation through team discussions.
Project interactive case management intra-family violence (1 year) Web based ICM Project	Domus Medica Antwerp	Research in progress. Includes a survey on use and access to website as well as referral to special care in the intervention region compared to control regions. Data available March 2012
Training for intimate partner violence (2 years)	Domus Medica (Flemish community) and Centre Academic General Medicine Free University of Brussels (French Community)	Includes pre and post training surveys; government report in press (end 2011)
Interactive case management intra-family violence (2 years) Federal training project	Domus Medica Antwerp	Includes formal research by Domus Medica Pre-intervention report available: http://www.domusmedica.be/onderzoek/psychosociale-problematieken/intrafamiliaal-geweld.html
Domestic violence training and referral to care provision (5 years)	Domus Medica/ CAW (Centre for General Well Being Work) Brussels-Halle-Vilvoorde	No
MOM -Difficult Moments and Feelings (1 year)	University of Ghent Flanders	Includes formal research by the University of Ghent
Intra-family violence in hospital context (5 months)	International Centre for Reproductive Health (ICRH) University of Ghent East Flanders, West Flanders, Limburg, Flemish-Brabant and Antwerp	Includes formal research, available from October 2011

Name of intervention	Coordinating organisation and geographical location	Evaluation activity
Protocol for the immediate admittance of victims of violence to the Academic Hospital (UZ) Ghent (7 years)	Academic Hospital, University of Ghent Ghent	No

Study 6 Belgium Study: Domus Medica, MOM Intervention; Child and Family Service (Kind en Gezine); and Centres for General Well Being (CAW)

Findings from the qualitative interviews

Sample

Due to time constraints, it was necessary to conduct use telephone interviews for all but one of the interviews in the Belgium study, which includes descriptions of interventions in a range of primary and maternity care settings. Two meetings were conducted with the Belgium partner (Leo Pas) prior to the interviews in order to plan.

Participants were chosen from child and family services (Kind en Gezin), Centres for General Wellbeing (CAW); a professional organisation for general practitioners in Flanders (Domus Medica); and a hospital-based maternity intervention (MOM).

Domus Medica and CAW were chosen as they work in collaboration providing domestic violence training to GPs. GPs are encouraged to refer patients affected by domestic violence to CAW. In addition to this, CAW also provide domestic violence training to their own personnel and offer counselling and ongoing support to clients affected by domestic violence. Child and family services (Kind en Gezin) work with families with young children at risk and work in close collaboration with Child Abuse Centres. In Belgium, primary care health relates to all services where there is direct access by patients without the need for a referral. This includes the child and family centres and (Kind en Gezin) and the Centres for General Wellbeing (CAW). As such, the Belgium study aimed to cover all direct access primary care services providing care to families affected by domestic violence. Interviews with the following participants were conducted:

- General Practitioner/Daphne partner: 30 years in general practice and 33 years with Domus Medica which is a professional organisation for GPs in Flanders. The GP is also responsible for the development and evaluation of domestic violence training and documentation initiatives in primary care and currently managing an intervention called Training on Partner Violence since 2009. The intervention is a collaborative project between Domus Medica, Scientific Society of General Medicine (SSMG) and the French-speaking Free University of Brussels (ULB), Department of General Practice.

- A PhD student (2 years in post) from Ghent University working on the MOM study. MOM, also known as “Difficult Moments and Feelings” is funded by the Scientific Research Foundation (FWO) and evaluates a hospital based domestic violence intervention for pregnant women. The evaluation started in 2009.

- A Remedial Teacher, Staff Officer (32 years) at a Child and Family Service in Brussels. Within the service, nurses works with families with children from birth to 3 years of age. The domestic violence intervention was implemented in 2008.

- A Social Worker who specialises in domestic violence (4 years in post) for the Centre for General Welfare (CAW) in Berchem. The domestic violence intervention at CAW in Berchem, Antwerp was implemented in 2007.

- A Social Worker who specialises in domestic violence (8 years in post) for the Centre for General Welfare (CAW) in Lennik, Brussels. The domestic violence intervention was implemented in 2006.

Centres for General Welfare (CAWs)

General Welfare Centres (CAWs) provide social services or welfare to people (www.caw.be). CAWS are funded by the Flemish government and only exist in the Flemish part of Belgium. There are 26 CAWs in Flanders and Brussels, of which 13 have social workers who are funded to specialise in developing domestic violence policy and training. Funding for this initiative came from the Ministry of Welfare in 2006.

Identification of domestic violence

With regards to some of the couple counselling referrals to CAW, the social worker will already be aware that domestic violence is an issue for a client. There are agreements in every city that if the police are called out to a domestic violence incident, that they will refer the couple to a CAW. However, they are trained to ask directly about domestic violence when people present with related problems such as depression or alcohol abuse. They do not use screening tools, but are given examples of questions during training. Currently risk assessment tool are lacking and there are no multi-agency meetings for high risk cases of domestic violence. However, Domus Medica is currently working in collaboration with CAW supporting institution and provincial coordination of violence on a project for 2012/2013 to develop these.

Care of victims and their families

CAW social workers provide primary care to clients in abusive relationships when it is safe and appropriate to do so. Each client is assessed individually before a decision is taken about whether this approach is safe. In cases where the woman is considered to be at serious risk, the social worker will assist with developing safety plans or finding a shelter. Some CAW social workers work with children living in domestic violence environments, but also refer to specialist children's services if more support is needed. Depending on the needs of the client, CAW social workers may have to work liaise other organisations including the police, alcohol programmes, women's shelters and mental health services.

> *"Well I do social work. I see people who are victims or those who use violence in the relationship. Mostly they get sent to me by the police. I speak to them about the consequences of their actions, their frustration, how to cope with their emotions, how to avoid aggression. But I also have a task in networking. So I made an agreement with the police and the justice system to follow-up people with domestic violence. Also with Domus Medica, to give courses to doctors in the neighbourhood and we cooperate with public campaigns."* [Social Worker, CAW, Brussels]

Interventions with perpetrators

Specialised programmes for perpetrators in Belgium are scarce and mainly reserved for prosecuted offenders, but one programme based at the CAW in Berchem, Antwerp is open regarding referrals:

> *"I try to coach the social workers and give them training. I give them some kind of theory about domestic violence and also how to talk about the violence in a direct way. You ask them very specific questions about the behaviour of violence. Also about the dynamics between two people in a relationship and then we have a methodology to stop the violence. The methodology we use is the time out procedure and we also give some psychological education about the violence. So they can recognise the stress signals and they must take a time out and stop."* [Social Worker, CAW, Berchem, Antwerp]

Training of professionals

In addition to direct client work, the specialist social workers funded by the Ministry of the Flemish Community responsible for Welfare provide mandatory basic domestic violence training to CAW workers and also provide voluntary training in conjunction with Domus Medica, the professional organisation for GPs. CAW workers may also elect to take additional modules on domestic violence or the train the trainer course at Domus Medica so that they can provide training in their region to physicians in primary care.

> *"I give training in collaboration with Domus Medica to health professionals and we have an external trainer who gives a three-day course to new people who work at CAW. Every two years there are courses in how to work better with children or how to work better with the couple. These trainings are for those people who want to have this domestic violence task in their role."* [Social Worker, CAW, Brussels]

Professional development and support for CAW for social workers is comprehensive and includes in-house coaching and external supervision by a psychologist if necessary. The Flemish Community also funds a special support centre for CAW to train these professionals.

> *"Yes indeed we get supervision. Every week there is an [internal] meeting where we discuss our cases. It's not only for domestic violence cases, but I see a lot of these cases. But we've also got an external supervisor [from the support centre mentioned above] for people who work with domestic violence. We've also got a group of people who work with domestic violence cases and they meet, I think five times a year to discuss the difficulties in these situations."* [Social Worker, CAW, Brussels]

Child and Family Service (Kind en Gezin, K&G)

The Child and Family Service (Kind en Gezin, K&G) is broadly equivalent to health visiting in the United Kingdom (www.kindengezin.be). Public health nurses provide care to children from birth to three years of age. The development of domestic violence initiatives was a natural progression from the work that Child and Family Services were undertaking with regards to child abuse ten years ago. In recognition of the fact that domestic violence can have a significant impact on children living in the household, a training programme for nurses was

developed. Due to lack of funds for training, they implemented a 'train the trainer' course which was attended by motivated nurses. They now currently have a pool of 24 in-house trainers from Child and Family Service who have domestic violence training as part of their job remit. The following comment demonstrates that although nurses screen routinely for many sensitive issues such as alcohol abuse and depression, their approach to identification of domestic violence is based on case finding based on signs and symptoms. Generic support for nurses in dealing with children and families affected by domestic violence or other issues, is provided at a regional level by a coordinator usually with a psychology background.

> *"We visit every family with a newborn child so we take a kind of picture of the family. So in their head they have a list, you say, is that okay? And if the nurse feels like they see signs about an issue, especially the issue of domestic violence, then they ask further about it. But they certainly ask questions about the wellbeing of the mother, the wellbeing of the father, the relationship between the parents, drug abuse, alcohol abuse, depression and the relation with the child."* [Remedial Teacher, Child and Family, Brussels]

MOM Study: 'Difficult Moments and Feelings'

The acronym is Dutch for **Mo**eilijke, '**M**omenten en Gevoelens tijdens de zwangerschap', or 'difficult moments and feelings during pregnancy'. The intervention project is based in the maternity services of 15 hospitals and is funded by the Scientific Research Foundation (FWO). A research team at Ghent University is conducting an evaluation of the intervention.

Identification of domestic violence

In the first phase of the study, English, Dutch or French speaking women who attend for antenatal care at the hospital are invited to complete an anonymous survey which includes sections on socio-demographic characteristics, partner violence and depression, fear, stress, anxiety and satisfaction with care. The survey contains information on how to get support and helpline details. In the survey, women are invited to include their contact details if they wish to participate in a further interview.

Counselling

Women who report partner violence in the survey (and provide their contact details) are invited for an interview and randomized single blind into an intervention or standard care group. During the postpartum check-up, women selected for the intervention, receive an envelope which contains a card with useful numbers and tips for security and safety behaviours. Women who are not selected for the intervention are given an envelope with a card that says 'thank you for your cooperation'. Women in both the intervention and control group are followed up at 6 and 12 months to complete an interview which includes measures on partner violence, depression and fear and help-seeking behaviour. At the time of interview, approximately 700 women had completed a survey and around 40 women were randomised to the intervention or control group. The research is still in process and results are not yet available.

Training

The interviewee representing the MOM study is also responsible for delivering domestic violence training to around 10 hospitals in Flanders and coordinates this within a federal projects with French speaking colleagues for another 10 hospitals in Belgium. Training began in 2011 with two to three hours of awareness raising including definitions of domestic violence, how to recognise the signs and symptoms, common risk factors, how to ask questions and how to respond to disclosures of domestic violence. In the second phase of this initiative, a further twenty hospitals were recruited for training and hospitals from the first phase are given an intensive programme of training over five sessions.

The interviewee representing the MOM study is also responsible for delivering domestic violence training to around 10 hospitals in Flanders and coordinates this within a federal project with French speaking colleagues in 1O additional hospitals in Belgium. Training began in 2011 with two to three

Further needs identified

The interviewee was asked to discuss how to sustain changes in practice beyond the initial domestic violence training. The interviewee described a need for lead persons from management to take responsibility for developing a care pathway for domestic violence within the hospitals and supporting health professionals in dealing with patients affected by domestic violence. Referrals pathways in the Flemish and French speaking parts of Belgium differ. In the Flemish part of Belgium, health professionals refer to the Centres for General Well Being (CAW) where patients can access multiple forms of assistance (e.g. counselling, shelters, welfare assistance, or referrals to other sources of help). However, these centres do not exist in the French part of Belgium and it is less clear where to refer women on to. In Ghent there are locally organised meetings known as the 'vulnerable women's group' at which different professionals can discuss particular cases or to address domestic violence in general. However, there is less multi-agency coordination at a regional level.

> *"Perhaps someone from management who is really taking the problem on board on a more structural level. Someone who is writing a critical pathway for example, if we screen what can be the referral pathway and how will it be organised in the hospital. So it can be one person who gets to see all the women who disclose domestic violence, that's one option, but it can also be someone from the management who organises everything."* [PhD Student, Ghent University]

In Belgium, most general practitioners work in single handed practices and many hospital based doctors are paid per consultation or procedure. Therefore, it is more difficult to get domestic violence initiatives embedded at a structural level. Dealing with patients affected by domestic violence can be time consuming and without a support system in place or at least a clear referral pathway, many doctors will be deterred from actively identifying violence.

> *"Most doctors working in a hospital environment are paid per thing they do*, so they get money for consultation, for dissection, so they don't have a fixed wage. If you're working, for example, as a gynaecologist in a university hospital, you have a fixed wage. But most doctors and gynaecologists just work independently and get paid*

through this health insurance system. I think if the government will give them a percentage of wage to really organise the care around domestic violence, I think it will be more of a structural thing that will have a long-term effect and get embedded in the hospitals." [PhD Student, Ghent University]
*****Note: Most doctors are salaried in public hospitals, but their salary comes from fee for service payment.

"I think it's a cultural issue because when you visit Belgium, everyone is building his own house the way he or she wants and it's all possible, but when you have a street with twenty different houses and it's really ugly. This is a metaphor for healthcare. So everyone does what he or she thinks is good and most of the time people take wonderful initiatives, but we lack coordination, we lack a general approach, but everyone is in the same boat. That is a big, big problem." [PhD Student, Ghent University]

Ghent University are organising a meeting in November 2011 of health professionals and representatives of professional bodies for health in order to discuss the issue of introducing routine enquiry for domestic violence in maternity care in hospital settings. This will focus on implementation issues, the challenges and how to overcome them.

Domus Medica

Training and support
Domus Medica offers two levels of training to GPs in Flanders: basic awareness raising about detection, counselling and collaborative care and a more in-depth interactive training which focuses more on identification skills for domestic violence, documentation and referral pathways. This training is further supported through national guidelines (De Deken et al. 2010a) and an interactive web tool which includes care pathways for partner violence, child abuse and elderly abuse. It also includes a display of available services (De Deken et al 2010b). A cluster randomised study is in progress (December 2010 to March 2012) providing practitioners in one province the possibility to post questions to a multidisciplinary support team.

A small proportion of motivated GPs who receive the basic and the intensive training decide to provide training themselves or act as a *"reference GP to be available in the area to run the training and to be support for their colleagues"*. Since GPs work in single handed practices, this training is delivered via GP circles to ensure maximum attendance. It is obligatory for GPs to attend 4 sessions of these circles per year in order to retain accreditation as a GP.

Domus Medica co-trains in these circles with social workers from CAW to promote direct contact between GPs and with the local agency taking referrals, as well as providing direct access and comprehensive primary care for partner violence. CAW trainers and GP reference trainers are followed up by two intervision groups each year to discuss problems and renew the methodology and content. Attendance at the basic awareness training has was successful reaching about 10% of local GP circles throughout the Flemish Community in four years However, attendance at the second level of training, which is offered twice

yearly, was less successful (only 5 of the 14 trained reference GPs provide new regular support distributed among provinces). Promotion of training is made by making a proposal to the chairman of GP circles and quality circles and with local initiatives in collaboration with CAW and provincial coordinators. In spring 2012, a joint sensitisation campaign will be launched in health care at federal level to promote identification of domestic violence in primary care as well as in hospital settings.

Intervention promoted for GP

With regards to identification, the training recommends case finding when patients present with vague symptoms, bruising, injuries or other complaints that are consistent with experiences of domestic violence. However, routine screening of all pregnant women is recommended. This is consistent with the national guideline for general practitioners developed by the two GP associations (French and Flemish) and accredited by the Belgian Centre for Evidence based medicine (CEBAM, local Cochrane branch).

Evaluation

Currently Domus Medica is adapting their training package in the Federal project in collaboration with their French partners based on pre and post training evaluation and comparative data from an enquiry among a random sample of GP in the community at large. They are piloting a pre-training assessment for health professionals in order to determine the change in role perception and self efficacy of their practice approach.

Risk assessment tools

As highlighted in interviews with CAW social workers, there are currently no validated tools for assessing whether a patient is at high risk of domestic violence and multi-agency risk assessment panels do not exist in Belgium.

> *"We are still lacking in evaluated and validated risk assessment tools. What we want to do in the near future is develop risk assessment panels to actually deal with high risk cases, and to be able to do that, we need an evaluated risk assessment tool. So this is our next task."* [GP, Domus Medica]

Integration into a more comprehensive strategy for mental health at GP level

One of the difficulties is that domestic violence training in the Flemish speaking community has to compete alongside other topics such as depression, suicide and alcohol in the psychosocial area and many other clinical topics (e.g. cardiovascular risk and diabetes care). GP circles have become overloaded with projects, which has decreased opportunities for more intense training on one topic. The situation in the French speaking community is slightly different as domestic violence training does not have to compete against so many other topics. In addition, the French speaking community have a hierarchy of GP circles at which delegates meet yearly, and the in-depth domestic violence training is offered at a delegate meeting.

When discussing the challenges of motivating GPs to take on board the issue of domestic violence, the interviewee highlighted the lack of coordination between the statutory organisations that provide assistance and a need for more open and responsible information sharing between them. Although shelter networks exist in Belgium, most single

practice GPs are less accustomed to working them. GPs based in multi-disciplinary community centres (called 'medical houses' MM or 'Community Health Centres' WGC) are more closely linked to community organisations.

> *"The major challenge is getting the collaborative care and the shared care approach or stepped care approach to be installed. GPs are still not asking questions unless we get a good shared care system so that is the main thing we are working on now. There should be adequate communication rules and the problem is that there are different ethical rules about this in different sectors of care. So in mental health care, nothing is disclosed to any other carer unless the client gives explicit permission. Social services share some information even if there is no agreement, if it's in the interests of the client. Primary health care has the view that information should always be shared with the coordinating physician unless the client opposes, which is a different approach. And then you have the whole justice and police system….they are not actually orientated to patient care, but more to prosecution and security, which means that they should interview all partners in the violent relationship about a case without permission."* [GP, Domus Medica]

The usefulness of disclosure teams of professionals or coordinating persons at a district level was also suggested by the interviewee. These multidisciplinary teams could be responsible for advising health professionals about how to deal with individual cases, ensuring that there is an identified care pathway for the patient, and collating all information at a central point so that it can be shared by other professionals involved in the patient's care.

Key learning points

- In Belgium, the majority of GPs work in single handed practices. Therefore, it is more challenging to motivate GPs to attend training and to monitor and maintain changes in practice regarding identifying and responding to domestic violence. There is a need for disclosure teams of professionals or coordinators for domestic violence at a district level, to provide advice for case management to health and social care professionals.

- There is a need for disclosure teams of professionals or coordinators for domestic violence at a district level, to provide advice to health and social care professionals

- General practice guidelines are under development for child abuse and elderly abuse in primary care. Sexual abuse and recommendations for special circumstances (e.g. mental health problems among victims; domestic violence in different cultural groups) should be further refine these guidelines. Multidisciplinary pathways including health care should be further developed and screening and assessment tools validated. In particular there is a need to review and adapt existing risk assessment tools for inclusion in future domestic violence training initiatives.

- Linked to the use of risk assessment tools, is the need to develop multi-agency risk assessment panels to review high risk cases of domestic violence. This would allow a more systematic approach and follow up. Structural embedding of training in vocational training and local care pathways is deemed necessary.

- There is a need for disclosure teams of professionals or coordinators for domestic violence at a district level, to provide advice to health and social care professionals.

- Formal recording and longitudinal follow up should improve knowledge about the utility and impact of different interventions for health professionals and patients.

References

De Deken L, Pas L, Hillemans K, Cornelis E, Van Royen P. (2010a) Detectie van partnergeweld. Een aanbeveling voor de huisarts (Detection of partner violence. A recommendation for the general practitioner) Huisarts Nu (GP Now) 39(3), S1-63 (Accessed 30th January 2012).
http://www.domusmedica.be/kwaliteit/aanbevelingen/overzicht/partnergeweld.html

De Deken L, Pas L, Hillemans K, Cornelis E, (2010b) De huisarts in contact met partnergeweld. een evidence based werkmodel. Huisarts Nu; 39(9):339-345 (Accessed 30th January 2012).
http://www.domusmedica.be/images/stories/huisartsnuarchief/h39_09_04_partnergeweld.pdf

Study 7: Serbia

Description of the health sector in Serbia

The Serbian healthcare system today is made up of a well-developed system of primary, secondary, and tertiary care centres. In the past few decades, changes in the Serbian authorities have transformed the healthcare system that had been set up when Serbia was a Republic of Yugoslavia. During those years, healthcare was free to all people and there were no fixed prices. Today, reforms have mandated a basic level of health services for all people, but at varying levels or co-payment. Services not covered may be supplemented by private insurance. This has caused many low and middle class citizens to pay for healthcare that they previously received for free. Current concerns in the field of Serbian healthcare are poor funding for primary care, and a lack of equipment and supplies, inadequate salaries, and continuing medical education.

Serbian health care is provided through a wide network of public health care institutions owned and controlled by the Ministry of Health. The state fund covers most medical services including treatment by specialists, hospitalisation, prescriptions, pregnancy and childbirth, and rehabilitation. The law provides for private practice which may be pursued exclusively by way of private funds. The private health care sector is not included in the public funding scheme and as such, it represents no supplementary component of the public system nor does it offer to insurers the possibility to exercise rights arising from compulsory insurance. The health care system in Serbia is funded through a combination of public finances and private contributions. The most important source of health care financing in Serbia is the Republic Health Insurance Fund (HIF). The public healthcare system is generally well documented, the opposite holds true for the private healthcare providers.

Primary health care
Primary health care is provided in 159 Health Care Centres and health care stations throughout the country. The provision of primary health care to the population in Serbia is relatively decentralized, where services for children and women are offered by paediatricians and gynaecologists along with general practitioners. Medical services provided by the Health Care Centres include general medicine, paediatrics, obstetrics and gynaecology, occupational medicine, dentistry, home care, preventive care, and laboratory services. They also provide emergency medical aid as well as laboratory, radiology, and other diagnostic services. Most primary care centres provide services such as general medicine, pediatrics, obstetrics, gynecology, preventive care and laboratory services in an outpatient setting. Smaller primary health stations offer services further out into communities in addition to the larger care centres. Services mainly rely on GP's. GPs make referrals, prescribe drugs, treat acute and chronic illnesses, and provide preventive care and health education.

Secondary and tertiary health care
These services are offered to both inpatients and outpatients in a string of health institutions across the country, including general hospitals, specialized hospitals or institutes and academic hospitals. Hospital or stationary health care in the public sector in the Republic of Serbia is provided by 37 general hospitals, 14 specialised hospitals, 19

specialized health centres, 23 single speciality clinics, 38 multi-speciality institutes, 5 clinical hospital centre, 3 clinical centre. In the private sector, there are 81 hospitals and 58 polyclinics.

The health care reforms aimed to focus on primary health care services and preventive measures versus curative, in order to decrease the rate of preventable diseases and also reduce health expenditures. It also aimed to reconfigure hospitals to more effectively respond to the needs of patients, to develop a new basic package of health services that will be in balance with the available resources. Overall, the recent healthcare reforms have tried to change the emphasis from curative to preventative care.

The population in Serbia according to 2011 statistics is 7,120,666.

Further information about the Serbian health care system is available at (Accessed 18th August 2011):
http://www.healthsystems2020.org/content/impact/detail/2285/

Further information about the population in Serbia can be found at (Accessed 30th January 2012):
http://en.wikipedia.org/wiki/List_of_countries_by_population

Domestic violence policy context in Serbia

The Ministries of Social Welfare, of the Interior and Health, officially manage gender-based violence (GBV) issues in Serbia. During the period 1990-2002, GBV issue was the concern of women's organisations and thanks to their activities it became visible and acknowledged as an important issue by the relevant governmental institutions. In the last decade, important steps were made, so that the following policies and strategies to combat GBV are available in Serbia:

- Integrated into the Criminal Law (2002) and the Family Law (2005)
- National strategy for improvement of position of women and advancement of gender equality and its Action Plan (2009-2010)
- National Strategy for Prevention of Violence against Women in the Family and in Partner Relationships (2011)
- In 2009, the Gender Equality Directorate started its unit called "Project to Combat Sexual and Gender-Based Violence" which appeared as the first gender-oriented state fund directed to CSOs.

WOMEN'S HEALTH PROMOTION CENTRE (WHPC)

Due to restrictions within the EU grant, it was not possible to conduct a case study for Serbia. However, this chapter includes a synopsis of the work of the Women's Health Promotion Centre (WHPC). The WHPC is a non-government organisation which has been leading the work on women's health and gender-based violence in Serbia since its inception in 1993.

The WHPC contributed to the development of the Special Protocol for the Protection and Treatment of Women Exposed to Violence which was adopted at a national level by the Ministry of Health in 2010. This is the first and only protocol of this kind for addressing gender based violence in Serbia. WHPC also wrote the first manual for health professionals on how to recognise and respond to female survivors of gender based violence which was published in 2008. They were also responsible for implementing the survey in Serbia as part of the WHO Multi-Country Study on Women's Health and Domestic Violence Against Women.

WHPC Mission:

- Promotion of gender equality in the field of health and improved access to high quality health services for all users irrespective of their gender, nationality, ethnic or sexual orientation, religious affiliation, physical and intellectual potential, or age.

- Ensuring a gender approach to women's health as an integral component of all health and social care programmes.

- Promotion of a holistic approach to women's health through the life span.

- Ensuring early detection of gender based violence and appropriate interventions for survivors of domestic violence and sexual abuse within the health care system.

WHPC Vision:

- To ensure women are able to access to the information and services they need; to eliminate violence against women; to mobilise political will and resources for women's rights and development; and to increase women's participation in civil and political processes.

- To achieve the above, WHPC implements educational programs for health care providers and members of government and non-governmental groups, conducts local and international research, produces health information resources, and organises a range of advocacy and outreach initiatives, as well as cooperates with governmental authorities in creating documents related to changes in managing women GBV survivors.

WHPC educational programmes for health care professionals

WHPC have developed and delivered training to range of health professionals and governmental and non-governmental organisations. They obtained accreditation for their training programmes from the Health Council, Republic of Serbia in 2010 and 2011 for the permanent education for health care providers. Primary care professionals are able to obtain points to maintain their medical license by attending the domestic violence training programmes.

- WHPC organised and delivered 69 training sessions for health professionals of which 51 were basic level and 18 were advanced level.

- These training sessions included 1,518 health professionals (e.g. physicians, nurses) and others working with survivors of gender-based violence survivors. Of these, 547 attended the basic level of training and 971 attended the advanced level of training.

- In 2001 to 2002, WHPC delivered 3 train-the-trainers sessions on women's health for 12 women's groups in Serbia which included 42 activists. The training provided them with the knowledge and skills to conduct public discussions and workshops on women's health and violence.

- WHPC conducted 72 public discussions on gender based violence and its health consequences in 12 towns in Serbia and hosted 25 workshops for members of women's organizations in Serbia.

WHPC involvement in research

Local surveys

- WHPC implemented several local surveys in order to identify the gaps and challenges in providing services within the health care system. The objectives were to identify: (i) health professionals' attitudes, reactions and readiness to include gender based violence in their professional activities; (ii) assess women's needs for support and identify the gaps in health care services; (iii) identify the necessary competencies for health professionals to respond to gender based violence (e.g. knowledge, attitudes, and self-judgement).

- The findings enabled WHPC to plan programes for education and write manuals for health care providers (e.g. *Violence Against Women: My Professional Responsibility*). www.cenrtarzdravljezena.org.rs/publikacije

- Survey findings enabled WHPC to plan activities and a strategy to lobby authorities for education and improvement of services. WHPC conducted the following local surveys:

- *Assessment of health care provider's attitudes regarding gender-based violence* (2006): which included 13 focus groups with 134 professionals in Primary Health Care Settings www.centarzdravljezena.org.rs/nasiljeizdravstvenasluzba/

- *Assessment of the needs of women survivors of gender based violence* (2006) which included interviews with *240* women users of Health Centres. www.centarzdravljezena.org.rs/nasiljeizdravstvenasluzba/

- *Formative evaluation of health care providers attitudes, knowledge and skills to repond to the violence against women* (2010)*:* which included 21 Health Centres and 588 health professionals.

International surveys

- *WHO Multi-country Study on Women's Health and Domestic Violence against Women* (2005): the study involved individual interviews with 1,456 women aged between 15 and 49 living in the Serbian capital Belgrade. This study provided data on the magnitude of the problem of intimate partner violence as well as the associated health effects and women's coping strategies. WHPC used the findings to establish partnerships and gain the cooperation of authorities, academic and professional institutions, as well as raise general public awareness about issue and influence programmes and policy in the health care system.
  http://www.who.int/gender/violence/who_multicountry_study/en/

WHPC partnership with governmental institutions

- WHPC worked with the Ministry of Health in developing the Special Protocol for the Protection and Treatment of Women Exposed to Gender Based Violence

- WHPC also created a special form for documenting gender based violence in the health care system which was adopted by Ministry of Health Republic of Serbia and was included in the Special Protocol for the Protection and Treatment of Women Exposed to Gender Based Violence.

- WHPC worked with the Gender Equality Directorate, Ministry of Labour and Social Affairs, Republic of Serbia to write the 2010 national strategy for preventing and tackling violence.

- WHPC worked with the Ministry of Labour and Social Affairs Republic of Serbia in developing the conference "*Women, Health and Violence*" in November 2011.
  www.centarzdravljezena.org.rs/konferencija

- WHPC implemented the project "*Use of the Special Protocol on Protection of Women Exposed to Gender Based Violence in Health Care settings*" in 2010.

- WHPC also implemented the project "*Detect, Register, Report: Capacity Building for the Protection and Management of Women GBV Survivors in Primary health Care Settings"* in 2011.

WHPC partnership with health sector and academic institutions

- WHPC participated in a pilot project with 12 health centres in which domestic violence training, routine enquiry, documentation of domestic violence and referral pathways was implemented. A total of 1,997 documentation forms for gender based violence were completed. WHPC held 144 meetings with staff of the 12 health centres and representatives of local community organisations such as the police, welfare centres and municipalities. Round table discussions were held with 25 management teams of the health centres, which comprised of 79 participants, in order to implement the Special Protocol on the Protection of Women Exposed to

Gender Based Violence. A total of 22 Letters of Agreement were signed with the health centres regarding the implementation of the permanent domestic violence educational programmes based on the WHPC accredited programmes. A total of 6 (3-day) train-the-trainer courses were organised and conducted for health professionals. Further information about WHPC's work can be found at: www.centarzdravljezena.org.rs

Publications involving WHPC

WHO (2005) Multi-country study on women's health and domestic violence against women. Geneva: World Health Organisation.
http://www.who.int/gender/violence/who_multicountry_study/en/

Violence against women: my professional responsibility. Manual for Health Care Providers (2007)
www.centarzdravljezena.org.rs/publikacije
http://www.centarzdravljezena.org.rs/en/

Boston Women's Health Book Collective (2002) *Our Bodies, Ourselves*. New York: Simon & Schuster.
www.centarzdravljezena.org.rs/publikacije
www.ourbodiesourselves.org/

Promotional and informative publications (e.g. leaflets, booklets, posters)
www.centarzdravljezena.org.rs/publikacije

Results of Serbia Mapping Survey

Dissemination

The mapping survey was disseminated by the Serbian associate partner, Stanislava Otasevic to 6 established domestic violence intervention projects that target primary and/or maternity care settings in Serbia. There is no central system in Serbia for collating information on domestic violence interventions in any health care settings. Therefore, the survey may not have captured all domestic violence interventions based in primary and maternity care settings in Serbia.

Respondents

The six respondents who completed the survey were a health centre worker (1); general practitioner (3); a health worker (1) and the Director of the Women's Health Promotion Centre (1). It was possible for respondents to select multiple answers for some questions.

Intervention settings

Respondents reported that the interventions targeted multiple health care settings including: primary care (6); maternity services (5); pre-school and school children (1) and psychiatric services (1).

Health professionals targeted in the interventions included: general practitioners (6); midwives (2); nurses (4); nurses (6); health visitors (5); obstetricians (2); gynaecologists (6); social workers (5); paediatricians (3); psychiatrists (3); and emergency service doctors and nurses (1).

All respondents indicated that female patients were the target population of the interventions and 2 also mentioned male patients.

Table 7.1 Coordination, funding and location of domestic violence Interventions in Serbia

Note: names of interventions given may be descriptions rather than official names

Name and length of intervention	Professionals targeted in the intervention	Coordinating organisation and geographical location	Funding source
No name given (1 year)	General practitioners; midwives; nurses; health visitors; obstetricians; gynaecologists; social workers; psychologists; psychiatrists; paediatricians	Women's Health Promotion Centre/Ministry of Health/Institutes within the Health Department Belgrade, Pirot, Leskovac	Not known
Training, routine enquiry, documentation and referral (4.5 years)	General practitioners; nurses; health visitors; social workers; psychiatrists; paediatricians	The Prevention Centre Pirot borough	No financial support
No name given (8 years)	General practitioners; nurses; health visitors; gynaecologists; social workers; emergency service doctors and nurses; psychiatrists; paediatricians	Women's Health Promotion Centre/Ministry of Health/Ministry of Labour and Social Policy Entire Serbian territory	Ministry of Health Ministry of Labour and Social Policy
Protocol for the protection of women subjected to gender violence (1.3 years)	General practitioners; nurses; health visitors; gynaecologists; social workers	Women's Health Promotion Centre - a non-governmental organisation Belgrade, Velika Plana, Nis, Pirot, Leskovak, Zajecar, Tutin, Cacak, Pozega, Valjevo I Kraljevo	Ministry of Labour and Social Policy
Protocol for the protection and management of women victims of gender based violence(1 year)	General practitioners; midwives; nurses; obstetricians; gynaecologists;	Women's Health Promotion Centre - a non-governmental organisation Tutin (in South East Serbia)	Department of Gender Equality, Ministry of Labour and Social Policy – 'Borba' project against sexual and gender violence
Training about actions to be taken in cases of domestic violence(6 months)	General practitioners; nurses; health visitors; gynaecologists; social workers; psychologists	Women's Health Promotion Centre - a non-governmental organisation Municipality of Cukarrica, Belgrade	Women's Health Promotion Centre

Policies on domestic violence
Of the 6 respondents, 3 reported that they had a policy developed specifically for the intervention and 5 had a policy based on the 'national guidelines'. The policy included the following actions and guidance: routine enquiry for domestic violence (4); documentation of domestic violence (6); how to refer patients who disclose domestic violence (6); how to assess the safety of the patient and any children or vulnerable adults who may be affected by domestic violence (6); confidentiality and information sharing (6).

Domestic violence training
All 6 respondents reported that the intervention involved domestic violence training for health professionals. Health professionals and other organisations targeted for training include: nurses (6); general practitioners (6); midwives (5); health visitors (6); psychologists/psychotherapists (5); gynaecologists (6); obstetricians (5); social workers (5); psychiatrists (1), police/prosecution service (1); and primary and secondary schools (1).

Four respondents said that domestic violence training was not mandatory for any staff. Training was mandatory for nurses (10; general practitioners (2); midwives (1); health visitors (1); gynaecologists (2); and social workers (2).

Five respondents said that training was provided by a domestic violence trainer from outside the healthcare setting who was not a health professional, and 5 reported that training was provided by a health care professional.

All 6 respondents who reported that domestic violence training was provided to health professionals said that the training included routine enquiry for domestic violence; how to document a disclosure of domestic violence; how to refer patients who disclose domestic violence; how to assess the safety of the patient; and how to deal with issues of confidentiality and information sharing.

Table 7.2 Frequency and length of domestic violence training interventions in Serbia

Coordinating organisation and geographical location	Professionals targeted in the intervention	Frequency of training	Length of training	Train the trainer course available
Women's Health Promotion Centre/Ministry of Health/Institutes within the Health Department Belgrade, Pirot, Leskovac	General practitioners; midwives; nurses; health visitors; obstetricians; gynaecologists; social workers; psychologists; psychiatrists; paediatricians	Not specified	Not specified	No
The Prevention Centre Pirot borough	General practitioners; nurses; health visitors; social workers; psychiatrists; paediatricians	Once a year. More frequent training planned with accreditation	Workshop 7 hours Lecture 1 hour	Yes
Women's Health Promotion Centre/Ministry of Health/Ministry of Labour and Social Policy Entire Serbian territory	General practitioners; nurses; health visitors; gynaecologists; social workers; emergency service doctors and nurses; psychiatrists; paediatricians	Once or twice a year	3 to 4 days	Yes
Women's Health Promotion Centre - a non-governmental organisation Belgrade, Velika Plana, Nis, Pirot, Leskovak, Zajecar, Tutin, Cacak, Pozega, Valjevo I Kraljevo	General practitioners; nurses; health visitors; gynaecologists; social workers	Irregular and disorganised within the health sector.	1 to 3 days	Yes
Women's Health Promotion Centre - a non-governmental organisation Tutin (in South East Serbia)	General practitioners; midwives; nurses; obstetricians; gynaecologists;	Rolling programme.	3 days	Yes
Women's Health Promotion Centre - a non-governmental organisation Municipality of Cukarrica, Belgrade	General practitioners; nurses; health visitors; gynaecologists; social workers; psychologists	Training of medical professionals has been carried out once in two months.	Depends on the level of the training offered	Yes

Routine enquiry for domestic violence in the intervention
Three respondents said that the intervention includes routine enquiry for domestic violence of female (3) and male patients (3). Of these, 2 reported that routine enquiry was monitored via audits of patient records and 1 reported that domestic violence was recorded on special abuse documentation forms. Routine enquiry was defined by the three respondents as: asking direct questions when patients present with symptoms indicative of domestic violence; or when a health professional suspects domestic violence; or when a patient spontaneously discloses domestic violence.

Documentation of domestic violence
In the intervention health professionals are advised to document the following:

Table 7.3 Documentation of domestic violence

Information documented	Yes (N)	No (N)
Whether or not the patient was asked about domestic violence	6	0
Whether or not the patient disclosed domestic violence	6	0
Name of the perpetrator	2	4
Relationship of the perpetrator to the patient	5	1
A description of the types of abuse experienced	6	0
A description of any recent incident of abuse	6	0
A description of the types and location of injuries	6	0
A body map picture indicating location of injuries	6	0
Whether referral information was offered to the patient	6	0
Whether the patient accepted the referral information	2	4
Indication of any action taken by the patient	3	3
Whether there are any children in the household	6	0
An assessment of the safety of the patient and any children	5	1

Referral pathways
All 6 respondents said that health professionals refer patients to specialist domestic violence organisations in the community and 4 also refer to other health professionals. Six respondents said that they sometimes refer patients to social workers and a further 6 refer to the police. Other services that patients are referred to include shelters (1); and public prosecution service (1).

All respondents said that they offer referral information to patients that disclose domestic violence and 4 said that the health professionals contact the organisation on behalf of the patient.

Evaluation
Respondents were asked whether the intervention included a research component and to provide details of any reports or publications. One respondent reported the inclusion of research.

Table 7.4 Evaluation of domestic violence interventions in Serbia

Coordinating organisation and geographical location	Evaluation activity
Women's Health Promotion Centre/Ministry of Health/Institutes within the Health Department Belgrade, Pirot, Leskovac	Not specified
The Prevention Centre Pirot borough	No formal research or evaluation. Case conference reviews are scheduled and members of the support team submit their results. These are used for evaluation methods with regards to actions taken and end results achieved.
Women's Health Promotion Centre/Ministry of Health/Ministry of Labour and Social Policy Entire Serbian territory	No
Women's Health Promotion Centre - a non-governmental organisation Belgrade, Velika Plana, Nis, Pirot, Leskovak, Zajecar, Tutin, Cacak, Pozega, Valjevo I Kraljevo	There are reports on projects completed by the Women's Health Promotion Centre, no further details provided.
Women's Health Promotion Centre - a non-governmental organisation Tutin (in South East Serbia)	No
Women's Health Promotion Centre - a non-governmental organisation Municipality of Cukarrica, Belgrade	No

Conclusion

The findings demonstrate that there are a range of promising interventions for women and children affected by domestic violence in primary and maternity health care settings in the UK, Finland, the Netherlands, Spain, Germany, Belgium and Serbia. The mapping survey found 81 interventions in these countries, although it is likely that there are many more that were not captured by the survey. Many of the interventions described have been functioning for many years and are beyond the pilot phase. They target multiple geographical areas, health care settings and health professional disciplines. Although the interventions are situated in very different contexts, they faced similar conceptual and implementation challenges. The extraordinary variation in creativity reflected in the case studies, highlights the importance of the work that is happening in Europe. As academics, policy makers, NGOS, health professionals, governments and survivors eagerly await the results of intervention studies, many committed individuals continue in their efforts to bring about change in the way the health sector responds to women and children affected by domestic violence. This report contains the experience of some of those individuals, offering examples of innovative interventions and recommendations for good practice.