An Exploration of Healthcare Professionals' Personal and Professional experiences of Domestic Violence and Abuse

A study commissioned by and on behalf of Cavell Nurses' Trust with the National Centre for the Study and Prevention of Violence and Abuse (NCSPVA) at the University of Worcester.

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Disclaimer

The views expressed in this report are the authors and do not necessarily reflect the views of Cavell Nurses' Trust.

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List of Acronyms and Abbreviations

A&E	Accident and Emergency
CPD	Continuing Professional Development
CNS	Clinical Nurse Specialist
CSEW	Crimes Survey for England and Wales
DoH	Department of Health
DVA	Domestic Violence and Abuse
EVAWG	End Violence Against Women and Girls
HRA	Health Research Authority
ID	Identification
IHS	Institute of Health and Society
NHS	National Health Service
NICE	National Institute for Health Care and Excellence
SPSS	Statistical Package for the Social Sciences
VAWG	Violence Against Women and Girls
WHO	World Health Organisation
WW1	World War One

Executive Summary

Context:

Domestic violence and abuse (DVA) is a serious health issue often affecting the well-being and welfare of victims in the context of their family home, their education, social relationships and employment (WHO, 2016). The impact of this violence and abuse highlights its pervasion to many aspects of daily living as much of this abuse and violence may be hidden from family and friends. At present, there is very little research available surrounding the personal and professional experiences of healthcare professionals in relation to DVA. As such, in addition to exploring whether DVA is prevalent in this population, it would be beneficial to gain an understanding of healthcare sector culture and professional practice in relation to both patient and staff DVA disclosures. This would enable employers, domestic violence charities and researchers to develop multi- faceted psychological and environmental interventions that can better support and increase victim's resilience and subsequent ability to seek support and respond to domestic abuse.

The Present Study:

The aim of this study was three-fold. Firstly, it aimed to determine, quantitatively, the rates of domestic violence amongst healthcare professionals; Secondly, if evidence of personal experiences were apparent, this study aimed to give voice to the experiences of these health professionals, as victims of domestic violence; and thirdly, it aimed to consider healthcare professionals comfort and ability in screening and caring for patients experiencing domestic violence. Overall, the study aimed to inform the healthcare sector in both supporting professionals in dealing with patient disclosures, as well as supporting employees who have experienced or are experiencing DVA within their personal life. In order to

address the above aims, the project employed an explanatory sequential design (Creswell & Clarke, 2010), consisting of two phases.

Findings:

This exploratory study utilised the responses to a survey (N=84) and the transcripts of interviews with six healthcare professionals to begin examining how DVA affects those working in UK healthcare settings.

Significantly and worryingly, almost half of the respondents (47%) had experienced DVA at some point in their lives. This is double the national average, highlighting a significant vulnerability in the workforce. Respondents reported minimal level of support from and confidence in the response of their employer when they require support for DVA. Furthermore, many reported feeling that the healthcare sector culture silences issues such as DVA, feeding the belief that private matters should remain private. Respondents felt that even if they needed support, they could not contradict this culture for fear of embarrassment and stigma. In addition, there was a perceived potential for confidentiality to be broken when a member of staff was the victim, despite confidence that confidentiality would always be respected for other patients. Furthermore, when discussing the potential for offering support to colleagues experiencing DVA, respondents began questioning their hypothetical colleague/victim's ability to work and be safe to practice. This adds to the silencing of victims of DVA who work in the healthcare sector.

The respondents and interviewees had various professional backgrounds, two thirds of whom routinely ask patients about their experiences of DVA. Furthermore, two thirds of the respondents' screen for DVA at least once a week, and three quarters of respondents reported having received a disclosure. In addition, 38% of the respondents were expected to ask every patient about DVA at the 1st and/or 2nd meeting. Surprisingly 62% of

respondents were left to decide if and/or when to ask themselves with no official guidance from management.

The analysis of the survey data highlighted several shortcomings in the training provided to frontline healthcare staff expected to screen for and deal with disclosures of DVA. Of the 64% of respondents who routinely screen for DVA, 22% had not received DVA specific training. In addition, of the 78% of staff who had received DVA specialist training, one third found this training 'not at all helpful' or only 'somewhat helpful'. In addition, half of the respondents suggested they did not feel comfortable screening for DVA and one third did not feel confident in dealing with disclosures. This highlights a significant and urgent need to revisit the DVA specialised training requirements of all frontline healthcare staff.

The Research Partners and the Legacy of Edith Cavell

The National Centre for the Study and Prevention of Violence and Abuse (NCSPVA) at the University of Worcester welcomed the opportunity to conduct this research on behalf of Cavell Nurses' Trust.

Cavell Nurses' Trust

Edith Cavell was a British nurse executed by a German firing squad on the 12th October, 1915 for helping Allied soldier escape from Germany occupied Belgium[1]. Subsequently, Cavell Nurses' Trust was founded in memory of Edith and her inspirational character. Cavell Nurses' Trust provides a range of support for students embarking on their careers, those currently practicing and retired nurses, midwives and healthcare assistants including, support in relation to financial hardship, disability, ill health and domestic violence.

The Trust has historically recognised that nurses, midwives and healthcare assistants experience domestic abuse and have responded by working with partners on the 'Abuse at Home' campaign which highlights the issue of domestic abuse amongst past and present members of the nursing profession. More recently, Cavell Nurses' Trust had identified an increase in nurses, midwives and healthcare assistants disclosing domestic abuse and requests for support relating to this concern. This concern led to a need to explore and understand this issue further. This research has sought to assist the Trust to be in a better position to respond to the needs of nurses in the context of employment, and those who identify as a victim and/or survivor of domestic violence.

The NCSPVA

The National Centre for the Study and Prevention of Violence and Abuse (NCSPVA) based at the University of Worcester is both interdisciplinary and inter-professional with an overall aim of *'providing a stimulating and inclusive environment in which to study and understand violence and abuse and its prevention - regardless of who it is perpetrated by, against or between'.*

Background to Study

Defining Domestic Violence and Abuse

Firstly, before contextualising the study it is important to define what it is when we refer to domestic violence and abuse (DVA). In March 2013, the Home Office extended the definition of DVA to include young people from the age of 16 years and to give recognition to the issue of coercive and controlling behaviours. Although this is not a legal definition, it is recognised and implemented across all government bodies:

> *Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of age, gender or sexuality. This can encompass but is not limited to the following types of abuse:*
>
> - *Psychological*
> - *Physical*
> - *Sexual*
> - *Financial*
> - *Emotional*
>
> *Controlling behaviour is a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.*
>
> *Coercive behaviour is an act or pattern of acts of assault, threats, humiliation or intimidation or other abuse that is used to harm, punish or frighten their victim (Home Office, 2016: 5).*

As such, for the purpose of the present project, the above definition will underpin all reference to domestic violence and abuse herein.

The Extent of Domestic Violence and Abuse in the UK

Domestic violence and abuse (DVA) is a serious health issue often affecting the well-being and welfare of victims in the context of their family home, their education, social relationships and employment (WHO, 2016). The impact of this violence and abuse highlights its pervasion to many aspects of daily living as much of this abuse and violence may be hidden from family and friends. There is cause for disquiet among the general population in considering that 1 in 4 women may be affected by this concern and 1 in 6 men (DoH, 2013). This issue is further compounded by the realities of children and young people who are caught in the destructive dynamics of witnessing violence and who may be directly affected by this abuse. This is particularly concerning when considering the linkage between child abuse and partner abuse in an estimated 40-60% of cases worldwide (García- Moreno, 2005).

The Crime Survey for England and Wales (CSEW, 2015) focused on the issue of DVA in the period of 2013 to 2014. The CSEW survey highlights:

- An estimated 1.4 million women and 700,000 men experience a range of different types of domestic violence. This includes abuse or violence perpetrated by other family members such as isolating the victim, stalking harassment by a former partner and includes rape or sexual assault.
- The CSEW reports that an estimated 1.1 million women and 500,000 men have reported partner abuse
- Women are more likely than men to be the victims of all types of domestic abuse.

These figures highlight the extent of DVA and the need for multi-faceted

on-going research and intervention. It is important to note, however that this household survey does have limitations in that it focuses on the experiences of men and women between the ages of 16 to 59 years and therefore overlooks the experiences of older adults who may be victims of DVA. There is added concern about the absence of representation of younger people under the age of 16 who are affected by DVA as part of their family life or their own intimate relationships.

Much research has been conducted concerning victims of DVA. As noted previously, DVA includes not only physical violence, but also psychological, emotional and financial abuse as well as coercive control (Home Office, 2016). As such, studies considering victims' experiences of DVA have identified a number of differing types of abuse experienced. Although varying in form and often overlapping, one of the most prevalent forms of abuse relates to the controlling behaviour on the part of the abuser (Gilchrist et al., 2004). Such behaviours might include the restriction of the victims' movements and choices, be it choice of food to choice of clothing. Thus, one approach to understanding the differing types and calculated use of varying abusive behaviours comes from the 'Duluth Power and Control Wheel' (Pence & Paymar, 1991). Within this wheel, there are a range of abuses subjected upon victims that are centered on the abusers' power and control. Research, however, has highlighted that those who fall victim to DVA vary. Furthermore, as illustrated above (Garcia-Monreno, 2005), when there is apparent violence and abuse between adults, this will co-exist with violence forwards children.

There are a number of myths prevalent within society surrounding both the dynamics of DVA, and victim and perpetrator behavior. For example, there is a common conception that those involved in abusive relationships can easily 'leave' the abusive partner (Gortner, Berns, Jacobsen & Gottman, 1997). However, such attitudes neglect to consider the significant, and sometimes lethal, implications this 'simple' act can have. For example, research has consistently demonstrated

how the point of separation in an abusive relationship is where the greatest risk of severe violence and abuse can occur (Serran & Fireston, 2004). Additionally, following separation research has noted that more than three quarters of those victims recruited experienced post-separation violence, with approximately one third experiencing continued violence and abuse for up to 12 months following separation (Humphreys & Thiara, 2003). Of those reporting a cessation in abuse, this was usually attributed to the survivor moving location. However, in the case of there being a child between the couple, perpetrators and survivors often have to maintain contact, increasing the risk of ongoing abuse.

In general, attributions made by victims of crimes tend to demonstrate self- blame from those who have been victimized (Janoff-Bulman & Frieze, 1983). It has been previously reported that such self-blame can often act as a functional coping mechanism as it can result in victims altering their behaviour in order to reduce potential future victimization (e.g. an individual who has their bag stolen when walking late at night might alter their behaviour to avoid positioning themselves in similar situations in future). Such trends have further been demonstrated by research considering blame attributions in DVA (Cascardi & O'Leary, 1992; Johnson & Ferraro, 2000). Although differing in extent, research has reported that victims of DVA are more likely to blame themselves than the violent partner, particularly during early stages of DVA (Cascardi & O'Leary, 1992). This is concerning when considering the potential negative implications associated with self- blame. For example, Walker (1979) posited that while victims of DVA blamed themselves for victimization, this self-blame could lead to depression if DVA persists.

Although, as noted above, it has been suggested that self-blame can act as a coping mechanism, such a mechanism maynot be functional in DVA relationships as victims may believe that through altering their own actions, their partner's actions will also alter. This, subsequently, can lead to greater risk of continued

violence and abuse. Linking with this is the prevalence of victim blaming in relation to survivors who seek help. For example, research has demonstrated how healthcare professionals can fail to attribute responsibility for abuse appropriately (Nayak, 2000). Such misattribution of blame can further lead to failed attempts at reporting instances of DVA and subsequent failings in support offered to survivors. Considering the population of the current study, then, it is important to consider these possibilities and their impact upon individual's ability to both access and gain appropriate and supportive intervention.

Feminist theories and perspectives attempt to explain domestic abuse in the general population but these theories tend to adopt a single faceted approach. Rather, multi- factorial approaches that combine both psychological variables and social context may prove useful in explaining the complex processes involved in DVA (Dutton, 1994). For example, the nested ecological model incorporates a number of variables from the broader cultural, social and individual contexts in an attempt to unpick domestic abuse. This model comprises four levels, all of which interact with one another:

1. Macrosystem: incorporates societal and cultural beliefs and values,
2. Exosystem: relates to social structures such as work, peer groups and support groups,
3. Microsystem: consists of the family unit and immediate context in which the abuse takes place,
4. Ontogenetic: relates to the individual characteristics and internal factors of the person.

Whilst this approach has been used substantially in providing an explanation for DVA and the perpetrators behaviour, Foe et al., (2000) believe this multi-factorial approach could also help in explaining victim behaviour. Foe et al., (2000) believe that it is essential to consider victim's behaviour within the context of DVA. Subsequently, this knowledge would develop an applicable way of

understanding the multiple strategies victims use in an attempt to reduce or avoid abuse. The way in which a victim responds to such abuse must be considered in a broad social, political, economic and cultural context.

As such an integrative conceptual framework combining both psychological and environmental factors in relation to victim's behaviour was developed. The framework consists of three constructs (i.e. domestic abuse, psychological difficulties, and resilience) with a multitude of psychological and environmental variables that can be both helpful and harmful to victims in responding to abuse. In short, the model suggests that domestic abuse, psychological difficulties and resilience all interact with one another to mediate experiences of DVA.

On experiencing DVA, a victim may develop psychological difficulties that impede their ability to either reduce risk or leave the abusive situation. A victim's experience of psychological difficulties, however, is mediated by their resilience. Heightened resilience can act as a protective factor against psychological problems that, in turn, can increase a victim's ability to reduce or leave an abusive situation. Lowered resilience, however, can lead to heightened psychological difficulties and, subsequently, reduce a victim's ability to reduce or leave an abusive situation. Furthermore, all of these constructs are impacted upon by psychological and environmental factors.

At present, there is very little research available surrounding the personal and professional experiences of healthcare professions in relation to DVA. As such, in addition to exploring whether DVA is prevalent in this population, it would be beneficial, to gain an understanding of healthcare sector culture and professional practice in relation to both patient and staff DVA disclosures. This would enable employers, domestic violence charities and researchers to develop multi-faceted psychological and environmental interventions that can better support and increase victim's resilience and subsequent ability to seek support and respond

to domestic abuse. For example, through identifying contributors to patterns of domestic abuse that are rooted in the larger community and a victim's support system, it would be possible to identify risk and protective factors specific to victim's that employers, charities and researchers can specifically target through policy, education/training and intervention.

Health Sector Responses to Domestic Violence

In 2000, the Department of Health published *Domestic violence: a resource manual for health care professionals*. This publication demonstrated that DVA was being increasingly acknowledged as a critical health concern across the spectrum of health services. The publication of this manual recognised the prime position held by the NHS in both the early detection of DVA and in providing support and after care; Care not only in terms of physical injuries and illness consequent to physical or sexual violence, but also emotional and psychological trauma experienced by survivors (Humphreys & Thiara, 2003).

Subsequently, the Department of Health (DoH) and the National Institute for Health and Care Excellence (NICE) have issued a range of guidance for health practitioners including (DoH, 2005; DoH, 2010; DoH, 2012; DoH, 2013; NICE, 2014; NICE, 2016). Such guidance includes handbooks for healthcare professionals in responding to DVA, awareness raising and responding to the health impacts of Violence Against Women and Children, as well as practical guidance to multi-agency working (including the application of Caldicott Guardian Principles and MARAC) and to practitioners working outside of the immediate health environment (i.e. health visitors, school nurses). Overall, there has been an on- going positive commitment by the DoH and the NHS and other healthcare providers to address the health problem of DVA in its various clinical and care giving environments. However, there is an additional challenge aside from the drive to assure excellent quality care for victims as patients within the

NHS and other health sector providers. Specifically, this challenge relates to the critical matter of ensuring that *all* health care professionals are confident and competent in screening for DVA, asking the question about DVA, and intervening safely and appropriately to support the victim at that place in time. However, some evidence suggests that this is not the case. For example, Peate (2013: p. 1043) states that 'Nurses may find it difficult to acknowledge and act on signs of domestic violence and abuse, being unclear about safe and effective responses to victims and perpetrators.' This point identifies the importance of good quality training for health professionals to increase their knowledge and confidence in dealing with this issue in their professional practice.

Literature Review

There is currently limited research focusing on the prevalence and experiences of nurses and other health care professionals living with and surviving domestic violence, especially in the UK. Therefore, this study is unique in the context of UK based research. The literature in this review draws mainly from studies conducted in India, Turkey and South Africa.

In searching the existing literature, three articles appeared to consider elements of the healthcare profession in relation to domestic violence. Firstly, the study by Christofides and Silo (2005) examined how the direct and indirect personal experiences of nurses in Pretoria, or those who have no personal experiences of domestic violence, may influence health service provision. More recently, Sharma and Vatsu (2011) conducted a study in New Delhi to determine the prevalence of domestic violence and impact of domestic violence on nurses, including their perceptions regarding 'acceptable behaviour for men and women' (p.222). Finally, the third paper by Selek *et al*. (2012) discusses the reluctance of Nurses in Eastern Turkey to seek legal interventions as victims of domestic violence. These studies consistently highlight the prevalence of domestic violence among female nurses and it is noted that the three studies specifically invited female participants as respondents to the research; although the prevalence of male nurses in these regions are thought to be minimal.

The Scale of Domestic Violence in Healthcare

It is estimated that more than one in four women have experienced at least one incident of domestic violence in England and Wales since the age of 16 (DoH, 2013). Domestic violence and rape comprise in the region of 5% to 16% of the global health burden with women and children as the primary victims (Heise et al., 1994; García-Moreno 2005). Thus, it may be plausible to expect a statistical significance in prevalence of domestic violence in female nurses and other female

healthcare professionals.

Sharma and Vatsu (2011) state that 'nursing is one the most women-centred professions that is impacted by violence on several fronts' (p.223). The impact of violence on victims is exacerbated by the 'nature of duty' and the challenging shift patterns that may themselves impact negatively on family life and their relationship with their partner. However, care must be taken with regard to interpreting these observations as these factors could be construed as victim-blaming for their career choices and work patterns and subsequent experiences of domestic abuse. Overall, in their study, Sharma and Vatsu reported that 60% of the 60 married female nurses in their research reported controlling behaviours by their partner, 65% reported emotional abuse, 43% described physical violence and 30% disclosed sexual violence.

Furthermore, 50% of the nurses agreed that a 'good wife' obeys her husband even if she disagrees with him; 58% agreed that there were no reasons to justify violence although the most accepted justification for violence was the wife being unfaithful at 31%. The acceptance of domestic violence was higher among nurses who had experienced domestic violence at 46% in comparison to those who had not at 15%.

In the context of sexual violence and rape in marriage, 70% of the nurses agreed that a woman could refuse to have sex with her husband if she does not want to, if he is drunk, if she is sick or if he mistreats her. However, a worrying 10% still believed that a woman did not have the right to refuse sex under any of these circumstances. There may be cultural issues in relation to gender norms and values within Indian culture that the authors may not have contextualised or considered adequately in the study that accounts for this. This speaks to the cultural socialisation of girls and women in their home and community environments (WHO, 2002) and the high regard for the institution of marriage

and the expectations of a wife and mother within the family. Of those nurses who reported violence in the study, Sharma and Vatsu highlighted that the violence and abuse was still current and that only three nurses had sought medical assistance for their injuries.

Natan and Rais (2010: p. 112) consider the knowledge and attitudes of nurses in Israel in identifying and responding to domestic violence which they suggest 'is often not manifested in practice'. Although this study does focus on the barriers to asking the question of patients such as:

> *Discomfort, frustration, missing skills, embarrassment, inability to find a remedy, fear of losing control, denial, guilt, and lack of awareness; beliefs that such questioning constitutes an invasion of privacy and that the situation is too complex to treat, feelings of hopelessness and helplessness; thoughts that questioning will not promote change , and the feeling that it is easier to suppress the problem than to cope with it, as well as health care workers ' lack of trust in the system (p.113).*

Chapin *et al*. (2013: p. 2) articulate in strong terms that 'a knowledgeable and caring nurse may be all that stands between a victim suffering in silence and being connected with potentially life-saving services.' Yet, there appears to be a remarkable absence of the acknowledgement that if the nurse herself is a victim it is likely to add another barrier to not asking or not responding to domestic.

Selek *et al.* (2012) surveyed 96 female nurses in Eastern Turkey, between the ages of twenty-two to forty-eight years of age with an intimate heterosexual partner. The authors firstly cite that between 26-58% of women have experienced domestic violence in Turkey. Their study further examines the prevalence among nurses, whether they sought help and explored other risk factors regarding domestic violence. Almost a quarter of the nurses reported domestic violence. The study indicates that nearly 1 in 4 Turkish nurses reported current or past verbal, physical, sexual and/or economic abuse, and the latter was the most frequently reported form of abuse.

Selek *et al.,* cite the patriarchal societies of Turkey, where the man is seen as the dominant head of the household and has economic control, as the cause of the higher correlation to economic abuse by the nurses in their study. Additionally, cultural norms specific to 'love marriages' (p. 387) and arranged marriages by the elders of Turkish communities were highlighted. Although the practice of arranged marriage is reported as less common in Turkey generally, it is still popular in Eastern Turkish communities. Rocca et al., (2009) suggest there is increased risk of domestic violence in arranged marriages, although they recognise the lack of robust evidence to support this.

The most significant finding within the Turkish study is that none of the nurses sought legal assistance, potentially due to the nurses' perceptions of the prohibitive costs involved in such action. Whilst Turkey was required to develop legislative measures to afford better protection for women as victims of violence and abuse (Human Rights Watch, 2011) there is still a significant detrimental risk of stigmatisation and fear of being ostracised for the women who might take these steps. There are additional cultural expectations of resolving domestic violence as privately within the family, potentially also explaining female nurses' reluctance to approach any legal entity or authority for support.

The Impact of Domestic Violence Victimisation on Clinical Practice

Christofides and Silo (2005) offer some helpful insights to the experiences of nurses of domestic violence on health care provision. Their paper highlights the data collated from 212 female nurses with an age range from twenty-three to sixty years of age. Nearly 40% of the participants reported experiencing either physical and/or emotional abuse, at some point in their lifetime. The authors considered how the socio-demographic characteristics of the nurses and the quality of care in clinical practice related to domestic violence and rape, and included nurses' experiences of domestic violence among their family or friends.

The study identified that personal experiences of domestic violence had no influence on the identification or management of domestic violence, while those who had family and friends as victims, were more likely to provide a better quality of care to those patients who presented in clinical practice. Those nurses who reported no direct personal experience or that related to family and friends presented a lower quality of care to patients. The study suggests that the experience related to prior intervention in a domestic violence scenario (in a family or friend context) meant a greater likelihood of nurses identifying domestic violence and in providing more robust and supportive care.

A lack of confidence in asking the question about domestic violence, and in knowing how to respond effectively has been raised in previous research studies. Christofides and Silo suggest that there should be more consistent quality training for nurses, midwives and healthcare assistants, beyond the use of the introduction of screening tools and that this provision should focus on the empowerment of nurses through better awareness of other community resources, counselling support and the increasing empathy and compassion for victims. This study will also address issues of Human Resources and employer responses to nurses as employees and colleagues who are also victims.

Conclusions

The evidence provided has highlighted domestic violence as a global public health and human rights issue affecting one in four women and one in six men in the UK at some point in their lives. Considering nurses, midwives and healthcare assistants are predominantly female this suggests significant portions of the workforce are themselves victims.

The health sector has repeatedly been identified as a key stakeholder for identifying domestic violence through routine screening and interventions. However, frontline staff frequently cite a lack of confidence in screening for and dealing with disclosures of domestic violence victimisation.

Interestingly, little has been done in the UK, or internationally to explore how DVA victimisation may affect healthcare professionals' ability and confidence in dealing with disclosures, or the impact on their personal lives. Furthermore, we know little about their help seeking experiences and whether there is something about a professional carers' disposition, and potentially their gender that makes them more susceptible to victimisation. Three international papers were presented here in order to highlight the role of patriarchal stereotypes in creating the context for domestic violence, which can also be located within the patriarchal systems at work within healthcare settings.

Research Aims and Questions

The aims of this study were three-fold. Firstly, it aimed to determine, quantitatively, the rates of domestic violence amongst healthcare professionals; secondly, if evidence of personal experiences were apparent, this study aimed to give voice to the experiences of these health professionals, as victims of domestic violence; and thirdly, it aimed to consider healthcare professionals comfort and ability in screening and caring for patients experiencing domestic violence. Overall, the study aimed to inform the healthcare sector in both supporting professionals in dealing with patient disclosures, as well as supporting employees who have experienced or are experiencing DVA within their personal life.

The overall objectives of the research were:

1. To establish the prevalence of Nurses, Midwives or Healthcare Assistants as victims of DVA;
2. To identify how the experience of DVA impacts on Nurses' Midwives' and Healthcare Assistants' ability to screen for and respond to disclosures of DVA;
3. To raise awareness about Cavell Nurses' Trust and how the Trust can support health professionals who have experienced or who are experiencing DVA;
4. To consider the implications for wider research beyond the scope of this small-scale study in the context of Health Professionals as victims and survivors of DVA.

Methodology

Design

In order to address the above research questions, aims and objectives, the project employed an explanatory sequential design (Creswell & Clarke, 2010), consisting of two phases. Phase 1 employed a survey design, distributed via the Bristol Survey Online, with phase two employing qualitative semi-structured interviews. The research proposal was firstly subjected to the scrutiny and review of the University's Ethics Committee, for details of proposal and consent forms please see Appendix 1.

Participants and Recruitment

Originally, the study population was restricted to the nurses, midwifes and healthcare assistants working in NHS within the Worcestershire area. However, after some recruitment challenges, the project was opened up geographically to include the whole of the West Midlands, and then widened further to include those working in Scotland, Wales and England. This covered a number of clinical sites and practitioners, including A&E nurses, midwifery, and palliative care nurses and so on.

Measures

Survey Questionnaire

The survey consisted of an information sheet, demographic questionnaire, a questionnaire exploring participant's professional and personal experiences with domestic abuse and the contact details of various support networks. The questionnaire of participant's professional and personal experiences consisted of five sub-sections, namely:

i. About your work
ii. Professional Experiences of Domestic Abuse
iii. Disclosures of Domestic Abuse
iv. Staff Policies on Domestic Abuse
v. Personal Experiences of Domestic Abuse
    a. Part one: experiences of domestic abuse and engagement with support
    b. Part two: experiences of abusive behaviours

After initial design, the questionnaire was piloted and reviewed by six professional and academic peers. This review suggested minor changes on wording and design, which were incorporated into the final version (see Appendix 2).

Qualitative Semi-Structured Telephone Interviews

A semi-structured interview schedule was developed (see Appendix 3) based upon the aims and objectives of the project. Resultantly, the schedule is based around five initial questions considering participants' experiences of domestic abuse in their workplace and their personal life, their awareness and experiences of domestic abuse support services and their perceptions on their career and the increased likelihood of domestic abuse.

Procedure

Survey Questionnaire

During the initial stages, gatekeepers were identified at each clinical site. Gatekeepers were contacted via the principle researcher who detailed the project information. Each gatekeeper was sent an invitation letter (see Appendix 4) and hard copies of the survey questionnaire along with a post box were delivered to the clinical sites. However, after a very low response rate, an online survey was developed using the Bristol Online Survey (www.survey.bris.ac.uk). Once developed, key NHS social media sites were

approached and asked if they could distribute the survey. Additionally, the survey was distributed through internal NHS forums and across clinical leads and managers via email. Furthermore, some Research Delivery Managers based with the Clinical Research Network distributed the survey via their contacts. The online survey was open for a total of 6 weeks with hard copies also being completed during this time.

Qualitative Semi-Structured Telephone Interviews

On completion of both the hard copy and online survey, participants were asked if they would like to take part in a telephone interview, giving options to leave contact details. Interested participants were sent an invitation email acknowledging their completion of the survey and their interest in taking part in the interview. Due to the nature of the project, this initial email remained vague, detailing only key elements around their completion of a project for Cavell Nurses' Trust. This aimed to eliminate any potential safety issues for those who may be experiencing domestic abuse. Following this, if participants wished to continue with the interview, a mutually convenient time and date was arranged and participants were asked to complete and return their consent form. All interviews were conducted via telephone and recorded using a Dictaphone.

Data Analysis

Survey Questionnaire

Adopting Statistical Package for the Social Sciences (SPSS 23), preliminary descriptive statistics were run to summarise the results.

Qualitative Semi-Structured Telephone Interviews

In order to generate themes relating to the key aims of the project, transcripts were analysed following Braun and Clarke's (2006) six stages of thematic analysis which examines raw data and then breaks it down into sub themes, using a coding method to analyse complex information.

Ethical Considerations

As this project was deemed a service evaluation, no ethical approval was needed through the HRA (see Appendix 6 for HRA decision tool). Nonetheless, approval was gained via the Research and Development Leads for each Trust and the West Midlands Research Delivery Manager. Further to this, the Research Ethics, RCN Guidance for Nurses (Royal College of Nursing, 2004), the British Society of Criminology's Ethical Procedure, the British Psychological Society's ethical code of conduct (BPS, 2009) and code of Human Research (BPS, 2011) were all adhered to throughout this project. Finally, the University of Worcester's Ethical Guidelines (2013) underpinned the project (see Appendix 1) with the IHS Ethical Committee granting approval for the project (Reference code: FRKM120116).

Participant Information Sheet and Consent

Each participant was provided with a participant information sheet before proceeding with either the quantitative survey or the qualitative interviews. In this information sheet (see Appendix 7), the aims and objectives of the project are detailed in clear and accessible language, including the reasons for its completion. Additional information included what their involvement would entail and the need for their consent, how their data will be used, how they could withdraw from the project and details of the researchers and research school.

Right to Withdraw

All participants will be made aware of their right to withdraw all of their information and data from the study for up to two weeks after completion of the survey and the interviews. It will also be made clear that participants do not need to provide a reason for their choice of withdrawal. When completing the hard-copy surveys, participants were asked to note down their unique ID number. This ID number was also recorded on their copy of the consent forms. For the online survey, participants were asked to record the receipt number presented when they submitted their completed survey. Finally, interview participants were asked to provide a memorable pseudonym that they could easily identify. In the case of removing their data, participants were asked to report these identification records. No other identifiable data was collected from participants.

Support Services

All participants were also provided details of support services relevant to the study area. For the online survey, participants were also provided with the hyperlinks to support services in order to aid accessibility.

Research Questions

Adopting the two-phase design, we sought to address a number of research questions with access to differing types of data. Specifically, the key questions this research will consider and address are:

1. What is the prevalence of personal experiences of DVA among healthcare professionals?
2. How do healthcare professionals view employers in terms of support and responses to staff disclosures of DVA?
3. What are healthcare professionals' experiences of patient disclosures of DVA and do they feel their training needs are supported in responding to these?

Data Collection and Analysis

Quantitative Results

Demographics

Eighty-four survey responses were collated. Employed respondents came from a number of differing healthcare backgrounds, identifying with a wide range of job titles (e.g. Nurse Practitioner, CNS Palliative Care, Midwife, Staff Nurse, Health Visitor, Mental Health Support Worker, School Nurse, Pharmacy Technician, Safeguarding Adult Practitioner) and having been employed for a wide variety of years (from 1 year to 44 years).

See Table 1 for a breakdown of participant's demographic data. While the majority of respondents were employed full time (84%), six respondents (7%) were full time students and seven were both students and employed (8%). Those who identified as students were studying a number of different courses (e.g. Midwifery, Adult Nursing, Public Health Visiting, Childcare and Dynamics of Domestic Violence) in relation to healthcare. Of the respondents, 98% identified as British/White British, 1% as Black British and 1% as Iranian, with 99% reported being 'resident since birth'. As demonstrated Table 1, age was spread particularly evenly. Whilst the focus of the research was on healthcare professionals as a group, interestingly all respondents identified as female.

A total of 34% reported being 'atheist' or having no religion, 58% identified as 'Christian', 2% as 'Islamic', 4% as 'Catholic' and 1% as 'Buddhist'. A large proportion of respondents identified as 'heterosexual' (88%), with 1% indicating that they were 'gay' or 'bisexual' and 9% reporting that they would 'prefer not to say'. Many reported being in a relationship of some sort (17% 'in a relationship', 10% 'cohabiting', 53% 'married' or 'civil partnership'), with 11% reporting their status as 'single', 1% as 'widowed' or 'other', and 7% as 'divorced.

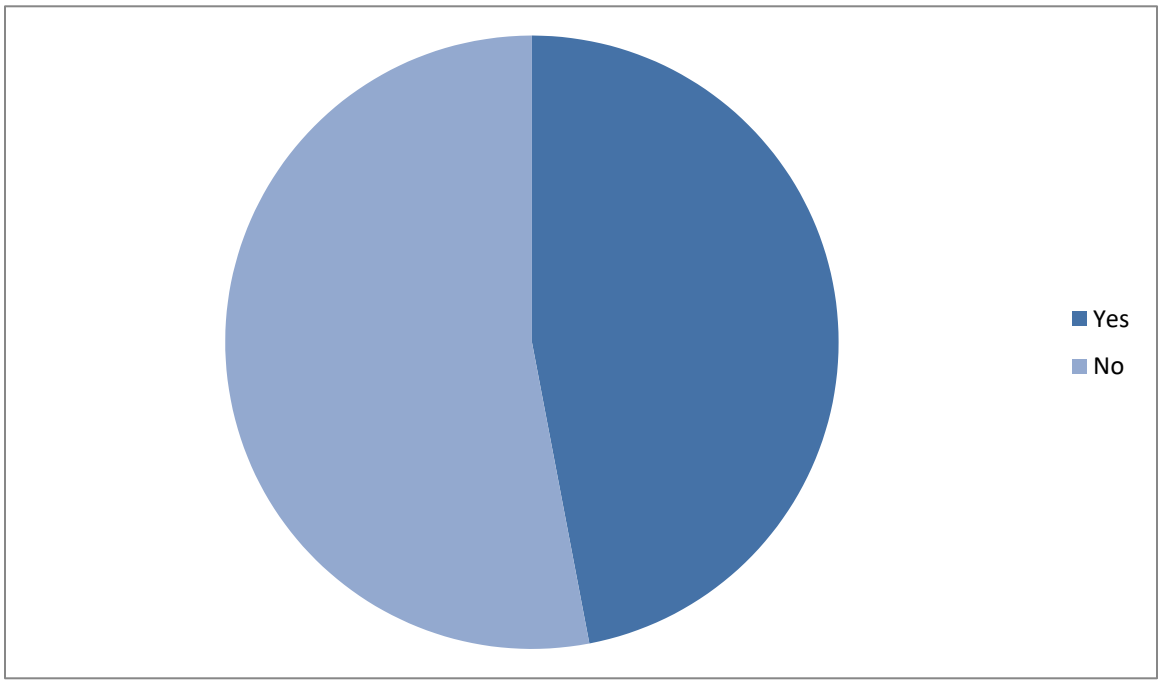
Table 1: Demographic breakdown of survey respondents

Variable	Percentage
Employment Status	
Employed full time	84
Student full time	7
Both employed and student	8
Ethnicity	
British/White British	98
Black British	1
Iranian	1
Religious Beliefs	
Atheist/No Religion	34
Christian	58
Islamic	2
Catholic	4
Buddhist	1
Sexual Orientation	
Heterosexual	88
Gay	1
Bisexual	1
Prefer not to say	9
Relationship Status	
In a relationship	17
Cohabiting	10
Married/ Civil partnership	53
Single	11
Widowed	1
Divorced	7
Other	1
Age	
18-25	8
26-30	7
31-35	9
36-40	11
41-45	16
46-50	12
51-55	20
56-60	12
61-65	5

Healthcare Professionals Personal Experiences of DVA

In order to address the research question regarding the prevalence of personal experiences of DVA by healthcare professionals, participants were asked to report whether they had experienced such abuse. When considering the breakdown of health professionals who had personal experience of domestic abuse, as seen in figure 1, 47% reported having experienced DVA.

Figure 1. A Breakdown of Healthcare Professionals' Personal Experiences of DVA



Whilst most were employed, a student or both during this time, some respondents reported the abuse having occurred before employment.

Table 2: Health professionals' personal experience of DVA during training or employment	
Did your personal experience(s) occur whilst you were a student or employed?	
Student	11%
Employed	33%
Both	20%
N/A	36%

Employer Support and Response to Staff DVA

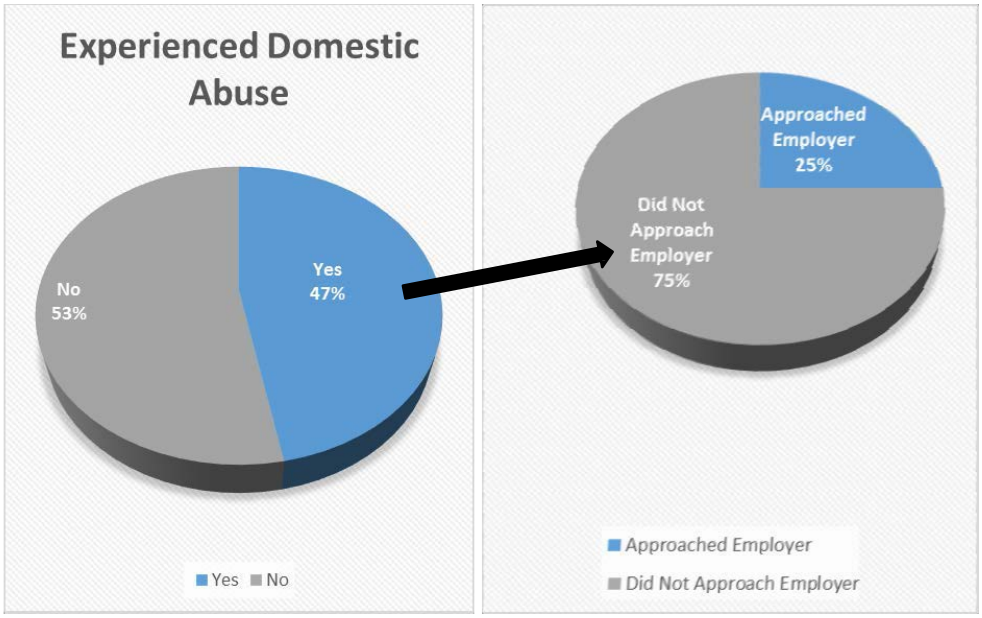
When exploring the possibility of a colleague experiencing domestic abuse, 69% of respondents were 'unaware' or unsure' if there were any domestic abuse policies specific to staff experiences of domestic abuse. Furthermore, 80% were 'unaware' or 'unsure' of any support provided by employers. Nonetheless, 66% agreed that they would approach their employer if they or a colleague were experiencing domestic abuse.

When asked how comfortable they would feel approaching their line manager or course tutor regarding personal issues, 33% indicated that they would feel 'comfortable' or 'very comfortable', 37% indicated that they would feel 'somewhat comfortable', with 30% reporting feeling 'not really' or 'not at all' comfortable.

Table 3: Healthcare professionals' feelings about disclosing personal issues that may be impacting on their work with their line manager/course tutor	
How comfortable do you feel in discussing personal issues that may be impacting on your work with your line manager or course tutor?	
Very comfortable	21%
Comfortable	12%
Somewhat comfortable	37%
Not really comfortable	23%
Not at all comfortable	7%

However, 71% of those who were employed or a student at the time of personal experienced did not report this to their employer or course tutor.

Figure 2: Healthcare professionals' experiences of DV during employment and disclosure to their employer



Of those who did notify their employer or course tutor, 52% reported responses to be 'supportive' or 'very supportive', 15% indicated responses were 'somewhat supportive' with 31% reporting responses to be 'not really' or 'not at all' supportive.

Table 4: Levels of support received from healthcare professionals' employer or course

How supportive were your employer or course tutor?	
Student	11%
Employed	33%
Both	20%
N/A	36%

Other sources of support came from the Police (10%), General Practitioner (17%), Domestic Violence Charities (19%), Friend/Colleague (44%), Local Council/Housing Association (2%) and Children's Services (7%). Of these services, 73% reported a 'supportive' or 'very supportive' response, 19% believed the response to be 'somewhat supportive'; with 8% indicating that their support was 'not really supportive'. No respondent reported that their response was 'not at all supportive'.

Of all the respondents, 42% indicated that they would like more information regarding Cavell Nurses' Trust.

Healthcare Professionals' Experiences of DVA Disclosures

Of the 84 respondents, 64% routinely ask patients about their experience of domestic abuse as part of their job role, whilst 72% have had a disclosure of domestic abuse from a patient (see Table 5).

Table 5: Number of healthcare professionals who ask about DVA and who have had a disclosure

Variable	*Percentage*
Ask patients	
Y	64
N	36
Received a disclosure	
Y	72
N	28

On asking respondents how often they see patients and are expected to ask about domestic abuse, of those who responded; 37% reporting having to ask at least once per day, 27% reported once per week, 8% reported once per month and 5% reported every couple of months.

Table 6: Healthcare professionals reported frequency of screening for DVA

How often do you see patients where you are required to ask about domestic abuse?	
At least once per day	37%
At least once per week	28%
At least once per month	8%
Every couple of months	5%
Very occasionally	20%
Never	3%

A total of 23% reported never or very occasionally asking patients about domestic abuse. Expectations of when to ask about domestic abuse were largely left to individual judgement (44%), while 38% indicated having to ask at the first or second meeting with a patient. Eighteen percent of respondents indicated that there was no specified requirement. Finally, a large majority of respondents reported having to ask patients about potential domestic abuse at regular intervals (49%).

Table 7: Healthcare professionals requirement to ask about DVA

When are you expected to ask patients about domestic violence?

At the first meeting	35%
It is left to individual judgement	44%
At the second meeting	3%
It is not specified	18%

When asking respondents about their levels of comfort in asking patients about domestic abuse, 48% of those who responded indicated that, they felt either 'comfortable' or 'very comfortable' broaching the subject. A total of 39% highlighted that they felt 'somewhat comfortable' with only 12% responding that they were 'not really' or 'not at all' comfortable asking patients.

Table 8: Healthcare professionals' views about how 'comfortable' they feel in asking about DVA

How comfortable do you feel in asking about domestic abuse?	
Very comfortable	20%
Comfortable	29%
Somewhat comfortable	39%
Not really comfortable	7%
Not at all comfortable	5%

When considering those who had received a patient disclosure of domestic abuse, 15% reported feeling 'very confident' whilst 54% indicated feeling 'confident'. Only 5% reported feeling 'not really' or 'not at all' confident, with 26% stating that they felt 'somewhat confident'.

Table 9: Healthcare professionals' views on levels of confidence in dealing with the disclosure of DVA

How confident are you in dealing with disclosures of domestic violence?	
Very confident	15%
Confident	54%
Somewhat confident	26%
Not really confident	2%
Not at all confident	3%

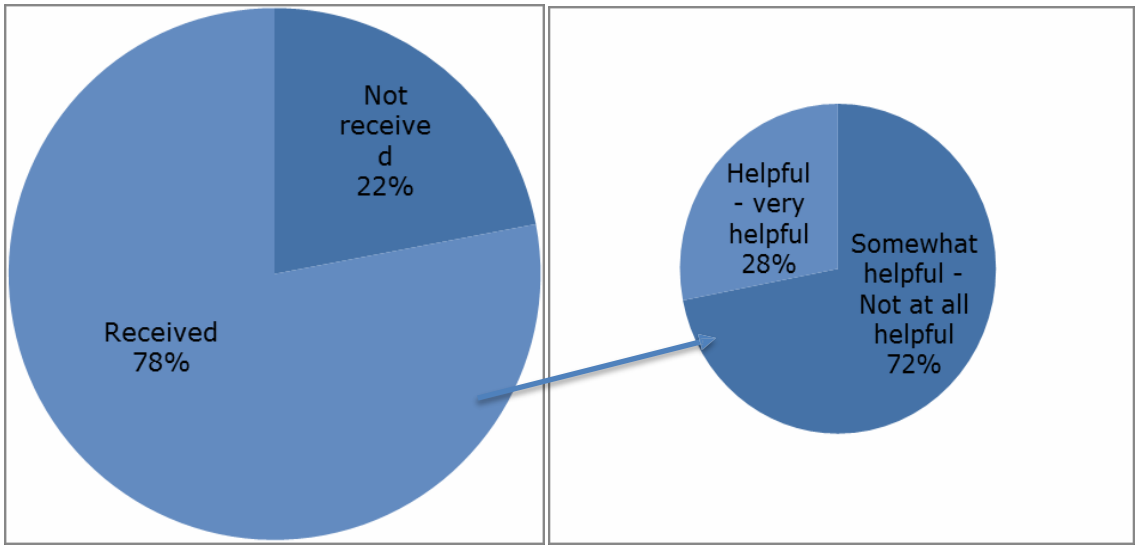
A total of 89% reported knowing where to signpost patients for domestic abuse related support, while 80% reported an awareness of the policies followed when

receiving a disclosure of abuse. Furthermore, 90% indicated that their employers were 'supportive' or supportive' of them when dealing with domestic abuse disclosures.

Healthcare Professionals Training and Support Needs

With regard to training, of the 64% of respondents who routinely ask patients about domestic abuse, 78% reported having attended training around dealing with domestic abuse. However, of these, 32% believed that this training was either 'somewhat' or 'not at all helpful'.

Figure 3: Healthcare professionals' experiences of training



The table below details the responses with regards to healthcare professionals' perception of training.

Table 10: Healthcare professionals' views on how the training has helped in asking patients about their experiences of DVA	
How helpful was the training you received?	
Very much	31%
Yes	35%
Somewhat	25%
Not really	2%
Not at all	6%

Summary

This quantitative survey begins to answer some of the questions posed at the outset of this research. Firstly, in considering the responses from our participants, it seems there is a high prevalence for healthcare professionals' themselves to have experienced DVA. Just under half of the respondents in this study indicated that they had experience violence and abuse, some of which experienced such abuse during their employment or time as a student. However, despite such high incidents of staff DVA experiences, over three quarters of respondents were unaware of any policies implemented regarding staff disclosures. Furthermore, while just under two thirds reported that they would feel comfortable in approaching their employer if they themselves, or a colleague, were experiencing DVA, of those who had reported such experiences, only one quarter had done so. Worryingly, of those who had approached their employers, just under one third reported receiving little to no support.

Another key aspect of this research was to consider healthcare professionals' experiences with patient disclosures of DVA. From the quantitative data, it seems a large number of the respondents had received a direct disclosure from a patient. Furthermore, over three quarters indicated receiving training related to DVA and having an awareness of employer policies surrounding patient disclosures.

However, just over a third reported that such training was not at all or only somewhat helpful in dealing with patients. Subsequently, the next section will consider the issues reported above in more depth.

Qualitative Responses

In addition to the closed questions within the questionnaire, the respondents were provided with space where they could expand or give reason for their answers. These qualitative responses for each section were analysed thematically and the key themes emerging are discussed.

Training

In relation to training on DVA, the respondents varied in the value they attached to DVA training. For example, whilst one respondent believed that training could not equip you fully with the key skills as some of these skills could '*only be learned through experience*', another believed that it would be highly beneficial if '*staff understood the dynamics of abuse*'.

Expanding on this, respondents reported gaps in training, suggesting there was limited advice on '*how to broach the subject*'. and that there was a need for specific training in relation to how to respond to disclosure '*expectations of the survivor particularly as once disclosed, the survivor can be emotionally vulnerable*'. Further respondents echoed these concerns, as when faced with a domestic abuse disclosure they were '*unsure what to do next, so just passed it to a health visitor, even though (they) still worked with the family*'. Respondents also highlighted the need for ongoing training identifying '*remaining up to date*' and '*understanding what is delivered to victims and perpetrators in programmes*' as being challenges for them.

With regard to employer's support, many respondents believed that they did in

fact receive the support needed in dealing with disclosures and there was a consensus in the comments, which highlighted a lack of '*specific guidelines and hospital guidelines*'. Both employed staff and students reported this lack of specific policy and guidelines. It was suggested that a specific '*policy could identify a pathway as to how to guide the survivor into support services*'. Respondents reported that current policy would be relating to wider '*safeguarding issues rather than specifically disclosures of domestic abuse*'.

Overall, it seems training needs to be explicit in both providing the theoretical underpinnings of domestic abuse and enabling practical situations and scenarios where individuals can engage with and build the skills needed in broaching domestic abuse.

Employers' policies and guidelines need to consider the unique aspects and nature of domestic abuse, developing specific policies and guidelines. If these are already available, staff need to be made aware of these even if their role does not require them to ask about domestic abuse on a regular occurrence. Additionally, due to the fast-paced, ever changing environment of the health sector, employers need to update staff of policy and available services regularly.

Experience of Domestic Abuse and Employers' Reaction

Overall, there were many comments left by respondents suggesting that they would refer colleagues or even disclose their own domestic abuse to their employers if they were experiencing this personally.

However, some reported that they '*would not feel comfortable*' doing this and that they '*would feel it was inappropriate*'. A number of reasons were given with respect to reasons why an individual may not disclose their experiences of DVA in the workplace. For example, a number revealed that this would be a '*private matter*' and that they would '*keep home issues separate from work*'.

When asking those who had experienced domestic abuse to expand on their reasons for not approaching employers, many highlighted personal '*embarrassment*' or a belief that it was '*inappropriate*' due to wanting to keep their '*home and work life separate*'. A fear of being judged as incompetent was reported by some, for example, some of those who indicated that they had not approached employers when they experienced domestic abuse highlighted that they worried employers would '*think that (they) wouldn't be able to support patients or be biased when working with other survivors*'. Furthermore, some respondents detailed personal experiences with employers with them explicitly stating to staff '*don't bring your problems to work – you are here for the clients*'.

Others provided reasons whereby the ability of their employers as being a source for credible support were questioned. For example, a number of respondents did not believe their employer would '*know how to advise*' them or that their '*role as a manager conflicts with their ability to give appropriate support*'. Additionally, there were concerns about confidentiality reporting that they believed that by disclosing this information to employers they would '*risk (their) problems being shared around*'.

The responses from the question asking why the respondent would inform employers if their colleague were experiencing domestic abuse drew a consensus around questioning that colleague's ability to care for patients. For example, some believed that experiencing abuse could 'a*ffect your work performance*' and that employers would have to '*determine if the abuse is causing the victim to fail to carry out their duties*' or that they are '*safe to practice*'.

There was some recognition within the respondents' narratives that there is a need to challenge the perceived lack of openness in discussing DVA in staff. For example one respondent indicated that there was a need for a '*more open approach towards this subject matter*' indicating that whilst they knew how to care for patients disclosing abuse this did not apply for colleague disclosures

(e.g. '*I feel we do not support our colleagues in allowing them to be more open*'). Another indicated that there was a need to '*create an open environment for talking, and to know that you are not going to be treated unfairly*'.

As such, it seems while there are many who would happily approach employers and feel that they would provide adequate support, many others believed that domestic abuse is a personal rather than professional issue and that such an approach would be inappropriate. Confidentiality and the potential for such issues to be logged on personal files were also issues considered to stop staff disclosures, with some highlighting the belief that they would be scrutinised on whether they could appropriately care for patients. Another issue seemed to relate on the environment of the workplace itself and the lack of openness around the possibility of staff experiencing personal abuse. This seems to lead to a strengthening of the personal/professional dichotomy and reluctance to approach employers.

Qualitative Semi-Structured Telephone Interviews

Following from the quantitative data, the qualitative interviews aimed to expand healthcare professionals' experiences surrounding DVA. Specifically, through a number of key prompts, the interviews aimed to explore professionals' experiences DVA in more depth, drawing out more nuanced explorations surrounding the prevalence of DVA, training needs in relation to both patient and staff disclosures, and employers' reactions to staff disclosures. The interviews were conducted with six women who were currently employed within the healthcare sector. Positions held by the women ranged from health visiting to psychiatric nursing. Overall, there were three predominant themes emerging from the interviews surrounding both their experiences with patient domestic abuse and their own and/or colleagues' personal experiences. Of the women interviewed, two reported

having experienced personal relationships where they were the victim of DVA. Analysis identified two superordinate themes, consisting of the hidden nature and silent culture surrounding health professionals' personal experiences of DVA and the open, active engagement and response to patient disclosures.

Staff Disclosures: A Private Matter

Overall, this theme highlighted the perception that staff experiences of DVA should remain outside of the workplace as support for such experiences were seen to be beyond the employers' remit, and more aptly placed as a private, individual matter.

As part of the interview, healthcare professionals were asked if they had experienced domestic abuse or whether they knew of colleagues who had had such experiences. While two reported having experiencing intimate relationships where DVA had occurred, one participant noted how they had possible experienced abuse during her teenage years. Furthermore, five of the interviewees also agreed that they were aware of colleagues who were or had experienced domestic abuse while working in the healthcare setting. For example:

> *I haven't experienced any domestic abuse but when I was younger and before I met my husband I was in a relationship that, on reflection, was possibly a coercive relationship and it was coercion around, whereabouts, going out with friends, what I wore and even starting to the point of how I spent my money (..) it was a relationship that could have become abusive because of loss of power (…) We had a member, a very young member of staff who used to turn up every Monday- almost every Monday with black eyes and discovered that she was being abused (Katyok).*
>
> *Yes, I have come across, I have to admit, quite a lot of colleagues that I know that have (Euncey).*

However, when asked about employers and whether they would approach employers for support, some interviewees indicated this would not be an option

for them. Embarrassment or shame was a particular sub-theme concerning barriers towards staff disclosures. For example:

> *(D: Did you see your employer as someone you could turn to?) no definitely not (…) I wouldn't have said anything and haven't said anything and wouldn't (…) possible hard to say why, maybe stigma shame, you know, why me as a professional wouldn't be able to walk away from that situation (Euncey).*

Stigma, or the belief that there was a particular stigma associated with being a survivor of domestic abuse seemed to be a key factor contributing to health professionals' reluctance to approach employers. A further sub- theme emerged in relation to the cultural notion of DVA as being a personal matter. This was noted by both interviewees who had and who had not experienced DVA. For example, when asking if interviewees would approach their employers if they were experiencing DVA, Jane, who self-identified as never having previously experienced DVA supported the professional/personal dichotomy whereby both should be kept separate: "I go to work to get away from what's happening at home and vice versa. I like to keep them separate" (Jane).

As such, upholding of such a dichotomy acts as a barrier towards individuals seeking support. Furthermore, being personal, it was suggested that employers did not need to be involved unless there was a direct impact upon the employees' professional conduct:

> *No, not really, I wouldn't have thought it was something- unless it was impacting on my working life, I can't see why it would be relevant to work () I suppose understanding if you need to take any time off from any reason would be a reason for why you would have to talk to work and hope that they would be understanding (Jane).*

Such notions of domestic abuse resonate with the traditional view of DVA being a private rather than public concern. This reinforces DVA as an individual's responsibility, only becoming a concern for employers if the DVA impacts on professional practice.

Privacy was another element to this theme. Despite the highly practiced nature of the healthcare system concerning patient confidentiality, some interviewees believed this not to be the case concerning staff members:

> *It's a very private matter and sometimes I think the biggest fear is your privacy, it's not like going to say 'oh look I've broken my leg' can you help with that', it's a very complex feeling and makes you very vulnerable. You're vulnerable anyhow but to expose it makes you more vulnerable (Euncey).*

Shame, embarrassment, the belief of a home/work separation and privacy are all perceived as key barriers towards the disclosure of DVA from healthcare professionals. Such a theme resonates with the quantitative data.

Workplace Culture and Norms

Another theme emerging from the interview data encapsulated barriers stemming from the healthcare sector itself and the normative practices of healthcare agencies. For example, it was also noted that despite the openness and encouragement from employers with regards to approaching and responding to patient disclosures, the same did not apply for staff disclosures. Rather, interviewees believed that the organisation had a culture of silence around domestic abuse when it came to professionals experiencing it themselves. For example, Jane detailed how she had never come across another colleague who had experienced DVA, possibly because of the unwritten norm of silence around personal 'problems': "No, I haven't heard about any maybe that's because we don't talk about it at work" (Jane).

This silence seemed to echo with regards to employer policies and support services for staff DVA also. When asking participants if they were aware of any policies directly related to staff personal experiences of domestic abuse, a number revealed that they did not know or had not been made aware of such policies,

only generic support services: "I don't know of any policies but then, I've never sought them out" (Scarlet); "we've got staff counselling services available but beyond that I don't know"(Jane);

> *Not that I'm aware of… I've never been made aware of any… I've known colleagues and I do know colleagues who are in relationships which could be described as abusive. I think it's only when they're off sick as a result and they might be referred to occ'y health and that might be discussed then, but it would be the generic counselling that staff are referred to. I've never known of any referral for staff to a specific service (Jessica).*

Subsequently, some of the interviewees believed that the organisations needed to address this culture, actively raising awareness of the potential for staff experiences and possible support services available: "making it more visible you know, just speaking about it and advertising about support services. You know, I don't recall hearing or seeing anything about it at the time" (Kim); "yeah even to just speak about it as it's not the thing to be spoken about other than with patients"(Jessica). Nonetheless, some did indicate that they felt if they were ever in such a situation, they would be happy to approach their managers in order to gain support:

> *I know of the staff counselling and we have a good management system although it's going through change but at the moment we have what we call team leaders and they work very closely with us and we have one-to-one with those. So I'm sure I were to have any experiences I could go to her and she would be able to signpost me but I couldn't say what that specifically was because I've never needed it (Scarlett).*

However, this was not the case for all interviewees. For example, Jessica indicated concerns with the culture underpinning her organisation in relation to domestic abuse:

> *I do think the NHS have a culture of bullying in a lot of parts so I don't think people always feel comfortable to ask about things like that. I think because it never really gets tackled, I think because if there is a problem either the staff member or the perpetrator will just be moved somewhere rather than it actually being dealt with. And like sometimes when there isn't much of a turnover of staff, you know, there's a culture that sort of develops in a team when certain behaviour is acceptable and yeah (Jessica).*

Despite these individual and environmental barriers, some interviewees believed that the workplace might well be the best place for staff members to pursue and receive support:

> *All staff have to do safeguarding training it could always be included in that. Um, because I suppose if people want to seek help and not let their partner know then doing it in work would probably be a good thing. If people have controlling partners and can't account for where they've been. I think it would be good to add that on to the safeguarding training, you know, if you've experienced this, or you could advise colleagues as well (Jessica).*

Thus, it seems in addition to the barriers situated within the individual, the tendency for healthcare organisations to reinforce a culture of silence can act as a further layer, challenging their access to support. The aspects surrounding healthcare professionals' experiences of domestic abuse, then, are far more complex.

A Duty of Care

The qualitative interviews also explored healthcare professionals' perceptions around why there may be a high prevalence of DVA amongst them. Subsequently, another sub- theme emerging from the data related to the healthcare professionals 'duty of care'. While such a duty underpinned their professional practice with patients, it seemed the same duty did not apply to their own personal care and advocacy. For example: "it's not up to you to be ill or have a problem, you're looking after people" (Euncey);

> *I think as well as um, advocating for a patient, you just do it. You'll challenge doctors you know but when it's yourself. I know when I've been ill and been to see the doctor I probably wouldn't stand up for myself like I would with a patient. When you're advocating for someone else you sort of have that drive to do it. I suppose when it's yourself you feel a bit vulnerable (Jessica).*

Furthermore, when discussing the reasons why many healthcare professionals could be experiencing or have experienced domestic abuse, some noted the personality of those who enter the caring profession. This was seen as a factor that could potential leave them vulnerable. For example:

> *Also the personalities you get in these caring prof- you know, professions- strong but there's quite a vulnerability because of their type of work, I think. They tend not to think so much of, often of themselves, although some do, they're giving out to other people … other than most, health visitors, are quite caring people, we want the best for people. So maybe we don't want to, often when people are being abused they really care for that person so maybe the protective side comes out (Euncey).*

Overall, the women participating in these qualitative interviews prescribed to the view that those individuals drawn to the healthcare profession had caring, nurturing and even protective traits. Although these traits stood such individuals in good stead for their profession, they could also leave them 'vulnerable' to the predatory traits by abusive men. It seems, whilst most healthcare professionals feel particularly driven to protect and abide by the duty of care underpinning their professional role, such a drive does not translate to their own personal care and protection.

Patient Disclosures and the Complexity of DVA

In contrast to the themes surrounding health professionals' personal experiences of DVA and employer responses, the interviews revealed far more insight and awareness of patient disclosures. When analysing the interviews, it was became evident that all the respondents had experienced disclosures of domestic abuse from patients: " yes we come across that quite a bit in our position" (Euncey); "yes several" (Jane); "yes I have done, as a practitioner I have and as a manager I've also come across members of staff who've also been subjected to domestic violence" (Katyok); "unfortunately yes" (Scarlet); "yes, multiple" (Kim); "yeah, quite frequently" (Jessica).

Some of the healthcare professionals also revealed actively asking patients whether they have or are experiencing domestic abuse, something encouraged within the healthcare sector: “we now ask them at least six times” (Euncey); “try to routinely ask about, um, mothers experience of domestic abuse” (Jane).

This awareness and open approach to patient experiences of DVA even expanded to other agencies and multi-agency working relationships: “other families, we’ve had some information shared from other agencies so from the police or from safeguarding, that there have been instances of domestic abuse and that’s how we find out about it” (Jane).

This active approach would help them build rapport with the women they spoke with, subsequently enabling them to divulge and confide in them: “sow the seed that you are somebody that they could confide in” (Jane); “we provided a safe environment for her to come and discuss her concerns” (Katyok).

It is clear from the data that domestic abuse is something highly prevalent in their day- to-day roles when engaging with patients. This active and open approach to engaging patients and responding to DVA situations significantly deviates from the hidden, unresponsive, unengaged culture underpinning staff DVA exposure.

Actively Seeking Training

Another theme emerging from the qualitative data was in relation to the training healthcare professionals received. Specifically, the interviewees, whilst acknowledging that they had attended training relating to their role, believed that there was a lack of specific domestic abuse focused training. Additionally, it was noted by some of the interviewees that this added training was needed particularly in considering the sensitive nature of domestic abuse and approaching the topic. For example, Euncey revealed that whilst she believed she

had received a 'fair' amount of training, more was needed due to the difficulty in discussing the topic appropriately: "we do have a fair bit of training. But I do think we could have more training because it can be quite a difficult topic to discuss without making the woman feel threatened by us too".

Others also noted a lack of training or having training without benefit. Specifically, some mentioned feeling as though there was information they felt important to their job role that they still did not have: "I've never felt I've ever had any real training- maybe back at registration I might have had it along safeguarding and domestic violence" (Katyok);

> *The first training I had when I was training and newly qualified was university stuff and in house things when I was newly qualified, they were really good, what I've done more recently hasn't been so great. (..)I mean the bits that I don't know, I still don't know. Things like molestation orders and what they exactly are and how people go about sorting that, other than saying go to women's aid for advice (Jane).*
>
> *Yes I think, I mean in my training I don't think we ever covered things like domestic abuse. I think we got the skills for active listening and building therapeutic relationship which then makes it easier to talk to people about difficult circumstances but the actual framework and the law and everything, and safeguarding, I don't know if it's changed now but we certainly didn't have anything to do with that (Jessica).*

Katyok reflected on a particularly complex case of domestic abuse where she was in a managerial position. During this position, she felt that there was very little training and that this had left her feeling unprepared for both the situation and the supporting of her team: "I felt quite unprepared for, and I managed the team that supported this lady and they looked to me for support and I felt completely inept" (Katyok).

Organisational support in these cases was also raised as an issue with some interviewees reporting a lack of support from their employers in dealing with the aftermath of domestic abuse cases. Below, Scarlet discussed a situation where one of the women she was supporting was murdered by her abuser:

> *Following our support, where he murdered her, there was no follow up from that. There was no support and I find that very short sighted. I've struggled with this for years and years and I've had no support from managers and I do the bereavement counselling for our children local and I had to go in and work with her children then on the death of their mum and again, it was very difficult (Scarlet).*
>
> *Because obviously there are going to be a significant number of staff affected too so asking all staff to be asking these questions where they might be personally in involved themselves, it could be very difficult if they haven't got a sort of outlet where they can support themselves (Kim).*

Overall, it was believed by participants that, although very much improved, the training packaged for staff members were lacking in relation to specific domestic abuse material. Whilst a theme of individual responsibility underpinned health professionals' discussions of staff experiences of DVA, when considering the disclosure of patients, openness and active engagement from employers and other agencies were promoted.

Discussion of Findings

Domestic violence and abuse (DVA) has been identified as a significant factor affecting healthcare professionals. This exploratory study utilised the responses to a survey (N=84) and the transcripts of interviews with six healthcare professionals to begin examining how DVA affects those working in UK healthcare settings.

Relating the data back to the research questions:

1. What is the prevalence of personal experiences of DVA among healthcare professionals?
2. How do healthcare professionals view employers in terms of support and responses to staff disclosures of DVA?
3. What are healthcare professionals' experiences of patient disclosures of DVA and do they feel their training needs are supported in responding to these?

This study is also concerned with healthcare professionals' personal experiences of DVA. In order to examine the links between victimisation and professional practice several questions were asked of respondents regarding their experiences of DVA, their employers' policies in dealing with staff who are victims of DVA, and whether the existing healthcare culture allowed for staff with personal issues such as DVA to be heard and supported to recover and continue practicing safely.

Significantly and worryingly, almost half of the respondents (47%) had experienced DVA at some point in their lives. This is double the national average, highlighting a significant vulnerability in the workforce.

Respondents reported minimal level of support from and confidence in the response of their employer when they require support for DVA. Furthermore,

many reported feeling that the healthcare sector culture silences issues such as DVA, feeding the belief that private matters should remain private. Respondents felt that even if they needed support, they could not contradict this culture for fear of embarrassment and stigma. In addition, there was a perceived potential for confidentiality to be broken when a member of staff was the victim, despite confidence that confidentiality would always be respected for other patients. Furthermore, when discussing the potential for offering support to colleagues experiencing DVA, respondents began questioning their hypothetical colleague/victim's ability to work and be safe to practice. This adds to the silencing of victims of DVA who work in the healthcare sector.

As such, it is of vital importance that employers urgently update staff policies and provide appropriate training and support for staff experiencing DVA. This should include a comprehensive review of the working cultures that stigmatise DVA victimisation, increasing its visibility and ensuring colleagues can openly discuss the issue. This is also demonstrated in the responses regarding the supportiveness of employers for those who had experienced DVA; with just half suggesting, it was indeed supportive. This compares to 73% of respondents who had experienced DVA and found external organisations to be supportive. This suggests that employers, and to a lesser although significant extent, external organisations need to review their response to those disclosing DVA.

Furthermore, there was a significant lack of visible staff policies and support across the board, and a consensus that personal issues were not to be dealt with at work. Despite this, two thirds of respondents suggested that they would seek support from their employer if they or a colleague were experiencing DVA. This contrasts significantly when considering those who have experienced DVA: 71% reported avoiding seeking help from their employer for fear of a negative response. This suggests that the previous group of respondents may in fact be answering hypothetically as suggested by Gadd et al., (2014).

The respondents and interviewees had various professional backgrounds, two thirds of whom routinely ask patients about their experiences of DVA. Furthermore, two thirds of the respondents screen for DVA at least once a week, and three quarters of respondents reported having received a disclosure. In addition, 38% of the respondents were expected to ask every patient about DVA at the first and/or second meeting. Surprisingly 62% of respondents were left to decide if and/or when to ask themselves with no official guidance from management.

This suggests three things. Firstly, it highlights that healthcare staff are in a unique position to identify and respond to disclosures of DVA yet this appears not to be being utilised effectively. Secondly, it suggests that patients, whether intentionally or not, are able to access DVA interventions through these healthcare staff. However, it also highlights that there is a lack of guidance and consistency from employers regarding this high-risk public health issue. There have been considerable improvements regarding routine screening for other conditions in healthcare settings, such as blood clots and bedsores, yet DVA appears not to be regarded in the same manner, putting patients at risk. Several respondents noted that a map of clear protocols to follow on receipt of a disclosure would be beneficial for staff and patients, ensuring consistency and accuracy in the response to a disclosure of DVA.

The analysis of the survey data highlighted several shortcomings in the training provided to frontline healthcare staff expected to screen for and deal with disclosures of DVA. Of the 64% of respondents who routinely screen for DVA, 22% had not received DVA specific training. In addition, of the 78% of staff who had received DVA specialist training, one third found this training ‘not at all helpful’ or only ‘somewhat helpful’. In addition, half of the respondents suggested they did not feel comfortable screening for DVA and one third did not feel confident in dealing with disclosures. This highlights a significant and urgent

need to revisit the DVA specialised training requirements of all frontline healthcare staff.

Furthermore, analysis of the interview data found that despite the high frequency of DVA disclosures, healthcare respondents receive no specialist DVA training beyond generic safeguarding training. This left respondents feeling underprepared for the task of routine screening for DVA, yet did not dampen their desire to assist patients and colleagues experiencing it.

In addition, respondents felt that there are few opportunities for staff to learn and use the key skills required to sufficiently deal with disclosures of DVA. This was particularly the case regarding managing patients' expectations regarding confidentiality and safeguarding. In addition, respondents felt that patients themselves had difficulty identifying their own victimisation, suggesting a broader awareness raising campaign is required. It was suggested that a resident departmental or hospital-wide key DVA worker would be able to take on this role, strengthened by multiagency partnership working.

Respondents made several further suggestions for improvements, including training which covers the departmental and hospital-wide protocols, the available support services, legal remedies, and how best to build rapport with a patient who is reluctant to disclose.

Applying the Nested Ecological Model to Healthcare Professionals' Experiences of DVA

There are a number of key themes emerging from the analysis surrounding healthcare professionals' experiences of DVA, largely associated with individual factors and environmental factors. Likewise, there are a number of theoretical perspectives surrounding the explanation of domestic abuse. The literature surrounding healthcare professionals as victims as mentioned, is very limited.

Therefore, this application is unique.

Feminist theories and perspectives attempt to explain domestic abuse in the general population but these theories tend to adopt a single faceted approach. Rather, and considering the varying issues emanating from the current project thus far, multi-factorial approaches that combine both psychological variables and social context may prove useful in explaining the above results (Dutton, 1994). As suggested previously in this report, the nested ecological model incorporates a number of variables from the broader cultural, social and individual contexts in an attempt to unpick domestic abuse. This model comprises four levels, all of which interact with one another:

1. Macrosystem: incorporates societal and cultural beliefs and values,
2. Exosystem: relates to social structures such as work, peer groups and support groups,
3. Microsystem: consists of the family unit and immediate context in which the abuse takes place,
4. Ontogenetic: relates to the individual characteristics and internal factors of the person.

Whilst this approach has been used substantially in providing an explanation for domestic abuse and the perpetrators behaviour, Foe *et al.,* (2000) believe this multi-factorial approach could also help in explaining victim behaviour. Foe *et al*., (2000) believe that it is essential to consider victim's behaviour within the context of domestic abuse. Subsequently, this knowledge would develop an applicable way of understanding the multiple strategies victims use in an attempt to reduce or avoid abuse, including secondary victimisation through careless responses to help-seeking. The way in which a victim responds to such abuse must be considered in a broad social, political, economic and cultural context.

This model aptly frames the findings of this research. The macrosystem reflects

the predominantly patriarchal society in the UK. This highlights the significant replication of these cultural norms within healthcare settings, whereby males are in managerial and senior leadership positions and females are tasked with caring for the vulnerable often to the detriment of their own wellbeing. The exosystem reflects the workplace cultures that work to silence healthcare professionals' experiences of DVA. This is evident in the respondents' reluctance to seek support from their employers, and the suggestion that a colleague who is suffering from DVA might not be safe to practice. The microsystem, represents the family unit and context in which DVA is likely to be occurring. The respondents' suggestion that private matters should remain private arguably seeks to contain DVA within the microsystem, despite the need for external support.

Ontogenic factors are those that relate to the individual. DVA has a huge impact on conceptions of the self, reducing self-esteem, causing depression and anxiety and prompting isolation from support networks. Each of these impacts could have potential to affect a healthcare professional/victim's practice, and the help-seeking behaviour of a patient/victim. This is not to blame victims for the potential impact their victimisation may have on their practice or ability to work. Instead, it highlights the role employers have in supporting victims to remain in work, with a focus on their wellbeing. This focus will also improve the frontline staff response to patient disclosures of DVA.

This model highlights the required action on four levels. Firstly, the macrosystem is must become 'gender-safe', essentially over riding patriarchal systems with egalitarian structures. In turn, this will allow the exosystem to recognise issues affecting the female workforce, such as DVA. Raising awareness and increasing the visibility of DVA should work to improve healthcare professional/victims' willingness to seek support at work and consequently increase the ability to effectively screen for DVA in patients.

Furthermore, raised awareness and improved visibility of support may enable healthcare professional/victims' to identify and respond to their own, a colleague's, and/or their patients' experiences of DVA with compassion and appropriate knowledge and skills. Consequently, the individuals may also feel empowered to improve their own position and subsequently their wellbeing and ontogenic factors. Arguably, such multilevel change reflects that portrayed in the whole school approach in preventing violence and abuse (See for example Bowen and Walker, 2015).

To conclude, health professionals who are or have been victims often indicated that they were embarrassed or thought it were inappropriate to approach their employers for support. It would be beneficial, to gain an understanding of this behaviour and the mechanisms at play. This would enable employers, domestic violence charities and researchers to develop multi-faceted psychological and environmental interventions that can better support and increase victim's resilience and subsequent ability to seek support and respond to domestic abuse.

Conclusion and Recommendations

Considering the study's findings, there are a number of important and particularly relevant issues emerging. The quantitative findings have highlighted positive as well as worrying figures. Firstly, it seems that although a large number of health professionals have received training in relation to domestic abuse; this training is not always helpful, highlighting the necessity for improvements.

A number of respondents indicate that such training is largely generic, failing to consider the complex nature of domestic abuse. Additionally, there seems to be uncertainty around the policies and support available from employers both in terms of dealing with patient disclosures and, particularly, around staff disclosures.

With regards to staff disclosures, two particularly prevalent themes emerge in relation to the barriers to approaching employers for support. Firstly, from the preliminary analysis, individual factors such as personal embarrassment, a lack of awareness and a reluctance to share personal information are key issues around staff disclosures. Specifically, the results seem to indicate that there continues to be a perception of domestic abuse as situated within the personal, not to be shared outside of the home. Secondly, the healthcare environment may heighten this perception. For example, there is some indication that whilst employers provide explicit guidance to staff regarding patient disclosures, the potential for staff to experience domestic abuse is generally ignored. Some respondents believed that there was a lack of explicitness and openness within the working environment, which heightened the sense of domestic abuse being a personal rather than professional issue. When considered as important for employers, this was often framed around the victim's ability to continue with adequate performance. The above issues seem to be emerging, also, from the qualitative material currently being collected. As such, the complex nature of domestic abuse and its intersection between the personal and professional lives

of victims may warrant further exploration.

In order to further explore the complex issues highlighted in this report, the authors have significant recommendations for further research and the healthcare sector.

Implications for Further Research Inquiry and Practice

In order to clarify the reported mismatch between frontline staff requirements and available DVA staff and patient policies, a review of national and trust specific DVA related policies is required. Once gaps in provision or implementation have been determined, this could be followed by a significant redesign of inclusive policies that aim to support victims of DVA appropriately, regardless of whether they are a patient or member of staff.

In addition, a comprehensive training package should be developed, calling on specialist organisations who would be able to explore the complex dynamics of DVA with all staff, including administrative and managerial staff. Furthermore, a trust specific map of local and national victim service provision could be collated to allow for multiagency working, smooth referrals, and to increase frontline staff confidence in the process of assisting a patient following a DVA disclosure.

The existing data set is not able to be representative due to the small (<100) sample size. This could be overcome by running the survey with a sample of 10,000+ individuals to allow for significant statistical analysis of the complex relationships found between being a healthcare professional, screening for DVA, and personal experiences of DVA.

In addition to having a high percentage of White British respondents, the survey indicated a higher ratio of health professionals reporting to have experienced

domestic abuse than expected. This may indicate some selection and recruitment bias. For example, web surveys, although proven to be an excellent resource in recruitment (Romo & Prochaska, 2012), have particular methodological issues. Firstly, specific groups in the population do not have easy access to the internet, leading to under-representation (Bethlehem, 2010). This can be particularly more prevalent with domestic abuse research due to the potential for participants to be observed or monitored (i.e. 'gag' factors; Yu, Stasny & Li, 2008), and differences in cultural backgrounds. Secondly, recruitment is based on self-selection in that participants see the web-link for the survey and choose whether to participate. The premise is that, should the respondent relate to the survey title, the likeliness of them completing would be higher (Ellsberg et al., 2001). This may be indicative of the higher than average reports of domestic abuse. Unfortunately, both self-selection and under- representation can lead to biased estimates. As such, findings from this project should be interpreted with caution and used with care.

Nonetheless, there are a number of strategies that could be used to overcome such biases. For example:

1. A simple method to address the issues of self-selection and under-representation would be to gain access to all NHS and healthcare employees. Here, the employing trust and key managerial personnel would administer the surveys to all employees in unmarked envelops. Additionally, an online version would also be emailed to all employees work email addresses. Subsequently, this would reduce the potential for self-selection due to the survey being targeted individually to each employee. Furthermore, it would increase access to underrepresented ethnicities.

2. Additional methods may be to engage with employees through computer assisted telephone interviewing or computer assisted personal

interviewing. Here, the employers would again provide access, with researchers making direct contact with employees over the telephone or at clinical sites (such methods have proven useful in other sensitive research areas, see Fenton et al., 2001).

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Appendices

APPENDIX 1 – Ethics Checklist and Proposal application

Application for Ethical Approval (Staff and Associate Researcher)

To be completed by staff and associate researchers proposing to undertake ANY research involving humans [that is research with living human beings; human beings who have died (cadavers, human remains and body parts); embryos and fetuses, human tissue, DNA and bodily fluids; data and records relating to humans; human burial sites] or animals.

Section A: Researcher and Project Details

Lead Researcher:	Kirsty McGregor
Other researcher(s):	Ruth Jones OBE, Claire Richards
Email:	k.mcgregor@worc.ac.uk
Institute/Department:	IHS
Status of lead researcher:	Staff
Project Title:	Nurses, Midwives and Healthcare Assistants who have been victims of Domestic Abuse: Prevalence, Impact and Issues for Practice
Project funding:	Ext. awarded

Section B: Checklist

		Yes	No
1.	Does your proposed research involve the collection of data from living humans?	☒	☐
2.	Does your proposed research require access to secondary data or documentary material of a sensitive or confidential nature from other organisations?	☐	☒
3.	Does your proposed research involve the use of data or documentary material which (a) is not anonymised **and** (b) is of a sensitive or confidential nature **and** (c) relates to the living or recently deceased?	☐	☒
4.	Does your proposed research involve participants who are particularly vulnerable or unable to give informed consent?	☐	☒
5.	Will your proposed research require the co-operation of a gatekeeper for initial access to the groups or individuals to be recruited?	☒	☐
6.	Will financial inducements be offered to participants in your proposed research beyond reasonable expenses and/or compensation for time?	☐	☒
7.	Will your proposed research involve collection of data relating to sensitive topics?	☒	☐
8.	Is pain or discomfort likely to result from your proposed research?	☐	☒
9.	Could your proposed research induce psychological stress or anxiety or cause harm or negative consequences beyond the risks encountered in normal life?	☐	☒
10.	Will it be necessary for participants to take part in your proposed research without their knowledge and consent at the time?	☐	☒
11.	Does your proposed research involve deception?	☐	☒
12.	Will your proposed research require the gathering of information about unlawful activity?	☐	☒

13.	Will invasive procedures be part of your proposed research?	☐	☒
14.	Will your proposed research involve prolonged, high intensity or repetitive testing?	☐	☒
15.	Does your proposed research involve the testing or observation of animals?	☐	☒
16.	Does your proposed research involve collection of DNA, cells, tissues or other samples from humans or animals?	☐	☒
17.	Does your proposed research involve human remains?	☐	☒
18.	Does your proposed research involve human burial sites?	☐	☒
19.	Will the proposed data collection in part or in whole be undertaken outside the UK?	☐	☒
20.	Does your proposed research involve NHS patients, staff or premises?	☒	☐

If the answers to any of these questions change during the course of your research, you must alert your Institute Ethics Coordinator.

Signatures

By signing below I declare that I have answered the questions above honestly and to the best of my knowledge:

Lead researcher: **Kirsty E McGregor** **Date:** **30/11/2015**

(**Please note** that the Lead Researcher is, where applicable, signing on behalf of all researchers involved with the research)

If you have answered NO to all questions you should now submit this form to your Institute Ethics Coordinator.

If you have answered YES to one or more questions you must now complete **Section C** (below) and submit the completed and signed form to your Institute Ethics Coordinator, *unless* you have answered yes to q.20. In this case you should

first contact Dr John-Paul Wilson (j.wilson@worc.ac.uk) to discuss whether you will need to submit to NHS ethical approval processes.

Section C: Full Application

Details of the research
Outline the context and rationale for the research, the aims and objectives of the research and the methods of data collection

The UK Cross Government (2013: p. 2) definition of domestic abuse is described as follows:
'Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass but is not limited to the following types of abuse:

- psychological
- physical
- sexual
- financial
- emotional.'

It is still a largely hidden crime and difficult to assess as measuring the true scale of the problem is hampered by the reluctance of victims to report their experiences and by the absence of a single criminal offence. The most reliable estimates come from the Crime Survey of England and Wales (CSEW) which estimates that in the year 2012/13; 7% of women (1.2 million) and 4% of men (700,000) experienced domestic abuse, with 30% of women and 16% of men experiencing domestic abuse since the age of 16. This is equivalent to around
4.9 million females and 2.7 million male victims. Violence against Women and Girls (VAWG) is a rising feature of the case work of the Crown Prosecution Service, 2014-15 saw the highest volume of police referrals, prosecutions and convictions, culminating in a conviction of over 11,000 defendants , a 17% increase from 2013-14 (CPS, 2015).

Such statistics are in line with research which consistently demonstrates that domestic abuse is a gendered issue with women most often being the victims and men most often the perpetrators. While the NCSPVA and Cavell Nurses' Trust recognise that domestic abuse also happens to men and do notminimise the impact of this experience; the focus of the proposed research will be on women as victims. This is relevant not only because current knowledge shows domestic violence is a gendered issue, but also because the focus of the research will be about the impact of experiencing domestic abuse on nurses, midwives and healthcare assistants and the vast majority of these are women. In the process of the research however, any data collected about men will also be considered.
Domestic abuse is far reaching and can be devastating. Victims can experience physical injury ranging from bruising and wounds to broken bones, gynecological injuries, pregnancy complications, disability and death (Stanko, 2000; Black, 2011) and can experience psychological effects including depression, anxiety and suicidal ideology (García-Moreno, 2005; Vidgeon,

2003; Walby, 2004). Domestic abuse can also affect the victim's ability to parent effectively, to socialise and to work (Kershaw & Walker, 2007).

Recognition that domestic abuse has a serious physical and mental health impact on those who experience it; that health is the service that 'victims' of domestic abuse are more likely to come into contact with and that thesefactors have a significant implication for health service delivery (the annual cost to health care is estimated to by £1.4 billion) has led to a number of healthdrivers leading to the implementation of policies and good practice guidance that require health professionals to routinely screen for domestic abuse and respond appropriately to disclosures. Research also shows that overall; patients do not mind routine screening for domestic abuse by health professionals and that 'victims' want to be asked about it (Bachus *et al.,* 2003; NICE, 2014).

In 2014, domestic abuse is firmly embedded in the Public Health agenda with recent Guidelines on Domestic Abuse published by NICE (2014) making it clear that health professionals have a duty to routine screen and create an environment to enable the disclosure. The guidelines also make it clear that health and social care service managers should provide training to enable frontline staff to recognise the indicators of domestic abuse and be able to help patients disclose their past or current experiences of such abuse. Such training has however been in place across the UK since long before the NICE guidelines were introduced. Staff at the National Centre for the Study and Prevention of Violence and Abuse (NCSPVA), at the University of Worcester have been instrumental in training health professionals about domestic abuse and on routine screening since health drivers and policies began to develop.

Discussion and debate with health professionals as part of this training has identified many barriers to health professionals feeling comfortable with responding to domestic abuse including but not exhaustive of; lack of confidence, lack of time, being fearful of damaging the professional/patient relationship and being unsure about what to do should a disclosure be made.

Such discussion/debate has also highlighted the fact that some health professionals are concerned about responding to domestic abuse because they are or have been 'victims' themselves. A brief review of the literature however shows a wealth of information for victims and a growing body of work on good practice for health professional working with patients known to be experiencing domestic abuse; as well as literature on screening. There is very limited literature about the impact of responding to domestic abuse on health professionals, though the NICE guidelines on domestic abuse (2014) recommend the establishment of clear policies and procedures to respond to staff who have been affected by domestic abuse, and that staff are given the opportunity to address issues relating to their own personal experiences, including those that may arise after contact with patients or service users. Listening to disclosures of domestic abuse can be upsetting, but particularly when the health professional has or is dealing with their own abuse. No other

health body nationally is collecting data on health professionals who are or who have been victims of domestic violence and the impact on them personally and professionally. The research outlined in this proposal is both timely and unique.

Domestic abuse will affect a significant proportion of health care staff and it is likely that the impact of it will not be confined to the home. The effects of domestic abuse are likely to impact on the victim in their work environment including the risk of the perpetrator's continued harassment of them at work by telephone, texting or personal visits (La Van et al., 2012; Bracken et al., 2010).

The overall aims of the proposed research would be:

e) To establish the prevalence of Nurses, Midwives or Healthcare Assistants as victims of Domestic Violence;
f) To raise awareness about Cavell Nurses' Trust and how the Trust can support health professionals who have experienced or who are experiencing domestic abuse;
g) To consider the implications for wider research beyond the scope of this small scale study in the context of Health Professionals as victims and survivors of Domestic Violence.
h) To identify how the experience of Domestic Violence impacts on Nurses', Midwives' and Healthcare Assistants' ability to screen for and respond to disclosures of Domestic Violence.

3.1) The research objectives

1. To set the research in context via a literature review.
2. To undertake empirical research with health professionals in the clinical disciplines of Midwifery, Accident and Emergency nurse practice and Mental Health nursing in local clinical environments in Worcestershire.
3. To offer significant learning points from the research to local NHS employers in relation to supporting health professionals who have experienced or who are experiencing domestic abuse.
4. Additionally, to offer learning points on how to support and supervise staff who are dealing with the experience of Domestic Violence in their professional role.
5. To disseminate the research findings and the support offered by Cavell Nurses' Trust via a final report and a dissemination event.

The research will be conducted from a feminist epistemology, aiming to empower the voices of those choosing to take part. Following a desk top analysis and interrogation of available secondary data, opportunities to take part will be offered to nurses, midwives and health care assistants. All participants (N=60) will be asked to complete the questionnaire (Appendix A) and will be asked to confirm if they would be willing to complete a follow up semi-structured interview (schedule Appendix B). Interviews will be arranged in a timely manner at the University of Worcester or another safe place at the participants' request.

Who are your participants/subjects? (if applicable)

Approximately 100 A&E nurses, midwives and mental health nurses in the Worcestershire area as identified by the R&D team.

How do you intend to recruit your participants? (if applicable)
This should explain the means by which participants in the research will be recruited. If any incentives and/or compensation (financial or other) is to be offered to participants, this should be clearly explained and justified.

Participants will be recruited via gatekeepers identified through Worcester Research and Development leads.

How will you gain informed consent/assent? (if applicable)
Where you will provide an information sheet and/or consent form, please append this. If you are undertaking a deception study or covert research please outline how you will debrief participants below

The information sheet (Appendix C) and consent forms (Questionnaire - Appendix D; Interview – Appendix E) are attached.

Informed consent will be gained when the participants are invited to take part in the study, and again when completing the questionnaires. Requests will be made for participants to take part in further interviews should they wish. Those who do opt to take part in said interviews will be asked to confirm their ongoing consent before beginning the interview. Participants will be able to withdraw from the study should they so wish within 14 days of data collection.

Confidentiality, anonymity, data storage and disposal (if applicable)
Provide explanation of any measures to preserve confidentiality and anonymity of data, including specific explanation of data storage and disposal plans.

All participants will be contacted through their gatekeeper, who will confirm that participants should not place any identifying information on their questionnaire, ensuring anonymisation of the data. For participants wishing to take part in further interviews, the researchers will ask that their contact details are provided on a separate document to the questionnaire, ensuring no connection between data and participant.

During transcription of the interviews, any identifying information will be replaced with pseudonyms, ensuring confidentiality. The audio and written transcripts will be stored securely on an encrypted USB, in a locked draw in the PI's office. The data will be destroyed in accordance with the Data Protection Act 1998.

Potential risks to participants/subjects (if applicable)
Identify any risks for participants/subjects that may arise from the research and how you intend to mitigate these risks.

Participants will be answering questions of a sensitive nature regarding their professional and private lives. It is possible that this will result in distress. Therefore support will be offered to all questionnaire participants through their local Women's Aid centre and Cavell Nurses' Trust. Those participants taking part in interviews will be reassured during their interview and also offered support through women's aid and Cavell Nurses' Trust.

Other ethical issues
Identify any other ethical issues (not addressed in the sections above) that may arise from your research and how you intend to address them.

It is possible that there will be an emotional response to the data collected from the researchers, therefore regular debriefs and team meetings will be arranged to counteract any negative impact.

Participants will be completing the questionnaires at work; therefore it will be made clear to them that taking part, or not, will have no impact on their employment.

Published ethical guidelines to be followed
Identify the professional code(s) of practice and/or ethical guidelines relevant to the subject domain of the research.

The research will adhere to the University of Worcester's Ethical Guidelines (2013); The Research Ethics, RCN Guidance for Nurses. (Royal College of Nursing, 2004) and the British Society of Criminology's Ethical Procedures.

Declaration of Researcher

I have read the University Ethics Policy and any relevant codes of practice or guidelines and I have identified and addressed the ethical issues in my research honestly and to the best of my knowledge

Signature: **Kirsty McGregor** **Date:** **07/1/16**

Institute Ethics Coordinator Declaration

(Tick as applicable)

The Institute Ethics Committee is satisfied that the researcher has identified and addressed the ethical issues and grants ethical approval for this research.

The Institute Ethics Committee is **not** satisfied that the researcher has identified and addressed the ethical issues and refers this Application for Ethical Approval to the University's Ethics & Research Governance Committee

Signature: **Professor Eleanor Bradley** **Date:** **19/04/2016**

Chair of the Ethics & Research Governance Committee Declaration

(Tick as applicable)

The Ethics & Research Governance Committee is satisfied that the researcher has identified and addressed the ethical issues and grants ethical approval for this research. The Ethics & Research Governance Committee is **not** satisfied that the researcher has identified and addressed the ethical issues in this research and **does not** grant ethical approval for this research.

Signature: **Professor Eleanor Bradley** **Date:** **19/04/2016**

APPENDIX 2 – Research Questionnaire

Section 1: About Your Work

a) Are you currently a student/employed/both? (Please tick)

Student		Employed		Both	

b) **If you are a student, what course are you studying?** (Please go to Section 2)

c) If you are employed, what is your current job title?

d) How long have you been employed in the NHS or another employer?

e) Which area of health do you work in?

Section 2: Professional Experiences of Domestic Abuse

a) Does your job role (including future job role if a student) **require you to routinely ask patients about their experience of domestic abuse?** (please tick)

Yes		No (please go to section 3)	

b) How often do you see patients where you are required to ask about domestic abuse? (please tick)

At least once per day		At least once per week	
Every couple of months		Very occasionally	
At least once per month		Never	

c) When are you expected to ask about domestic abuse? (please tick)

At the first meeting with the patient		At the second meeting	
It is left to individual judgement		It is not specified	

d) How often are you expected to ask each patient? (please tick)

Once		At regular intervals	
Only if an issue arises		It is not specified	

e) Have you received training on how to ask about domestic abuse? (please tick)

Yes		No - please go to question (g)	

f) Do you feel this training helped you in asking patients about their experiences? (please tick)

Very much		Yes		Somewhat		Not really		No not at all	

g) Please tell us more about any additional training needs you have regarding asking about domestic abuse?

h) How comfortable do you feel in asking about domestic abuse? (please circle)

Very comfortable	Comfortable	Somewhat comfortable	Not really comfortable	No not at all comfortable

i) Do you have any concerns regarding asking about domestic abuse?

j) How comfortable do you feel about approaching your employer/course leader about these concerns? (please circle)

Very comfortable	Comfortable	Somewhat comfortable	Not really comfortable	No not at all comfortable

k) If you do not feel comfortable in approaching your employer/course leader, can you please tell us why?

Section 3: Disclosures of Domestic Abuse

a) Have you ever had a disclosure of domestic abuse from a patient? (please tick)

Yes		No	

b) If yes, how confident did you feel in dealing with the disclosure of domestic abuse? (please circle)

Very confident	Confident	Somewhat confident	Not really confident	No not at all confident

c) Do you know where to signpost patients for support if they do disclose domestic abuse? (please tick)

Yes		No		Unsure	

d) Are you aware of which policies you need to follow if you do receive a disclosure of abuse?

Yes		No		Unsure	

e) How supportive is your employer/course leader in helping you deal with disclosures of domestic abuse? (please circle)

Very supportive	Supportive	Somewhat supportive	Not really supportive	Not at all supportive

f) Is there anything further you feel they could do to help?

<u>Section 4: Staff Policies on Domestic Abuse:</u>

a) Are you aware if your employer/course provider has a policy for staff/students that have experienced domestic abuse? (please tick)

Yes		No		Unsure	

b) Are you aware of any support your employer/course provider can provide to staff/students who have experienced domestic abuse? (please tick)

Yes		No		Unsure	

If Yes, please tell us more:

c) If you or a colleague were experiencing domestic abuse, would you approach your employer/course leader for support (or advise your colleague to do so)?

Yes		No	

Why is this?

d) How comfortable do you feel in discussing personal issues that may be impacting on your work with your line manager/course tutor?

Very comfortable	Comfortable	Somewhat comfortable	Not really comfortable	No not at all comfortable

e) Is there more you feel your employer/course provider could do you support staff to disclose personal experiences of abuse?

<u>Section 5: Personal Experiences of Domestic Abuse (Part One)</u>

a) Have you ever experienced any form of abuse from a partner/ex-partner or family member? (If the answer is No, please move on to Section 5 Part Two)

Yes		No	

b) Did this occur whilst you were a student or employed?

Student		Employed		Both		N/A	

c) Did you disclose this abuse to your employer/course leader?

Yes		No	

If no, please tell us more about why that was?

If yes, how supportive was the response you received?

Very supportive	Supportive	Somewhat supportive	Not really supportive	Not at all supportive

Please tell us more about the response you received. For example who responded well or not so well, what you found

helpful or unhelpful etc.

d) Please tell us if you feel there is more your employer or course leader could have done to help you disclose or seek support?

e) Did you seek support from any other sources? (please tick)

Police		Domestic Violence Charities		Local Council/Housing	
GP		Friend/Colleague		Children's Services	

Other (Please state)

If yes, how supportive was the response you received?

Very supportive	Supportive	Somewhat supportive	Not really supportive	Not at all supportive

Please tell us more about the response you received from each source where applicable:

Section 5 (Part Two): Personal Experiences of Domestic Abuse:

Have any of your partners: (please tick all that apply)
Note: if more than one partner has used these behaviours, please make note of this.

	Never	Once	A few times	Often	All the time
Made fun of you?					
Shouted at you/screamed in your face/ called you hurtful names?					
Said negative things about your appearance/body/family/friends?					
Threatened to hurt you/family/friends unless you did what they wanted?					
Told you who you could see and where you could go?					
Constantly checked up on what you were doing e.g. by phone or text?					
Used private information to make you do something?					
Used mobile phones or the internet to humiliate or threaten you?					
Pressured you into kissing, touching or something else?					
Physically forced you into kissing touching or something else?					
Pressured you into sexual intercourse?					
Physically forced you into sexual intercourse?					
Used physical force such as pushing, slapping, hitting or holding you down?					
Used more severe physical force such as punching, strangling, beating you up, or hitting you with an object?					
Any further information you feel is relevant:					

About you:

How old are you? (Please circle)

18-25	26-30	31-35	36-40	41-45	46-50	51-55	56-60	61-65	65+

What is your nationality?

What is your immigration status? (Please circle)

Resident since birth	Indefinite leave to remain	Student visa	Asylum Seeker
Discretionary Leave	Other:		

What is your religion? (Please tick)

Christian	Islam	Catholic
Hindu	Agnostic	Atheist
Buddhist	Anglican	Sikh
Jewish	None	Other:

What is your sexual orientation? (Please circle)

Heterosexual	Gay	Lesbian	Bisexual
Asexual	Prefer not to say	Other:	

Do you consider yourself to have a Disability?

Yes		No	

Disability is defined as any physical or mental impairment which has a substantial and long term (over 12 months) adverse effect on a person's ability to carry out normal day to day activities.

What is your relationship status? (Please circle)

Single	In a relationship	Cohabiting	Civil partnership
Married	Widowed	Divorced	Other:

Would you be interested in hearing more about the Cavell Nurses' Trust? Would you like to take part in a follow up interview?

Yes		No	
Yes		No	

If yes, please provide your name, email and phone number:

Name:_____

Phone:_____

Email: _____

APPENDIX 3 – Telephone Interview Schedule

1. Please tell me about your experiences of domestic violence in the workplace?

2. Please tell me about experiences of domestic violence in your personal life?

3. Please tell me about any domestic violence services, local or national, you are aware of?

4. Please tell me about your experiences of domestic violence support services?

5. Some research suggests nurses, midwives and healthcare assistants are more likely to be victims of domestic violence. What are your thoughts about this?

Questions formulated via preliminary analysis of survey data:

1.
2.
3.
4.

Further questions:

1.
2.
3.

APPENDIX 4 – Gatekeeper Letter

The National Centre for the Study and Prevention of Violence and Abuse
University of Worcester Bredon Building BB200 St. John's Campus
WR2 6AJ

6 July 2016

Dear XXXX,

Many thanks for assisting with this important project by the National Centre for the Study and Prevention of Violence and Abuse, commissioned by Cavell Nurses' Trust. The aim of the study is to explore the experiences Nurses, Midwives and Health Care Assistants have of domestic violence, be it personally or professionally.

We also hope to raise awareness of Cavell Nurses' Trust, and how the Trust can support health professionals who have or are experiencing domestic abuse, or are in crisis.
In order to take part we ask that your team:

1. Read and keep the information sheet and support information and decide if they wish to take part in the project.
2. Complete the participant consent form. The research coordinator has already co-signed the form.
3. Complete the questionnaire as thoroughly as possible. Being sure to complete the final 'About You' page, confirming if they wish to be part of the next stage of the project.
4. Place the questionnaire and consent form into the envelope provided and place it into the box provided.

Due to the tight time scale associated with this project, we ask that questionnaires are completed by **29th July 2016**. However we will arrange a later collection should you wish? If for any reason someone would like to return a questionnaire after the collection they should post it to the above address clearly marked FAO Kirsty McGregor.

Kind regards,

Kirsty

Kirsty E McGregor
01905542933

APPENDIX 5 - Copy of Email to Respondents for Telephone Interview

Dear (respondent's name),

My name is Danielle and I work at the University of Worcester. I am emailing due to you leaving your contact details on a recent survey you completed considering your experiences as a nurse. I wanted to confirm that you are still interested in taking part in a short telephone interview? If so, I shall send over all the information and we can arrange a time and date most suited for you.

If you are not interested in this and do not wish to receive any further information, could you please respond with the below:

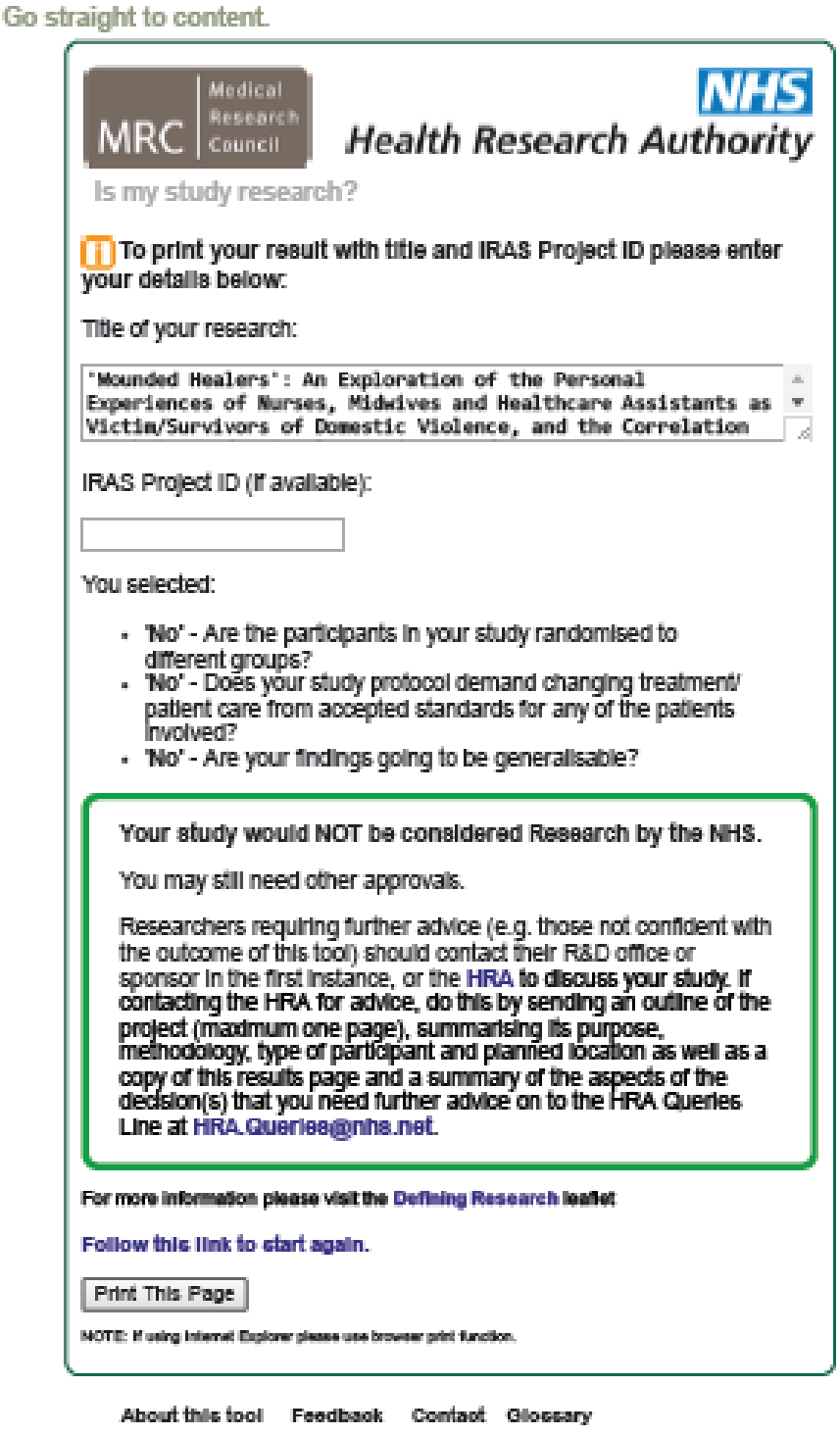
"Please remove my details from your contact list"

I look forward to hearing from you,

Best wishes,

Dr Danielle Stephens-Lewis, PhD, BSc, MBPsS
Research Fellow
University of Worcester
St Johns Campus,
Henwick Grove,
St Johns,
Worcester,
WR2 6AJ
Email: d.stephens-lewis@worc.ac.uk

APPENDIX 6 – HRA Decision Tool



Go straight to content.

MRC Medical Research Council

NHS Health Research Authority

Is my study research?

To print your result with title and IRAS Project ID please enter your details below:

Title of your research:

"Wounded Healers": An Exploration of the Personal Experiences of Nurses, Midwives and Healthcare Assistants as Victim/Survivors of Domestic Violence, and the Correlation

IRAS Project ID (if available):

You selected:

- 'No' - Are the participants in your study randomised to different groups?
- 'No' - Does your study protocol demand changing treatment/ patient care from accepted standards for any of the patients involved?
- 'No' - Are your findings going to be generalisable?

Your study would NOT be considered Research by the NHS.

You may still need other approvals.

Researchers requiring further advice (e.g. those not confident with the outcome of this tool) should contact their R&D office or sponsor in the first instance, or the HRA to discuss your study. If contacting the HRA for advice, do this by sending an outline of the project (maximum one page), summarising its purpose, methodology, type of participant and planned location as well as a copy of this results page and a summary of the aspects of the decision(s) that you need further advice on to the HRA Queries Line at HRA.Queries@nhs.net.

For more information please visit the Defining Research leaflet

Follow this link to start again.

Print This Page

NOTE: If using Internet Explorer please use browser print function.

About this tool Feedback Contact Glossary

APPENDIX 7 – Ethics amendment letter

27th July 2016

Reference: FRKM120116

Dear Eleanor,

Many thanks for your letter outlining the required details associated with this amendment. I hope each of the points has been addressed appropriately but please do let me know of any further information required.

- A full list of the online forums to be approached is necessary.

The following Facebook groups have been identified:

Worcestershire Health and Care NHS Trust
Worcestershire Acute Hospitals NHS Trust
The Royal College of Midwives
Royal College of Nursing
Health Care Assistants UK
Nurses UK
Midwives UK

- Information about the relevant policies in relation to contacting users for each of the online forums is needed - and any implications for your research study. Each is likely to have a different policy in relation to this issue so this should be supplied for each online forum. This should include evidence of permission to utilise the forum in this way - or a description of how this permission will be attained (and then forwarded once granted).

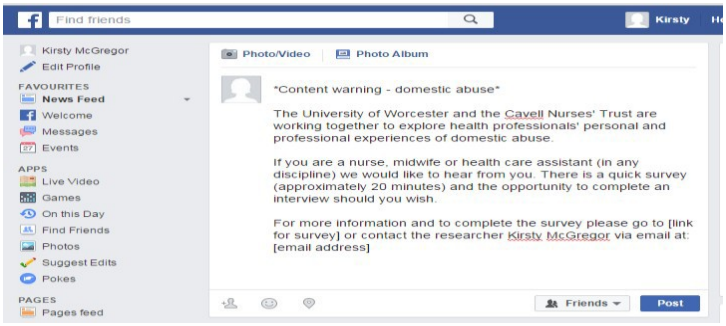
Site administrators have been identified for each forum. We will be contacting the administrators for each page and inviting them to become gatekeepers, i.e. they share the project information and the survey on their page. This will ensure the credibility of the study whilst offering potential participants our contact details. In the instance that gatekeepers would prefer we share the information and survey, this will be done through a Facebook login in created solely for this purpose. This will ensure any data collected will be secured. Once each administrator provides us with permission we will file and forward their written consent.

- Previously, the study was to be introduced to potential participants via a gatekeeper. For a sensitive study of this type - this offered further opportunity for participants to be signposted to supportive information on request. With an online approach, there is the potential that information about the study could appear on someone's facebook account - and this could result in distress, without the availability of subsequent signposting information. Could you clarify

how the gatekeeping process is going to work in relation to the use of these online forums in more detail - or indeed, whether a gatekeeper will be required.

If not, what information will appear about the study initially on these sites and will this be accompanied by signposting information? This information should be supplied.

As with the paper version of the survey, participants will be introduced to the survey via a gatekeeper – the site administrator. This administrator moderates the site content and those allowed to access the site. Any post within these sites relating to the study will include contact details for support services. One of the benefits of having an online recruitment strategy is that support services can be embedded into posts (via hyperlinks) ensuring potential participants can directly access such support. As the sites to be accessed are moderated by the administrator and the majority are 'closed' (i.e. only those approved by the administrator can access content) the likelihood of someone seeing a post about the project is reduced. However in case a post does slip through the moderation process the standard online 'content warning' will be used on each post also. This reduces the likelihood of distress and immediately signposts users to support without them having to 'click' on the post. An example of the post to be shared by gatekeepers or the researchers (according to the gatekeepers' policy]:



As with all online surveys, once the participants have clicked on the survey link, they must read the information sheet and give informed consent (via a required tick box on the opening page) before they can answer any questions. As the survey requests sensitive information there will be an additional content disclaimer at the beginning of the survey in case participants come to the link without having read the post on social media.

I look forward to receiving your feedback.

Best wishes,

Kirsty McGregor
National Centre for the Study and Prevention of Violence and Abuse
University of Worcester

APPENDIX 8 – Information Sheet for Respondents

Participant Information Sheet

Title of project: Nurses, Midwives and Healthcare Assistants who have been victims of Domestic Abuse: Prevalence, Impact and Issues for Practice

Invitation

We would like to invite you to take part in a research project. Before you decide whether to take part it is important that you understand why the research is being done and what it will involve. Please take time to read this carefully and ask the researcher if you have any questions. Feel free to talk to others about the study if you wish. You will have at least 10 days to decide if you want to take part.

What is the purpose of the study?

This study aims to explore the experiences Nurses, Midwives and Healthcare Assistants have of domestic violence, be it personally or professionally. We also hope to raise awareness of Cavell Nurse's Trust, and how the trust can support health professionals who have or are experiencing domestic abuse.

Why have I been invited to take part?

You have received this invitation because you are a Nurse, Midwife or Healthcare Assistant whose practice may prompt disclosures of domestic violence from patients and/or colleagues, or perhaps you have personal experiences of domestic violence. We are hoping to recruit 100 participants for this study.

Do I have to take part?

No. It is up to you to decide whether or not you want to take part in this study. Please take your time to decide; we will wait for at least 10 days before asking for your decision. You can decide not to take part or to withdraw from the study until 14 days following receipt of your questionnaire and/or interview. If you wish to have your data withdrawn please contact the researcher with your participant number and your data will not be used. If you do decide to take part you will be asked to sign a consent form.

What will happen to me if I agree to take part?

If you agree to take part you will be asked to complete a questionnaire regarding your professional and/or personal experiences of domestic abuse. We anticipate that this will take no longer than 20 minutes.

Participants will also have the option to take part in an interview at another time. Should you choose to take part in the interview you will meet with the researcher at a place and time that is convenient for you. We anticipate that the interview will take no longer than 1 hour.

Are there any disadvantages risks to taking part?

The questionnaire may evoke an emotional response due to the personal

nature of some of the questions. We will provide you with details of your local Women's Aid and Cavell Nurses' Trust who can offer support in order to minimise any potential negative effect.

Will the information I give stay confidential?

Everything you say/report is confidential unless you tell us something that indicates that you or someone else is at risk of significant harm. We would discuss this with you before telling anyone else.

The information you give will be used for a research report, but it will not be possible to identify you from this report or any other opportunities to share the findings of the research. Personal identifiable information (e.g. name and contact details) will be securely stored and kept for up to 10 years after the project ends in December 2016 and then securely disposed of as per the Data Protection Act (1998). The research data (e.g. interview transcripts) will also be securely stored and will be accessed by the research team only.

What will happen to the results of the research study?

The findings of this study will be reported to Cavell Nurses' Trust and may also be published in academic journals or at conferences.

If you wish to receive a summary of the research findings please contact the researcher.

Who is organising the research?

This research is being organised by the National Centre for the Study and Prevention of Violence and Abuse, and is being funded by Cavell Nurses' Trust. This research has been approved by the University of Worcester Institute of Health and Society Ethics Committee.

If you decide to take part or you have any questions, concerns or complaints about this study please contact one of the research team using the details below.

Kirsty McGregor k.mcgregor@worc.ac.uk 01905 542693

Claire Richards c.richards@worc.ac.uk 01905 542487

If you would like to speak to an independent person who is not a member of the research team, please contact Dr John-Paul Wilson at the University of Worcester, using the following details:

John-Paul Wilson 01905 542196
Research Manager j.wilson@worc.ac.uk
Graduate Research School