Researching Education to Strengthen Primary care ON Domestic violence & Safeguarding

RESPONDS

FINAL REPORT

FOR THE DEPARTMENT OF HEALTH

POLICY RESEARCH PROGRAMME PROJECT

Bridging the Knowledge and Practice Gap Between Domestic Violence and Child Safeguarding: Developing Policy and Training for General Practice – 115/0003

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Disclaimer

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Executive summary

1. Study aims and objectives

To clarify and develop policy and guidance for general practice on the interlinked issues of domestic violence and abuse (DVA) and child safeguarding, developing an evidence-base for training and incorporating that policy, guidance and research evidence into a new training intervention for general practice teams.

(i) To analyse the DVA content of child safeguarding training for GPs, practice nurses and practice managers.

(ii) To systematically review evidence on interventions to improve the response of professionals to disclosure of DVA when children are exposed and to identification of child maltreatment when DVA is present.

(iii) To understand the barriers to developing practice at the interface of DVA and child safeguarding in the context of general practice.

(iv) To identify and analyse examples of positive practice in this field.

(v) To formulate specific guidance for general practice about the interface between DVA and child safeguarding.

(vi) To integrate that guidance into a training curriculum.

(vii) To evaluate acceptability and utility of that guidance when applied in general practice training sessions.

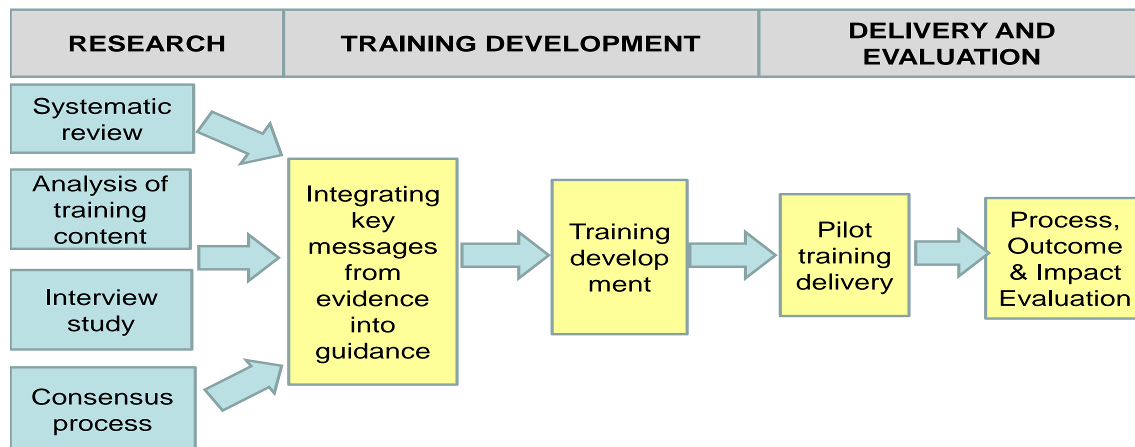
2. Background

The response of health services, including general practice, to DVA should include the needs of children exposed to DVA. There is a direct impact on the health and wellbeing of children in households where DVA is present as well as an overlap between exposure to DVA and other forms of child maltreatment.

The poor engagement of general practice clinicians with DVA and the uncertainty about managing its interface with child protection is a major gap in policy, resulting in missed opportunities to support victims and their children experiencing DVA.

3. Study methods

The RESPONDS study integrated heterogeneous evidence sources into guidance for general practice clinicians and a training intervention to deliver that guidance. The integration by the study team was informed by a consensus process with a multi-professional stakeholder group and meetings with survivors of DVA.



4. Patient and Public Involvement in the research

In the development of the RESPONDS study, we engaged two existing groups of DVA survivors who were advising on other parts of our research programme as well as an organisation that supports young people who have experienced DVA. Once the project commenced we formed the RESPONDS PPI group consisting of four women survivors of DVA with children. This group helped develop our research tools, such as the topic guide for general practice professional interviews, the consensus statements underpinning our guidance, as well as the content of our training intervention; contributed to analysis and interpretation of

our initial findings and two members attended our consensus meeting and project advisory group meetings.

5. Equality and diversity issues

The RESPONDS research team was mindful of inequality and diversity as it is expressed in access to services and a general practice response that is proportional to need, which is influenced by factors such as age, gender, economic status and ethnicity. In the systematic review of interventions for DVA and child maltreatment, we highlighted the socio-demographic profiles and geographic settings of the primary studies in our interpretation of the findings. In the interview study, our sampling took into account local and individual ethnic and socio-economic diversity, as did our pilot sites for the training intervention. In the training intervention we discussed the challenge of variation in cultural norms around DVA. In the evaluation of the RESPONDS training we became aware that we needed a wider ethnicity and, possibly, class profile for characters in the video training vignette.

6. Research evidence streams: findings and discussion

6.1 Systematic review of interventions to improve professional responses to children exposed to DVA

Eighteen studies tested individual training interventions, three tested system level interventions. Three were randomized controlled trials, 12 were pre/post-test design, and three post-test only, with the majority in US paediatric settings. All the training and system-level interventions showed significant improvements in knowledge and most showed improvement in attitude of participants with regards to DVA**.** The studies also reported improvements in self-reported competence and clinician behaviour change. Only one study measured parental outcomes, finding improvement in patient-rated clinical interactions and none measured outcomes for children.

6.2 Training curricula study

We received 32 questionnaires and 22 examples of training material on safeguarding children training courses that either contained some reference to DVA or specifically focused on DVA. A significant minority were judged good or very good in their DVA coverage. The needs and safety of the non-abusive parent (usually the mother) were not sufficiently addressed in most curricula and guidance on talking with children was virtually absent. Other than LSCB training materials, there is little guidance on collaborative working with other agencies. There is scant attention to management of the tension between keeping confidentiality and maximizing safety of DVA survivors and their children.

6.3 Consensus process: consensus survey and meeting

The consensus process identified particularly difficult issues in general practice at the interface of DVA and child safeguarding. The outcomes of the formal consensus process and the meeting highlighted the complexity of positions around some of these issues. Although a policy and practice consensus was generated, there was a recognition of differing professional perspectives and scope for local specificities and individual practices whilst retaining important principles of safety and confidentiality. The process also broadened the scope and sharpened the focus of the RESPONDS research studies.

6.4 Interview study

Although there were many examples of positive practice, there was generally great uncertainty amongst clinicians about directly responding to the exposure of children to DVA. The lack of clarity in guidance and training for general practice clinicians in responding to the linked issues of DVA and child safeguarding may, at least in part, account for the considerable variation in professionals' responses, approaches to the issues, assumptions and perceptions of harm thresholds.

6.4.1 General practice clinicians' understandings of risks, processes and procedures in relation to DVA and child safeguarding

Awareness of the relationship between DVA and child safeguarding was generally low. Clinicians in our sample had limited experience of identifying DVA in families and it was rare for them to have referred children to children's social services as a result of concerns about DVA.

Clinicians tended to focus on physical abuse of victims and their children, rather than neglect or emotional abuse when identifying and responding to DVA in families with children. They struggled to manage families where the risks were uncertain or judged less than high.

6.4.2 Having difficult conversations around DVA and child safeguarding

Clinicians demonstrated a lack of confidence and experience in having conversations about DVA with patients. Children and young people experiencing DVA were rarely engaged with directly. Some clinicians articulated approaches which could exacerbate risk to DVA survivors and their children or fail to meet the standards set in existing guidelines.

6.4.3 Working together, working apart: General practice professionals' perspectives on interagency collaboration in relation to children experiencing DVA

Clinicians were unfamiliar with procedures for co-ordinating service responses to children who were below the high risk threshold and most did not see themselves as having a role in contributing to a 'jigsaw' of information about children that was shared between agencies.

General practice professionals had poor relationships with children's social services and felt isolated from other professional groups. Limited participation in multi-agency safeguarding procedures restricted their role to referral and information exchange rather than joint work. They were unaware of local and national DVA resources and they lacked understanding of the services they offer. Effective interagency communication and team working was limited by insufficient understanding of other professionals' and agencies' sphere of operations, as well as lack of interagency trust and self-confidence.

6.4.4 Documenting DVA and child safeguarding in general practice

General practice clinicians have a confused and inconsistent approach to documenting child safeguarding in the context of DVA. This is partly due to their lack of awareness of national and local guidance on documenting DVA. General practice clinicians were uncertain about how to resolve conflicting principles of preserving confidentiality and potentially increasing safety when considering documentation of abuse in the records of different family members.

7. The development of the RESPONDS training intervention

We developed an evidence-based, multi-component training on child safeguarding and DVA for general practice professionals. The aim of the training is to bridge the knowledge and practice gap between DVA and child safeguarding.

The training pack was designed and developed collaboratively using multi-professional expertise from health, research, training and practice in DVA and child safeguarding. The training was based on the integration of the four research evidence streams: the systematic review of interventions, the training curricula study, the interviews with clinicians and the formal consensus process. Integration featured in the structure as well as content and delivery method of the training: our strategy was to model integrated working between services through the structure of training delivery.

8. Training pilot and training evaluation

The aims of the mixed-method evaluation study were to assess utility and feasibility of the pilot training and inform further research. We wanted to measure the short and medium term impact of training; assess contextual and individual factors that might affect training outcomes; and inform further refinement of the training structure and content.

Overall the training was well received by primary care clinicians. After the training, GPs were more confident in knowing how to proceed in a consultation when they suspected a child's exposure to DVA or it was spontaneously disclosed and the appropriate next steps. They had a greater awareness of current relevant service provision and referral routes. They also reported increased willingness to engage

directly with children and to discuss this appropriately with their non-abusive parent and this led to some changes in case management. The training increased the total measure of self-reported knowledge and self-efficacy about DVA and child safeguarding. However, there was no evidence of an improvement in the participants' beliefs and attitudes.

9. Policy and practice implications

Policy and guidance on multi-agency partnerships should emphasize the importance of cohesive and consistent responses that link DVA and child safeguarding services.

Both DVA and child safeguarding, and the different issues they entail regarding confidentiality and safety, should be included in policies on documenting and information-sharing by clinicians. The 2014 NICE DVA guidelines provide a useful starting point for inclusion of both DVA and child safeguarding in such policies.

Policy and guidance on training for general practice professionals regarding DVA and child safeguarding should emphasize the complexity in ensuring safety of children and their non-abusive parent where there is DVA, the need for training on the interface between DVA and child safeguarding, and appropriate management of adults and children living with DVA in the same family.

10. Conclusions and further research

In RESPONDS we have integrated evidence from an overview of existing UK child safeguarding and DVA curricula, a systematic review of training interventions, extensive interviews with primary care professionals, meetings with young people and adult survivors of DVA and expert consensus to design a training intervention for general practice on the interface between DVA and child safeguarding. Delivery of that intervention to 11 general practices was well received by participants and resulted in positive changes in confidence/self-esteem and knowledge regarding DVA and plans to change practice.

In addition to providing some evidence that the RESPONDS training has the potential to improve the response of general practice to the interface between DVA

and child safeguarding, a major conclusion from our primary interview-based research is the challenge that clinicians face in engaging with this issue.
As a stand-alone intervention it could be implemented more widely, but there remains uncertainty about its effectiveness in actually changing clinician behaviour, improving outcomes for families experiencing DVA, and its potential for integration with other DVA training for general practice.

Given the problems general practice professionals face in responding appropriately and safely to children exposed to DVA and the positive outcomes of the RESPONDS intervention in our pilot study, we propose further development and testing of the intervention. That would involve integration of training and practice support with regards to *all* adult patients and children exposed to DVA. DVA training streamlined into a single module involving one local advocate team would generate easier access to DVA training and services and would also improve the outcomes of training by increasing identification, documentation and referral to ***all*** patients experiencing domestic violence and abuse, irrespective of age, gender or victim/perpetrator status.

11. Dissemination plans

We will deliver a programme of dissemination (both academic and non-academic), knowledge mobilisation, and stakeholder engagement to maximize the impact of the RESPONDS research findings on a range of sectors and audiences. Our outputs will have three target audiences: academic, public and practitioners. The training package is freely available online, its delivery facilitated by a toolkit and its usage monitored via registration on our website (***bristol.ac.uk/responds-study***).
Dissemination and knowledge mobilisation through diverse channels for various audiences will be vital, not only for the appropriate and effective use of the RESPONDS training package but also to inform target audiences of the key findings of our systematic review and primary research on engagement of general practices at the interface between DVA and child safeguarding.