Llywodraeth Cynulliad Cymru
Welsh Assembly Government

Evaluation of the All Wales Ante-Natal Domestic Abuse Pathway

Research Report

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1) Background and methodology

Background

The All Wales Ante Natal Domestic Abuse Pathway (Pathway) is a legal record of care provision which provides Midwives and Health Visitors with an evidence-based, structured approach to encourage disclosures of domestic abuse and to assess the level of risk faced by the woman and unborn child. The Pathway was launched in 2005 across Wales, which involved training all Midwives and Health Visitors in the use of the Pathway and raising awareness about the impact and nature of domestic abuse. The Pathway is still being rolled out in Wales and three NHS Trusts are yet to implement it.

The Pathway itself consists of two forms. The first form, RE DA1 (Routine Enquiry into Domestic Abuse 1) is used to document the initial enquiry made by the Midwife or Health Visitor. The second form, RE DA2 (Routine Enquiry into Domestic Abuse 2) is completed if a disclosure of domestic abuse is made. The RE DA2 form consists of a risk assessment and signposts the health worker to a course of action, depending on the level of risk determined.

The Pathway is supported by a training resource pack which can be accessed via a website. The resource pack was also distributed in hard copy to all NHS Trusts in Wales. The implementation of the Pathway is being co-ordinated by the All Wales Health Visitors and Midwifery Networking Group (Networking Group), which is chaired by a Consultant Midwife who is based at North Glamorgan NHS Trust.

The Welsh Assembly Government provided funds for the development of the RE DA1 and RE DA2 forms and this was undertaken by a Consultant Midwife and a Senior Midwife seconded from North Glamorgan NHS Trust to the Welsh Assembly Government.

During the course of this evaluation, additional funding was obtained from the Welsh Assembly Government for a secondee to scope and develop the Pathway for use in Accident and Emergency settings. Funding has also been received from the Home Office for a secondee to scope and develop the Pathway for use in Gynaecology and Sexual Health settings across Wales.

Methodology

Overview

The aims of this evaluation are to provide:

- An assessment of the extent to which the Pathway has been implemented across Wales
- An examination of the interim impacts of the Pathway on Health Visitors and Midwives' practice and attitudes, as well as on women patients

- An assessment of the key mechanisms through which the Pathway has realised its outcomes
- An assessment of the transferability of the Pathway to other healthcare settings

Additionally, the research resulted in a set of recommendations for the future development of the Pathway and provided a framework for the ongoing evaluation and monitoring of the project.

Evaluation Approach

The health impact of domestic abuse and the role health services can play in tackling the problem is a complex issue (Humphries, 2007). Evaluation methodology should take account of this complexity. As a complex intervention, the Pathway required an evaluation that attempted to understand the process of change and how it occurs as well as the outcomes (Hunter and Killoran, 2004). This is because the impacts and outcomes of the Pathway are likely to be the result of a number of factors, which are difficult to 'control' as they would be in an experimental design (Hunter and Killoran, 2004). The approach chosen for the evaluation is based on Programme Theory. This allows the processes of the Pathway, as well as the outcomes, to be examined and is based on theory-driven methodology, particularly programme theory evaluation (Chen, 1990).

Programme Theory

Programme theory is concerned with the different 'domains' or themes relating to how and why a project may be successful or not. This approach allows evaluators not only to understand the impact of an intervention or project but also to describe and attribute the underlying causes and barriers to achieving the desired impacts and outcomes. As the evaluation is an interim evaluation, there is a further advantage in using a programme theory-based methodology because programme theory allows lessons learnt to be fed back to the programme managers and developers, to inform the future roll out. In this respect, the evaluation was also a formative process and was not concerned simply with measuring the impacts against the inputs (Creswell et al, 2007). The 'domains' of the approach are demonstrated in chart one, below. The chart is based on Chen's framework in 'Theory Driven Evaluation' (1990).

Chart 1. Evaluation domains

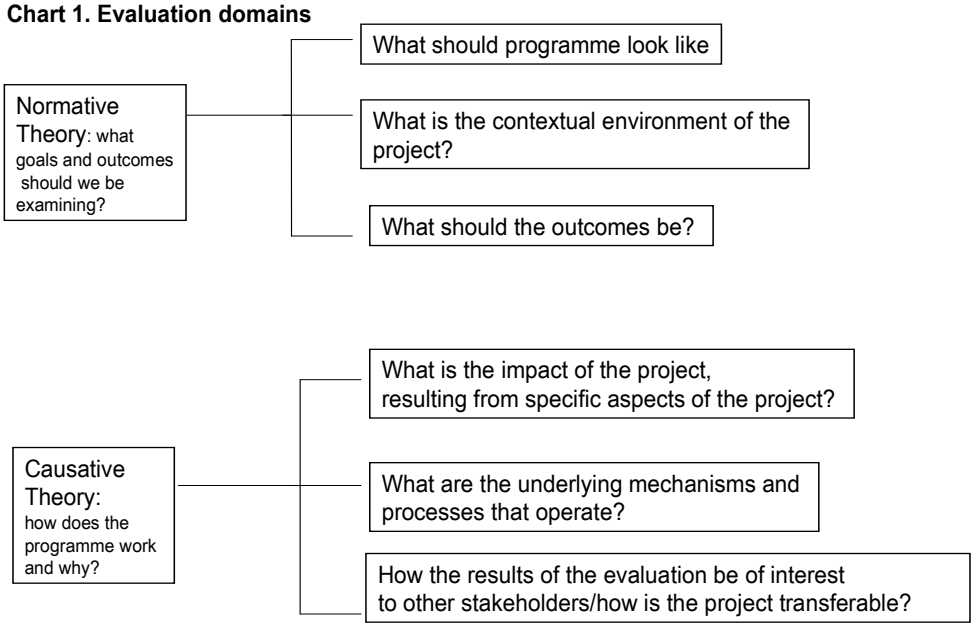

Table one below demonstrates what data collection sources were used to achieve the different research objectives.

Table one: Research objective and research methods

Research objective	**Research method**
Assess of the extent of implementation of the Pathway	- Examination of information submitted on use of RE DA1 and RE DA2 forms - Telephone interviews with Heads of Midwifery and Health Visiting - Postal survey
Examine the interim impacts of the Pathway on Health Visitors and Midwives' practice and attitudes, as well as on women patients	- 'Theories of change' interviews with heads of Midwives and Health Visitors - 'Case study' site visits and interviews - Examination of information submitted on use of DA1 and DA2 forms - Postal survey
Assess of the key mechanisms through which the Pathway has realised its outcomes	- Literature review - 'Theories of change' interviews with heads of Midwives and Health Visitors - Postal survey - Interviews with survivors - Case study visits
Assessment the transferability of the Pathway to other healthcare settings	- 'Theories of change' interviews with heads of Midwives and Health Visitors - Delphi study and policy forum

Overview of research methods

Literature review
A review of existing studies, policy documents and guidance was conducted to help establish the main rationale and 'theories' behind the pathway. The literature review also identified the potential barriers to the Pathway outcomes being achieved.

Theories of change interviews
The 'theories of change' interviews were conducted to help understand the main 'theories' behind the Pathway; in other words, to understand the rationale, inputs, contexts and expected outcomes. The interviews picked up on the themes identified through the literature review.

Members of the All Wales Midwifery and Health Visiting Networking Group (Networking Group) as well as the evaluation steering group were interviewed. The interviews were semi-structured and the questions were reviewed by the evaluation steering group before use.

Interviews were conducted on a one-to-one basis over the telephone. The interviews were written up and coded by using specialist qualitative data management software called Weft QDA.

Postal Survey
A survey questionnaire was developed for all Midwives and Health Visitors in Wales, which built on the themes of the literature review and theories of change interviews. Two versions of the survey were distributed, one for Health Visitors and one for Midwives. The purpose of these surveys was to determine respondents' expectations of the Pathway and, where applicable, reactions to the training.

Postal surveys were sent to all Health Visitors and Midwives across Wales and were distributed through Heads of Midwifery and Health Visiting. In addition, a separate survey was sent to Heads of Midwifery and Health Visiting. In some cases, Heads of Midwifery or Health Visiting communicated with the researchers they had not implemented the Pathway fully and would, therefore, need a different version of the survey. A second version of the survey was then sent out, which included separate sections for those members of staff who had and those who hadn't completed the training.

The surveys contained a mixture of structured and semi-structured questions. The questions were designed to probe and explore the answers given. The surveys were fairly in-depth and provided an opportunity for reflection. The surveys were entirely anonymous and respondents were encouraged to be as open and honest as possible.

A total of 2200 surveys were sent out and 253 completed surveys were returned in total, which is an overall response rate of 11.5%. The 253 responses included 31 'low implementation state' surveys (response rate 31%) and 3 responses from Senior Midwives and Health Visitors (response

rate 6%). The overall response rate was consistent with similar studies in which respondents were asked to give a fairly in-depth amount of information (eg. Macavoy and Kaner, 1996 and 1998). Other studies with more structured questions have yielded higher response rates but for this evaluation, more qualitative information and opinion was sought.

Examination of the RE DA1 and RE DA2 audit
The use of the Routine Enquiry into Domestic Abuse forms one and two (RE DA1 and RE DA2) is routinely examined as part of the mandatory bi-annual peer reviewed record keeping audit across NHS Wales, which is undertaken by all Health Trusts in Wales. The bi-annual audit presents an opportunity to collate and compare information on the use of the Pathway forms and this is done by the chair of the Networking Group, as a separate exercise to the biannual audit. The information collected through this process was examined as part of the present evaluation, to establish levels of implementation and use of the Pathway paperwork.

Follow up interviews with Heads of Midwifery and Health Visiting
These interviews were designed to 'follow up' on key points that had been identified through the postal survey, as well as to validate some of the findings from the survey. The 'follow up' interviews were conducted over the telephone with Heads of Midwifery and Health Visiting and sought to explore in more depth some of the key mechanisms, barriers and impacts of the Pathway. The interviews were recorded, written up and coded using specialist coding software.

Interviews with women survivors
Two women survivors were interviewed. It was not possible to interview more than this as participants had to be 'recruited' to take part in the interviews through specialist support agencies and not through health workers, due to confidentiality issues. Unfortunately, support agencies do not routinely keep records of where referrals originate. It was, therefore, difficult to discern which women had been referred through the Pathway. The interviews were conducted and recorded with the explicit consent of the participants. The interviews were written up and anonymised for inclusion in this report.

Case study visits
Visits were made to three NHS Trust areas across Wales. The purpose of these visits was to see the actual environment where the Pathway was being used and to provide the opportunity to talk to health workers face-to-face.

The case study areas were as follows:

- A rural area with an early state of implementation
- An urban area with a high state of implementation
- A mixed area with moderate amount of implementation.

These areas were selected to represent the range of Trust areas that exist across Wales: rural, urban and mixed as well as different levels of implementation of the Pathway.

Health Visitors were interviewed in one area and Midwives were interviewed in two others. The interviews were recorded, transcribed and coded using specialist coding software.

Ethical approval for the case study visits was obtained through the Central Office of Research Ethics Committees (COREC).

Delphi study
A Delphi study was conducted to reflect on the main findings of the research and to try to gain consensus over what constitutes the key mechanisms for ensuring that the Pathway is effective and in what other health contexts the Pathway could be introduced.

A Delphi Study acts like a form of poll. It involves a systematic round of questioning to a group of people with either interest in or knowledge of a subject. Responses to the questions are reflected back to the whole group (with clarification where necessary) to provide an opportunity for non-confrontational decision-making. This is repeated as necessary in order to establish an acceptable level of consensus.

Policy forum
A meeting was held with respondents to the Delphi study and other stakeholders to discuss the findings of the evaluation and to think about ways to address the barriers that had been identified. In addition, the meeting was also convened to think about the next steps for the Pathway and where else it might be rolled out.

Details of participants in the Delphi Study and Policy Forum are included at Appendix five.

Respondents

The number of respondents to each element of the research were as follows:

- 'Theories of Change' interviews with members of the networking group: n=7
- Postal survey responses: n=253
- Follow up interviews with heads of Midwifery: n=10
- Follow up interviews with heads of Health Visiting: n=14
- Case study site visit one: n= 7 Health Visitors, n=4 women patients
- Case study site visit two: n=6 Midwives
- Case study site visit three: n=7 Midwives
- Interviews with women survivors who had been referred through the Pathway: n=2
- Delphi Study: n=10
- Policy Forum: n=12

Barriers to the research

As the research was an interim evaluation of a national programme, an important barrier encountered was the differential states of implementation across the NHS Trusts in Wales. This meant that some areas were not able to respond to the postal survey in its original format and had to be re-issued with a slightly different survey, so-called 'low implementation state' surveys. In addition, some health workers were not able to attend training due to sickness or holidays and so, were not able to comment on the Pathway training. The postal survey was administered over the Christmas period, which may have resulted in delays in surveys being returned. The survey also coincided with another survey on workforce management, which might have reduced responses.

Another significant barrier was the tight time scale of the research, which had to allow for clearance through COREC for the case study element of the research. The length of this process meant that, in some cases, only short notice could be given to case study areas.

Rationale for the Pathway

There is ample evidence of the high prevalence of domestic abuse in society and of the prevalence of domestic abuse in pregnancy. The prevalence of partner-perpetrated violence during pregnancy is estimated to be between 2.5% and 22% (Bacchus et al, 2003). Domestic abuse is the largest cause of morbidity in women aged 19-44 in the UK, greater than war, cancer and motor vehicle accidents (Welsh Assembly Government, 2005). In pregnancy, the effects of domestic abuse can include miscarriage, maternal death, premature birth, babies with low birth weight, stillbirth, infant injury and death (Ramsay et al, 2002).

Studies inside and outside the UK have found that women experiencing domestic abuse often report negative encounters with health professionals, who fail to recognise the signs of the abuse or who fail to provide support when abuse has been established (Bacchus et al, 2003; Gerbert et al, 1996). In the last decade, however, domestic abuse has gained increasing recognition as a major public health issue amongst health professionals, academics and specialist domestic abuse agencies. Health professionals have been identified as having a unique role in supporting women and children affected by domestic abuse through practices such as routine enquiry and the documenting of abuse, providing safety assessments and referring to organisations that can provide assistance (Department of Health, 2000). A growing number of guidelines and position statements have been published by health governing bodies and institutions which '*emphasise the prevalence of domestic abuse and advocate recognition, assessment and referral within and beyond the health service'* (Ramsay et al, 2002, p. 314). For example, the Royal Colleges of Midwives (1997) and Nursing (2001) and the National Institute of Clinical Excellence (2003) have developed guidelines for the identification and support of women affected by domestic abuse.

The recognition of the role health professionals can play, as with other professionals such as the Police, Social Services, Education and local policy-makers, has been influenced by a growing feminist critique of the problem of domestic abuse, which encourages it to be seen as a public safety, crime or public health issue (Peckover, 2003). Recent important additions to the policy framework around domestic abuse include the Domestic Violence, Crime and Victims Act 2004, the Welsh Assembly Government's Domestic Abuse Strategy: 'Tackling Domestic Abuse, the All Wales National Strategy' (Welsh Assembly Government, 2005) and the Home Office 'National Action Plan on Domestic Violence' (Home Office, 2005). Importantly, the Department of Health is soon to release revised guidance for health practitioners, 'Responding to Domestic Abuse: A Hand Book For Health Professionals', which incorporates an action plan based on recommendations made to Ministers by an Advisory Group consisting of Royal Colleges of Midwives, Nursing, Obstetricians & Gynaecologists, GPs, Psychiatrists and domestic abuse voluntary organisations.

However, despite the gains made by feminist arguments which have resulted in domestic abuse being treated seriously in other parts of the public sector, some research into Health Visitors' and Midwives' understanding and treatment of the problem shows the feminist perspective has been slower to take hold amongst this group (Peckover, 2003).

The barriers facing health professionals in tackling domestic abuse have been shown to include: time constraints, lack of confidential time with women, safety issues for health workers, staff shortages, low staff morale and Midwives' personal experiences of domestic abuse (Peckover, 2003). Fear of offending the women is commonly cited by health professionals as a reason for not getting involved (Scobie and McGuire, 1999).

Some studies have examined women patients' views on being routinely asked about domestic abuse. These studies have shown that once women have experienced routine enquiry, they are usually in favour of the policy. This is true both for those who have experienced or are experiencing abuse and for those who have not (Macey and Bewley, 2001).

Evidence supporting routine enquiry or 'screening'
Jean Ramsay and colleagues' 2005 review of the evidence of effectiveness of routine enquiry into domestic abuse found that 'system centred interventions' or those which are intended to improve '*organisations' response to domestic abuse'* (p.20) can increase referral rates to support agencies in the short term. However, Ramsay found insufficient evidence to recommend 'screening' programmes. Taket and colleagues (2003) make the distinction between 'screening' and 'routine enquiry'. The former, defined by the UK National Screening Committee (Taket et al, 2003, p. 673) is the application of a standardised question or test according to a procedure and does not vary from place to place. In Routine Enquiry, '*procedures are not necessarily standardised but questions are asked routinely in certain settings or if indicators of abuse arise.*' (Taket et al 2003, p. 674). The authors conclude

routine enquiry is more suitable within the health care context. Taket and colleagues argue that a strong case exists to support *routine enquiry* into partner abuse in many healthcare settings. The All Wales Ante Natal Domestic Abuse Pathway is a process of routine enquiry and not screening.

Women from Black and Minority Ethnic communities and domestic abuse

The problem of staff unwillingness or inability to enquire about domestic abuse may be exacerbated for women from Black and Minority Ethnic (BME) communities (Thiara, 2005). This may be because fears of being seen as racist or insensitive to other cultures can '*operate as a basis for non-intervention'* (Thiara, 2005, p. 4). This issue, described as '*cultural privacy*' (Thiara, 2005, p. 9), creates further barriers to services for women from BME communities.

2) Main findings

Key learning points from the findings of the evaluation study are placed in text boxes throughout the report.

'Theories of change' interviews: *what is the Pathway supposed to do*?

Rationale for the Pathway

Midwives and Health Visitors from the Networking Group were asked to comment on the overall rationale for the Pathway. This question helped to understand the overall desired aims and outcomes for the Pathway, against which its success can be measured.

The rationale for the Pathway is that it should bring about a change in professional attitudes towards domestic abuse so that it is seen as part of Health Visitors' and Midwives' responsibility to address the issue. The Pathway is seen as an agent for change in professional practice and attitude.

Responses were given as follows:

> *'[Prior to the Pathway] there was no formal structure and staff did not have authority to tackle domestic abuse, the Pathway and training is changing attitudes and the confidence to tackle the issue'.*
>
> *'Historically Health Visitors and Midwives are aware of the problem but not willing to get involved or jeopardise their position of trust, but they are aware that levels of abuse is very high.'*
>
> *'The Pathway was designed to press behind the issue of domestic abuse so that it is not such a taboo.'*

Main Priority for the Pathway

Midwives and Health Visitors were asked to comment on what they thought were the main priorities for the pathway.

The main priority for the Pathway is for women and children's safety to be improved.

Responses to the question '*what is the main priority for the Pathway?' were as follows:*

'*To Safeguard Women'*

'To Promote safety'

'To ensure safety for the women and children'

'To promote awareness amongst health professionals and women'

'That women are identified and given support to help them decide on what their outcome should be… and keeping children safe'.

'To reduce morbidity of the foetus and women'

Outcomes for women victims

Midwives and Health Visitors were asked what the main desired outcomes were for women victims.

The desired outcomes for the Pathway, in the longer term, are around promoting awareness amongst women victims at risk of harm and encouraging women to seek help.

One of the main desired outcomes of the Pathway for women victims was to affect a change in attitude, in order to raise awareness of the risks of domestic abuse. As the following quote illustrates:

'*Self awareness of risk...it is very clear that sometimes victim not aware of the level of risk they are in.'*

Outcomes for health professionals

Midwives and Health Visitors were asked the same question about desired outcomes for health professionals.

The desired outcomes of the Pathway for health professionals are for an increased knowledge base and changes in professional attitude towards the issue of domestic abuse so that health workers will be more willing to help.

The responses were summarised by the following quote**:**

'*The main outcomes should be to be comfortable to ask the question. To have a structure in place to be able to deal with the issue. To be more willing to ask. To have increased knowledge*.'

Most important mechanisms

Midwives and Health Visitors were asked to consider what might be the most important mechanisms that need to be in place in order to achieve the desired outcomes of the Pathway.

Staff training and resources are felt to be the most important mechanisms in order for the desired outcomes of the Pathway to be achieved.

In addition, some respondents mentioned the importance of internal staff policies on domestic abuse:

'To have a Human Resources policy in place for staff who are also experiencing the problem of domestic abuse.'

Main anticipated barriers

Midwives and Health Visitors were asked what might be the likely barriers to the Pathway being implemented or the outcomes being achieved.

Midwives and Health Visitors indicated a range of potential barriers to the Pathway being implemented. These are either around gaps in staff knowledge and skills in dealing with cases of domestic abuse or in terms of practical barriers and constraints such as lack of resources or pressures on staff time.

The following quotes illustrate these potential barriers:

'Not knowing how to work with ethnic minority women and deal with the problems of translation'

'There may be worries about consent issues and child protection, resources available and knowing where to refer to.'

'Time constraints. There may be a worry about not having time'.

Attitudinal and cultural issues

Midwives and Health Visitors expressed concern over the willingness or ability of staff to adopt the new processes of the Pathway and the support that might be required to overcome these potential problems.

The following quotes demonstrate some anxieties respondents had about potential barriers connected with staff attitudes and reluctance to adopt new practices.

'*There may be a fear of 'opening a can of worms'.*

'Creating the opportunity to ask the question – it requires a different level of trust and a support mechanism for the staff involved'.

'The Pathway is still in its infancy but the main barrier was the initial reluctance by health staff to take this on, but the training helped'.

Logistical barriers

The potential logistical barriers to implementing the Pathway are connected with resources or availability of staff time.

Some barriers to implementation at the early stages of the Pathway being introduced were connected with the delivery of the training sessions.

'*Limited resources – we could only afford half a day training sessions but we could have benefited with longer training sessions'.*

'*Training needs to be wider to include hospital staff to ensure that the Pathway is extended to when women are in hospitals and to ensure joint working'*.

'Following implementation, concerns were around work load'.

'The main concern is the potential increase in the work load, and the follow through once disclosure has been achieved. There aren't many resource available for this'.

The lack of internal domestic abuse policies for health staff was also indicated as a potential barrier.

It was felt, in some cases, staff might be incapable of asking the question about domestic abuse to their clients, if they themselves have been victims. This issue was considered to be a potential barrier to implementation and had to be addressed before the Pathway could be fully implemented.

Postal Survey

The main findings of the postal survey are described below. Unless otherwise stated, percentages are given for the total number of actual responses to each question.

Historical problems with dealing with domestic abuse as part of health workers' practice.

Respondents were asked to describe briefly any problems they had encountered in the past in addressing domestic abuse. The purpose of this was to assess if the Pathway had addressed the problems health workers

faced in dealing with domestic abuse. Respondents gave a range of views in answer to this question. The following are the most frequently mentioned historical problems:

- 18% mentioned partners or another member of the family being present and not being able to find confidential time alone with the woman
- 17% mentioned difficulties with broaching the issue of domestic abuse initially
- 16% stated that women's own inability or reluctance to accept that abuse is a problem was a problem they had encountered. This included women who 'minimise' the seriousness of the problem or do not feel that abuse is unacceptable and women who are too afraid to address the problem.

Issues mentioned less frequently included:

- Domestic abuse being too complicated for the health worker to deal with
- Poor communication between agencies such as Police and Social Services and with other health workers
- Poor communication between Health Visitors and Midwives
- Health workers not having a clear structure or process in place for dealing with domestic abuse.

Did the training help?

Respondents were asked if the training helped them overcome the historical problems they mentioned.

Overall responses are summarised in tables two and three below.

Table two: Did the training help overcome problems dealing with domestic abuse?

Partially	39%
Yes	30%
No	25%

Broken down into the most frequently mentioned historical problems, the training was felt to assist in the following ways:

Table three: what did the training help with?

Historical problem	**yes**	**No**	**Partially**
Broaching the issue of domestic abuse and having confidence to discuss the topic with women	35%	4%	58%

Partner being present/problems gaining confidential time with women	12%	51%	37%
Woman's reluctance to accept that abuse should be addressed	10%	30%	45%

Respondents were further probed about any gaps they felt existed in the training. Only two dominating responses emerged:

- 10% of respondents felt they would have liked more help and advice with what to do after there had been a disclosure, including how to find external support or deal with external agencies
- 15% of respondents observed that there was a time lag between training and implementation. This was particularly the case with Health Visitors.

Less frequently mentioned 'gaps' in the training were:

- Not enough focus on Health Visitors' role and too much focus on the role of Midwives
- The need for further support following the training. This theme was picked up elsewhere in the survey responses.

Levels of confidence with dealing with domestic abuse as a result of the training

Respondents were asked to summarise their confidence with a range of aspects of dealing with domestic abuse, following their training. Respondents could choose from the following statements to reflect their confidence level:

Yes, I feel confident with this	*I feel better about this but still have some uncertainty*	*I still don't feel confident with this*	*The training didn't address this at all*

In addition, the statement 'this wasn't important to me' was provided as an option. However, only two respondents used this option. The responses were given a score of between one and four, 'one' representing the most confident and 'four' the least confident.

Table four below shows the levels of confidence for each aspect of dealing with domestic abuse. The table shows the mean and median score of all valid responses. The higher the score, the less confidence expressed.

Table four: confidence following training

Aspect of dealing with domestic abuse	Mean confidence score	Median confidence score
Being able to ask the question about domestic abuse routinely	1.8	2
Being able to obtain confidential time alone to ask the question about domestic abuse	2	2
Being able to deal with a woman who you are unable to see alone throughout her pregnancy	2.2	2
Being able to complete the form RE DA 1 with women	1.9	2
Being able to complete the form RE DA2 with women who have disclosed	2	2
Being able to refer a woman who had disclosed	1.8	2
Knowing what to do afterwards, once you have referred a woman who has disclosed domestic abuse	2.2	2
Knowing where your responsibilities start and finish with women victims	1.9	2
Being able to work with Health Visitors/Midwives to ensure that there is continuity in support when a woman has disclosed	1.5	1
Being able to share information and under what circumstances with Social Services Child Protection teams	1.5	1
Being able to share information and under what circumstances with the Police	1.6	2
Knowing where to go for further information and support about the issue of domestic abuse with clients	1.5	1
Knowing where to go for further information and support about the issue of domestic abuse if you or a colleague/friend have suffered from it	1.6	1

Table four shows the issue of being able to find confidential time alone with a woman to make the enquiry about domestic abuse and being able to complete form RE DA 2 were issues on which health workers had the least confidence.

The overall confidence level demonstrated through this exercise was quite good, with an overall mean score of 1.7 (median 2).

Overall support for the Pathway

Respondents were asked about their overall levels of support for the Pathway with the following question:

"To what extent would you agree with the statement 'the domestic abuse pathway and the training that goes with it has meant that domestic abuse is less of a hidden issue for Midwives/Health Visitors and is now routinely tackled".

Respondents could answer on the following scale:

Strongly agree	*agree*	*Neither agree or disagree*	*disagree*	*Strongly disagree*

The responses were given a score of one to five; 'one' corresponds with 'strongly agree' and five corresponds with 'strongly disagree'. The mean score of responses was 2.4, (median 2), which represents a moderate level of overall support for the Pathway and Pathway training.

Respondents gave a moderate rating in terms of their overall support for the Pathway and Pathway training.

We asked respondents to give reasons for their responses to this question. These responses were analysed for patterns. The findings are presented in table five below.

Table five: Reasons for higher levels of confidence (<3)

Reason	***% of <3 responses***
Because there will be more awareness generally and the issue of domestic abuse will be less hidden	*17.5%*
Because health professionals will have more confidence to ask the question about domestic abuse	*12%*
Because domestic abuse is normalised as part of practice and so it will be easier to address.	*6%*

For scores >3, reasons were as follows:

- 9%: Health Visitors already knew how to deal with domestic abuse

Less frequently expressed comments for scores >3 include:

- There is a gap between training and implementation
- Communication between Health Visitors and Midwives is poor and information is not being shared.

What are the most important elements to ensure the Pathway is used effectively?

Respondents were asked this question to attempt to isolate the key elements of the Pathway for ensuring its success. This question was also useful to establish if the Pathway could be rolled out to other areas of the health care service. The most frequent responses are given in table six below

Table six: most important mechanisms for the Pathway to be used effectively

To provide updates and refresher training for health workers	14%
To ensure actual use – through monitoring	13%
Communication and information sharing between agencies	11%
To ensure that there is training and support to health workers to deliver the pathway	7%

No key mechanisms were identified by survey respondents, which would have precluded routine enquiry into domestic abuse being rolled out into other health service areas.

Expected outcomes of the Pathway

Respondents were asked what they expected the outcomes of the Pathway would be for survivors/victims, Midwives and Health Visitors and also for women generally. Tables seven and eight below give the main responses.

Table seven: Expected outcomes for survivors/victims and women generally

More opportunity for women to disclose	9%
Victims are able to access support and help	3%
More awareness of the issue generally in the population and willingness to address the issue	41%

Table eight: Expected outcomes for Midwives/Health Visitors

More confidence to ask the question	18%
More pressure on staff time and resources	5%
A more structured framework in which to tackle the problem of domestic abuse	13%

The main anticipated outcomes of the Pathway are that there will be more awareness of domestic abuse generally in the population and willingness amongst victims and women generally to address the issue.

A further question was posed to help summarise health workers' views on the likely future impact of the Pathway. Respondents were asked their opinion of how likely it was that the following set of outcomes would be achieved:

More women victims are identified generally
More women victims are referred to support services

Midwives are able to deal with domestic abuse more effectively
Health Visitors are able to deal with domestic abuse more effectively
More children are protected from the effects of domestic abuse
Other health agencies are more aware of domestic abuse
Midwives are able to communicate better with Social Services
Health Visitors are able to communicate better with Social Services
There will be more awareness amongst women generally that domestic abuse is not acceptable

Respondents were given a choice of answers as follows:

Very likely	*Likely*	*Can't say*	*Unlikely*	*Very unlikely*

Responses were scored from one to five; one being 'very likely', five being 'very unlikely'. Table nine below presents the mean score of responses for each question.

Table nine: Confidence levels in each outcome being achieved.

Outcome	**Mean confidence score**	**Median confidence score**
More women victims are referred to support services	2.2	2
Midwives are able to deal with domestic abuse more effectively	2.2	2
Health Visitors are able to deal with domestic abuse more effectively	2.3	2
More children are protected from the effects of domestic abuse	2.3	2
Other health agencies are more aware of domestic abuse	2.1	2
Midwives are able to communicate better with Social Services	2.4	2
Health Visitors are able to communicate better with Social Services	2.4	2
There will be more awareness amongst women generally that domestic abuse is not acceptable	1.8	2

The overall mean score for this exercise was 2.1, closest to 'likely', (median 2). This indicates the level of confidence that a number of outcomes will be achieved is reasonable and that a reasonable level of optimism exists.

Midwives and Health Visitors are generally optimistic that the desired outcomes of the Pathway would be achieved, particularly that there will be more awareness amongst women generally that domestic abuse is not acceptable

Ability to undertake routine enquiry

The standard for the Pathway, as it is fully implemented, is that *all* women patients will be asked the initial routine enquiry with the aid of the Routine Enquiry into Domestic Abuse form 1 (RE DA1). Survey respondents were asked if this had been possible in practice. Although it is expected that rates of routine enquiry will improve as implementation is further advanced, the question was designed to examine the day-to-day barriers to implementation experienced by health workers. Responses to the question, 'have you been able to ask all women patients about domestic abuse since the Pathway was introduced' were as follows:

Figure one: responses to the question have you been able to ask all of your women clients about domestic abuse since the Pathway was introduced?

no	**81%**
yes	**18%**

However, a strong note of caution should be sounded as this result includes Health Visitors, whose role is not to routinely ask all women but to ask only those who had *not* been asked by Midwives.

Respondents were further asked why they had not been able to ask all women patients.

The overwhelming answer (80% of responses) to the question, 'could you describe some of the reasons why it has not been possible to ask all women clients about domestic abuse' was: 'partners or other family being present'.

Results from the bi-annual audit of routine enquiry forms

In general, implementation of the Pathway has been successful in that it has been implemented in all but three Trusts. Except for the three Trusts which have not yet implemented, training has been made available to all Midwives and Health Visitors in Wales. It is too early to give a full analysis of the impacts and outcomes for women referred through the Pathway as implementation is not yet mature.

The overall aim for the Pathway is that all women patients will be subject to routine enquiry *twice* during their pregnancy or postpartum period. Table eight below demonstrates that some Trusts have been able to gain as much as a 87% rate of women being asked once (using RE DA1 forms). In some cases, rates of RE DA1 (asked once) are reasonably high but not for asking twice.

However, the actual change in practice which the Pathway is seeking to achieve is to that 100% of women are subject to routine enquiry twice, as part of their normal package of care. There is still some way to go before achieving that. Table ten below shows the rates of enquiry for some Trusts in Wales.

Table ten: rates of routine enquiry

NHS Wales Trust	% of new clients asked RE DA1 once	% of new clients asked RE DA1 twice	% of new clients undertaken RE DA2	% of RE DA2 determined as medium risk	% of RE DA2 assessments determined as high risk	% of RE DA2 determined as very high risk	% of women asked RE DA2 who have been referred to another agency.
Cardiff and Vale	15%	1%	Not available	4%	5%	12%	12%
Gwent	25%	2%	3%	2%	1%	0%	3%
North Glamorgan	75%	0%	10%	2%	0%	12%	10%
Carmarthen	87%	69%	5%	5%	0%	0%	5%

Follow up interviews with heads of Midwifery and Health Visiting

How embedded is the Pathway?

Implementation levels vary across the Trusts. Trusts are responsible for stating their own implementation dates and for managing the roll out of the training. Some respondents reported there have been problems in obtaining robust data about use of the RE DA1 and RE DA2 forms in their areas. In some cases, Heads of Midwifery or Health Visiting were unable to monitor the use of the RE DA1 and RE DA2 forms, or were unsure about how they would go about this. This would present a significant barrier to monitoring the effective use of the Pathway across Wales.

Each Trust had to manage the task of co-ordinating training for their own staff and ensuring the Pathway was implemented in a timely manner. Some Trusts were keen to wait until all relevant staff had received the training before they 'launched' the Pathway process, in which case there was a long period between the first round of training and implementation. One Trust ensured all staff were aware of the Pathway process even if they had not yet received the formal training.

Implementation can be measured both in formal terms for example, the number of women who have been asked about domestic abuse using the RE DA1 and RE DA2 forms, or in less formal terms such as how many Health Visitors and Midwives feel the Pathway is part of everyday practice.

In some Trust areas, respondents felt implementation had actually taken place formally but practice was still not following the policy:

> *'The supervisor Midwife undertook an audit, and they found out that either the women weren't being asked or the Midwives weren't actually recording it in the appropriate places.'*

Health Visitors generally had less experience of using the pathway. However, this is to be expected due to the design of the Pathway process.

In one case there was quite a pronounced hiatus between training and actual use for Health Visitors:

> *'We had training a couple of years ago now and it doesn't actually seem to be up and running because there's nothing coming through to us yet via Midwives or anything'.*

Health Visitors appeared to be less clear about their responsibilities for using the Pathway because it was thought to be a process mainly for Midwives, despite the fact that Midwives and Health Visitors were jointly trained in many Trust areas. This confusion was felt to be partly as a result of the time lag between training and implementation, which was particularly long for Health Visitors.

In some cases information about whether routine enquiry had been undertaken with women patients was not being passed on to Health Visitors. Respondents were unsure as to why:

> *'I don't know exactly a hundred per cent why. It's either to do with consent or confidentiality or something like that, they've had a bit of a hold up from that point of view.*'

Other areas felt that the Pathway had become an integral part of practice:

> '*Well, it's very well embedded. The Antenatal Pathway is used by all the community Midwives very well, and it highlights ... it has highlighted a number of kind of concerns that women have raised. So it is well embedded'*.

The Pathway as a 'change' issue

Organisational cultural issues were also felt to be a barrier. The Pathway was thought by respondents to mean a cultural change in Midwifery and Health Visiting practice, which would take longer to resolve than technical or logistical issues:

> '*Obviously it's a change in culture and that's what we need to handle really, but the training I think is going a long way to address that in how to ask the questions'*.

> '*So I think that Midwives themselves felt that the ... it would adversely affect their relationship with the women if there was a disclosure. Because of course, they would follow up with saying, depending on what the disclosure was, about Social Services being informed, and they felt that that may well impact on their relationship that they are trying to develop with the women'.*

Changes in professional attitude and confidence, it was felt, should be measured as part of monitoring the Pathway's success.

It was commented by senior Health Visitors and Midwives that, in the longer term, the Pathway would become part of 'normal practice' and perhaps even, it was hoped, get to a point in which the paperwork was not needed because the issues of domestic abuse are well understood and documented as a matter of course:

'I mean, I would like to see in the future that we don't have actually the paperwork, that it's just embedded into practice and it's part of the questioning for antenatal care'.

That the Pathway should become an accepted part of routine practice, no longer requiring specific forms is supported by Taket and colleagues (2003) who suggest routine enquiry should not be about systematically filling in forms but should be accepted as a way of managing risk as part of normal health care. However, it was accepted by respondents that the forms will help to bring about this change in practice.

Barriers to implementation

Many of the barriers to implementation described by senior Midwives and Health Visitors were due to uncertainty or anxiety about the effects of the Pathway in the early stages. In practice, however, some respondents found these barriers were overcome as implementation matured.

As the Pathway has become embedded, attitudes to the Pathway were altered, for example:

> '*I think there were major concerns it would be a huge problem, but it actually hasn't been*'.

Respondents discussed some of the concerns held by Midwives and Health Visitors, which had acted as barriers to the Pathway being implemented in the early stages. It was felt by Senior Midwives and Health Visitors that staff were worried they would not be able to deal with the problem of domestic abuse as they were not suitably qualified or trained or skilled:

> '*I think it became an issue for the Midwives feeling that they weren't going to ever be qualified enough to be able to deal with the effects of domestic abuse or even just asking the question*'.
>
> '*They don't really know kind of what to ask and then what advice to give and where to refer them'.*

Other barriers documented were related to resources and pressures on staff time:

'*It's again time and releasing staff to do the training, because it's a whole day's training course'*.

'*You can't say well I'm going to ask her today because I've got a bit of time today, you might not be able to do that, because she's not on her own. And the times she's on her own is when you've got six other bookings and a really busy clinic and about ten minutes'*.

Trusts decided for themselves which approach they would take to implementation. Some Trusts had to address structural and infrastructure issues within their organisation before the pathway could be implemented.

For example, two trusts mentioned the necessity of ensuring an internal staff policy on domestic abuse was in place before they could begin implementation.

Other Trusts faced problems because of their size and scale:

'…so, you know, it's a big service. So yes, obviously we couldn't train them all one week and implement it the next week.'

One of the larger Trusts ensured that Midwives were aware of the Pathway process even if they hadn't yet had their training and were given the Pathway referral information to use. This was to ensure the Pathway could be implemented in a timely manner.

Larger Trusts seemed to have wider time gaps between training and implementation. This was felt to be a barrier to successful implementation.

The effect of the 'time lag' between training and implemented were described:

'*I think you lose a little bit of motivation, you know, and I do think that that is a problem. It is better to have the training one week and then, you know, implement it the next week'*

One respondent mentioned a difficulty with actually ensuring the RE DA1 and RE DA2 forms were used. Some health workers were simply failing to use the forms and it was not known why this was the case. Senior Health Visitors and Midwives often relied on the mandatory bi-annual audit of paperwork to provide them with performance information around the usage of the forms however, this does not happen regularly enough to constitute ongoing, pro-active monitoring.

Elements that actually changed practice

Heads of Midwifery and Health Visiting were asked to reflect on the elements of the training or Pathway process that had actually brought about a change in practice. Responses were as follows:

'*Raising people's awareness through the training so that they could perhaps recognise women that had obviously been systematically abused over years, that they could actually recognise the traits and the trends of how these women appeared.'*

'At least we've got a Pathway and we've got a referral system that we didn't have before. I think it was up to each Midwife sort of having to flounder in the darkness, but now at least they have got a set way of doing things, which is helpful.'

'I would say it's the universal asking of that question and the documentation of it.'

The main effects of the Pathway in terms of changing professional practice were brought about through the training, which had helped to change staff attitudes and awareness of domestic abuse. In addition, the routine-ness of the Pathway was thought to be an important factor that would change attitudes within the health services.

What more could be done to improve the rate of disclosure?

Heads of Midwifery and Health Visiting were asked what other elements and practices could be introduced in order to improve the rates of disclosure and ensure women are directed to support.

More women-only or women-centred practices were seen as one potential source of improvement in rates of disclosure of domestic abuse.

Comments from Senior Midwives and Health Visitors were as follows:

'*I think if there was more of those places that were outside of GP services, so it was looked upon as a service for women, a Midwifery service for women to access.'*

'*I'm sure if women could access services better maybe there would be more opportunity for the women to disclose*.'

Others felt that if the process was embedded further then more disclosures would be achieved:

'If we could be at the stage where all the Midwives are confident, and we know they're confident that they're asking at the first opportunity that the woman is by herself, I think that would be the ideal gold standard.'

Interviews with survivors

Two women survivors were interviewed to illustrate some of the experiences women have of being identified for support through the health services.

Examples from women survivors who had been referred for support by health workers show the importance of the relationship that is built up between the health worker and the woman, in gaining the woman's confidence and trust.

In both women's stories, the health workers had been well informed about domestic abuse and knew how to identify it as a problem. Health workers also knew how and where to refer a woman. The stories also illustrate how the women chose to talk about their experiences for very individual reasons but a common factor was the personality and approach of the health worker. In both stories the women did not talk about their abuse as a result of *routine* questioning but through a process of building up trust and support with their health worker. Also of interest is the problem of security in a hospital mentioned in story two, which seems to have prevented the woman from talking about her abuse and seeking help.

Both stories also illustrate the potential concerns women have about Social Services' involvement and the importance of reassuring women about what this might mean. In story two these concerns were perhaps prevented by the Health Visitor's constant reassurance about the steps she was taking and informing the woman about the process all along the way.

Story one

The problem I was experiencing was mental abuse and it was very difficult to come to terms with this. The Health Visitor saw that I needed support to be able to go out again and lead a normal life. My confidence was very badly affected.

The Health Visitor was very good, she phoned up to make sure I was ok. She helped me to get in touch with my support agency. I'm involved with a programme with the support agency now to try to build up my confidence.

It is difficult to be asked about domestic abuse. A woman is very vulnerable at the time because she is emotionally upset and lonely. Sometimes women can talk too much if they are desperate and there might be problems with Social Services. I think health workers need to be very aware of this, that women might say things they don't want to because they are lonely and desperate.

Story two

I think it was during the second visit to my home that it just came up with the Health Visitor. I don't know why it did but it felt right to talk to her. I told her a few things that had been a problem and she asked me questions about it and said 'that sounds like domestic abuse'. To me it was just a 'bad experience', so I hadn't really thought of it like that before. She was able to give it a name.

The Health Visitor had done research into domestic abuse for her dissertation so she knew a lot about it. There wasn't any physical abuse but it was mental

abuse, as such, so no one could stop it but the Health Visitor seemed to understand. It made me feel that I wasn't completely alone. I felt much better when she talked to me about it.

The Health Visitor gave me details of an agency that could help me. She gave me a number and a name and I called up.

It was the fact that the Health Visitor was very compassionate and understanding that made me feel that I could talk to her. The conversation came up in my home. There was no need for a lot of questions because once I started talking to her it just all came out. It helped to be able to talk to someone who wasn't related to me, other people in my family knew about the problems but it helped that it was someone outside.

Before, when I was in hospital, I mentioned a few things to Midwives which might have sounded like there was a problem but they didn't pick up on it. It wasn't that there were any obvious signs I suppose, but I asked to stay in hospital for extra time because of problems at home. They agreed but didn't ask any more about it. Unless you've been in the situation yourself or you have done some research, you wouldn't necessarily know to pick up on signs like that. All I said was 'he's difficult'.

There was no security in the hospital so I was worried he could turn up at any time.

They gave me the impression when I arrived at hospital, that it is up to me who visits but in reality they don't ask 'such and such is here, do you want to see them?' They are so busy so they can't really control visitors. At home I felt more comfortable talking but this might be because I knew the father wasn't around. It might have been different if I thought he could turn up.

The Health Visitor visited me four or five times after I talked to her and it was only when the issue was sort of resolved that she stopped visiting.

What was really important was that she explained what she was doing at every step. She reassured me that Social Services were only interested in protecting me and the child and that it wasn't about me as a parent. This really helped. It was so important that everything was clear. It was also important that she gave me the impression she just wanted to listen and she wasn't judging me.

I was very impressed with the Health Visitor. For any health practitioner, it is so important that they explain what they are doing. This built up trust and that was crucial.

Case study visits

The main findings of the case study visits are as follows:

Case study visit one: Rural Area

Introduction:

The opportunity presented itself to attend a meeting of Health Visitor co-ordinators at a central location in the Trust area. This was a valuable opportunity to meet a group of Health Visitors face-to-face at the same time, something that would have been difficult to do otherwise as Health Visitors are based in different community locations across a large geographical area.

One focus group was held with six Health Visitors at the co-ordinator meeting and an additional site visit was made to a health centre during a mother and baby drop in session to interview two additional Health Visitors. The opportunity was also taken at the drop in session to ask women patients about their attitudes to routine enquiry into domestic abuse.

The Health Visitors interviewed had all received the training for the All Wales Ante Natal Domestic Abuse Pathway but had not themselves had any experience of using the Routine Enquiry into Domestic Abuse forms (RE DA 1 and RE DA2), as might be expected in an area which had only recently implemented the Pathway.

A central administrator was responsible for collating and storing RE DA1 and RE DA2 forms. The same administrator worked as a PA to both Heads of Midwifery and Health Visiting. She was, therefore, in an ideal position to co-ordinate the information from both groups of workers.

It was observed that the administrator/PA appeared to be very efficient. She ensured that if forms had not been filled in correctly or signed off by the appropriate health worker, she would follow this up with them so that records were made correctly. This appeared to be an important strength in the way the Pathway was implemented in the area.

The nature of Health Visiting in a rural area:

The geographical spread of Health Visitors was itself a pertinent issue for the introduction of the Pathway as there seemed to be limited opportunities for Health Visitors to meet to share professional experience and ideas.

The Health Visitors interviewed at their co-ordinator meeting were able to share information at these meetings; however, these happened infrequently and were not always well attended.

Health Visitors at the co-ordinator meeting were asked how they were able to learn from each other in the context of being in a large rural area and how they could share and support each others' professional practice. Health

Visitors said that they work in different community teams. In some localities, there would be a Health Visitor with a great deal of experience and in others there would be less experienced staff. To a large extent, it depends on how the different local teams are configured as to how much professional support and experience is available in the local teams. However, there seemed to be ways in which Health Visitors could obtain peer support and clinical supervision was also available on a regular basis. The Health Visitors interviewed at the drop-in session stated they were offered clinical supervision once every month and there were further team meetings once a month so there would be an opportunity for meeting other Health Visitors at least fortnightly. In addition, more experienced Health Visitors were able to offer ad hoc advice and support to lesser experienced Health Visitors as issues came up over the telephone.

At the focus group with Health Visitors, the issue of supervision around domestic abuse was discussed. Health Visitors commented there is no formal structure for supporting and monitoring of use of the Pathway. Health Visitors felt, in theory, monitoring or supervision of the Pathway could be picked up through the child protection or vulnerable families' route. However, it was questioned as to whether this would be adequate:

> *'It's interesting isn't it? We've got some access problems around supervision for ad hoc problems*. '

It was suggested that more informal peer support would be necessary around the issue of domestic abuse,

> '*We still need more 'informal' debriefing. I've had phone calls from less experienced Health Visitors who have been in difficult situations and they felt they wanted to talk.'*

This was reiterated by the Health Visitors interviewed at the mother and baby drop-in session who felt the facility to talk to one team member in particular, who was very experienced, was important. A member of the focus group added it was not always arranged thus in other community areas.

A further issue about working in a rural area was that professional learning was felt to be slower because 'issues don't come up as much' (such as domestic abuse) as they might do in urban areas. More positively, staff turnover was said to be slower in rural areas so there was more continuity between staff and, therefore, it was easier for Health Visitors to build up relationships with each other to learn and share experience. This was also thought to be positive in terms of building up relationships with families over time.

In rural areas there may be an additional need to ensure the Ante Natal Domestic Abuse Pathway is used by health workers, because the geographical spread of health workers may make staff development and learning more difficult.

What Health Visitors think about the Pathway:

There was a strong consensus, amongst the Health Visitors interviewed, the Pathway was a good idea. In particular, Health Visitors felt that domestic abuse would be increasingly brought out into the open.

> '*Even if they didn't disclose at first, they might say something later*.'

> '*It's a good thing. Many women are afraid to inform us about it and often the fathers are present. The training really helped with that*.'

It was also felt that having a consistent process, shared between Health Visitors and Midwives would improve communication about the issue of domestic abuse. The Health Visitors were clear that if Midwives were unable to ask about domestic abuse and undertake the initial routine enquiry, it would fall to them to ensure it was asked. In this way, there was a sense that domestic abuse would always be picked up.

Historical problems encountered in working with women suffering domestic abuse

Reflecting comments made elsewhere in the research, Health Visitors had found difficulties in obtaining private time with women to ask them about domestic abuse. Health Visitors felt the training had helped with this. Other problems Health Visitors had encountered historically included stigma felt by women and their reluctance to talk about their abuse:

> '*There was a problem about them being open and honest and maybe ashamed about what's going on and maybe afraid to share their views*,'

> *'Many women are afraid to inform anyone. It takes a few incidents before they will come forward.'*

> '.. *and even then they might not want to do anything because it's a process they're going through'.*

It was felt the training supported Health Visitors around these issues because it reassured them that women wanted to be asked. It was felt the training set the boundaries of what Health Visitors should be providing women with, in terms of support and advice.

Key mechanisms:

The role of personality and the experience of individual health workers are important for the use of the Pathway.

An important mechanism was the role of individual Health Visitors and the strength of their personality and experience. As one Health Visitor explained:

'She [Health Visitor] does a lot of clinical supervision. With health visiting, every day is different. Clinical supervision is so good because you can reflect. A lot of us work on our own and some are in teams. Being able to bounce off peers is important.'

The Health Visitors interviewed at the drop-in session also shared a building with Midwives working in the community, which enabled face-to-face contact with them. This was thought to facilitate communication so that if there were problems with families, such as domestic abuse, this would be passed on to the Health Visitor and vice versa.

The connection between Health Visitors and the local community was also felt to be essential. In the rural setting, Health Visitors were felt to be more connected to the communities they serve, compared with other areas. This meant they were able to develop relationships with the families they work with.

'*She [Health Visitor] is a very known and respected Health Visitor in the community. Women know they can go to her*.'

During the interviews at the drop-in session, communication with other agencies outside of health service was discussed. Respondents said the relationship with the Police was very good in their area. This meant information was passed on to the Health Visitors by the Police when incidents involving children occurred. In the past this had not always been the case and it was sometimes 'a few weeks' before information was received by the Health Visitor.

The arrival of a Police Liaison Officer in their local police organisation had made a difference and improved the flow of information around domestic abuse from the Police.

Barriers:

Gaining private time with women to make the enquiry:
Being able to gain private time with women to discuss domestic abuse was felt to be the largest barrier, particularly if it was felt that domestic abuse was an issue in a family.

'…but in the most severe cases [of domestic abuse] the mothers are always accompanied. There isn't a lot one can do in those situations'.

The training had helped to some extent but the problem still remained.

It was felt by interview participants that the more experienced Health Visitors were able to deal with the problem of obtaining confidential time with women more effectively by engineering opportunities to talk to women alone

This was down to the confidence and skills which had been built up over time by experienced Health Visitors. It was thought this was an issue for ongoing staff development and training.

'*Because of the job you can get around it somehow, through an immunisation clinic or catch them at other times. You have to be a bit of a detective and engineer it sometimes'.*

Making Home Visits:
Home visits were felt to be problematic in situations where there was thought to be a risk of domestic abuse, particularly in rural settings in which the Health Visitors may be more isolated and, therefore, potentially at risk themselves. The rural setting was also felt to be more isolating for some women if there was an issue with domestic abuse, particularly if the woman had no access to transport.

'In small villages, not serviced by buses well, it would be difficult for women to get to talk to a Health Visitor. In towns women have an excuse to be near the clinic but in small villages it's not the same.'

Communication between Health Visitors and Midwives:
Communication with Midwives was felt to be a problem amongst Health Visitors participating in the focus group, although not by the Health Visitors at the drop-in session. The problems were mainly connected with the lack of Midwife time and staff shortages. These constraints meant Health Visitors were not confident that information which should have been passed to them about domestic abuse had been.

'Communication is very poor. Maybe it varies from area to area. They have been working as integrated Midwife teams and are being pulled into wards to fill in when there are staff shortages but they have gone back to old style. This might make a difference because the long hours they were working meant that communication was poor.'

'Many of them work part time and maybe information isn't being passed on. Sometimes Midwives are covering too large a patch'.

A Health Visitor highlighted the limits of existing communication between Midwives and Health Visitors:

'For example, I was on the phone to a Midwife about a student placement and she happened to mention, 'oh by the way', there was a problem with domestic abuse. It was good that she told me because I was prepared when I went into the family but it was 'by-the-by.'

It was felt by Health Visitors that communication between them and Midwives would improve in the near future as some of the teams were due to be co-located, which may improve face-to-face contact. In addition, Midwives in the Trust were moving away from an 'integrated team' model of working (in which community Midwives would be pulled into hospital wards if there were staff shortages) back to being more fixed in their community areas.

Implementation problems:

Implementation was at the early stages in case study area one. All Health Visitors and Midwives had received the training but use of the DA1 and DA2 forms had been limited. Records of the forms being used were only just starting to 'come through' into Health Visitor's hands. Only one of the women patients interviewed at the mother and baby drop-in session had been routinely asked about domestic abuse.

One concern was expressed by a Health Visitor about the gap between undertaking the training and actually using the RE DA1 and RE DA2 forms.

> '*The only thing is that there was a gap. Sometimes the freshness you have from the training is sometimes lost.'*

There were also concerns about the collection and storage of the RE DA1 and RE DA2 forms:

> *'I'm a bit concerned where the papers end up. My understanding is that they go into the Dnotes for the mother. We can't keep them in the family records. We don't know where the paper ends up.'*

Health Visitors were relying on Midwives to pass them information about whether RE DA1 and RE DA2 forms had been used and the outcomes of this. However, Health Visitors were not confident this system was reliable.

In addition, it was felt by Health Visitors that the arrival of the Pathway process was not underpinned by formal co-ordinated supervision which would have ensured the Pathway processes were being adhered to.

Women client/patient views on routine enquiry:

During the visit to the mother and baby drop in session there was an opportunity to talk to four women clients. The purpose of these short interviews was to ask women their views about routine enquiry into domestic abuse and also, if they had been subject to routine enquiry, how they felt it was approached and handled.

One respondent had been subject to routine enquiry into domestic abuse, three had not.

All women clients who were asked felt that it was appropriate to be asked about domestic abuse. They felt that it was acceptable as part of their routine care and that of their families.

Although reflective of a very small group of respondents the women's support for routine enquiry into domestic abuse does reiterate findings from another study into women's attitudes, which found women to be accepting of routine enquiry as part of their care (Macey and Bewley, 2001).

The one respondent who had been subject to routine enquiry felt it was a good thing. In her case, the enquiry had been made by a Midwife. The respondent was asked how she felt the enquiry was handled.

> '*She [the Midwife] felt more awkward than I was. If you didn't get on with the Midwives it would be difficult. She was almost embarrassed about it*.'

However, the respondent didn't mind that the Midwife was embarrassed at asking her and still believed that it was a good thing that women are asked the question about domestic abuse routinely.

The other three respondents felt routine enquiry would be a good thing for women generally because it would bring the issue of domestic abuse into the open and make sure that it was picked up more often.

> *'It might make mothers speak about it when otherwise they might not have.'*

Other observations:

The mother and baby drop-in took place at a GP surgery based in a small town. This was the only GP surgery in the town. The clinic was divided into separate areas for health visiting, a dental clinic and other general practice, with a central waiting area. The mother and baby drop-in session took place in a large room behind the main waiting room and involved weighing the babies. The drop in provided an opportunity for mothers to sit and chat and for children to play with toys. Some of the mothers at the session appeared to know each other. The session was also open to men and one father attended.

The drop-in session was not particularly conducive to women obtaining private time with the Health Visitor if they needed to because it was an 'open' session which men were able to attend but, as the Health Visitors interviewed stated, it would be possible to 'engineer' an opportunity for women to talk to them if necessary.

At the time of the visit, it appeared that no posters or information about domestic abuse were available. However, it is not possible to validate if this is typical of other health care settings across the County. Indeed, it is reported by area representatives at the All Wales Health Visitors and Midwifery Networking Group that materials on domestic abuse are widely available to women.

Case study two: an urban area

Introduction:

Case study two is an urban area in which the Pathway had been implemented 12 months prior to the case study site visit.

The researcher attended two maternity ward sites to interview Midwives and other health workers. It was hoped that women patients could be interviewed at these locations but this was not possible due to issues of patient care. Six Midwives and one auxiliary Midwife assistant were interviewed in case study area two.

All Midwives interviewed had received the training for the Ante Natal Domestic abuse Pathway.

Both locations in case study area two were specialist Midwifery-led wards in which women attended to give birth and stayed for a short time afterwards. In some cases, women returned to the unit if there were problems following the birth. In most cases, however, the stay was short term and the relationship between women patients and the Midwives was also short term.

Some Midwives interviewed were based at the wards and others were community Midwives, based in the community but came into the wards if the need arose. Typically, the ward-based Midwives would have a short term relationship with the women.

At one ward, there was a team of specialist Midwives who were trained to work with vulnerable families for example, where there had been an issue with substance misuse or child protection issues.

On the day of the visits to the wards, it was observed the Midwives were very busy and short staffed. This was apparently not unusual, according to staff.

What Midwives feel about using the Pathway:

Midwives felt the pathway was a useful thing; that more domestic abuse would be identified and more women victims would be helped as a result.

Midwives felt that routine enquiry into domestic abuse is well embedded in the case study area and is now part of normal practice both in the wards and in community Midwifery.

Barriers:

At case study area two Midwives felt problems with obtaining confidential time alone with women to ask the question about domestic abuse remained. It was felt the training could not really address this problem.

Problems with obtaining confidential time alone with women is felt to be particularly problematic at booking time.

> *'…because the fathers tend to be there at the start and they are excited it is difficult to get women alone. It may be that the second appointment at about eight weeks is more appropriate.'*

Another issue of concern for some of the Midwives interviewed is having enough time to be able to make the enquiry into domestic abuse.

> '*the booking appointments are so busy that it's difficult to find time to ask women. There is so much to do during the booking that it is difficult to fit it in.' Sometimes it is better to wait for the second appointment.*'

There were also some issues with security at one of the wards.

It was observed by the researcher that security was not particularly tight and non-patients were wondering in and out of the ward, despite an intercom system.

Key mechanisms:

A strong theme to emerge from visits to case study area two was that the child protection specialist advisor was an important source of information, support and advice for staff.

The child protection advisor's telephone number was advertised on the walls of the staff common room and many Midwives stated that the child protection advisor would be the person to contact if there were any problems or concerns with a woman. For example:

> '*One thing that isn't clear is what to do if a woman discloses that she had experienced domestic abuse 20 years ago. I would be able to talk to other Midwives or the specialist Child Protection advisor about this.'*

At the beginning of using the Pathway, Midwives were worried about how women would react to routine enquiry but it was felt that the training reassured them on how to approach the routine enquiry.

The Midwives had built up confidence through experience of asking women about domestic abuse and were now comfortable with using routine enquiry.

Other observations:

The ward administrator at one of the locations commented that security was not particularly good. The ward has a secure entry phone system and staff gained access by using swipe cards. However, it was not possible to observe the visitors who were waiting to be let in, without leaving the reception office, so people were automatically 'buzzed in' if the ward was busy. It was easy for families (or other people) to gain entry and walk around the ward. It is possible to see that if a woman felt insecure or frightened, the security arrangements would not be reassuring for her.

Case study area three: mixed urban and rural area

Introduction:

Case study area three is a mixed urban and rural area in which implementation of the Pathway was initiated five months prior to the site visits.

The interviews with Midwives took place in a hospital labour ward which was Midwifery-led. Both community-based Midwives and ward-based Midwives were interviewed. The ward was not particularly busy at the time of the interviews. During the site visit, an ante-natal clinic was also taking place in another section of the ward.

What Midwives feel about using the Pathway:

Midwives were generally positive about the Pathway and were aware of the intended outcomes of increasing disclosure and raising awareness amongst health professionals. However, there was a great deal of uncertainty about what the Pathway would mean to Midwives' actual practice. This was because Midwives hadn't yet had much experience of seeing or using the Pathway in practice. The Routine Enquiry forms were only just starting to 'filter through'.

Implementation:

The area Trust was still in the process of deciding some key policies around the Pathway process. These were being worked out as implementation matures. For example, internal discussions had revealed there may be problems with obtaining confidential time alone with women to make the enquiry. In response to this, the Trust was in the process of deciding if it should become Trust-wide policy to undertake the initial enquiry into domestic abuse in a clinic and not within a woman's home, as it was felt that clinics provided more opportunity for health workers to be alone with women.
At the same time, the Trust was also considering whether to make it Trust-wide policy to only conduct booking appointments in clinic settings as opposed to women's homes. This was because of concerns over health workers' personal safety when they conduct booking appointments in patient's homes.

During the early stages of implementation in case study area three, it was decided health workers would not fill in the RE DA1 forms but simply use the information contained in the form as a prompt for the routine enquiry. A record that the enquiry had been undertaken was made by placing a tick on the patient's hand-held notes.

The Trust had not yet decided how information relating to RE DA2 forms would be stored. The problem facing the Trust was that the Midwifery-led units were based in two sites in the Trust and, therefore, it was unclear as to which site the RE DA2 forms would be stored.

Again, the point at which the second RE DA1 enquiry would be made was not yet decided due to lack of experience of using the Pathway. Midwife respondents felt the second enquiry should be made later on in the pregnancy or during the first stages after birth and possibly by Health Visitors. Again, these issues were felt to be in development and would be resolved as the Pathway became more mature in the area.

The Midwives themselves were not particularly sure about how the Pathway would affect their practice because they had not had much opportunity to use the RE DA1 and RE DA2 forms.

Midwives were also unclear about where information on the RE DA2 forms would be stored and also about where to seek professional advice about domestic abuse if cases were identified.

Barriers:

The main barriers to the Pathway being implemented were connected to the lack of maturity of the Pathway in the area. These problems are likely to be overcome as the Pathway is used. As none of the practitioners interviewed had had the opportunity to use the Pathway in their work, they were unsure what the effect of actually asking the questions would be. However, Midwives were broadly optimistic the Pathway would lead to an increase in cases of domestic abuse being identified and that women would be amenable to being asked the question.

The Pathway training had helped to address some of the Midwives' fears and anxieties about using the Pathway but respondents said that experience was needed before they could feel truly confident.

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Key mechanisms:

Midwives felt there was good communication between Midwives and Health Visitors in case study area three and this would ensure the Pathway would be implemented well. The good communication was said to be down to the practice of formal handover sessions with Health Visitors and also the fact that Midwives were organised in area teams, attached to particular areas. This ensured some degree of continuity of care between patients.

Other observations:

At the time of the visit, it appeared no posters or information about domestic abuse were available. However, it is not possible to validate if this is typical of other health care settings across the County.

3) Issues from the field research by theme

This section addresses the key issues to emerge from the evaluation study by theme. It draws on all aspects of the field research.

Health Visitors' engagement with the issue of domestic abuse

A general note from the postal survey is that Health Visitors seemed to provide more in-depth information in their responses, suggesting they were more engaged with the issue of domestic abuse. This could be due to Health Visitors having more time or space to be able to fill in the questionnaire, although this possibility was not tested during the research.

The notion that Health Visitors are already more engaged with the issue of domestic abuse is suggested by a number of unprompted comments by Health Visitors' in the postal survey along the lines of: '*Health Visitors already deal with domestic abuse and it is already part of their practice*.' However, it should be noted, the purpose of the Pathway is to *formalise* responses to domestic abuse, even if good practice is already in place. This goal to formalise health workers' response was recommended by sixth report of the Confidential Enquiry into Maternal and Child Health (CEMACH, 2004).

An important point to emerge from the postal survey was that Health Visitors generally had less experience of using the Pathway than Midwives. In many cases, postal survey questions were answered with responses such as *'too early to say'*. This response is to be expected as the Health Visitors' role is to ask women only if Midwives have not been able to undertake routine enquiry. This means that Health Visitors would first experience using the Pathway much later than Midwives.

Health Visitors often expressed an anxiety about the lack of communication with Midwives and confusion about when Health Visitors should be making the initial enquiry into domestic abuse.

14% of Health Visitor responses to the survey question '*what are the most important things to ensure the Pathway to be used effectively*?' were coded as '*we must ensure actual use' or 'the Pathway isn't being used'*. This may reflect delays in implementation but nevertheless, Health Visitors did express a lack of confidence that the Pathway processes were actually being followed. This was supported by some comments in the case study site visit where Health Visitors were interviewed.

20% of Health Visitor responses to the survey question, '*what are the most important things that need to be done for the pathway to be used effectively*?' were '*effective communication between Midwives and Health Visitors'*, which demonstrates the importance of communication between the two groups in order for Health Visitors to feel confident with using the Pathway.

The case study visits also revealed an anxiety about the information flow between Midwives and Health Visitors, with many respondents commenting they did not know how they would gain information about the use of the RE DA 1 forms or that they were not confident they would be able to share information with Midwives. The concern about information sharing with Midwives was felt by Health Visitors to be particularly problematic over

information on prior histories of domestic abuse that women may have experienced during previous pregnancies.

A small number of Health Visitors responding to the postal survey also expressed a concern that the training was too focused on Midwives' role and not enough on Health Visitors' roles.

Adoption of the Pathway principles and barriers to this

There was, in general, a high level of acceptance of the main rationale behind the Pathway. There was a high level of acceptance of the view that health workers would become more aware of the issue of domestic abuse as a result of the Pathway and training and, therefore, would be able to bring the issue of domestic abuse into the open.

However, the survey did reveal a significant barrier to the Pathway outcomes being realised. This barrier was the difficulty health workers face in getting women alone to ask about domestic abuse. This was down to partners or other family members being present. This barrier would seem to indicate that *community* Midwives might be better placed to ask the initial 'Routine Enquiry into Domestic Abuse 1' question because they are likely to have more time with women in the private environment of patients' homes. However, there were also felt to be barriers to this approach in that Midwives expressed concerns about their own safety when visiting women in their homes. Furthermore, in areas of high unemployment, partners are likely to be present at home because they are not out at work.

Health Visitors also expressed difficulties with getting women alone, away from partners and other family members, despite being more likely to visit women in their homes. These factors all act as barriers to the Pathway fully achieving its desired outcomes.

Other barriers included time constraints and pressurised work environments felt by Midwives in particular. For example,

> '…*Running a busy clinic with a lot of women waiting to be seen means there is little time to ask the question [about domestic abuse]'*.

A small number of respondents also mentioned that it is difficult to enquire about domestic abuse at booking appointments because of the amount of other information that needs to be gathered at the same time.

Communication between Health Visitors and Midwives

Health Visitors and Midwives reported problems in communicating information about the use of the RE DA1 and RE DA2 forms between Health Visitors and Midwives.

The process for using the RE DA1 and RE DA2 forms is as follows:

Using the Pathway - overview:

- *Midwives enquire once at booking appointment and once more in the antenatal period, using the RE DA1 form*
- *A record of the whether RE DA1 has been undertaken is made in code form on the patient's hand held notes and the actual RE DA1 form is kept in the patient's medical notes, which is handed over to Health Visitors. The RE DA1 form is never kept in the patient's hand held records.*
- *If a patient has disclosed domestic abuse, a RE DA2 enquiry is made and a record of whether this has been done is also recorded on the patients' hand held notes, by use of a code. The form itself is kept within the medical notes and never within the hand held notes.*
- *When Midwives have not been able to undertake the RE DA1 enquiry, a record of this should be made with the reasons why. In these circumstances, Health Visitors will then make the enquiry.*

In practice, the exchange of information between Midwives and Health Visitors over the use of the RE DA1 enquiry is not happening consistently. In some cases Health Visitors were simply not aware of 'any information' on RE DA1 forms 'coming through'. At a case study site, Midwives based in a labour ward were not aware of how to obtain information relating to RE DA1 or RE DA2. At another case study site some labour ward-based Midwives reported they had not seen the codes relating to the RE DA1 or RE DA2 enquiry which were supposed to be placed on the patient's records.

To a large extent, these problems are to be expected as implementation develops. For those areas which are still in the early days of implementation, not all Midwives would have begun using the Pathway and they would not yet have collected information on the RE DA1 enquiry.

However, each Trust must develop a process for ensuring information on whether an enquiry has been made is passed on systematically to relevant Health Visitors. There is a limit to the amount of information that can be kept in hand held notes due to confidentiality, so a robust process for storing and passing information on the enquiry and any further details on risk assessment, referrals and involvement of other agencies must be in place.

The training and support needs of Health Visitors and Midwives using the Pathway

All Midwives and Health Visitors are due to receive training on the use of the Pathway as well as some background and awareness-raising around the issue of domestic abuse. The training is based on the training pack developed by the Networking Group.

Many respondents to the survey and interviewees at the case study visits felt that training should be supported by either follow up 'refresher' training sessions or by support through clinical supervision.

A problem highlighted with the training, especially for Health Visitors, was too large a gap between the training and the actual implementation of the Pathway. This meant, in some cases, Health Visitors felt they had forgotten what to do with the RE DA1 and RE DA2 forms. As Health Visitors are less likely to have used the forms in their practice at this stage, given that Midwives are supposed to undertake the initial enquiry, the need for updates or 'refresher' training for Health Visitors is perhaps even more relevant for them.

It was felt by many respondents that updates or 'refresher training' does not necessarily have to be done in the form of a formal training session, it may be carried out through clinical supervision or through materials being distributed.

Engagement with external agencies

Health workers expressed some anxiety about how to engage with other services outside of health care and about what services and resources were available to women if they disclosed domestic abuse.

> *'Training was ok but lacked focus on how best to support women who disclosed'.*
>
> *'There should be more information on how to support women in their own homes.'*

However, it was also felt this uncertainty would be reduced once the Pathway had become more embedded.

Despite the anxieties about working with other agencies, there seemed to be strong support for working with the Multi Agency Risk Assessment Conference System (MARAC), which appeared to be working well in the opinion of health workers. However, these conferences are intended for high risk cases of domestic abuse only.

In the postal survey, 14% of respondents to the question *'what are the most important things that need to be done in order for the Pathway to be used effectively*?' gave the answer '*multi-agency co-operation'*.

Case study visits also revealed uncertainty about where to refer women, once a disclosure of domestic abuse had been made. Midwives and Health Visitors mentioned Social Services and the Police as agencies that may be able to help but no voluntary sector agencies were mentioned during the case study visits.

Health workers' confidence with using Routine Enquiry

Responses from the case study interviews revealed that some health workers still felt anxiety about initially broaching the issue of domestic abuse with

women. These anxieties were expressed as ‘not feeling comfortable’ or ‘not wanting to offend women’. However, nervousness about broaching the subject of domestic abuse was not felt to deter health workers from conducting routine enquiry.

It was also felt that asking women about domestic abuse would be easier once the health workers had had the opportunity to use the Pathway and the questioning became ‘*part of their stride’*.

The need for further support and continuous development around dealing with domestic abuse for health workers was highlighted in the research.

Limitations of the pathway

During the Pathway training Health workers are advised their role is simply to identify and signpost women to seek support, should they need it, in response to domestic abuse. In this respect, the role of the health worker is limited. However, during the research, many health workers mentioned frustration that they could not do more to assist women suffering from abuse. This was largely due to women not wanting to reveal they are suffering or not being in a position to seek help.

The Pathway training underlines the importance of questioning women in a non-judgemental way and of not pushing too hard for women to take steps to change their situations, as this in itself may precipitate abuse. Some health workers expressed the view they would like to be able to do more to help women but felt that ‘they can only do so much’ if women themselves are unable to deal with the problem.

Some health workers expressed a desire to know what to do in situations where they know abuse is occurring but patients are not prepared to discuss the problems. This may be another area where further guidance and support for health workers is needed.

Supervision needed by health workers

Staff in case study areas were asked about the levels of support they received on a daily basis around the issue of domestic abuse.

In general, in the case study areas, health workers felt they had enough support and sources of advice in cases where they felt they needed extra guidance. However, it is worth noting some health workers still felt a little unclear about the actual Pathway process. To help with this, a flow chart, which sets out the Pathway process, is available in the training pack (see appendix four). This flow chart may benefit from being blown up in poster size and placed in staff common areas, where appropriate.

Health workers also felt a need for more formal supervision around how to work with women where domestic abuse may be a problem. Although some supervision and support was available through the child protection advisors, Health Visitors felt that access to such supervision is limited. The importance of peer support around domestic abuse was also highlighted through the case study visits. Health Visitors, in particular, can work in isolated ways, especially in rural settings and the availability of peer support was felt to be important.

Participants in the case study interviews considered it important for both Health Visitors and Midwives to know who they can talk to informally about domestic abuse, perhaps with colleagues who are more experienced. This would seem to make a case for a named domestic abuse officer or advisor in each Trust area.

Implementation

A key area of enquiry for the research was how the Pathway had been implemented across Wales.

Although the Pathway initiative is co-ordained by a Welsh Assembly Government-led Networking group, it is up to each Trust to organise the training and implementation of the Pathway. This would inevitably lead to different experiences and methods of implementation. We were keen to examine the mechanisms and potential barriers to effective implementation and to compare these to national and international experience.

Wider implementation environment

Implementation of the Pathway is co-ordinated by the individual Trusts. It is the Trust's responsibility to organise training and to find funds to provide the RE DA1 and RE DA2 forms, which are part of the Pathway. Implementation of the training and paperwork is being approached in different ways across Wales as the implementation environment differs from area to area.

Two Heads of Midwifery who were interviewed mentioned the role of the Trust executive in the implementation of the Pathway. One talked about the process of gaining support for the Pathway though the Trust Board and another about finding money from the Trust to support the Pathway.

> *'There was a launch of the Pathway, yes, within the Trust. I had to go through the Trust Board and had to go through then the, you know, the formal processes within the Trust. And then there was a formal launch of the Pathway prior to implementation*.'

> *'We didn't have any financial support so we had to find money internally.'*

In both cases the Trusts did support the requests for resources but this did however, delay the training and implementation of the Pathway. No respondents reported difficulties with getting Trusts to adopt the Pathway as

policy. This is most likely due to the high level commitment across NHS Wales to tackling domestic abuse.

In some areas, barriers faced by health workers were connected to the availability of services and agencies outside of the health sector for supporting women if they disclose domestic abuse. This was mentioned both in the postal survey returns and during the case study site visits. A key mechanism for successful implementation can be said to be the availability of and good links with partner agencies such as the Police or Women's Aid. This was also said to be important by the women survivors interviewed who both felt that Health Visitors had pointed them in the direction of useful support agencies.

The wider domestic abuse support infrastructure is a potential confounding factor in how the Pathway is implemented or used by health workers. For example, in one Trust area the local Police Domestic Abuse Liaison Officer was said to be pivotal in improving co-operation between Health Visitors and Police, whereas before the Liaison Officer was in post communication with the Police was said to be difficult. In another area the attitude of individual Social Services workers was said to be important in determining the outcomes that women experience if they were to disclose. Factors such as the availability and quality of external agencies are largely beyond the control of individual health workers and even NHS Trusts but it does, however, highlight the importance of senior stakeholder engagement with organisations outside of the NHS, to ensure that partnerships are developed as much as possible.

Findings from other national and international studies point out the importance of supporting domestic abuse training for health professionals with continuous professional support and a well developed wider support infrastructure. Macey and Bewley (2001) find, for example, that '*without organisational support for domestic violence screening, ongoing training and support for the professionals involved and the availability of identifiable resources in the community to refer women who report domestic violence, any recommendation for routine domestic violence screening by NHS staff is not sustainable'* (Macey and Bewley, 2001, p.3).

Again, Heise and colleagues (1999) suggest health workers cannot address domestic abuse simply through the education of staff; reforms throughout the organisations are necessary: '*Achieving lasting change requires transforming the health system itself as well as changing the behaviour of individual providers. When managers, administrators, and the health care system itself encourage and reward new, caring behaviour towards victims of abuse, providers will feel better able to recognize and address violence*' (Heise et al, 1999[1]).

The findings of this evaluation supports both the Heise et al and Macey and Bewley research in terms of the wider implementation environment factors

[1] www.infoforhealth.org/pr/l11/l11boxes.shtml#strength

that need to be in place in order for domestic abuse to be addressed by health services.

A strong theme to emerge throughout this research is that continuous training and support is necessary to ensure that the Pathway is implemented to its best effect. Health workers still expressed low levels of confidence, particularly in areas where implementation was not very mature, with broaching the subject of domestic abuse with women and with obtaining private time with women. Naturally, the more experienced health workers would be more confident but implementation of a nation-wide process should account for those who are the least confident, to ensure a minimum level of competency.

Some Senior Midwives suggested implementation should not be measured just in terms of the numbers of referrals but also the levels of confidence and 'normalisation' of the Pathway processes across the whole service. As one respondent put it:

> *'If we could be at the stage where all the Midwives are confident, and we know they're confident that they're asking at the first opportunity that that woman is by herself, I think that would be the ideal gold standard'.*

Barriers to implementation

The barriers to successful implementation documented in this evaluation reflect findings elsewhere, for example a study of health care providers in the USA and their perceptions of barriers to implementation of routine questioning into domestic abuse (Minsky-Kelly et al, 2005). Minsky-Kelly and colleagues found five main barriers to routine enquiry into domestic abuse:

> *(a) questions about the appropriateness and value of screening given patient presentation and clinical setting*
> *(b) inadequate provider expertise resulting in feelings of frustration*
> *(c) concerns about time and workload priorities*
> *(d) concerns about the process of screening*
> *(e) concerns about the outcome and efficacy of screening' (*Minsky-Kelly et al, 2005, p.*1293).*

These categories fit exactly with the barriers mentioned by participants in this evaluation, with the exception that respondents to this study were generally very supportive of the overall principle and desired outcomes of routine enquiry. In the Minsky-Kelly study, health providers questioned whether it was their responsibility to 'save the world', or to pro-actively address domestic abuse (Minsky-Kelly et al, 2005, p. 1294). No such attitudes were detected in this evaluation study.

Minsky-Kelly and colleagues conclude that ongoing staff training, feedback to staff on patients who are helped, problem-solving of privacy concerns and flexibility as to when patients are screened, are necessary factors to overcome some of the barriers to implementation of routine enquiry into domestic abuse. The Minsky-Kelly findings are supported by this evaluation.

Other serious barriers were found in the evaluation around the differential nature of communication between Health Visitors and Midwives across areas in Wales. In some cases, information flow was very good between the two groups and this was down to historical circumstances such as being co-located or having an effective formal handover process. One purpose of the Pathway is to tackle any communication problems between Midwives and Health Visitors. It is likely the Pathway will become part of the solution to communication problems. It will take time for this hypothesis to be tested, however, important lessons for implementation at this stage are that the actual use of the Pathway forms should be monitored and the place of storage of the RE DA 1 and RE DA2 forms should be known by all health workers so that they can be accessed if necessary. This would improve communication between Health Visitors and Midwives.

In areas of less mature implementation, how forms are collected and stored is not well known amongst health workers. In low implementation areas there appears to be some confusion and indecision about where the RE DA1 and RE DA2 forms are kept and how they will be disseminated to health workers. This has worked better in areas where one person is responsible for the collation and co-ordination of the forms. Having one person in charge of form collection and storage also helps senior health practitioners to monitor the use of the Pathway paperwork.

As one senior health worker noted, 'some Midwives are just not filling in the forms'. There should be a system in place where non-completion of forms is actioned for example, in one case study area a single person collates the RE DA1 and RE DA2 forms and sends them back to Midwives if they are not filled in properly.

Other barriers to implementation found in this evaluation are reflected in other research for example Waalen et al (2000) and Stenson et al (2005). Both these studies point out the problems health workers have with gaining confidential time with women and problems with patients' inability to talk about their abuse through stigma or fear. Waalen et al and Stenson et al also point out the structural barriers that exist, such as lack of staff time and resources, to deal with the issue of domestic abuse. These issues are also identified by respondents in this research.

Solutions to the implementation barriers are suggested by respondents to this study. Many respondents felt that as time passes and with greater use of the RE DA1 and RE DA2 forms, health workers would become more confident in their use. NHS Trusts are trying to develop their own ways of overcoming problems connected with gaining private time with women. For example, one Trust is discussing providing stickers in all patient toilets for women to place on urine samples to indicate that they wish to talk to someone privately. These developments may not have taken place if it were not for the introduction of the Pathway.

The Pathway appears to have acted as a catalyst for changing general practice around domestic abuse which is a positive outcome. As Trusts seek to find ways of ensuring the Pathway can be implemented effectively, they are learning best practice around domestic abuse more generally.

4) Future policy

Delphi Study

The Delphi study was aimed at ten key people with both strategic and operational interest in the All Wales Ante-Natal Domestic Abuse Pathway and who would be able to contribute to a discussion on how to roll out the Pathway to other areas of health care. Respondents were from a range of agencies within health, community safety and voluntary sector organisations

The results of the Delphi study are displayed in table eleven below. Respondents were given five options from 'strongly agree' to 'strongly disagree', which range from one to five, respectively. Statements which obtained responses with the value above 2.5 have been highlighted in blue. These indicated the statements which attracted the *least* agreement.

Table Eleven: Delphi study responses (1= strongly agree, 5 = strongly disagree)

Statement	**Round 1**	**Round 2**
Q1) In order to ensure that domestic abuse is dealt with effectively in health care settings please state your opinion of the following statements:		
Domestic abuse should be part of *routine* assessment for *all* patients	1.7	1.9
Domestic abuse should be enquired about at the first contact with a patient	2.7	2.3
Domestic abuse should only be dealt with as part of an ongoing relationship between a health worker and patient	4.1	3.7
Domestic abuse is a public health concern and should be a priority for health services	1.6	1.4
Domestic abuse should be identified by health care staff but dealt with in the longer term by other agencies	2	2.4
Only specially trained staff should make the enquiry	1.8	2.0
Q2) What do you think are the most important aspects of a domestic abuse pathway in a health care context, in order for it to be effective.		
Staff are able to gain privacy with the patient (including privacy from close relatives)	1.3	2.1
Staff have the time to be able to talk to patients to give them the opportunity to discuss domestic abuse	1.8	2.0
Staff have understanding of the duty towards child protection in issues of domestic abuse	1.3	1.0
Health agencies have good working relationships with support agencies such as Women's Aid	1.5	1.9

Clinical supervision is available for staff to deal with issues of domestic abuse	1.3	2.0
Q3) Which of the following do you think would present barriers to routine enquiry about domestic abuse being introduced in health care settings:		
Lack of time for health care workers	2.5	2.4
Difficulty in seeing patients alone	1.6	1.9
Staff unwillingness to deal with domestic abuse as part of their practice	2.0	1.9
Lack of resources to train staff sufficiently	2.3	2.7
Q4) In which of the following settings do you think routine enquiry about domestic abuse should be introduced?		
Primary Care settings	1.6	1.6
Mental health care settings	1.4	1.3
Alcohol and substance misuse treatment centres	1.2	1.3
GUM and sexual health clinics	1.2	1.3
Child health centre (such as children's centres)	1.5	1.6
Women's health clinics	1.6	1.4
Gay and bisexual men's clinics	1.5	1.4
Clinics for young people under 19	1.5	1.4
Emergency A & E	n/a	1.0
Minor injury unit	n/a	1.4
Walk in centre	n/a	1.3
Elderly centres	n/a	1.3

The statement obtaining the least agreement was that '*Domestic abuse should only be dealt with as part of an ongoing relationship between a health worker and patient*'.

It was generally felt 'routine enquiry' was a good policy and should be adopted more widely. In particular, it was felt that routine enquiry should be rolled out into a range of other sectors as listed in question four of the Delphi study.

Policy Forum

Key points to emerge from the meeting were as follows.

a) Barriers faced by women from black and minority ethnic communities (BME)

It was pointed out that women from BME communities face particular barriers in accessing support, especially in discussing problems of domestic abuse initially. This is largely due to problems of language and difficulties with gaining privacy with women away from family members. Although the issue of gaining private time with patients is a problem for other women, policy forum participants felt that this was exacerbated by the language barrier. Written materials may not always be appropriate as some women from BME communities may be unable to read in their language.

The policy forum discussed difficulties in ensuring translation for women who feel they need it. Language Line is typically used to provide translation but this was felt to be difficult to organise and consequently was often neglected. As Trusts are advised strongly not to use family members to provide interpretation or translation to undertake the routine enquiry, the language barrier is particularly problematic. A representative from Black Association of Women Step Out (BAWSO), a BME women's' organisation who attended the policy forum, was keen to ensure BAWSO materials on domestic abuse are integrated into the Pathway. The BAWSO representative was also keen to ensure that and All Wales Networking Group communicates with BAWSO to establish good practice around working with women from BME communities[2].

b) Difficulties in gaining private time with women to undertake the routine enquiry

This problem was discussed at length at the policy forum. Participants felt that as ante-natal practice has more recently been concerned with encouraging men to be involved in their partner's pregnancy, it is now difficult to insist on having private time with women.

Participants also felt the more confident and experienced Midwives and Health Visitors would be able to engineer private time with women more easily and could simply 'order' men away. However, for less confident practitioners, this could prove more of a problem.

A recommendation from the policy forum is that each Trust should assess the feasibility of having a Trust-wide policy of obtaining private time alone with women during their pregnancy. This time would be used not just to discuss domestic abuse but also any other sensitive issues that women may want to discuss

It was also suggested that Welsh Women's Aid would work with the Networking Group to ensure that no negative outcomes result from any such 'privacy' policy.

c) Communication between Health Visitors and Midwives

The problem of communication between Midwives and Health Visitors was also discussed at the policy forum. It was acknowledged this problem exists more generally in Midwifery and Health Visiting practice and not just in terms of the Ante Natal Domestic Abuse Pathway. It was decided that senior Health

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[2] *Welsh language:*
As the time of writing this report, the Pathway forms and training materials have not yet been translated into Welsh. However, the tools are for professional use and in theory, women patients are able to access Welsh speaking Midwife or Health Visitor who would translate as appropriate. The need for Welsh language translation was not raised as an issue during the policy forum or the field research, however this was not specifically addressed in the research design.

Visitors and Midwives would ensure, through auditing and monitoring, that information on the RE DA1 and RE DA2 enquiries were being handed over in a timely manner. It was also agreed that the Pathway representative from each Trust would develop and report back to the Networking group a method by which handover of information between Midwives and Health Visitors would be achieved. This may be through formal handover of family notes, as in the case of Carmarthenshire.

5) Transferring the Pathway to other health care settings.

The domestic abuse pathway is currently being developed in Accident and Emergency and Gynaecology settings across Wales. The development is being supported by two secondees who are developing standards and processes for each setting.

Learning from the evaluation of the Health Visiting and Midwifery-led Pathway will inform the development of this work.

Introduction

An aspect of this evaluation was to consider how the Pathway processes could be introduced in other health care contexts.

An important starting point for this question is to consider the normative aspects of the Pathway. That is, what the Pathway is *supposed* to do and what outcomes are *desired.* The extent to which the desired outcomes and rationale are applicable to settings other than Ante-Natal services is the first 'test' of whether the project can be rolled out to other settings.

The rationale and desired outcomes for the Pathway are as follows:

- To achieve changes in professional attitude and confidence
- To improve women and children's safety
- To promote awareness of domestic abuse and its impact on health
- To promote awareness amongst women that domestic abuse does not have to be tolerated.

The desired outcomes and objectives of the Ante Natal Domestic Abuse Pathway are transferable to other health care contexts. However, if applied elsewhere, the focus would not necessarily be on women and children or unborn children but to <u>all</u> potential victims.

Are the mechanisms of the Pathway transferable?

Throughout the evaluation, an understanding of the most important mechanisms of the Pathway was drawn out. The extent to which these mechanisms can be introduced in other settings will determine if the Pathway can be applied elsewhere. The key mechanisms were identified as follows:

- adequately trained staff
- updates and/or refresher training on domestic abuse for health workers
- a Human Resources policy for staff experiencing domestic abuse
- a monitoring system to ensure the Pathway is being used in practice
- effective communication and information sharing between agencies both within the health service and beyond.

These mechanisms *could* be applied in other settings and are not exclusively applicable to Midwifery or Health Visiting services. However, these mechanisms will require resources in order to be introduced. For example, training is costly and requires staff to spend time away from their normal practice to attend. This will be more feasible in some contexts than in others. The experience of the All Wales Ante Natal Domestic Abuse Pathway is that the training was effective in its present form, which included half day didactic sessions with support materials. However, in other projects for example, routine enquiry in an Accident and Emergency department in Australia, staff received training lasting between 20-45 minutes and key staff received between three and six hours (Ramsay et al, 2005, p. 35). The amount of domestic abuse training required in other health care contexts should be established from the outset before routine enquiry is introduced elsewhere. In addition, clinical support and supervision around dealing with domestic abuse was found to be an important mechanism in this evaluation. Again, this supervision and support has resource implications and will need to be considered before the Pathway can be introduced in other settings.

In some areas a key mechanism was felt to be the ongoing relationship the health worker had built up with her patients. In settings such as Accident and Emergency, GUM clinics, outpatient or other contexts where the relationship between the patient and health practitioner is short term, this would obviously not be possible.

On balance, an ongoing relationship between health practitioners and patients is not an essential factor in ensuring the Pathway achieves its outcomes.

Indeed, participants in the Delphi study mainly disagreed with the statement '*Domestic abuse should only be dealt with as part of an ongoing relationship between a health worker and patient'.* Moreover, the case study site visit to one Midwifery-led labour unit, where patients are known to workers for a short time, demonstrates that routine enquiry could be effectively introduced where there is not a long term relationship between health practitioners and patients.

Some health workers who were interviewed during the evaluation felt that a home visit was the best situation in which to conduct the routine enquiry into domestic abuse. However, this view is disputed by some respondents who feel it is too risky for both the health practitioner and the woman to undertake such an enquiry in the home.

There is no necessity for routine enquiry to be undertaken in the patient's home.

Barriers to implementation and lessons for future roll out of the Pathway

A number of barriers to implementation of the Pathway were examined during the evaluation. These barriers would need to be addressed before introducing the Pathway to other health care settings.

Some Trusts and settings may face problems due to their size and scale. This can mean it takes a long time to ensure that all necessary staff are trained, leading to a delay between when the first staff received their training and implementation of the Pathway.

Larger organisations should consider how to manage the introduction of the Pathway so that implementation can follow an individual's training in quick succession. This may mean introducing the Pathway in one health care location at a time, rather than across whole Trusts.

Rural areas present particular problems for training community-based health practitioners. This is because the large geographical spread of the area makes it difficult for some staff to attend central venues. For practitioners such as district nurses, or outreach workers this issue should be considered.

Another important barrier mentioned during the evaluation was around ensuring that the necessary paperwork (RE DA1 and RE DA2 forms) would be stored and passed on to other health practitioners. Obviously, as the Pathway is introduced into other health care settings, there will be more partners to share information with and data collection and storage becomes increasingly important. There is a need for a named member of staff who would be responsible for ensuring records are kept and accessed as necessary.

Communication between different health care departments and organisations should be ensured by use of effective protocols for sharing information on the issue of domestic abuse. This would be particularly important in settings where there is a large staff turnover

Difficulties with obtaining confidential time alone with patients in order to undertake the routine enquiry into domestic abuse was highlighted as an important barrier by Midwives and Health Visitors. This was felt to be particularly difficult in the ante-natal period because partners often accompany patients in their time of excitement and anticipation. It was also felt that as fathers have been encouraged to 'participate' in the care of the woman and the unborn child, seeking private time runs contrary to this. In other settings, where it is 'normal' to have private time with patients, this issue may be less problematic.

6) Summary

The All Wales Ante-Natal Domestic Abuse Pathway has developed from a clear evidence base by a dedicated team of people working from within Midwifery and Health Visiting, who acknowledge the importance of domestic abuse as a *health* concern.

The desired outcomes and rationale were very clear for those involved in implementing the Pathway, namely Trust representatives belonging to the All Wales Midwifery and Health Visiting Networking Group, the Chair of that group and the senior midwife secondee from North Glamorgan NHS Trust who was involved in developing the tools for the Pathway. Also instrumental was the nursing lead in the Welsh Assembly Government.

The Pathway training was felt to be very effective by those who had undertaken it. It was fit for purpose and addressed the issues which are documented in evidence from other studies on health services and domestic abuse. The training also addressed some of the historical problems health workers stated they had experienced in tackling domestic abuse in their own practice. Particular elements of the training such as the provision of general statistics on the prevalence and effects of domestic abuse were thought to generate changes in practice and attitudes amongst health workers.

Overall confidence levels in dealing with the key issues faced by health workers addressing domestic abuse were high, as a result of the training provided.

In terms of the outcomes achieved by the Pathway, increased confidence and awareness amongst health professionals can be claimed as a success.

The fact so many health workers have received training and awareness raising sessions is another significant outcome.

However, there is still much work to be done. This is to be expected as the Pathway is in early days of implementation. There are still three trusts that have yet to implement.

In a number of cases health workers still expressed a level of anxiety about how the routine enquiry RE DA 1 and RE DA2 forms should be used and how the information contained within the forms will be shared. Health workers are aware the Pathway is in place and they are expecting to see it in practice. Where this is not yet happening, due to forms not yet ‘coming through’, this has generated a certain amount of anxiety and anticipation.

However, it is expected that once health workers have become used to the Pathway forms, the forms will become part of normal practice and Midwives and Health Visitors will be more comfortable with the Pathway. This process of ‘bedding down’ the Pathway should be supported by continuous monitoring of how the forms are being used and ensuring that supervision, materials and sources of advice are available to health workers.

There are other barriers which need to be addressed and which simple implementation delays will not explain. These are mainly to do with difficulties in finding private or confidential time with women patients and with language barriers for women from black and minority ethnic backgrounds for which the problem of gaining privacy is exacerbated.

Trusts are advised to investigate the feasibility of having a privacy policy with all ante-natal patients as a matter of course.

In general, implementation has been successful. It is too early to give a full analysis of the outcomes and impacts of the Pathway as implementation is not yet mature. However, early feedback from an audit of the use of RE DA1 and RE DA2 forms demonstrates that some Trusts have been able to gain as much as a 87% rate of enquiry for RE DA1 enquiries (done once) and 69% (done twice).

However, the actual aim for the Pathway is to have routine enquiry for *100%* of women as part of their normal package of care. There is still some way to go before achieving that across Wales. It is the opinion of the evaluators that by the end of 2007, the rate of enquiry for RE DA 1 (asked twice), should be up to at least 80% for all Trusts. This will only be achieved if usage of the tools is being closely monitored at a local level.

One key outcome of the Pathway is that it has generated discussion and thought about domestic abuse more generally. The Pathway has acted as a catalyst for changing practice. In many cases the Pathway has stimulated discussion on how to shape services to ensure that women gain confidential time with Midwives and Health Visitors. The introduction of the Pathway has also highlighted the importance of domestic abuse as an issue for NHS Wales staff and has encouraged the development of internal staff domestic abuse policies.

This evaluation has demonstrated the introduction of the Pathway has acted as an agent for change in that it is encouraging new ways of thinking about and tackling domestic abuse in the health care context.

7) Recommendations

The following list of recommendations has been developed from the research findings and policy development work. A monitoring and evaluation framework, which supports these recommendations, has been developed and is included at Appendix six.

Being able to undertake routine enquiry into domestic abuse with all women:

- Each Trust should assess the feasibility of developing a Trust-wide privacy policy for the ante-natal period whereby all women are seen privately, as a matter of course.
- The Networking Group should work with organisations representing women from Black and Minority Ethnic Communities to ensure that issues of language barriers or other cultural barriers to implementing routine enquiry are addressed.
- The Networking Group should monitor, through communication with its members, the extent to Welsh language needs are met through the Pathway and if there are any barriers to routine enquiry as a result of this issue.

Ensuring professional support and monitoring is available to continuously improve the outcomes of the Pathway*:*

- Trusts should develop ways of ensuring advice and support is available to staff who need it, about domestic abuse cases. The source of this support should be known to all health workers. Trusts should also develop ways of ensuring that formal and informal 'refresher' training is available as required by staff. In some cases training around domestic abuse has become part of mandatory training. However, each Trust should develop their own policy around the continuous training and development of staff around domestic abuse.
- Materials and on-line support should be continuously developed and promoted by the Networking group.
- A clear Pathway flow chart, which is currently available in the training packs, should be developed into poster size and placed in staff areas where appropriate.
- Staff supervision should regularly include monitoring on how Health Visitors and Midwives are using the Pathway and any difficulties they may have encountered.
- Lead staff, preferably heads of Midwifery/Health Visiting or Consultant Midwives should be responsible for continuously monitoring the use of the RE DA1 and DA 2 forms and this should happen as part of regular monitoring, preferably more than bi-annually. This is particularly important at the earlier stages of implementation when new practices need to be re-enforced and encouraged. Where the Pathway has not been followed correctly, for example, staff not signing forms or recording use of the RE DA1, action should be taken to ensure staff do this. Examples of such action might include having a person responsible for quality checking the use of the paper work and chasing health workers to complete forms correctly if they have missed parts.
- Materials and training should regularly collate and share good practice particularly in terms of ensuring privacy or enlisting support of agencies for minority ethnic women.

- The role of the Health Visitor and the steps they need to take if a Midwife has been unable to undertake the RE DA1 enquiry should be clarified and communicated again at a local level, probably through staff supervision.
- Annual surveys of women clients' views should be undertaken to establish levels of satisfaction with the way health workers had handled their referral. This can be administered via the support agencies, perhaps as part of their own monitoring processes.

Improving multi agency working and communication:

- Each Trust should clearly state and communicate to all relevant health workers, including Health Visitors, Midwives, GPs and Social Services where RE DA1 and RE DA2 forms are being stored.
- Agencies that receive referrals from Midwives and Health Visitors should be regularly contacted to ensure that referrals are appropriate and so that health workers are kept up to date on developments within these agencies. This contact could be made by the representatives on the Networking Group on a quarterly basis.
- Roll out of the Pathway into other areas is currently focused on Accident and Emergency and Gynaecology settings. The focus for future settings for roll out of the Pathway should be supported by research which strongly supports roll out in GUM and sexual health clinics (Martin et al, 1999). Respondents to the Delphi study were also supportive of rolling out the pathway to alcohol and substance misuse centres.
- Other health care settings should share an understanding of risk assessment, referral routes and record keeping around domestic abuse. The Pathway processes should be advertised and communicated with these other settings, particularly GP surgeries.

Internal staff policies on domestic abuse:

- Robust human resources/staff policies and support mechanisms around domestic abuse should be in place as a matter of urgency. It should be acknowledged that domestic abuse can only be dealt with by health care staff who are sufficiently supported themselves.

Appendix one) All Wales Ante-Natal Domestic Abuse Pathway Survey Script for Midwives

All Wales Ante-Natal Domestic Abuse Pathway interim evaluation form for Midwives December, 2006
The Welsh Assembly Government have commissioned us to evaluate the All Wales Ante-Natal Domestic Abuse Pathway, to see what has worked well, what more we can do to support the work and see what problems we need to address. We would be grateful if you could complete the following survey and return it using the envelope and Freepost address label provided by <u>February 16th 2007.</u> *You don't have to give your name* and we encourage you to be a frank as you wish. Thank you for your time, your help is very important to us.
Job title: LHB Area:
Please say briefly in your own words, what problems you have experienced in the past in addressing the issue of domestic abuse in your practice.
Has the All Wales Ante-Natal Domestic Abuse care pathway training helped you to overcome any of these problems? Please tick: Yes No Partially
What gaps, if any, are there in what the All Wales Ante-Natal Domestic Abuse care Pathway training provided you with?

How confident would you say you felt in the following areas, as a result of the All Wales Ante-Natal Domestic Abuse care pathway training:
(tick one or two as appropriate)

	Yes, I feel confident with this	*I feel better about this but still have some uncertainty*	*I still don't feel confident with this*	*The training didn't address this at all*	*This wasn't important to me*
Knowing what the signs of domestic abuse are					
Knowing what is the prevalence of domestic abuse in society					
Knowing what groups are at risk and when					
Knowing how domestic abuse affects different ethnic groups					
Being able to ask the question about domestic abuse routinely					
Being able to obtain confidential time alone to ask the question about domestic abuse					
Being able to deal with a woman who you are unable to see alone throughout her pregnancy					
Being able to complete the forms DA 1 with women					
Being able to complete the form DA2					

with women who have disclosed					
Being able to refer a woman who had disclosed					
Knowing what to do afterwards, once you have referred her					
Knowing where your responsibilities start and finish with women victims					
	Yes, I am now confident with this	*I feel better about this but still have some uncertainty*	*I still don't feel confident with this*	*The training didn't address this at all*	*This wasn't important to me*
Being able to work with Health Visitors to ensure that there is continuity in support when a woman has disclosed					
Being able to share information and under what circumstances with social services, child protection					
Being able to share information and under what circumstances with the police					
Knowing where to go for further information and support about the issue of domestic abuse with my clients					
Knowing where to go for further information and support about the issue of domestic abuse if you or a colleague/friend have suffered from it					

To what extent would you agree with the statement 'the domestic abuse pathway and the training that goes with it has meant that domestic abuse is less of a hidden issue for Midwives and is now routinely tackled'. Please tick as appropriate - strongly agree - agree - neither agree or disagree - disagree - strongly disagree
Could you give brief reasons for your answer please?
What broad outcomes do you think the introduction of the Pathway has achieved for women *victims* of domestic abuse, in your experience. (By 'outcome' we mean 'broad results', for example, an outcome of a road safety publicity campaign might be 'increased awareness of risks amongst children')
What outcomes do you think the introduction of the Pathway has achieved for you, as a health practitioner?
Can you please tell me, without naming names, an example of a successful outcome for a woman victim that has been referred through the Pathway.

Have you been able to ask *all* of your women clients about domestic abuse since the Pathway was introduced?
If not, could you describe some of the reasons why it has not been possible to ask all women clients about domestic abuse?
Have you been able to share information about the women who had disclosed domestic abuse with Health Visitors?
Where this has not been possible, please describe some of the barriers you have encountered.
Have there been any difficulties in ensuring that women are referred to get the support they need once they have disclosed? If so, please say why.
Please use this opportunity to highlight any other difficulties you have had in using the Pathway effectively. This could include anything from wider policy in the health service, your own confidence in dealing with the issue, time constraints.

Since the introduction of the Pathway, please indicate how likely the following outcomes are to be achieved, in your opinion:

	Very likely	Likely	Can't say	*Un*likely	Very *un*likely
More women victims are identified generally					
More women victims are referred to support services					
Midwives are able to deal with domestic abuse more effectively					
Health Visitors are able to deal with domestic abuse more effectively					
More children are protected from the effects of domestic abuse					
Other health agencies are more aware of domestic abuse					
Midwives are able to communicate better with social services					
Health Visitors are able to communicate better with social services					
There will be more awareness amongst women generally that domestic abuse is not acceptable					

Was there any aspect of the training that worked *particularly* well for you, in terms of helping you to address domestic abuse in your practice? (this could be something quite specific like the venue of the training or the way materials were written)

Is there any aspect of the DA 1 and DA 2 forms that the Pathway uses that works particularly well for you?

What are the most *important* things that need to be done in order for the Pathway to be used *effectively*?

Is there any thing that you can think of that is *not* working well in how the Pathway is used?
Please use this space to say anything else you would like to mention about the Pathway or its introduction.

Thank you for completing the form, please send it back to KM Research and Consultancy Ltd using the envelope and address label provided

Appendix Two) Survey Script for Health Visitors

All Wales Ante-Natal Domestic Abuse Pathway interim evaluation from for Health Visitors
December, 2006

The Welsh Assembly Government have commissioned us to evaluate the All Wales Ante-Natal Domestic Abuse Pathway, to see what has worked well, what more we can do to support the work and see what problems we need to address. We would be grateful if you could complete the following survey and return it using the envelope and Freepost address label provided by Friday 26th January, 2007. *You don't have to give your name* and we encourage you to be a frank as you wish. Thank you for your time, your help is very important to us.
Job title: LHB Area:
Please say briefly in your own words, what problems you have experienced in the past in addressing the issue of domestic abuse in your practice.
Has the All Wales Ante-Natal Domestic Abuse care pathway training helped you to overcome any of these problems? Please tick: Yes No Partially
What gaps, if any, are there in what the All Wales Ante-Natal Domestic Abuse care Pathway training provided you with?

How confident would you say you felt in the following areas, as a result of the All Wales Ante-Natal Domestic Abuse care pathway training:
(tick one or two as appropriate)

	Yes, I feel confident with this	*I feel better about this but still have some uncertainty*	*I still don't feel confident with this*	*The training didn't address this at all*	*This wasn't important to me*
Knowing what the signs of domestic abuse are					
Knowing what is the prevalence of domestic abuse in society					
Knowing what groups are at risk and when					
Knowing how domestic abuse affects different ethnic groups					
Being able to ask the question about domestic abuse routinely					
Being able to obtain confidential time alone to ask the question about domestic abuse					
Being able to deal with a woman who you are unable to see alone throughout her pregnancy					
Being able to complete the forms DA 1 with women					
Being able to complete the form DA2					

with women who have disclosed					
Being able to refer a woman who had disclosed					
Knowing what to do afterwards, once you have referred her					
Knowing where your responsibilities start and finish with women victims					
	Yes, I am now confident with this	*I feel better about this but still have some uncertainty*	*I still don't feel confident with this*	*The training didn't address this at all*	*This wasn't important to me*
Being able to work with Midwives to ensure that there is continuity in support when a woman has disclosed					
Being able to share information and under what circumstances with social services, child protection					
Being able to share information and under what circumstances with the police					
Knowing where to go for further information and support about the issue of domestic abuse with my clients					
Knowing where to go for further information and support about the issue of domestic abuse if you or a colleague/friend have suffered from it					
To what extent would you agree with the statement 'the domestic abuse pathway and the training that goes with it has meant					

that domestic abuse is less of a hidden issue for Health Visitors and is now routinely tackled'. Please tick as appropriate - strongly agree - agree - neither agree or disagree - disagree - strongly disagree
Could you give brief reasons for your answer please?
What broad outcomes do you think the introduction of the Pathway has achieved for women *victims* of domestic abuse, in your experience. (By 'outcome' we mean 'broad results', for example, an outcome of a road safety publicity campaign might be 'increased awareness of risks amongst children')
What outcomes do you think the introduction of the Pathway has achieved for you, as a health practitioner?
Can you please tell me, without naming names, an example of a successful outcome for a woman victim that has been referred through the Pathway.
Have you been able to ask *all* of your women clients about domestic abuse since the Pathway was introduced?

If not, could you describe some of the reasons why it has not been possible to ask all women clients about domestic abuse?
Have you been able to share information about the women who had disclosed domestic abuse with Midwives?
Where this has not been possible, please describe some of the barriers you have encountered.
Have there been any difficulties in ensuring that women are referred to get the support they need once they have disclosed? If so, please say why.
Please use this opportunity to highlight any other difficulties you have had in using the Pathway effectively. This could include anything from wider policy in the health service, your own confidence in dealing with the issue, time constraints.

Since the introduction of the Pathway, please indicate how likely the following outcomes are to be achieved, in your opinion:

	Very likely	Likely	Can't say	*Un*likely	Very *un*likely
More women victims are identified generally					
More women victims are referred to support services					
Midwives are able to deal with domestic abuse more effectively					
Health Visitors are able to deal with domestic abuse more effectively					
More children are protected from the effects of domestic abuse					
Other health agencies are more aware of domestic abuse					
Midwives are able to communicate better with social services					
Health Visitors are able to communicate better with social services					
There will be more awareness amongst women generally that domestic abuse is not acceptable					

Was there any aspect of the training that worked *particularly* well for you, in terms of helping you to address domestic abuse in your practice? (this could be something quite specific like the venue of the training or the way materials were written)

Is there any aspect of the DA 1 and DA 2 forms that the Pathway uses that works particularly well for you?

What are the most *important* things that need to be done in order for the Pathway to be used *effectively*?

Is there any thing that you can think of that is *not* working well in how the Pathway is used?
Please use this space to say anything else you would like to mention about the Pathway or its introduction.

Thank you for completing the form, please send it back to KM Research and Consultancy Ltd using the envelope and address label provided

Appendix Three) Survey Script for low-implementation state areas (Midwife example)

All Wales Ante-Natal Domestic Abuse Pathway interim evaluation form for Midwives
December, 2006

The Welsh Assembly Government have commissioned us to evaluate the All Wales Ante-Natal Domestic Abuse Pathway, to see what has worked well, what more we can do to support the work and see what problems we need to address. We would be grateful if you could complete the following survey and return it using the envelope and Freepost address label provided by March 16th, 2007. *You don't have to give your name* and we encourage you to be a frank as you wish. Thank you for your time, your help is very important to us. **The survey is for Midwives who have received their training and for those who have yet to. Please answer the relevant sections as best you can.**
Section one) Job Title: Health Board Area/NHS Trust:
Please say briefly in your own words, what problems you have experienced in the past in addressing the issue of domestic abuse in your practice.
Have you undertaken the All Wales Ante-Natal Domestic Abuse Pathway training? (If you answer yes, please go to section two below, if you answered no, please go to section three).
Section two) (for Midwives who have received the All Wales Ante-Natal Domestic Abuse care pathway training)

When did you receive your training?
Has the All Wales Ante-Natal Domestic Abuse care pathway training helped you to overcome any of the problems you have encountered in your practice? (please refer to your answer in section one) Please tick: Yes No Partially
What gaps, if any, are there in what the All Wales Ante-Natal Domestic Abuse care pathway training provided you with?

How confident would you say you feel in the following areas, as a result of the All Wales Ante-Natal Domestic Abuse care pathway training? (tick one or two as appropriate)

	Yes, I feel confident with this	*I feel quite confident but have some uncertainty*	*I don't feel confident at all*	*This wasn't covered at all*	*This isn't important*
Knowing what the signs of domestic abuse are					
Knowing what is the prevalence of domestic abuse in society					
Knowing what groups are at risk and when					
Knowing how domestic abuse affects different ethnic groups					
Being able to ask the question about domestic abuse routinely					
Being able to obtain confidential time alone to ask the question about domestic abuse					
Being able to deal with a woman who you are unable to see alone throughout her pregnancy					
Being able to complete the forms DA 1 with women					
Being able to complete the form DA2 with women who have disclosed					
Being able to refer a woman who had disclosed					
Knowing what to do afterwards, once					

you have referred her					
Knowing where your responsibilities start and finish with women victims					
	Yes, I feel confident with this	*I feel quite confident but have some uncertainty*	*I don't feel confident at all*	*This wasn't covered at all*	*This isn't important*
Being able to work with Health Visitors to ensure that there is continuity in support when a woman has disclosed					
Being able to share information and under what circumstances with social services, child protection					
Being able to share information and under what circumstances with the police					
Knowing where to go for further information and support about the issue of domestic abuse with my clients					
Knowing where to go for further information and support about the issue of domestic abuse if you or a colleague/friend have suffered from it					

To what extent would you agree with the statement '*the domestic abuse pathway and the training that goes with it has meant that domestic abuse is less of a hidden issue for Midwives and is now routinely tackled*'. Please tick as appropriate:

- strongly agree - agree - neither agree or disagree - disagree - strongly disagree
Could you give brief reasons for your answer please?
Can you tell me, without naming names, an example of a successful outcome for a woman victim that has been referred through the Pathway?
Have you been able to ask *all* of your women clients about domestic abuse since the Pathway was introduced?
If not, could you describe some of the reasons why it has not been possible to ask all women clients about domestic abuse?
Have you been able to share information about the women who had disclosed domestic abuse with Health Visitors?
Where this has not been possible, please describe some of the barriers you have encountered.
Have there been any difficulties in ensuring that women are referred to get the support they need once they have disclosed? If so, please say why.

Please use this opportunity to highlight any other difficulties you have had in using the Pathway effectively. (This could include anything from wider policy in the health service, your own confidence in dealing with the issue, time constraints).
Was there any aspect of the training that worked *particularly* well for you, in terms of helping you to address domestic abuse in your practice? (*this could be something quite specific like the venue of the training or the way materials were written)*
Is there any aspect of the DA1 and DA2 forms that the Pathway uses that works *particularly* well for you?
What are the most *important* things that need to be done in order for the Pathway to be used effectively?
Is there anything that you can think of that is *not* working well in how the Pathway is used?
Section three (for Midwives who have not yet received the All Wales Ante-Natal Domestic Abuse care pathway training)
What would you like to see covered in any training to help address some of the problems you have encountered in addressing domestic abuse in your practice? (refer to your answer in section 1)

How confident would you say you feel in the following areas as a health practitioner? Tick one or two as appropriate

	Yes, I feel confident with this	*I feel quite confident but have some uncertainty*	*I don't feel confident at all*	*This isn't important*
Knowing what the signs of domestic abuse are				
Knowing what is the prevalence of domestic abuse in society				
Knowing what groups are at risk and when				
Knowing how domestic abuse affects different ethnic groups				
Being able to ask the question about domestic abuse routinely				
Being able to obtain confidential time alone to ask the question about domestic abuse				
Being able to deal with a woman who you are unable to see alone throughout her pregnancy				
Being able to complete the forms DA 1 with women				
Being able to complete the form DA2 with women who have disclosed				
Being able to refer a woman who had disclosed				
Knowing what to do afterwards, once you have referred her				

Knowing where your responsibilities start and finish with women victims					
	Yes, I feel confident with this	*I feel quite confident but have some uncertainty*	*I don't feel confident at all*	*This isn't important*	
Being able to work with Health Visitors to ensure that there is continuity in support when a woman has disclosed					
Being able to share information and under what circumstances with social services, child protection					
Being able to share information and under what circumstances with the police					
Knowing where to go for further information and support about the issue of domestic abuse with my clients					
Knowing where to go for further information and support about the issue of domestic abuse if you or a colleague/friend have suffered from it					

In your opinion, to what extent would you agree with the statement '*routine enquiry about domestic abuse in antenatal settings will mean that domestic abuse is less of a hidden issue for Midwives and is routinely tackled'*. Please tick as appropriate:

- strongly agree

- agree
- neither agree or disagree
- disagree
- strongly disagree

Section four) <u>all</u> Midwives to complete

What broad outcomes do you think the introduction of the Pathway or 'routine enquiry about domestic abuse in antenatal settings' will achieve for women *victims* of domestic abuse, if any?
(By 'outcome' we mean 'broad results', for example, an outcome of a road safety publicity campaign might be 'increased awareness of risks amongst children')

What outcomes do you think the introduction of the Pathway or 'routine enquiry' might achieve for you, as a health practitioner?

Please use this opportunity to highlight any other difficulties you anticipate in using the Pathway or routine enquiry effectively? This could be very broad issues or very specific ones.

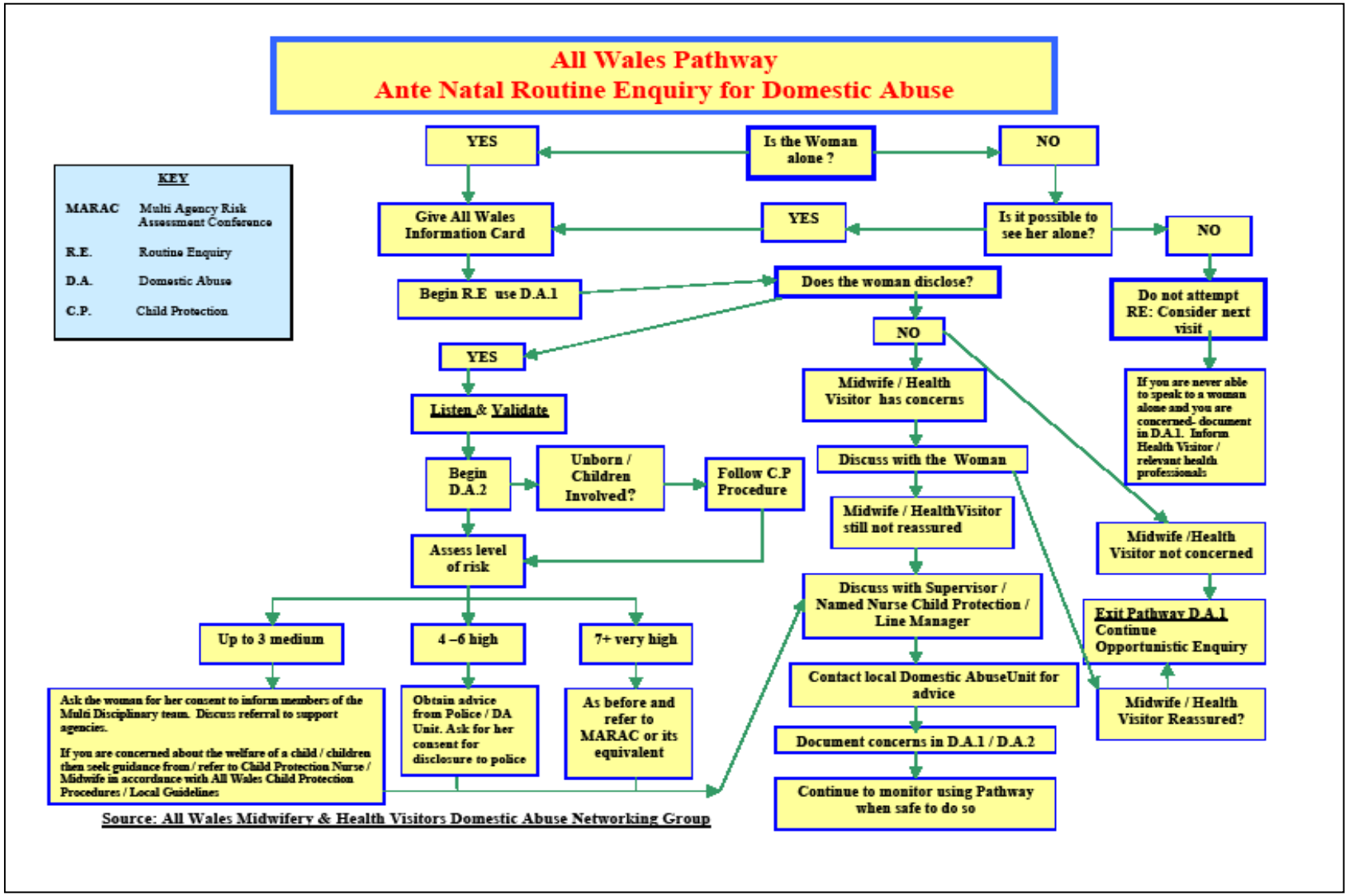
As a result of the introduction of the Pathway or 'routine enquiry' please indicate how likely the following outcomes are to be achieved, in your opinion:

	Very likely	Likely	Can't say	*Un*likely	Very *un*likely
More women victims are identified generally					
More women victims are referred to support services					
Midwives are able to deal with domestic abuse more effectively					
Health Visitors are able to deal with domestic abuse more effectively					
More children are protected from the effects of domestic abuse					
Other health agencies are more aware of domestic abuse					
Midwives are able to communicate better with social services					
Health Visitors are able to communicate better with social services					
There will be more awareness amongst women generally that domestic abuse is not acceptable					

Please use this space to say anything else you would like to mention about the Pathway or 'routine enquiry' or its introduction.

Thank you for completing the form, please send it back to KM Research and Consultancy Ltd using the envelope and address label provided

Appendix Four) All Wales Ante Natal Domestic Abuse Pathway flow chart



Appendix five: Participants in the Delphi study and policy forum:

Delphi Study Participants

Dr Aideen Naughton
Consultant Paediatrician
Neville Hall Hospital

Ellen Pierce
Welsh Women's Aid

Jan Pickles
Cardiff Women's Safety Unit

Professor Joyce Kenkre
School of Care Sciences
University of Glamorgan

Peter Jones
Head of Community Safety
Welsh Assembly Government

Rakhshanda Shahzad
Domestic Abuse Manager South Wales
Black Association of Women Step Out, Women's Aid (BAWSO)

Grant Williams
Accident and Emergency Domestic Abuse Pathway development worker
Welsh Assembly Government

Dr Jane Ludlow
Senior Medical Officer
Office of the Chief Medical officer
Welsh Assembly Government

Lynn Lynch
Consultant Midwife North Glamorgan NHS Trust
Chair, All Wales Midwifery and Health Visiting Networking Group

Polly Ferguson
Nursing Lead
Welsh Assembly Government

Policy Forum Participants

Dr. Karen Bathgate
Social Justice and Regeneration, Housing
Welsh Assembly Government

Suzanne Hardachre
Senior Midwife, North Glamorgan NHS Trust

Lynn Lynch
Consultant Midwife North Glamorgan NHS Trust
Chair, All Wales Midwifery and Health Visiting Networking Group

Peter Jones
Head of Community Safety
Welsh Assembly Government

Rakhshanda Shahzad
Domestic Abuse Manager South Wales
Black Association of Women Step Out, Women's Aid (BAWSO)

Claire Sharp
Welsh Women's Aid

Grant Williams
Accident and Emergency Domestic Abuse Pathway development worker
Welsh Assembly Government

Carole Bell
Acting Head of Midwifery/Supervisor of Midwives
Carmarthenshire NHS Trust

Polly Ferguson
Nursing Lead
Welsh Assembly Government

Professor Joyce Kenkre
School of Care Sciences
University of Glamorgan

Dr Jane Ludlow
Senior Medical Officer
Office of the Chief Medical officer
Welsh Assembly Government

Katie McCracken
Director, KM Research and Consultancy Ltd

Appendix Six: Proposed Performance Management and Evaluation Framework (PMF) for the All Wales Ante Natal Domestic Abuse Pathway

The framework is a set of outcome measures arranged by theme which may be adopted by the All Wales Health Visitors and Midwifery Networking Group (Networking Group) to monitor the development of the Pathway. The framework should be reviewed annually by the Networking group

Theme one) implementation					
Outcome	Measure(s)	How measured	Target suggestion	By when	Lead responsibility
Women are routinely asked about domestic abuse, at appropriate stages in their pregnancy and/or motherhood	Number of RE DA1 and RE DA2 forms completed, as percentage of all new bookings	Bi annual audit of record keeping and ad hoc audits as necessary	100%	End 2007	Chair of Networking Group/WAG midwifery lead
	All Trusts/LHBs have reviewed the feasibility of introducing a universal policy of interviewing women alone at least once during the ante-natal period. All Trusts/LHBs to have agreed on their policy	Feedback to Networking Group	100% of Trusts/LHBs have reported a successful review and agreed on a policy	End 2007	Representatives on Networking group
Midwives and Health Visitors have received training for the Pathway	Numbers of Health Visitors and Midwives trained as % of all	Ad hoc audits as necessary	100%	End 2007	Chair of Networking Group/WAG midwifery lead
Theme two) pathway effectiveness					
Women are referred to appropriate sources of	% of women subject to RE DA2 forms, referred to	Bi annual audit of record keeping and	100%	End 2007	Chair of Networking

support as required	another agency for support	ad hoc audits as necessary			Group/WAG midwifery lead
	% of referred-to agencies that are satisfied that referrals are appropriate	Regular (quarterly) contact with agencies using a short questionnaire/ pro-forma	100% agencies saying they are 'generally satisfied' with referrals	Ongoing	Representatives on Networking group
Women are satisfied with the way they are referred	% of women referred to agencies who report general satisfaction with the appropriateness of the agency they were referred to	Annual survey of women clients who had been referred to agencies for support. *Can be by including a question in support agencies own monitoring programmes.*	100% women saying they were generally 'satisfied'	Ongoing	Representatives on Networking group
	% of women subject to RE DA2 forms who are satisfied with the way health workers managed their referrals	Annual survey of women clients who had been referred to agencies for support. *Can be by including a question in support agencies own monitoring programmes*	100% women saying they were generally 'satisfied'	Ongoing	Representatives on Networking group
Women are aware of support available for domestic abuse	All Trusts/LHB areas have a system in place for ensuring up to date leaflets and posters are available	Feedback to Networking Group	100% of areas reporting a system for providing up to date materials is in place	Ongoing	Chair of networking group
Women are able to access information and	All Trusts/LHB areas to have a policy in place to	Feedback to Networking group	100% of areas reporting that a	By end 2007	Representatives on Networking

advice in language of choice	ensure information is available in all community languages and Welsh. This should be regularly reviewed		policy on language provision is in place and have agreed methods of reviewing this		group
Theme three) support for Midwives and Health Visitors					
Midwives and Health Visitors feel able to access support and advice on the issue of domestic abuse	Source of support and advice designated for each area	Feedback to Networking group	100% of areas reporting a designated source of advice and support	ongoing	Chair networking group
Staff are supported to address any personal issues of abuse	Each Trust/LHB area has an agreed staff policy on domestic abuse, agreed at an executive level	Feedback to Networking group	100% of areas reporting that a staff policy on domestic abuse is in place	End 2007	Human Resources leads within Trusts/LHBs
Theme four) communications and information sharing					
Midwives and Health Visitors are able to share information effectively about domestic abuse	Each Trust/LHB area has procedure in place to ensure records of routine enquiry are handed over to Health Visitors	Feedback to Networking group	100% of areas reporting that a procedure has been agreed	End 2007	Representatives on Networking group
	Areas have a designated, secure place to store records of RE DA1 and RE DA2	Feedback to Networking group	100% of areas reporting that a storage place has been agreed	End 2007	Representatives on Networking group

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