violence prevention
the evidence

Reducing violence through victim identification, care and support programmes

Series of briefings on violence prevention

This briefing for advocates, programme designers and implementers and others is one of a seven-part series on the evidence for interventions to prevent interpersonal and self-directed violence. The other six briefings look at reducing access to lethal means; increasing safe, stable and nurturing relationships between children and their parents and caregivers; developing life skills in children and adolescents; promoting gender equality; changing cultural norms that support violence; and preventing violence by reducing the availability and harmful use of alcohol.

For a searchable evidence base on interventions to prevent violence, please go to: www.preventviolence.info

For a library of violence prevention publications, including the other briefings in this series, please go to: http://www.who.int/violenceprevention/publications/en/index.html

liverpool JMU
Centre for Public Health

World Health Organization

WHO Library Cataloguing-in-Publication Data

Reducing violence through victim identification, care and support programmes.

(Series of briefings on violence prevention: the evidence)

1.Violence – prevention and control. 2.Crime victims – classification. 3.Crime victims – rehabilitation. 4.Physical examination. 5.Interpersonal relations. 6.Health policy. I.World Health Organization.

ISBN 978 92 4 159847 7 (NLM classification: HV 6250)

Designed by minimum graphics
Printed in Malta

Overview

Protecting health and breaking cycles of violence

In addition to physical injury, violence can lead to life-long mental and physical health problems, social and occupational impairment and increased risk of being a victim and/or perpetrator of further violence. Interventions to identify victims of interpersonal violence and provide effective care and support are, therefore, critical for protecting health and breaking cycles of violence from one generation to the next. Evidence for such interventions is currently promising but remains limited in two respects: first, most of it comes from the United States and other developed countries and, second, there is insufficient research on the long-term effects of such interventions.

A range of interventions can help identify victims and initiate a response

Screening tools appear promising to identify victims of intimate partner violence and elder abuse. Violence education programmes can raise awareness of violence and increase knowledge of how to identify and support victims. Mandatory reporting systems, however, although established in many countries, remain controversial. In England and Wales, multi-agency risk assessment systems enable staff in a range of services to identify high-risk victims of intimate partner violence and better plan a support strategy.

Advocacy services, sexual assault nurse examiner programmes and women's shelters

Advocacy support programmes – which offer services such as advice, counselling, safety planning and referral to other agencies – can increase victims' safety behaviours and reduce further harm. Sexual assault nurse examiner programmes show promise in improving victim care and support and facilitating prosecution of perpetrators. Evidence of the effectiveness of women's shelters for reducing intimate partner revictimization is currently insufficient.

Helplines and psychosocial interventions

Limited evidence suggests that helplines can help decrease callers' distress and sense of hopelessness. Some psychosocial interventions (e.g. trauma-focused cognitive behavioural therapy) have been found to reduce mental health problems, such as post-traumatic stress disorder, associated with violence.

Criminal justice system measures to support victims of violence

Protection orders, which prohibit a perpetrator from contacting the victim, can help reduce revictimization among victims of intimate partner violence. Special courtroom measures, such as giving evidence by live video link or using an intermediary for questioning, have been shown to improve victims' experience of court. Specialist courts, which aim to improve coordination between the criminal justice and social service agencies, have been found, for instance, to increase arrests, guilty pleas and conviction rates.

1. Introduction

Internationally, over half a million people die from interpersonal violence each year (*1*) and millions more are victims of non-fatal violence. In 2004, violence was one of the top 20 causes of death and disability globally (*2*). For many forms of violence, such as intimate partner violence and child maltreatment, victims can suffer repeatedly and for many years without such abuse coming to the attention of authorities (*3*). In addition to physical injury, violence can have life-long health and psycho-social consequences. These include mental health problems; physical health problems, such as cardio-vascular disease and cancer due to the adoption of health risk behaviours, such as smoking and harmful use of alcohol, as a means of coping with the psychological consequences of child maltreatment in particular; and impaired social and occupational functioning. The burden of violence can extend to families, friends and public services that deal with the ongoing impacts of violence (e.g. criminal justice agencies and health, social and welfare services). Being a victim[1] of violence can also increase an individual's risk of further abuse and of becoming a perpetrator of violence (*1*). Identifying, caring for and supporting victims of violence through the use of evidence-based initiatives is thus crucial in protecting health and breaking cycles of violence. This document outlines evidence of the effectiveness of interventions to identify, care for and support victims of interpersonal violence. The area of pre-hospital and emergency medical care is not covered by this document since it is already addressed by three WHO guidelines (*4–6*). It covers the following:

1) **Measures to identify and respond to victims of interpersonal violence:**
   - Screening tools;
   - Education programmes on violence and victim identification;
   - Mandatory reporting systems; and
   - Multi-agency risk assessment and response.
2) **Care and support programmes for victims of interpersonal violence:**
   - Advocacy programmes;
   - Sexual assault or forensic nurse examiner programmes;
   - Women's shelters;
   - Helplines;
   - Psychosocial interventions;
   - Protection orders; and
   - Special courtroom measures, specialist courts and police stations that exclusively cater to women.

Few rigorously evaluated studies have examined victim identification, care and and support programmes, and most evidence has been generated in developed countries, particularly the United States of America. Interventions to identify, care for and support victims of violence covered here should be seen as part of broader strategies that seek not only to support victims, but also to alter the individual, relationship, community and societal factors that promote or prevent violence.

[1] Witnessing violence can have severe impacts on health and wellbeing and thus witnesses of violence also require identification, care and support.

2. Measures to identify and respond to victims of interpersonal violence

A large proportion of interpersonal violence is unreported to criminal justice agencies, often because individuals fear stigma (e.g. from family and friends) or retribution from abusers for revealing their abuse (*7*,*8*). However, violence often leads to physical injury and a range of emotional and social problems, which can bring victims into contact with health and other services (e.g. primary care, emergency departments, mental health services) (*9*,*10*). Consequently, such settings provide an opportunity to identify victims of violence, provide support and refer them appropriately (*11–13*). However, a range of obstacles can prevent agencies from identifying and supporting victims of violence. For staff working in healthcare settings, for example, these can include lack of education; time constraints; stereotyping; fear of offending the patient; fear of accusing the perpetrator; powerlessness, and feelings of hopelessness and frustration; lack of screening routines; and a lack of perceived responsibility (*14–16*). In addition, many victims will not disclose their situation unless they are directly asked. Therefore, health and other professionals require the information, knowledge and skills to ensure that they can recognize victims of violence and respond to their needs.

2.1 Screening tools to identify victims of violence

Screening is a process used to identify people at risk of a disease or condition, who may otherwise remain undetected. For victims of violence, screening aims to increase identification, lead to appropriate interventions and support and decrease subsequent exposure to violence and related problems (*17*). A range of screening tools have been developed for use in settings such as emergency departments, pre-natal services and mental health care settings, most commonly for identifying victims of intimate partner violence and child maltreatment (see **Box 1**). The tools generally consist of a series of questions about a person's current relationships and their experience of physical, sexual and emotional violence. Evidence suggests that screening by health care providers can be effective in facilitating the disclosure of intimate partner violence and thus improving identification levels (*18–21*). For example, a study in a Canadian emergency department compared the use of a five question screening tool for intimate partner violence with routine emergency care, and found that the tool increased detection rates from less than 1% of female patients to 14% (*20*).

While screening for violence within healthcare settings is widely promoted, there is little evidence on its sustainability or effectiveness in helping to reduce violence. A systematic review of studies exploring screening for victims of intimate partner violence in healthcare settings found that modest improvements were made in identification of victims. However, there was no evidence that improvements in identification were sustained beyond initial implementation (*17*). Another systematic review found that while screening in emergency departments can be effective in improving victim identification, there are a number of barriers to introducing and sustaining this routinely. These include inadequate knowledge and skills among staff, lack of privacy or after hours services within emergency department settings and lack of staff ownership and acceptance of the questions posed (*19*).

Screening for victims of violence can be implemented universally (i.e. with all patients) or targeted at patients considered to be at-risk (e.g. presenting with physical injuries [*22*,*23*], depression, anxiety or sexual health problems). It has been suggested

BOX 1

Screening tools for intimate partner violence in health care settings

Some of the more commonly used screening tools include the Abuse Assessment Screen; Hurt, Insulted, Threatened with harm and Screamed at (HITS); Indicators of Abuse Screen; Ongoing Violence Assessment Tool (OVAT); Partner Violence Screen (PVS); Slapped, Threatened or Thrown scale; Woman Abuse Screening Tool (WAST); and Women's Experience with Battering scale (WEB).

A systematic review of research on screening tools for intimate partner violence in health care settings identified a number of valid and reliable tools for use in these environments (*20*). The HITS screening tool was found to show the greatest diagnostic accuracy, concurrent validity and reliability compared to a range of other screening tools (e.g. OVAT, PVS, WAST, WEB).

The HITS screening tool was developed in the United States for use by family physicians to identify victims of verbal abuse and physical violence (*24*). The tool consists of four questions developed by a group of family physicians and includes:

- How often does your partner physically hurt you?
- How often does your partner insult you or talk down to you?
- How often does your partner threaten you with harm?
- How often does your partner scream or curse at you?

Patients answer each of the four questions using a five-point scale from never [1] to frequently [5]. Scores are summed; a score of 10 plus suggests the patient is abused.

However, another systematic review concluded that the evidence base is currently too limited to allow any particular screening tool to be recommended (*25*). Furthermore, with the number of questions asked in screening tools varying, particular tools may only be suitable in certain health care settings where there is adequate time and privacy for victims to answer questions (*26*). Also, there is some debate about whether presenting such screening tools in writing (using either a paper-based form or computer entry) or in face-to-face questioning is best.

that routine screening is more beneficial than targeted screening as it increases the potential of victim identification among all patients (including those with symptoms not overtly associated with violence) (*19*). A study in the United States found that while the majority of abused and non-abused women attending emergency departments supported routine screening, those who had suffered abuse were less supportive (*26*). Limited resources may mean routine screening is not possible and that identified victims are not offered subsequent support. Consequently, the choice of whether or not to screen and, if so, the screening method used must be made in light of available resources.

There is little evidence examining the effectiveness of screening for other types of violence (e.g. elder abuse, youth violence, child maltreatment). In the United Kingdom, the introduction of a reminder flowchart to improve detection of child maltreatment for staff in an emergency department found that it increased staff awareness, consideration and documentation of intentional injury (*27*). However, evidence from systematic reviews suggests that screening for child maltreatment can result in high levels of false-positives and consequently should not be recommended (*28*,*29*). Further, all studies meeting quality criteria for these reviews assessed tools directed at parents. This can create reliability problems as information may be obtained directly from the perpetrator (*1*). For elder abuse, it has been recommended that public health care workers screen for abuse as a necessary first step in a chain of interventions. However, the implementation of screening should take place within an interdisciplinary framework and be accompanied by ongoing research, evaluation and capacity building (*30*).

The benefits of screening tools may only be realised if they are complemented by protocols that incorporate victim identification and support into routine practice (*11*,*31*). For example, in the United States, a pre- and post-test controlled study explored the effectiveness of having an abuse assessment protocol in prenatal clinics. During the 15 months following the introduction of the protocol, an audit of patient charts found that 88% of patients in the intervention clinics had been assessed. Furthermore, detection of abuse increased from under 1% to 7% of patients in the intervention

clinics; there were no changes in the comparison clinics (*32*). Adequate auditing, training and support are required to ensure such protocols are followed (*31*,*33*).

2.2 Education programmes on violence and victim identification

A lack of violence-related education among healthcare staff can be a barrier to the recognition, identification and support of victims of abuse (*14*,*34*–*36*). A range of training programmes have been developed for health care staff to aid their understanding of violence and increase victim identification and subsequent support and referral (*37*). These cover topics such as improving staff knowledge on issues surrounding violence, including its extent, impacts and risk factors; reasons why victims may not report their abuse and staff competence in screening; documenting evidence; assessing victim safety; and referring victims for appropriate support.

Evaluations of two such programmes that focused on the education of health care professionals about intimate partner violence (*38*,*39*) suggest that training can improve knowledge of, and attitudes towards, screening for intimate partner violence (*41*–*44*), as well as perceived self-efficacy in supporting victims (*37*).

Although fewer studies have examined the effectiveness of education programmes in tackling other types of violence (e.g. child maltreatment and elder abuse), some positive results have been reported. For instance, child maltreatment education can increase knowledge, appropriate attitudes and perceived self-competency to manage child abuse cases among medical staff immediately after training (*37*). Longer term outcomes have generally not been measured. Rigorous studies on the effectiveness of education on managing elder abuse are lacking. However, such interventions can improve knowledge and level of comfort in handling elder abuse and neglect (*37*).

Outside the healthcare sector, organizations such as the police and specialized non-governmental organizations (e.g. Victim Support in the United Kingdom) can also provide training to staff and volunteers. Specific agency guidance for supporting victims has also been developed. For example, in Uganda, a handbook for police on responding to intimate partner violence provides information on the issue, along with risk assessment forms, interview guides and practical examples of how to support victims (*40*). There is little research available on how such measures impact on levels or quality of support provided to victims or victimization.

2.3 Mandatory reporting

Some countries (e.g. Australia, Canada, England, South Africa and the United States[*41*]) have mandatory child maltreatment reporting laws. In general, these require professionals in contact with children to report all suspected child maltreatment cases to authorities with legal responsibility for child protection. This aims to ensure that appropriate enquiries and interventions are initiated. However, there is little consensus on the usefulness of mandatory reporting of suspected child maltreatment. Critics have raised concerns including the fear of investigation deterring families from accessing services; child protection resources being focused on the investigation of allegations of maltreatment at the expense of supporting victims; and a lack of legal, child protection and support services being available to act on a report (*41*,*42*). In some states in the United States, differential response systems allow child protection agencies more flexibility to address cases based on perceived risk and the family's personal circumstances. Low and moderate risk cases can be offered a family assessment to determine needs and encouraged to access support services most appropriate to them (*43*).

In some states in the United States, mandatory reporting of intimate partner violence incidents has also been established. Again, debate surrounds the appropriateness of this approach (*11*). While supporters believe it can enhance victim safety and improve health care responses to intimate partner violence and data collection, critics believe that it may place women at risk of further abuse and deter them from accessing services (*11*). Although mandatory reporting systems are in operation in many countries, there is little evidence relating to their effectiveness in preventing any form of violence.

2.4 Multi-agency risk assessment and response

In some countries, multi-agency victim identification protocols and risk assessment tools have been developed to provide a coordinated response to identifying and supporting victims. In England and Wales, multi-agency risk assessment conferences (MARACs) aim to provide an enhanced response to high-risk victims of intimate partner violence through multi-agency data sharing and coordinated service provision. Once identified using a risk

assessment tool, high-risk cases are discussed in MARAC monthly meetings during which multi-agency data on the high-risk individual is shared to enable an appropriate response. All discussions and data sharing take place with the individual's consent. Initial research indicates that this coordinated response is effective in reducing revictimization (i.e. being a victim of violence again), improving the safety of staff working with perpetrators of violence (through establishing multi-agency visits) and improving information sharing between agencies (*44*).

3. Care and support programmes for victims of interpersonal violence

Following the identification of victims, it is crucial that effective systems are in place to care for and support them and reduce the likelihood of revictimization.

3.1 Advocacy support programmes

Advocacy programmes provide support and guidance to vulnerable individuals and their families. Services range from providing information and counselling to job training, referrals to treatment for substance abuse and assistance in dealing with social and legal services (*1*). A number of advocacy support programmes have reported success in improving the quality of life and social support for victims of violence and some have shown positive impacts in reducing revictimization, at least in the shorter term.

Brief support and counselling interventions

In healthcare settings, studies have assessed the impact of brief support and counselling interventions for women identified as intimate partner violence victims through screening. In China, a randomized controlled study evaluated an intervention delivered to abused pregnant women accessing public clinics. Counselling sessions aimed to improve safety behaviours and reduce further victimization. At follow up, women in the experimental group reported significantly less psychological abuse, less minor (but not severe) physical violence and lower postnatal depression scores (*45*). A randomized controlled study in primary care clinics in the United States assessed the impact of two interventions for female victims of intimate partner violence: the first providing wallet-sized cards with a safety plan and details of local support services, and the second, a 20-minute nurse-led discussion, which included support, guidance and referrals. The study found equal reductions in violence and improvements in safety behaviours across groups (*46*). Both interventions also led to improvements in the behavioural functioning of the victims' children (*47*).

Post shelter advocacy

In the United States, a randomized controlled trial assessed an intervention providing advocacy services (4–6 hours per week) to victims of intimate partner violence for the first ten weeks post-shelter. The programme trained female undergraduate students to work with a single client to identify unmet needs and mobilize appropriate community resources, including education, employment, housing, legal assistance, child care and healthcare. The study found the intervention reduced revictimization and improved quality of life, social support and access to community resources at two year follow-up (*48*). While positive effects on quality of life and level of social support were sustained at three year follow-up, effects on revictimization were not (*49*). The programme also resulted in children of women in the intervention group reporting significantly higher self-worth and competence in a range of domains (e.g. physical appearance), and witnessing lower levels of abuse, at four month follow-up (*50*).

Encouraging positive safety seeking behaviours

Interventions designed to encourage positive safety seeking behaviours (sometimes referred to as a safety plan) among victims of intimate partner violence have shown promising results. Examples of safety seeking behaviours promoted include obtaining copies of, and hiding, important documents (e.g. personal identification, driver's license); saving and hiding money; and having a known place

BOX 2

Evaluation of Child Advocacy Centres (CACs) in the United States

A study of four CACs in the United States found that, compared to communities providing traditional child protection services (CPS), CACs had greater law enforcement involvement in abuse investigations, more evidence of a coordinated multi-agency response, better access to medical exams for victims, more victim referrals to mental health services and greater care giver (non-abusive) satisfaction with the investigation process (*52*). Research in the United States has found that for every dollar invested in a CAC, there is a saving of $3.32 dollars through reduced costs of investigation and associated support (*53*). Some research suggests that it is the multi-agency nature of CACs that make them effective and have found that other multi-agency models (e.g. Child Protection Teams in the United States) are equally effective (*54*).

to go to for safety if required (*51*). A randomized controlled trial assessed a safety seeking behaviour intervention in a family violence unit based in a United States District Attorney's office. Women in the intervention group were offered six phone calls to discuss safety seeking behaviours, alongside standard services. This resulted in them practising significantly more safety behaviours than controls – an effect that was sustained at 18 month follow-up (*55*,*56*).

Child advocacy centres

Child Advocacy Centres (CACs) provide a multi-disciplinary approach to assessment, care and treatment for abused children and young people. CACs convene, often in one location, child protective services, criminal justice agencies and medical and mental health professionals. The multi-agency approach aims to decrease the duplication and fragmentation of services with improved coordination and, consequently, reduce the potential for secondary victimization,[2] improve the provision of support and increase conviction rates (*57*,*55*). In the United States, national standards have been set for accreditation of CACs, including the provision of a child-friendly facility, a multi-disciplinary investigation team, case reviews, medical evaluation, therapeutic interventions and victim advocacy services (*58*).

CACs have been also established in a number of other high-income countries. While some focus exclusively on forensic issues, others aim to provide multi-agency services to child victims of violence. Few studies have assessed the long-term impacts of these services on revictimization, yet studies to date show promising results regarding victim support (see **Box 2**).

[2] Secondary victimization occurs when the societal response to, for instance, child maltreatment, rape, disability, or mental disorder is more disabling than the primary condition itself.

In countries including Bangladesh, Malaysia, Namibia and Thailand, one-stop crisis centres have been implemented at a national level (*31*). These centres offer a range of integrated services to address child abuse, intimate partner violence and sexual violence, addressing victims' medical, legal, psychological and social problems at a single location. However, no evidence is currently available for their effectiveness.

Advocacy in the criminal justice system

Advocacy services have been established to support victims in their dealings with the criminal justice system and improve perpetrator conviction rates. In England and Wales, Witness Care Units (WCUs) manage the care of victims and witnesses from the point of charging the alleged perpetrator through to the conclusion of the case. Providing a single point of contact, they aim to keep victims and witnesses informed of case progress; assess their needs; and provide them with appropriate support, such as childcare, transport to court or referrals to other services. An initial evaluation of WCUs found increased witness attendance in court, improved trial outcomes and improved witness and victim satisfaction (*59*).

3.2 Sexual assault or forensic nurse examiner programmes

In several developed countries (e.g. Canada, England and the United States), sexual assault (or forensic) nurse examiners (SANEs) are employed to provide care and support to victims of sexual violence (*60–62*). Often located in hospital settings, the key roles of SANEs are to conduct medical evaluations; counsel and support victims, focusing in particular on their emotional and psychological wellbeing; refer them to appropriate agencies; collect forensic evidence; and provide evidence in court. A review of studies on SANE projects

concluded that they can be psychologically beneficial, providing comprehensive medical care, obtaining forensic evidence both correctly and accurately, and facilitating the prosecution of rape cases (*61*).

A cohort study in the United States explored the impact of SANEs in a paediatric emergency department by retrospectively comparing treatment received by sexual assault victims (aged under 18) seen by a SANE and those who were not. Patients who had received SANE care were more likely to have had an STI test, pregnancy prophylaxis and a referral to a rape crisis centre (*63*). In the United Kingdom, the cost of providing forensic examination services has been found to be significantly lower when delivered by SANEs compared to doctors, with rates of satisfaction and standards of service remaining high (*60*).

3.3 Women's shelters

Women's shelters provide temporary, safe accommodation for women and children who have left an abusive relationship. In addition to housing and food, women's shelters often provide counselling and emotional support, help in obtaining housing and medical and legal assistance. Although women's shelters are widely used within many countries, there have been few attempts to rigorously measure their effectiveness in reducing violence's impact or re-occurrence (*64*). One cohort study suggested that time spent in a shelter could have beneficial effects, but only when victims had already started to take control of their lives before entering (*65*). Other evaluations suggest that victims feel safe while residing in a shelter (*66*), and become less depressed and more hopeful following a two-week stay (*67*). The effectiveness of a shelter is likely to depend on the types of supportive programmes it provides, and these are often the focus of evaluation studies. For instance, reductions in revictimization and improvements in quality of life have been reported for free advocacy services offered to women in the first ten weeks post shelter (see section on advocacy support programmes). At present, there is insufficient evidence to judge the effectiveness of shelters on intimate partner violence revictimization. Furthermore, because shelters are often packaged with other services (support groups and legal assistance) (*68*), it is difficult to separate the effects of shelters alone.

3.4 Helplines

In many countries, helplines have been set up for victims of violence to report their abuse, and access support, advice and referral to appropriate services. In the United States, an evaluation of a suicide hotline found that there were significant decreases in callers' crisis states and hopelessness during the call and these were sustained during the following three weeks for both suicidal and non-suicidal callers (*69*,*70*). However, the evaluation indicated that improvements were needed in the referral of callers to appropriate support agencies and implementation of outreach strategies, such as follow-up phone calls, to provide additional support (*70*). Another limitation of helplines can be their hours of availability. A survey of a domestic abuse helpline in Scotland found that although it closed after midnight, nearly half of victims of intimate partner violence thought it would be easier to call after that time (*71*). The survey reported that 30% of those who called about their abuse had not talked to anyone else about it (*71*).

Many countries have established child abuse helplines to provide advice and support to children or those concerned about a child's welfare. Child Helpline International aims to create a strong and unified support system for such helplines. It has developed recommendations for their implementation and sustainability (*72*), although to date there are no rigorous studies on such helplines' effectiveness.

3.5 Psychosocial interventions

After exposure to a traumatic event, such as an act of violence, a proportion of people will suffer mental health problems such as anxiety, post traumatic stress disorder (PTSD; *73–75*) and depression. Psychological treatments are often used to address these symptoms. There are a number of different methods, but all techniques treat emotional and behavioural problems through conversation with a therapist. Psychological interventions may be carried out individually or in groups.

While psychological debriefing is widely used to prevent chronic PTSD and other mental health problems following a traumatic event, reviews suggest that there is no evidence for the effectiveness of single-session psychological debriefing, and that this method may even increase the risk of PTSD and depression (*76*). In contrast, there is evidence for the use of early trauma-focused cognitive behavioural therapy in preventing chronic PTSD (*77*,*78*).

This therapy was also found to be more effective than alternative psychosocial interventions (*77,78*). One systematic review found that among adults suffering from PTSD for a variety of reasons (including violence) trauma-focused cognitive behavioural therapy, eye movement desensitisation and reprocessing[3] and stress management/relaxation improved PTSD symptoms more than usual care or being on a waiting list. However, there was less evidence for the use of other therapies, including hypnotherapy, non-directive counselling and psychodynamic therapy (*79*). Treatments that focus specifically on the trauma incident are thought to be more effective than those that do not (*79*). There is some evidence for the effectiveness of psychological interventions to improve the mental health of both adults (*80–82*) and children (*83*) who have been victims of child sexual abuse.

3.6 Protection orders

Protection orders are used to prohibit perpetrators of violence from further abusing the victim. Research in the United States has found that protection orders can be effective in reducing revictimization among victims of intimate partner violence. For example, a prospective cohort study compared abuse among female victims of police-reported intimate partner violence who obtained a civil protection order following the incident with those who did not. Between the first (5 month) and second (9 month) follow-up periods, women with protection orders were found to have a decreased risk of contact with the perpetrator, of threats involving a weapon, of injury and of abuse-related medical care. Stronger decreases in risk were found among those who maintained the protection order for longer periods (*84*).

Regardless of whether or not a protection order is granted, applying for an order may be sufficient to reduce future violence. For instance, a cohort study in the United States involving women who had applied for a two-year protection order found levels of violence decreased whether or not they were granted the protection order, with reductions sustained at 18 month follow-up (*85*). A review of research on protection orders suggested that generally they lead to improvements in victims' lives through increases in perceived self-worth and safety (*86*). While evidence suggests that protection orders can be effective, their utility is limited when enforcement is inadequate.

3.7 Special courtroom measures, specialist courts and police stations that exclusively cater to women

Special courtroom measures and specialist courts aim to improve victims' experience of proceeding through the court system and giving evidence. Special courtroom measures may include using screens in the courtroom so that the witness cannot see, or be seen by, the defendant; giving evidence by live video link from a separate room in the court building; using video evidence in cross examination; clearing the public gallery of spectators; removing court attire, such as wigs and gowns (e.g. in the United Kingdom); and using an intermediary for questioning (*87*). An evaluation of such measures put in place for vulnerable and intimidated witnesses in England and Wales found positive results. These included improvements in satisfaction with the criminal justice process and reductions in perceived levels of intimidation and experience of anxiety. Further, a third (33%) of witnesses stated that they would not have been willing or able to give evidence without special measures (*88*). Despite this, research indicates that special measures are not used as often or effectively as they could be (*89*).

Specialist courts for intimate partner violence have been in place in parts of Canada and the United States since the 1980s, and more recently have been established across many areas in England and Wales. The objectives are to increase coordination between criminal justice and social service agencies, hold defendants accountable and address victims' needs effectively (*90*). Core components include access to advocacy services, coordination of partner agencies and their information systems, victim and child friendly courts, specialist trained personnel, evaluation and accountability, protocols for risk assessment, ongoing training, compliance monitoring and consistent sentencing (*91*). While rigorous, long-term evidence of the impact of specialist courts has yet to be established, evaluations have found them to be effective in increasing arrests (*90*), guilty pleas (*92,93*) and conviction rates (*93*); reducing recidivism (*89*); and increasing the speed at which cases are processed (*93*).

Police stations that exclusively cater to women are a further initiative to address violence against

[3] Eye movement desensitization and reprocessing involves the patient focusing on the traumatic event, thoughts and emotions while receiving stimulation in the form of eye movements (e.g. following a moving light).

women. These have been developed in a number of countries in Latin America and parts of Asia (*1*) with the aim of increasing the number of women reporting abuse, and improving the response of the police towards them (*1*). However, these initiatives have met with a number of problems, including the dismissal of women reporting to regular police units (*1*). The scarcity of all women police stations also means that women are often forced to travel long distances to report abuse (*1*).

4. Summary

Interventions to identify victims of interpersonal violence and provide effective care and support are an important part of efforts to break cycles of abuse from one generation to the next. Victims of violence can experience abuse for years without ever contacting police; yet they may come into contact with many other agencies that are well placed to identify their needs and initiate support. Thus, a range of interventions have been established to improve victim identification, including screening tools, professional education programmes, mandatory reporting systems and multi-agency risk assessments. Most interventions have focused on intimate partner violence and have been implemented in developed countries, particularly the United States.

Current evidence for the effectiveness of screening for intimate partner violence is promising, showing that simple screening tools, often implemented in health settings, can identify victims of violence. However, increases in levels of identification can be short-lived and screening for intimate partner violence may be most successful when complemented by protocols that incorporate identification and management of victims into routine practice. More research is needed on screening's applicability to, and impact on, child maltreatment and other types of violence.

Violence education programmes can be useful in raising awareness of violence and increasing knowledge of how to identify and support victims and, consequently, can increase victim referrals to appropriate support services. Most programmes studied have been tested in medical settings. In some countries, mandatory reporting systems require professionals to report suspected cases of child abuse to authorities responsible for child protection. Such systems, however, are largely unevaluated and remain controversial.

Once identified, it is crucial that victims are offered effective care and support. Interventions that provide advocacy services such as advice, counselling, safety planning and referral to other agencies can increase victims' safety behaviours and reduce further harm. These measures can be implemented following screening, or can be used to provide additional support to those proceeding through criminal justice systems. Specialist measures for victims of sexual violence, in the form of Sexual Assault Nurse Examiner (SANE) programmes, have also shown promising results in improving victim care and support and facilitating the prosecution of rape cases. Further, a range of measures developed in the criminal justice system, such as protection orders and specialist courts, can help improve victims' experience of proceeding through the court system, increase conviction rates and reduce revictimization. Evidence to evaluate the effectiveness of women's shelters on intimate partner revictimization is at present insufficient; this is partly due to the difficulty of isolating the specific effect of shelters from the other services provided at the same time. To address mental health problems associated with experiencing violence (such as PTSD), some psychosocial interventions, such as trauma-focused cognitive behavioural therapy, have been successfully used with both children and adults.

Overall, however, rigorous scientific evaluations of the long-term effects of care and support programmes are currently limited, with most evidence from the United States and other developed countries. Thus, it is difficult to draw firm conclusions about their effectiveness and applicability in other settings. More research is needed to develop our understanding of care and support programmes and of measures for identifying victims, particularly for violence other than that between intimate partners.

References

1. Krug EG et al., eds. *World report on violence and health*. Geneva, World Health Organization, 2002.
2. *The global burden of disease: 2004 update*. Geneva, World Health Organization, 2008.
3. Povey D et al. *Homicides, firearm offences and intimate violence 2007/08 (supplementary Volume 2 to Crime in England and Wales 2007/08)*. London, Home Office, 2009.
4. Mock C et al. *Guidelines for trauma quality improvement programmes*. World Health Organization, 2009.
5. Sasser S et al. *Prehospital trauma care systems*. World Health Organization, 2005.
6. Mock C et al. *Guidelines for essential trauma care*. World Health Organization, 2004.
7. McCauley J et al. Inside "Pandora's box": abused women's experiences with clinicians and health services. *Journal of General Internal Medicine*, 1998, 13:549–555.
8. Rodríguez MA, Quiroga SS, Bauer HM. Breaking the silence. Battered women's perspectives on medical care. *Archives of Family Medicine*, 1996, 5:153–158.
9. Ilrich YC et al. Medical care utilization patterns in women with diagnosed domestic violence. *American Journal of Preventive Medicine*, 2003, 24:9–15.
10. Lo Fo Wong S et al. Utilisation of health care by women who have suffered abuse: a descriptive study on medical records in family practice. *British Journal of General Practice*, 2007, 57:396–400.
11. Culross PL. Health care system responses to children exposed to domestic violence. *Domestic Violence and Children*, 1999, 9:111–121.
12. Taket A et al. Tackling domestic violence: exploring the health service contribution. Home Office Online Report 52/04. (http://www.homeoffice.gov.uk/rds/pdfs04/rdsolr5204.pdf, accessed 16 June 2009).
13. Taket A. Tackling domestic violence: the role of health professionals. Home Office development and practice report 32. (http://www.homeoffice.gov.uk/rds/pdfs04/dpr32.pdf, accessed 16 June 2009).
14. Rönnberg AKM, Hammerström A. Barriers within the health care system to dealing with sexualized violence: a literature review. *Scandinavian Journal of Public Health*, 2000, 28:222–229.
15. Stinson CK, Robinson R. Intimate partner violence: continuing education for registered nurses. *Journal of Continuing Education in Nursing*, 2006, 37:58–62.
16. Yonaka L et al. Barriers to screening for domestic violence in the emergency department. *Journal of Continuing Education in Nursing*, 2007, 38:37–45.
17. Ramsay J et al. Should health professionals screen women for domestic violence? Systematic review. *British Medical Journal*, 2002, 325:314.
18. McFarlane JM et al. Assessing for abuse: self-report versus nurse interview. *Public Health Nursing*, 1991, 8:245–250.
19. Olive P. Care for emergency department patients who have experienced domestic violence: a review of the evidence base. *Journal of Clinical Nursing*, 2007, 16:1736–1748.
20. Morrison LJ, Allan R, Grunfeld A. Improving the emergency department detection rate of domestic violence using direct questioning. *The Journal of Emergency Medicine*, 2000, 19:117–124.
21. Feder et al. How far does screening women for domestic (partner) violence in different health-care settings meet criteria for a screening programme? Systematic reviews of nine UK National Screening Committee criteria. *Health Technology Assessment*, 1999, 13: DOI: 10.3310/hta13160.
22. Muelleman RL, Lenaghan PA, Pakieser RA. Battered women: injury locations and types. *Annals of Emergency Medicine*, 1996, 28:486–492.
23. Warshaw C, Ganley AL. *Improving the health care response to domestic violence: a resource manual for health care providers*. San Francisco, Family Violence Prevention Fund, 1998.
24. Sherin KM et al. HITS: a short domestic violence screening tool for use in a family practice setting. *Family Medicine*, 1998, 30:508–512.
25. Rabin et al. Intimate partner violence screening tools: a systematic review. *American Journal of Preventive Medicine*, 2009, 36:439–445.

26. Glass N, Deanwater S, Campbell J. Intimate partner violence screening and intervention: data from eleven Pennsylvania and California community hospital emergency departments. *Journal of Emergency Nursing*, 2001, 27:141–149.
27. Benger JR, Pearce AV. Quality improvement report: simple intervention to improve detection of child abuse in emergency departments. *British Medical Journal*, 2002, 324:780–782.
28. Nygren P, Nelson HD, Klein J. Screening children for family violence: a review of the evidence for the US Preventive Services Task Force. Annals of *Family Medicine*, 2004, 2:161–169.
29. MacMillan HL. Preventive health care, 2000 update: prevention of child maltreatment. *Canadian Medical Association Journal*, 2000, 163:1451–1458.
30. Perel-Levin S. *Discussing screening for elder abuse at primary health care level*. Geneva, World Health Organization, 2000.
31. Colombini M, Mayhew S, Watts C. Health-sector responses to intimate partner violence in low- and middle-income settings: a review of current models, challenges and opportunities. *Bulletin of the World Health Organization*, 2008, 86:635–642.
32. Wiist WH, McFarlane J. The effectiveness of an Abuse Assessment Protocol in public health prenatal clinics. *American Journal of Public Health*, 1999, 89:1217–1221.
33. Lewis CM et al. Evaluation of a rape protocol: a five year follow-up with nurse managers. *Journal of the American Academy of Nurse Practitioners*, 2003, 15:34–39.
34. Othman S, Adenan NAM. Domestic violence management in Malaysia: a survey on the primary health care providers. Asia Pacific *Family Medicine*, 2008, 7:2.
35. Kaye DK, Mirembe F, Bantebya G. Perceptions of health care providers in Mulago hospital on prevention and management of domestic violence. *African Health Sciences*, 2005, 5:315–318.
36. Cann K et al. Domestic violence: a comparative study of survey levels of detection, knowledge, and attitudes in healthcare workers. *Public Health*, 2001, 115:89–95.
37. Cohn F, Salmon ME, Stobo JD, eds. *Confronting chronic neglect: the education and training needs of health professionals to respond to family violence*. Washington DC, National Academy Press, 2002.
38. Harwell TS et al. Results of a domestic violence training program offered to the staff of urban community health centres. *American Journal of Preventive Medicine*, 1998, 15:235–242.
39. Roberts GL et al. Impact of an education program about domestic violence on nurses and doctors in an Australian emergency department. *Journal of Emergency Nursing*, 1997, 23:220–226.
40. Uganda Police Force. *Responding to domestic violence. A handbook for the Uganda Police Force*. Kampala, Centre for Domestic Violence Prevention, 2007.
41. Butchart A et al. *Preventing child maltreatment: a guide to taking action and generating evidence*. Geneva, World Health Organization, 2006.
42. Melton GB. Mandating reporting: a policy without reason. *Child Abuse and Neglect*, 2005, 29:9–18
43. Child Welfare Information Gateway. *Differential response to reports of child abuse and neglect*. Washington DC, Department of Health and Human Sciences, 2008.
44. Robinson AL. Reducing repeat victimization among high risk victims of domestic violence: the benefits of a coordinated community response in Cardiff, Wales. *Violence Against Women*, 2006, 12:761–788.
45. Tiwari A et al. A randomised controlled trial of empowerment training for Chinese abused pregnant women in Hong Kong. *BJOG: an International Journal of Obstetrics and Gynaecology*, 2005, 115:1249–1256.
46. McFarlane JM et al. Secondary prevention of intimate partner violence. A randomized controlled trial. *Nursing Research*, 2006, 55:52–61.
47. McFarlane JM et al. Behaviors of children following a randomized controlled treatment program for their abused mothers. *Issues in Comprehensive Pediatric Nursing*, 2005, 28:195–211.
48. Sullivan CM, Bybee DI. Reducing violence using community-based advocacy for women with abusive partners. *Journal of Consulting and Clinical Psychology*, 1999, 67:43–53.
49. Bybee D, Sullivan CM. Predicting re-victimization of battered women three years after exiting a shelter program. *American Journal of Community Psychology*, 2005, 36:85–95.
50. Sullivan CM, Bybee DI, Allen NE. Findings from a community-based programme for battered women and their children. *Journal of Interpersonal Violence*, 2002, 17:915–936.
51. Family violence prevention fund. *National consensus guidelines on identifying and responding to domestic violence victimization in health care settings*. San Francisco, Family violence prevention fund, 2002.
52. Cross TP et al. *Evaluating children's advocacy centres' response to child sexual abuse*. Washington DC, US Department of Justice, 2008.
53. Shadion A et al. *Executive summary. Findings from the MCAC cost-benefit analysis of community responses to child maltreatment*. (http://www.nationalcac.org/professionals/research/CBA%20Executive%20Summary.pdf. accessed 27 November 2008).
54. Wolfteich P, Loggins B. Evaluation of the children's advocacy center model: efficiency, legal and revictimization outcomes. *Child and Adolescent Social Work Journal*, 2007, 24:333–352.
55. McFarlane JM et al. An intervention to increase safety behaviors of abused women: results of a randomised clinical trial. *Nursing Research*, 2002, 51:347–354.

56. McFarlane JM et al. Increasing the safety-promoting behaviours of abused women: in this study, telephone intervention for victims of intimate-partner violence showed efficacy for 18 months. *American Journal of Nursing*, 2004, 104:40–50.
57. Hornor G. Child advocacy centers: providing support to primary care providers. *Journal of Pediatric Health Care*, 2008, 22:35–39.
58. National Children's Alliance. *Standards for Accredited Members. Revised 2008*. National Children's Alliance (http://www.nationalchildrensalliance.org/index.php?s=76, accessed 26 November 2008).
59. Avail Consulting. *No Witness, No Justice (NWNJ) pilot evaluation*. Executive summary. London, Avail Consulting, 2004.
60. Regan L, Lovett J, Kelly *L. Forensic nursing: an option for improving responses to reported rape and sexual assault*. London, Home Office, 2004.
61. Campbell R, Patterson D, Lichty LF. The effectiveness of Sexual Assault Nurse Examiner (SANE) programs: a review of psychological, medical, legal and community outcomes. *Trauma, Violence, and Abuse*, 2005, 6:313–329.
62. Cole J, Logan TK. Negotiating the challenges of multidisciplinary responses to sexual assault victims: sexual assault nurse examiner and victim advocacy programs. *Research in Nursing and Health*, 2008, 31:76–85.
63. Bechtel K, Ryan E, Gallagher D. Impact of sexual assault nurse examiners on the evaluation of sexual assault in the pediatric emergency department. *Pediatric Emergency Care*, 2008, 24:442–447.
64. Wathen CN, MacMillan HL. Interventions for violence against women: scientific review. *Journal of the American Medical Association*, 2003, 289:589–600.
65. Berk RA, Newton PJ, Berk SF. What a difference a day makes: an empirical study of the impact of shelters for battered women. *Journal of Marriage and the Family*, 1986, 48:481–490.
66. Bennett L et al. Effectiveness of hotline, advocacy, counseling and shelter services for victims of domestic violence: a statewide evaluation. *Journal of Interpersonal Violence*, 2004, 19:815–829.
67. Sedlak AJ. The use and psychosocial impact of a battered woman's shelter. In Hotaling GT, Finkelhor D, eds. *Coping with family violence: research and policy perspectives*. Newbury Park CA, Sage, 1988.
68. Whitaker DJ, Baker CK, Arias I. Interventions to prevent intimate partner violence. In Doll LS et al., eds. *Handbook of injury and violence prevention*. New York NY, Springer US, 2007.
69. Kalafat J et al. An evaluation of crisis hotline outcomes part 1: nonsuicidal crisis callers. *Suicide and Life-Threatening Behavior*, 2007, 37:322–337.
70. Gould MS et al. An evaluation of crisis hotline outcomes part 2: suicidal callers. *Suicide and Life-Threatening Behavior*, 2007, 37:338–352.
71. Scottish Executive. *Evaluation of the Scottish domestic abuse helpline*. Edinburgh, Scottish Executive Social Research, 2004.
72. Child Helpline International. *Child helplines: one year later. UN violence against children report*. Amsterdam, Child Helpline International, 2007.
73. Zinzow HM et al. Prevalence and mental health correlates of witnessed parental and community violence in a national sample of adolescents. *Journal of Child Psychology and Psychiatry*, 2009, 50:441–450.
74. Fowler PJ et al. Community violence: a meta-analysis on the effect of exposure and mental health outcomes of children and adolescents. *Development and Psychopathology*, 2009, 21:227–259.
75. Woods SJ et al. Physical health and posttraumatic stress disorder symptoms in women experiencing intimate partner violence. *Journal of Midwifery and Women's Health*, 2008,53:538–546.
76. Rose SC et al. Psychological debriefing for preventing post traumatic stress disorder (PTSD). *Cochrane Database of Systematic Reviews*, 2002, Issue 2. Art. No.: CD000560. DOI:10.1002/14651858.CD000560.
77. Roberts NP et al. Systematic review and meta-analysis of multiple-session early interventions following traumatic events. *American Journal of Psychiatry*, 2009, 166:293–301.
78. Korner H et al. Early trauma-focused cognitive-behavioural therapy to prevent chronic post-traumatic stress disorder and related symptoms: a systematic review and meta-analysis. *BMC Psychiatry*, 2008, 8:81–91.
79. Bisson J, Andrew M. Psychological treatment of post-traumatic stress disorder (PTSD). *Cochrane Database of Systematic Reviews*, 2007, Issue 3. Art. No.:CD003388. DOI:10.1002/14651858.CD003388.pub3.
80. Price JL et al. A review of individual psychotherapy outcomes for adult survivors of childhood sexual abuse. *Clinical Psychology Review*, 2001, 21:1095–1121.
81. Callahan KL, Price JL, Hilsenroth MJ. A review of interpersonal-psychodynamic group psychotherapy outcomes for adult survivors of childhood sexual abuse. *International Journal of Group Psychotherapy*, 2004, 54:491–519.
82. Martsolf DS, Draucker CB. Psychotherapy approaches for adult survivors of childhood sexual abuse: an integrative review of outcomes research. *Issues in Mental Health Nursing*, 2005, 26:801–825.
83. MacDonald G, Higgins JPT, Ramchandani P. Cognitive-behavioural interventions for children who have been sexually abused. *Cochrane Database of Systematic Reviews*, Issue 4. Art.No.:CD001930. DOI:10.1002/14651858.CD001930.pub2.
84. Holt VL et al. Do protection orders affect the likelihood of future partner violence and injury? *American Journal of Preventive Medicine*, 2003, 24:16–21.
85. McFarlane J et al. Protection orders and intimate partner violence: an 18-month study of 150 Black, Hispanic, and White women. *American Journal of Public Health*, 2004, 94:613–618.
86. Logan TK et al. Protective orders. Questions and conundrums. *Trauma, Violence and Abuse*, 2006, 7:175–205.

87. *What is an intermediary*? Crown Prosecution Service (http://www.cps.gov.uk/derbyshire/casework/special_measures/what_is_an_intermediary/, accessed 1 December 2008).
88. Hamlyn B et al. *Are special measures working? Evidence from surveys of vulnerable and intimidated witnesses*. Home Office Research Study 283. London, Home Office Research, Development and Statistics Directorate, 2004.
89. Burton M, Evans R, Sanders A. *An evaluation of the use of special measures for vulnerable and intimidated witnesses*. Home Office Findings 270. London, Home Office Research, Development and Statistics Directorate, 2006.
90. Gover AR, MacDonald JM, Alpert GP. Combating domestic violence: findings from an evaluation of a local domestic violence court. *Criminology and Public Policy*, 2003, 3:109–132.
91. Sacks E. *Creating a domestic violence court: guidelines and best practices*. San Fransisco, Family Violence Prevention Fund, 2002.
92. Newmark L et al. *Specialized felony domestic violence courts: lessons on implementation and impacts from the Kings County experience*. Washington, The Urban Institute, 2001.
93. Scottish Government. *Evaluation of the pilot domestic abuse court*. Edinburgh, Scottish Executive Justice Department, 2007.