Refuge response to UK National Screening Committee. Domestic Violence - an evidence review
20th August 2013

Refuge opened the world’s first refuge in 1971 and is now the country’s largest single provider of specialist domestic violence services. On any one day, around 2,000 women and children access Refuge’s services. These services include:

- **Freephone 24 Hour National Domestic Violence Helpline**: Run in partnership between Refuge and Women’s Aid
- **Refuge accommodation**: Refuge runs 45 refuges across 16 local authority areas
- **Floating support**: Working with women who are either still living with their abuser and/or those who have left their abuser and require support
- **Community outreach**: Refuge supports women from ethnic minority groups, including Vietnamese and East European women from Bulgaria, Poland and Romania
- **Independent advocacy**: Refuge’s independent domestic violence advocates operate across London and Coventry and Warrington, supporting women through the civil and criminal courts and in a hospital setting.
- **Prevention and education**: Refuge works to influence the Government’s response to domestic violence and raise public awareness of the issue

Refuge’s response
Introduction

Refuge is pleased that the government has recognised the very serious, wide ranging health impacts of domestic violence upon women, children and young people and that it is currently engaged in consultation regarding how best to identify and support this at risk population.

In brief, Refuge believes it is important to both screen¹ for domestic violence and to routinely enquire² about the occurrence of domestic violence in the lives of all women, children and young people. Screening and routine enquiry need not be alternative processes but could instead operate in a parallel and complementary fashion. Refuge also believes that initial and on going training, to ensure sensitive and appropriate questioning by NHS staff, is essential to the success of these processes, as is the availability of high quality domestic

¹ “Screening, as defined by the NSC, is a public health service in which members of a defined population, who do not necessarily perceive they are at risk of, or are already affected by a disease or its complications, are asked a question or offered a test, to identify those individuals who are more likely to be helped than harmed by further tests or treatment to reduce the risk of a disease or its complications...... The use of the term ‘screening’ as defined by the NSC refers to the application of a standardised question or test according to a procedure that does not vary from place to place”. Feder G, Ramsay J, Dunne D, Rose M, Arsene C, Norman R, Kuntze S, Spencer A, Bacchus L, Hague G, Warburton A, and Taket A (2009) How far does screening women for domestic (partner) violence in different health-care settings meet criteria for a screening programme? Systematic reviews of nine UK National Screening Committee criteria

² “Routine enquiry, as it pertains to partner violence, refers to ‘asking all people within certain parameters about the experience of domestic violence, regardless of whether or not there are Signs of abuse, or whether domestic violence is suspected”. Ibid
violence services to which victims can be referred. Establishing close working across the NHS and domestic violence service providers will be crucial.

Comments on The draft Domestic Violence Screening Consultation for Adults

Refuge considers that the narrow medical format used by the National Screening Committee to assess the viability of domestic violence screening is inappropriate. Although domestic violence has health consequences, it is not a medical condition like for example diabetes, where a blood test can be used to determine its presence. Domestic violence cannot be ‘diagnosed’ and ‘treatment’ prescribed to restore health. Domestic violence is instead, a complex social problem, with a wide range of indicators, some of which are medical and others not.

Identification and or disclosure of domestic violence is correspondingly complex and the rate of false negatives (failure to identify or disclose domestic violence) is likely to be higher than those seen in blood tests to identify medical conditions. There are many understandable reasons why an abused woman fails to disclose, when asked, that she is a victim of domestic violence. She may decide not to disclose because she is fearful, ashamed or blames herself for the abuse or she may see little point, believing there is no way out regardless of who she tells. She may have started to misuse drugs or alcohol to numb the pain or she may be afraid that disclosure will lead to removal of her children. A failure to disclose during one off screening or during routine enquiry (should a woman be lucky enough to be fall within a predetermined ‘at risk’ group and be asked) does not necessarily mean that she is not a victim of abuse. Asking more than once, and in a sensitive, non-judgmental manner may be more likely to result in disclosure.

Similarly, it is not always possible to know the impact that questioning about domestic violence has had upon abused women who have or have not disclosed. It is likely however that questioning has some positive effects for both groups (even if they appear to have taken no action as a result) in that they have been made aware they are not alone, that it is their right to talk about it and to be safe and there are specialist supportive services available. Nevertheless, the committee concludes

“Screening for domestic violence is not recommended because there is insufficient evidence on the benefit of interventions. Comprehensive screening programmes can increase the level of screening (asking about domestic violence) undertaken, disclosure and identification but to date there is no evidence of reduction in level of such violence or positive health outcomes following screening. There are alternative methods that are equally successful in eliciting disclosure.”

Refuge believes that although all the outcomes of such questioning may not be immediately apparent or even known in the long term, this does not mean we should not ask. Tackling domestic violence and improving

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3 2.1 The condition should be an important health problem
2. The epidemiology and natural history of the condition, including development from latent to declared disease, should be adequately understood and there should be a detectable risk factor, disease marker, latent period or early symptomatic stage
4 3.5. There should be an agreed policy on the further diagnostic investigation of individuals with a positive test result and on the choices available to those individuals.
4.1. There should be an effective treatment or intervention for patients identified through early detection, with evidence of early treatment leading to better outcomes than late treatment
outcomes for victims requires a multiagency approach, with an equal focus on bringing perpetrators to justice. It is, in our view, unrealistic to expect that asking about domestic violence alone should result in its reduction.

Refuge is aware of the work of Feder et-al⁶, supports the widespread implementation of the IRIS project and agrees with the committee’s conclusion that alternative methods are successful in eliciting disclosure and that “There is an intervention which is thought to be cost effective that could be implemented in primary care to increase referral to specialist services”.

Nevertheless, the degree of discretion affecting the implementation of routine enquiry concerns Refuge and we are worried that questioning may only be triggered by specific ‘prompts’⁷ in medical records when health conditions associated with domestic violence are logged. **Refuge therefore recommends universal screening for domestic violence alongside routine enquiry about the occurrence of domestic violence in the lives of all women, children and young people. For the either process to succeed, training for staff is essential, as is close working between health and specialist domestic violence services.**

Refuge is in agreement with the Committee’s conclusion that ‘There is no one tool which can be said to be the sole screening tool for screening in the UK’ and concurs with the distinction made within screening for domestic violence and a medical condition. ‘Judging a screening tool for screening of partner violence is not like considering a screening tool for a medical condition. Women who disclose to a clinician that they are victims of partner violence have already gone through a complex process of recognition of the problem and by disclosure they are willing to trust the clinician with information that may open them up to further violence and other difficult decisions. It is not clear when and why women choose to disclose abuse and what may trigger a response’. **Refuge would therefore recommend engaging women in conversation and attempting to establish some form of rapport prior to asking about domestic violence in their lives. Embedding standardised questions within such conversations may help to personalise the process. Tick box/check list approaches to screening or routine enquiry may be less likely to elicit a positive disclosure.**

Although the Committee acknowledge there is some evidence that advocacy for abused women may be helpful⁸ their general conclusion is that ‘There are a range of interventions for partner violence. There is a lack of clear evidence on the effectiveness of these interventions’.

Refuge recently commissioned the New Economics Foundation (NEF) to evaluate the economic and social value of its services. The women they consulted as part of this process identified four aspects of their lives that

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⁷“The [IRIS] intervention included an electronic pop-up template in the patient’s medical record. When a GP or practice nurse entered particular coded symptoms (such as depression, chronic pain or tiredness) the template would appear as a reminder of the links to abuse and to prompt the clinician to ask questions about domestic violence”. Johnson M (2010) ‘Herding cats’: the experiences of domestic violence advocates engaging with primary care providers’ Safe. The domestic abuse quarterly. Winter 2010.

⁸A Cochrane review of ten randomised controlled trials of advocacy for intimate partner abuse up to July 2008 concluded that; it is possible that intensive advocacy for women recruited in domestic violence shelters or refuges reduces physical abuse one to two years after the intervention but we do not know if it has a beneficial effect on their quality of life and mental health. Similarly, there is insufficient evidence to show if less intensive interventions in healthcare settings for women who still live with the perpetrators of violence are effective. Feder made a similar conclusion but also considered that as most studies show some benefit from advocacy for some outcomes it is a legitimate referral option for healthcare professionals especially for women who have sought help from professional services. The outcomes for such women are reduction in abuse, increased social support and enhanced quality of life. (p8)
had been improved by Refuge’s services. These are safety, social wellbeing, economic wellbeing and health. NEF concluded that through Refuge’s provision of specialist domestic violence services to abused women and children “An estimated £3.4 million is generated in savings to the state. State savings are highest in the area of health, followed closely by safety through reduced costs to the criminal justice system”.

Refuge agrees with the Committee’s conclusion⁹ that most women would like to be asked about domestic violence and understands, but is not surprised, that the majority of professionals do not find it acceptable to enquire. Lack of domestic violence training and or coaching in how to ask sensitive questions, uncertainty about referral pathways and fears about increasing client vulnerability may be factors affecting a professional’s willingness to enquire about domestic violence. Refuge believes these issues could be overcome with appropriate training and information sharing between the domestic violence sector and health services. Refuge has its own Independent Domestic Violence Advocates located within a maternity department of an East London hospital. Integral to the success of this project is the ability of maternity staff to ask patients about domestic violence and so training in ‘how to ask’ was an essential part of the start up phase¹⁰. Refuge recommends that all NHS staff are trained in how to ask about domestic violence and provided information about appropriate referral services.

Refuge agrees with the Committee’s conclusions¹¹ about the health service’s response to domestic violence and endorses the comments made by the Department of Health Taskforce¹², of which Refuge was a part, in 2010, which states “the many NHS practitioners who deal with violence and abuse as part of their daily clinical practice understand the role that violence and abuse play in causing ill-health and distress. Despite this, we have not seen the same rigorous and systematic approach to this agenda as has been applied to other areas of NHS work such as diabetes or stroke services. This is an area where urgent action is needed. It is a disgrace that so little has been done by the NHS so far. I urge the Government not only to accept the report but also to implement the recommendations as a matter of urgency. The report recommended increased training, better collaboration, processes and policies, better oversight by the commissioners and a national steering group”.

Refuge agrees that ‘further research is required to identify what interventions are most effective for perpetrators and recipients of intimate partner violence in reducing violence and the health implications’. Refuge is uniquely placed to both offer intervention to and provide outcome data for its large client base of abused women and children. Refuge would therefore urge the government to financially enable Refuge to build on the recent work of the New Economics Foundation by expanding its capacity to capture and analyse the effectiveness of its interventions with a view to improving services for abused women and children across England and Wales.

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⁹ Clinicians internationally and in the UK do not consider partner violence screening in healthcare settings acceptable. Generally, women find being asked about domestic violence acceptable but with certain caveats, such as the manner of asking and the type of abuse they have experienced (p14)

¹⁰ Refuge embedded skills training in ‘how to ask’ within domestic violence awareness training for Maternity staff. Refuge also worked with the hospital to adapt their protocols for pregnant women, making them aware they would be seen alone for a short period at their first appointment while the midwife gathered more medical information. This period became known as ‘Time to Talk’ and provided a safe confidential environment where, alone with a midwife, women could be asked about domestic violence. Refuge also worked with the hospital to establish safe, confidential storage of this information so it would not be accessible to their partner/perpetrator.

¹¹ Conclusion Reports suggest the present services for domestic violence are not at an optimum level of delivery.