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Empowering Women and Providers: Domestic Violence and Mental Health

The University of Hertfordshire is leading an EU funded Daphne III project with universities and practice organisations in England, Greece, Italy, Poland and Slovenia from 2011 to 2013 examining the dual issues of domestic violence and mental health. Our UK partners are Welwyn Hatfield Women's Refuge, in collaboration with Herts Partnership Foundation Trust.
We designed, delivered and evaluated three free training programmes for:

1. women who have experienced domestic violence and mental health difficulties, designed to increase their wellness, coping capacity, self management and control over their environment, by applying evidence-based interventions. A variety of interactive methods, self-help and mutual support strategies were applied in this therapeutic educational programme.

- ☆ 8 half-day sessions; recruitment target of 20 women per country in 2 groups of 10.

2. mental health providers (men & women), designed to increase awareness of the impact of domestic violence on women and children; facilitate victim identification; gain understanding of perpetrators' behaviour; increase knowledge and skills for strength-based interventions with women. Continuing Professional Development Certificate of Attendance sent to attendees.

- ☆ 4-8 one-day sessions depending on availability of hours; recruitment target of 10 providers per country.

3. women wishing to become co-facilitators of support groups for women, this programme focussed on developing their leadership skills, understanding group dynamics, how to work well together with a co-facilitator, be supportive to members in the group and encourage them to explore issues related to uncomfortable past experiences in a constructive way.

- ☆ 5 half-day sessions; recruitment target of 5 co-facilitators per country.

Programme evaluations were administered at the pre-programme, immediate post-programme and 6-month post-programme stages to establish whether the training was effective and to observe any longer term effects. This entailed content and process evaluations in order to examine how and why participants deemed their training to be effective or ineffective. Quantitative and qualitative data were elicited from all programme participants through survey evaluation forms. In addition, training facilitators provided written feedback on programme delivery in action. Focus group discussions were led by site researchers on the last training session for mental health providers and trainee co-facilitators.

Key Findings

WOMEN'S PROGRAMME

The two most common themes threading through women's expectations of the programme were building their self confidence and looking to the future. There is evidence of a language of optimism and progress rather than victimhood:

'To gain some self esteem by doing the course,' 'To accept what happened and change my future.'

Wellness Recovery Action Plan (WRAP) (Copeland, 1997): this is what carries a sense of meaning or significance for me, this is what inspires me and reminds me of my values: 'children' was the most commonly cited response mentioned by around half the respondents from all countries, followed by family.

The length of time experiencing domestic violence ranged from 5 months to 26 years, with the average being 5 years.

The length of time experiencing mental distress for which GP or mental health providers were consulted ranged from 1 to 16 years. 86% of women from all countries had experienced domestic violence prior to experiencing mental distress. One fifth of women had not sought professional help for mental distress and they were mainly from Greece.

The best aspect about the programme according to cross-national participants was being able to talk about experiences with other women undertaking the programme as well as with the programme facilitators. Having feelings affirmed by the programme also proved valuable.
The least satisfactory aspect about the programme was not having enough time to cover matters in sufficient depth. There was also a wish for programme sessions to be held more often, especially where they had taken place fortnightly rather than weekly.

Self-Esteem Scale (Rosenberg, 1965): to date, responses show that pre-programme scores for women participants had increased on the 6-month post-programme evaluation showing a consistent pattern of enhanced self-esteem.

Aspects that should continue to be delivered: there was consensus that all of the programme was valuable including:

'The understanding it's not our fault.'

Women who experience domestic violence and mental health needs often encounter externally and/or internally imposed blame, and 'the understanding it's not our fault' is a key theme for future strength-based recovery programmes.

MENTAL HEALTH PROVIDERS' PROGRAMME

Aspects you would like to achieve as a result of participating in this programme: participants wished, firstly, to be better equipped to identify and manage cases of domestic violence and, secondly, to have increased awareness of the links between domestic violence and mental health. Cross-nationally there was a thirst for knowledge concerning recognition and detection of domestic violence, how to talk with potential victims including during first contact meetings, how to react upon seeing evident violence, accessing and signposting professional help, legal issues; put succinctly: a desire for 'a framework of intervention in domestic violence'. Mindful to avoid bad practice one participant noted:

'what kind of mistakes I shouldn't make dealing with domestic violence victim'.

Health Care Provider Survey on Intimate Partner Violence (IPV) (developed by Short): interim findings suggest that it is the initial identification of IPV which may prove problematical for some service providers rather than subsequent discussion of abuse with service users. Providers may be hesitant to come to the conclusion of IPV if a woman herself has not disclosed it.

Providers tended to be more confident at the end of the training to deal more effectively with domestic violence and mental health issues. Some suggested providers from different areas of service provision attend the training, such as GPs, therapists and the police, in order to facilitate greater inter-agency working.

CO-FACILITATORS' PROGRAMME

Some women felt they were at the right point to undertake co-facilitator training due to their ability for constructive self-reflection on past experiences:

'I am no longer a victim of domestic violence but a survivor.'

The ripple effect of co-facilitating support groups for women in the future was also anticipated:

'[I] would like to support other women in gaining the support of other women to improve confidence and improve life choices.'

Most participants noted they would use their co-facilitator skills in the future to help others, but there was also recognition of the personal benefits that helping others was a means of 'self empowerment.'

Programme facilitators were commonly seen as supportive which, in the words of one woman, created 'a trusting bond between us as a group', and 'safe conditions' accordingly to another. Developing a sense of trust and safety often carries particular significance for those adversely affected by intimate partner betrayal. Another beneficial aspect of the training was how programme facilitators used various activities to demonstrate group behaviour thereby enabling experiential learning. Additionally conducive to group dynamics was the non-didactic style of training sessions: *'I like that the communication is "two way".'* The training was also alluded to as a foundation on which to build skills for running support groups in the future:

'The programme has been good experience to gain confidence to actually believe you can run a group and you do not have all the answers, but that is ok!'

Some women reported a sense of empowerment having undertaken the training and most had plans, albeit often in embryonic form, to start running groups for women, sometimes in conjunction with the practice organisations through which they had been recruited to the study. While their eagerness to run support groups was grounded in the reality of logistics, such as venue, time, children, transport and cuts to welfare budgets, practical considerations did not diminish their keenness for helping other women.

Interim conclusions

Although additional 6-month post-programme data are due over the coming months, evaluation responses hitherto indicate that training has been a predominantly positive influence for participants undertaking all three programmes across the five partner sites. The finding that the majority of participants wished training to be of longer duration and to cover complex issues in greater depth suggests that programmes are playing an important role in attending to the needs of women and service providers involved in addressing the enduring tandem issues of domestic violence and mental health needs.