Population, Policy & Practice Department
UCL GOS Institute of Child Health
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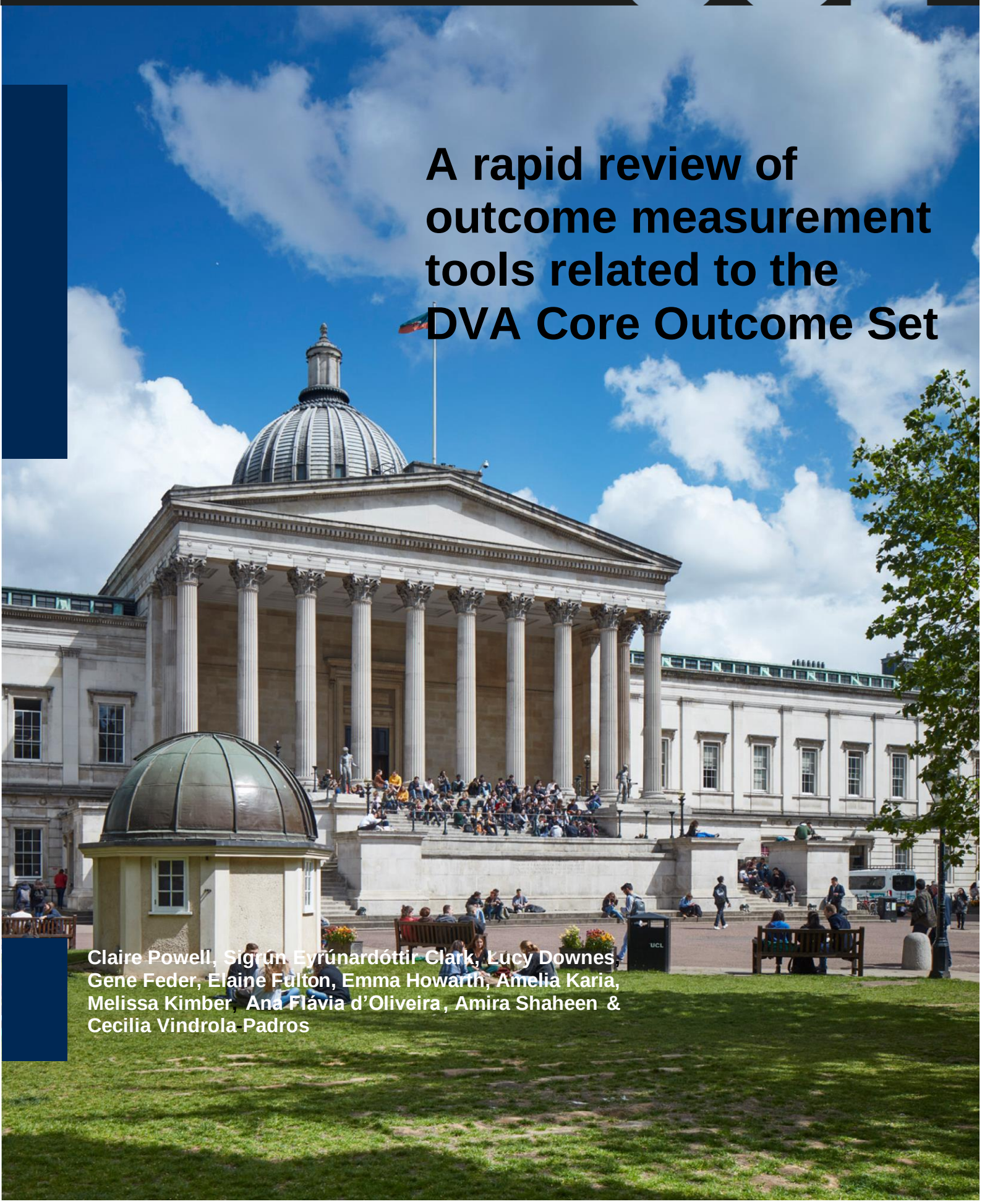
A rapid review of outcome measurement tools related to the DVA Core Outcome Set



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Survivor Advisory Group

Voices survivor panel: ▪ Ursula Lindenberg ▪ Karen Johns ▪ Sridevi Rose ▪ Survivors who wished to remain anonymous ▪ https://www.voicescharity.org/

Executive Summary

Aim

This Home Office funded rapid review aims to provide an understanding of the tools and measures currently being used by practitioners to capture core outcomes for children who are victims and survivors[1] of domestic abuse (DA)[2], both in the UK and internationally. The review provides insight into the practical considerations and suitability of these tools from practitioner, researcher, and victim and survivor perspectives.

Methods

We carried out a four-stage process to identify and assess outcome tools currently used in practice relevant to the domestic violence and abuse core outcome set (DVA-COS) [1]. The stages of the process included A – a review of grey literature and a call for evidence; B – mapping measurement tools to the DVA-COS; C – usability and acceptability assessments; D – an adapted consensus process[3] with two rounds of workshops with the steering group, practitioner group, and survivor advisory group separately to recommend tools based on our usability and acceptability assessments.

Key findings

We identified 163 measurement tools, 55 of which mapped to the DVA-COS. Overall, we identified two types of measurement tools currently in use in practice: 1) 'in-house' DA service tools that are not validated[4]; 2) measurement tools designed in health and wellbeing contexts that are not specific to DA or the DA sector but are more likely to be validated.

Although we found 55 tools that related to the DVA-COS, the consensus from the advisory groups resulted in only one measurement tool being recommended based on our usability and acceptability assessments: the Warwick Edinburgh Mental Wellbeing

[1] We have used the terms victims and survivors throughout this report. Survivors reflects the preference of our advisory group and victim is in line with legislation and guidance. We acknowledge this is contentious and many domestic abuse organisations prefer the sole use of 'survivor'.
[2] We refer to 'domestic abuse' or DA throughout as the UK legal definition includes physical violence.
[3] A consensus process is a research approach which aims to bring different groups of people into agreement on a certain issue.
[4] Validated in this context means a questionnaire has been rigorously tested to ensure it measures what it is designed to measure. We scored tools as validated if they had at least one peer reviewed published validation study using any statistical test of validity such as correlations.

Scale (two versions). This tool maps on to the core outcomes of *Child emotional health and wellbeing* and *Caregiver emotional health and wellbeing.*

Of the 55 tools, there were 37 tools used to measure the core outcomes of *Feelings of safety*; *Freedom to go about daily life*; and *Family relationships*. However, our practitioner and steering groups agreed that none could be recommended for use. Many tools were not DA specific; this was a particular issue for family relationship tools, all of which focused on the interparental relationship without attending to the dynamics of abuse. Victims and survivors, and practitioners felt that these tools might cause harm.

Four key features were identified as important for the future development or refinement of outcome measurement tools. Tools should be *trauma-informed*, provide *space for narrative*, be *accessible* for all needs (including free to use) and clearly *link outcomes to service delivery*.

Recommendations

As a result of the advisory consensus process the use of the Warwick-Edinburgh Mental Wellbeing Scales is recommended for use in practice by DA services, to capture caregiver and child emotional health and wellbeing. This tool would be enhanced by the addition of a comments box for victim and survivor reflections.

We suggest that a full COSMIN (COnsensus-based Standards for the selection of health Measurement Instruments) process is funded to identify (or develop) a set of measurement tools that robustly capture outcomes for the DVA-COS that are acceptable to victims and survivors, practitioners, and researchers.

Any future measurement tools should be developed from a trauma-informed perspective and in collaboration with victims and survivors, and practitioners. If possible, tools currently in use should be reviewed and refined from a trauma-informed perspective to ensure they are not inadvertently causing harm.

Contents

Background and Aims of the Review

Measuring outcomes for child-focused DA interventions

Domestic abuse (DA) is a common form of abuse that can have long term health and wellbeing consequences for children. [2,3] To address this problem, a range of targeted interventions for children and their families affected by DA have been developed for delivery in the UK and abroad. [4,5] However, high-quality evidence for the effectiveness of these interventions is limited. [6,7] Many frontline services do not have the appropriate tools to measure outcomes specific to DA; [8] and even when frontline services *do* measure outcomes or when DA interventions are evaluated as part of research studies, outcomes are often inconsistently measured, making it difficult to compare interventions. [6, 9] Additional evidence indicates that the outcomes selected by researchers as markers of success do not reflect the priorities of DA victims and survivors, service users, or practitioners. [10]

The domestic violence & abuse core outcome set (DVA-COS)

One way to address this challenge is to develop a core outcome set (COS) – a small number of outcomes that service users/victim and survivors, practitioners/service providers, commissioners, policymakers, and researchers agree are the most important tools for measurement in academic research and programme evaluation. [11] When applied widely, COSs are known to improve the quality of evidence by increasing the consistency with which outcomes are measured, and by reducing reporting bias.

As part of another study, we developed a COS for DA interventions (DVA-COS) through a two-year consensus process involving over 300 victims and survivors, practitioners, and researchers. [1,12] The core outcomes identified were *Child emotional health and wellbeing*; *Feelings of safety*; *Caregiver emotional health and wellbeing*; *Family relationships*; and *Freedom to go about daily life*.

However, we did not determine how these outcomes should be measured: an exercise that requires its own consensus process. This report summarizes the processes and results of a Home Office funded project that aimed to identify, describe, and propose measurement tools in each of the DVA-COS domains for use in DA research and practice. [13]

Aims of this review

This review aimed to understand the range of measurement tools currently used in child-focused DA practice which measure any aspect of the DVA-COS. We assessed the usability and acceptability of measurement tools as part of the review.

We used the following definition for domestic abuse based on the Domestic Abuse Act, 2021 'physical or sexual abuse, violent or threatening behaviour, controlling or coercive behaviour, economic abuse, psychological and emotional abuse.' However we focused specifically on DA between parents or carers (also known as intimate partner violence) because our focus was on children affected by DA. Whilst we have used gender-neutral terms for parents and caregivers throughout to reflect the inclusion of interventions that work with both parents or same-sex couples, it is important to acknowledge that women are at most risk of severe and repeated violence perpetrated by men.

Our review questions were:

1) Which tools do the DA sector in the UK and internationally use to measure the outcomes of interventions and services?

2) How do the tools used in the sector map to the DVA-COS (i.e., what is measured and what is not) and where are the gaps?

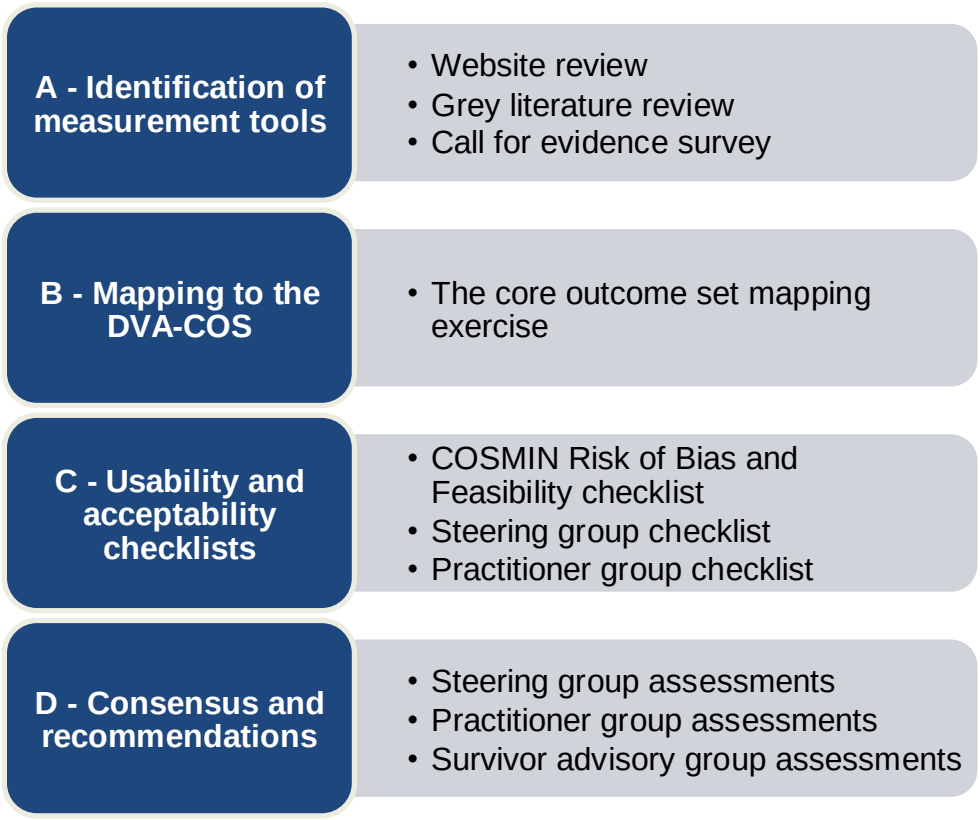
3) What are the current barriers or challenges of attempting to capture outcomes within the DVA-COS framework using available measurement tools?

4) What are the victim and survivor, practitioner, and researcher perspectives in relation to the 'usability and acceptability' of the tools in their measurement of the DVA-COS?

Methods

We followed features of Tricco et al.'s rapid methodology, [14] the Preferred Reporting Items for Systematic Reviews and Meta-Analyses Extension for Scoping Reviews [15] and the COS consensus process. [11] We have made our protocol available on the Open Sciences Framework preprint server (reg no: J3UKC). [16]

Four stage process - Overview



A - Identification of Measurement Tools

Data collection methods

The below eligibility criteria below were developed and adopted.

Inclusion criteria:

- Measurement tools relevant to child-focused domestic abuse interventions (that include support to children and/or parents/caregivers).
- Tools used in practice with families that have experienced DA.

Exclusion criteria:

- Publications from academic journals and reports; instead a focus on what is currently used in practice.
- Reports published prior to 2016.

We identified 163 measurement tools through: 1) grey literature database searches; 2) screening DA organization websites; 3) distributing a call for evidence survey; and 4) following up on expert recommendations.

1) Grey literature: We conducted a systematic search of four grey literature databases using terms for domestic violence and abuse AND families AND outcome measures. A total of 787 articles were identified and systematically reviewed by one researcher (SEC) for title and abstract screening, and another researcher (AK) for full text. The two researchers cross-checked 10% of each other's exclusions (N=736 at title and abstract, N=42 at full text). A total of 17 articles were eligible for inclusion, from which 49 separate measurement tools were identified (see Appendices 1-3 for further details).

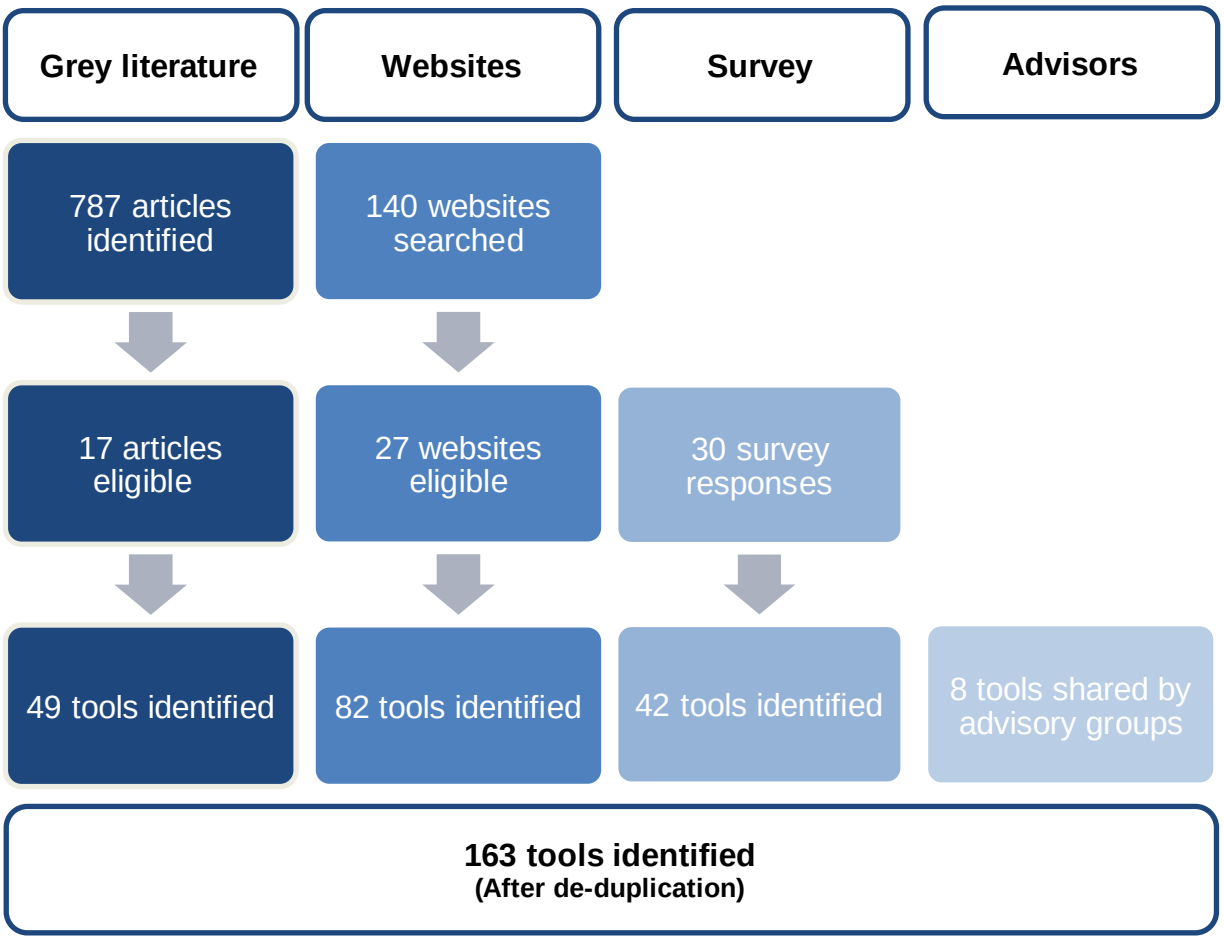
2) Websites: A list of 140 websites were collated due to their relevance to DA, based on recommendations from the practitioner group, steering group, research team and other known contacts from the field. The websites and their publications were then systematically reviewed by two researchers (SEC, AK) using a list of key terms for measurement tools AND domestic violence and abuse. The two researchers cross-checked 10% of exclusions. A total of 27 websites were eligible for inclusion, from which 82 separate measurement tools were identified (see Appendices 4-6 for further details).

3) Survey: A call for evidence survey was developed by the research team in five different languages (English, French, Spanish, Portuguese, and Italian[5]). The surveys were then distributed to contacts of the practitioner and steering groups, the network of stakeholders that developed the DVA-COS, through twitter, and through the Open Science Framework preprint server. There were 30 responses to the survey, spanning English, French, and Portuguese versions. Within the 30 responses, 42 separate measurement tools were identified (see Appendices 7-8 for further details).

4) Expert recommendations: Eight measurement tools were shared by members of the advisory groups (see Appendix 6).

All identified tools were summarized, and 18 duplicates were identified at this stage, resulting in a final list of 163 tools for consideration in our review (see Appendix 9).

Summary of identification process



[5] We selected these languages because we had the translation capacity within the team.

B - Mapping Tools to the Core Outcome Set

Core Outcome Set

The DVA-COS, developed by National Institute for Health and Care Research (NIHR) Children and Families Policy Research Unit, comprises the following five broad core outcomes:

1) Child emotional health & wellbeing

Includes emotions, mood, internalising problems, emotional regulation, emotional security, and emotional numbness.

2) Feelings of safety

Global safety for the non-abusive parent and child, including psychological, physical, bodily safety, safety of family, safety around perpetrator, safety at home, at school, in the community, on social media, from abusive individuals, from child removal, from court proceedings.

3) Caregiver emotional health & wellbeing

Includes emotional functioning, emotional reactions, emotions, emotional self-regulation, control over emotions, ability to connect to emotions, mood, frame of mind, general sense of well-being.

4) Family relationships

Includes overall family relationships and functioning, quality, and type of relationships, feeling closer as a family, family conflict resolution, feeling closer to children, changes after leaving abusive partner; sibling relationships including after separation; child relationship with birth and foster/adoptive families.

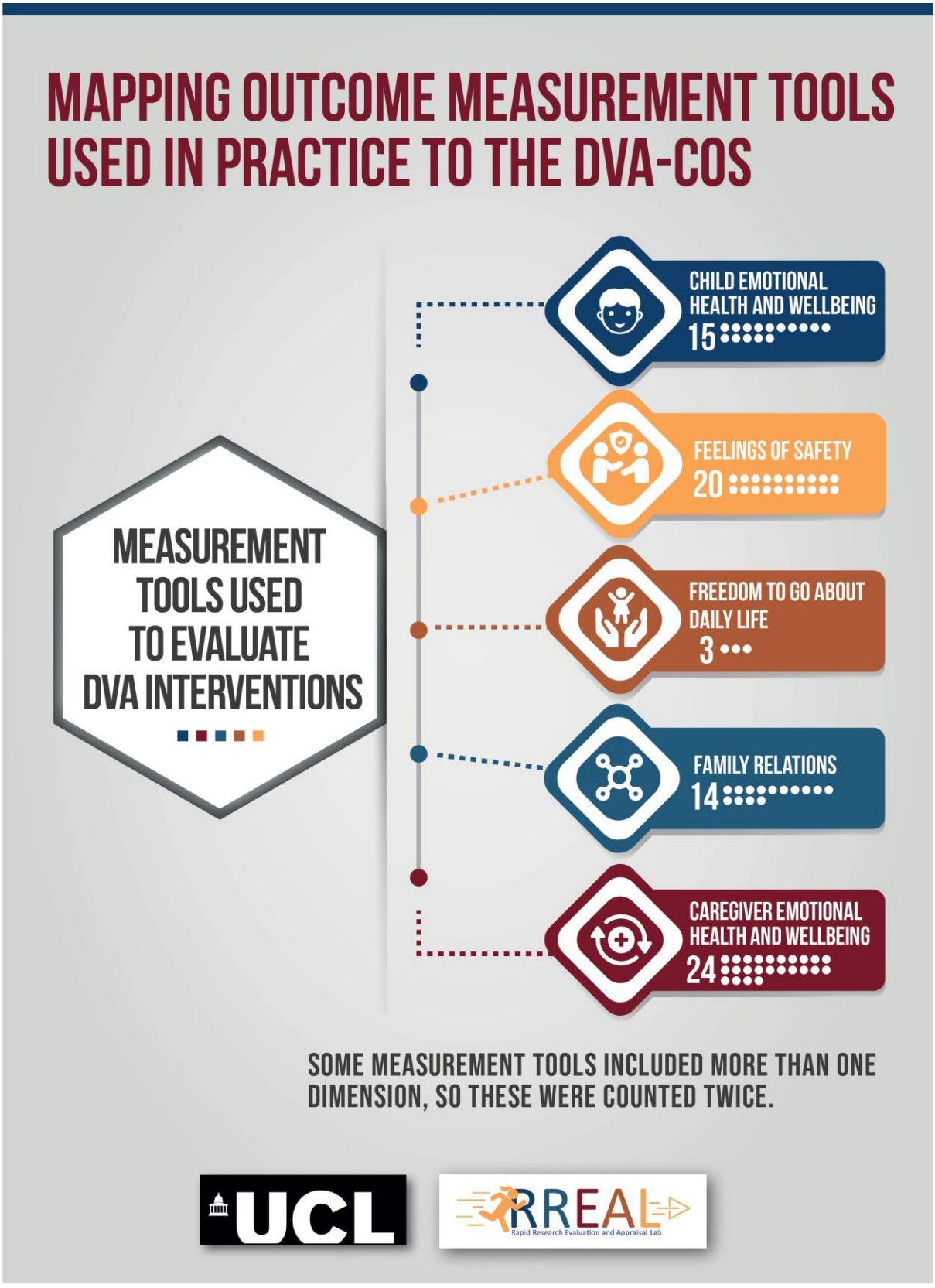
5) Freedom to go about daily life

Includes ability to get home safely from school/ work/ friends/ family, or any aspect of daily life that might have been restricted by DA.

Mapping process

The measurement tools identified were mapped across each of the five core outcomes listed above (see Appendix 10). A total of 55 measurement tools were found to map to at least one core outcome as highlighted in the table and infographic below (see Appendix 11 for more detail).

Infographic of measurement tools and their DVA-COS domains



Summary of measurement tools that map to the DVA-COS

See Appendix 12 for more details on the sources of measurement tools.

Outcome	Measurement tool
Child emotional health and wellbeing	Adolescent Wellbeing Scale
	Child Health Utility instrument (CHU9D)
	interRAI Child and Youth Mental Health Assessment
	Strengths and Difficulties Questionnaire
	Young Persons Clinical Outcomes in Routine Evaluation (CORE)
	Apgar score
Caregiver emotional health and wellbeing	Adult Wellbeing Scale
	Clinical Outcomes in Routine Evaluation Outcome Measure (CORE-OM)
	Emotional Awareness Questionnaire
	Impact of Events – Revised Scale
	Psychological Wellbeing Scale
	Quality of Life Index
	Kessler Scale of Psychological Distress
	Visual Analogue Scales (VAS) thermometer
	Outcome Rating Scale
	Patient Health Questionnaire-9 (PHQ-9)
	Generalised Anxiety Disorder-7 (GAD-7)
	WHOQOL-BREF (abbreviated version of the World Health Organisation Quality of Life-100 assessment)
	Depression Anxiety and Stress Scale
	Emotional Regulation Questionnaire
Family relationships	Co-Parenting Relationship Scale
	Maternal Antenatal Attachment Scale
	Maternal Postnatal Attachment Scale
	Parent-Child Relationship Inventory
	Parenting Alliance Measure
	Paternal Postnatal Attachment Scale
	Dyadic Adjustment Scale

	Evaluation and Nurturing Relationship Issues, Communication and Happiness (ENRICH) Marital Satisfaction Scale
	Prenatal Attachment Inventory
	Experiences in Close Relationships-Revised
	Relationship Dynamics Scale
	Relationship Questionnaire
Freedom to go about daily life	World Health Organization Disability Assessment Schedule (WHODAS)
Feelings of safety	*Danger Assessment questionnaire**
	*Domestic Abuse, Stalking, Harassment and Honour based violence (DASH) risk assessment**
	*Domestic Violence Intervention Programme (DVIP) evaluation tool**
	*Impact toolkit**
	*Measure of Victim Empowerment Related to Safety (MOVERS) scale**
	*Identification and Referral to Improve Safety (IRIS) – service user feedback form**
Multiple outcomes	Outcome Stars
	Warwick-Edinburgh Mental Wellbeing Scale and Short Warwick-Edinburgh Mental Wellbeing Scale
	*Asian Women's Resource Centre User – evaluation forms**
	*Domestic Violence Survivor Assessment**
	EQ5D/ EQ5DY (EuroQol 5 Dimensions of health)
	*Her Centre – exit and follow up survey**
	*Insights tool**
	Ipsos Mori Family survey
	*On Track**
	*Personal Outcomes and Wellbeing Records (POWeR) forms**
	*Rainbow Dial**
	*Space for Action**
	Havering Indicators of Need Matrix tool
	*Barnardo's Domestic Violence Risk Identification Matrix (DVRIM)**
	Havering neglect tool
	*Project Mirabal Interview guide**

Table 1. The list of 55 measurement tools that mapped to each DVA-COS domain
**Measurement tools that have a DA focus*

C - Usability and Acceptability Assessment

Usability and acceptability assessment process

A series of four checklists were developed to assess the usability and acceptability of the identified measurement tools. A summary of the checklists can be found below.

- Steering group checklist: developed based on workshops with the group of 6 researchers and practitioners listed on page 2, to identify the aspects they deemed most important for any tool in the DA field.

- Practitioner group checklist: developed based on workshops with the group of 7 practitioners listed on page 2, to identify the aspects they deemed most important for any tool in the DA field.

- COSMIN (COnsensus-based Standards for the selection of health Measurement Instruments) Risk of Bias (RoB) checklist: developed based on an amended version of the COSMIN Risk of Bias checklist for Patient Reported Outcomes. [17]

- COSMIN feasibility checklist: developed based on an amended version of the COSMIN feasibility guidelines. [13]

Detailed information about the criteria through which the measurement tools were assessed can be found in Appendices 13-16. Our initial aim was to develop a victim and survivor checklist to sit alongside the other checklists; however, the time constraints of the project forced us to adopt a different approach. To inform a possible future checklist, we collected narrative commentary from victims and survivors on preferred measurement tools.

Summary of scores

A summary of the scores for outcome areas can be seen in the table below (further details of scores can be found in Appendix 17). Across all outcome areas, practitioner advisory scores were usually the lowest; this was due to this checklist's focus on narrative data collection, a feature that was included in few of the tools. Research-focused tools were more likely to have been psychometrically validated compared to tools that were developed within DA services/programmes; thus, research-focused tools tended to score higher on the COSMIN RoB checklist.

The steering group checklist and the practitioner group checklist scores were combined to identify the top 50% of the total 55 tools identified (Appendix 17). The COSMIN RoB and feasibility scores were not included at this stage because the

steering group checklist also accounted for psychometric robustness and most DA-specific tools would have been excluded based on psychometric criterion. The COSMIN RoB and feasibility scores were still used by the steering group to guide them in their recommendations on tools.

Professional groups and COSMIN scores

The professional group scores were based on the steering group checklist and the practitioner group checklist. The COSMIN scores were based on adapted versions of the COSMIN RoB checklist and the COSMIN feasibility checklist. Both COSMIN checklists were developed by the COSMIN research body to assess and thus identify appropriate outcome measurement instruments in practice. However, since these checklists were heavily based on use in systematic reviews; and as our research used rapid review methods; the checklists were adapted. Details can be found in Appendices 13-14.

The table below shows the average and the range of checklist scores for the tools that fell under each outcome area listed below. Each checklist had a total possible score of 1.

Outcome	**Steering group** Avg (Range)	**Practitioner group** Avg (Range)	**COSMIN RoB** Avg (Range)	**COSMIN feasibility** Avg (Range)
Child emotional health and wellbeing	0.81 (0.54-0.96)	0.25 (0.06-0.50)	0.68 (0.00-0.94)	0.70 (0.50-1.00)
Caregiver emotional health and wellbeing	0.92 (0.80-1.00)	0.24 (0.00-0.37)	0.78 (0.38-1.00)	0.80 (0.50-1.00)
Family relationships*	0.87 (0.60-0.98)	0.21 (0.10-0.25)	0.70 (0.00-0.88)	0.67 (0.50-0.75)
Freedom to go about daily life	0.95 *(only 1 tool assessed)*	0.30 *(only 1 tool assessed)*	0.88 *(only 1 tool assessed)*	0.50 *(only 1 tool assessed)*
Feelings of safety*	0.66 (0.48-0.92)	0.45 (0.30-0.60)	0.40 (0.00-0.81)	0.62 (0.25-0.75)

Multiple outcomes*	0.51 (0.26-0.91)	0.30 (0.13-0.58)	0.21 (0.00-1.00)	0.42 (0.00-1.00)

Table 2. The average and range of checklist scores of measurement tools that fell under each DVA-COS domain

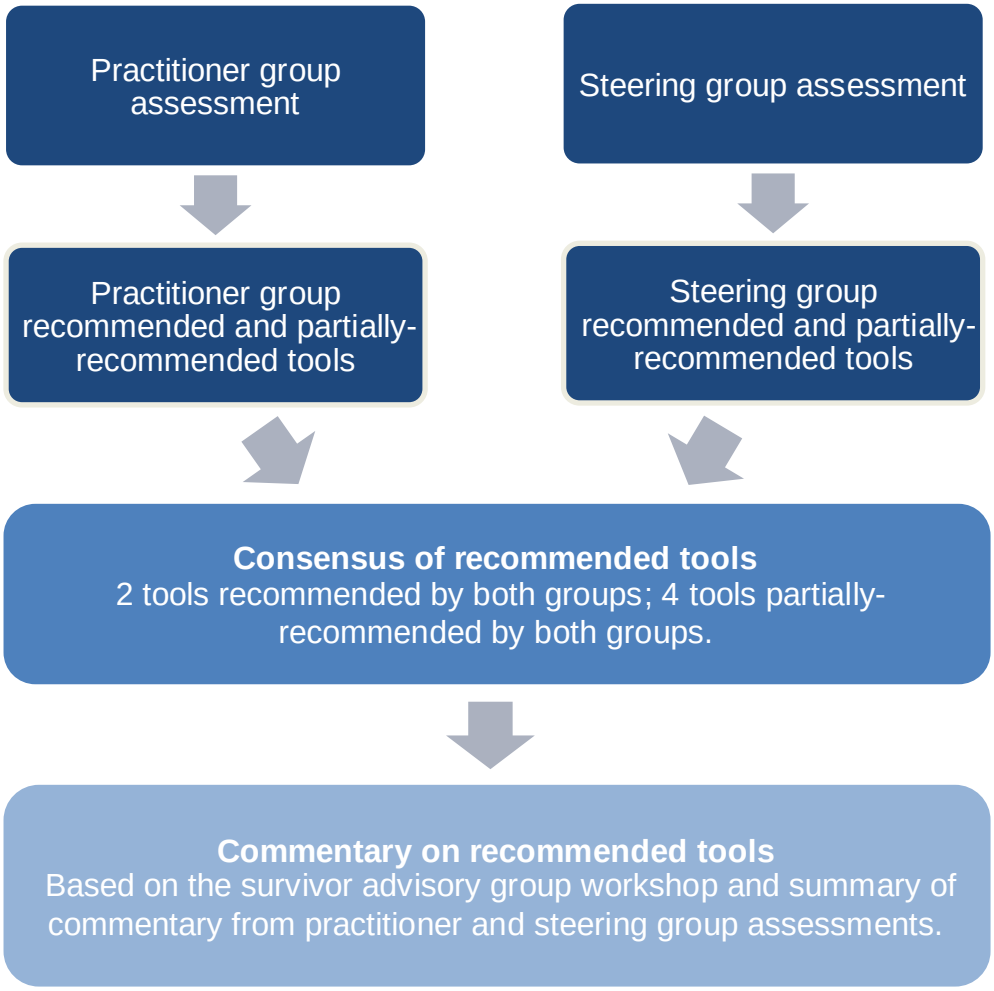
*Tools were excluded if we were unable to access a full version of the tool and complete our data extraction (Family relationships – 2 tools with missing data; Feelings of safety – 2 tools missing data; Multiple outcomes – 2 tools missing data).

D - Consensus and Recommendations

Assessment of top-rated tools

Once the top 50% of rated tools had been identified (Appendix 17), the practitioner group and steering group were asked to review these tools during independent workshop sessions facilitated by the research team. Each group was asked to review and discuss checklist scores, as well as the parameters of each tool, and to make a recommendation for or against each tool. The recommended tools were then shared with the survivor advisory group for further commentary. The original study design included a victim and survivor checklist, and victim and survivor input into the recommendations; however, we were forced to adapt the process due to unforeseen delays. Unfortunately, this meant we were only able to include victim and survivor input at a later stage.

A summary of this process can be seen below.



Consensus for recommended tools

Consensus was reached for the tools if they were recommended by both the practitioner group and the steering group. A small number of tools were 'partially recommended' i.e., one group recommended the tool, and the other group was unsure. A summary can be seen below and in Appendices 18-19.

Recommended	Child EH&W	Caregiver EH&W	Feelings of Safety	Multiple outcomes
Both groups	SWEMWBS (0.95/0.31/1.63)	WEMWBS (0.98/0.30/1.75)	-	-
Partially	-	ORS* (1.00/0.20/1.63) AWS† (0.85/0.32/1.63)	MOVERS* (0.92/0.35/1.56)	Rainbow dial* (0.65/0.58/0.50)

Table 3. The measurement tools that fell under each DVA-COS domain that were either recommended or partially recommended
(Total possible score = Steering group (1) / Practitioner group (1) / COSMIN checklists (2))
*Recommended by practitioner group, partially-recommended by steering group
†Partially-recommended by practitioner group and by steering group
EH&W – Emotional Health and Wellbeing; SWEMWBS – Short Warwick Edinburgh Mental Wellbeing Scale; WEMWBS – Warwick Edinburgh Mental Wellbeing Scale; MOVERS – Measure of Victim Empowerment Related to Safety Scale; ORS – Outcomes Rating Scale; AWS – Adult Wellbeing Scale

No tools were recommended or partially-recommended under the following core outcomes:

- *Family relationships*
- *Freedom to go about daily life*

Tools that mapped onto these outcomes were not generally DA specific, thus groups judged them as unsuitable to be used in the context of child-focused DA interventions. There were concerns about increasing the risk of harm when using a family relationship measurement tool that focused on the interparental relationship without attending to the dynamics of abuse.

Further details for recommended tools

Further information about the licencing requirements, training requirements and methods of tool development can be found below and in Appendix 20.

Details	SWEMWBS	WEMWBS
Licensing	Copyrighted. Registration required but free for non-commercial organisations. [18]	Copyrighted. Registration required but free for non-commercial organisations. [18]
Training	*None required.	*None required.
Development	Based on the WEMWBS and assessed in 11–16-year-old students in Wales and was suggested as appropriate for tracking the development of wellbeing across adolescence. [19]	Developed by an expert panel in 2007 drawing on current academic literature, qualitative research with focus groups, and psychometric testing. [20]
Language and cross-cultural applications	Available in six languages. [21] Validated in Danish population. [22]	Available in 25+ languages. [23] Validated in four cross-cultural validation studies. [24-27]

Table 4. Further details on the tools that were recommended by both steering and practitioner groups
*NB practitioners highlighted that whilst training is not formally required, supervision and support is needed to ensure the tool is used sensitively.

Victim and survivor commentary on recommended tools

Recommended tools

The SWEMWBS and WEMWBS, recommended by both professional groups, were reviewed by the survivor advisory group. Victims and survivors reflected that they appreciated the positive wording of the tools, their clarity, and their brevity.

A key concern raised by victim and survivors was that neither tool is trauma-informed. More specifically, the group identified specific wording that could be emotionally difficult for child or adult victims and survivors of DA, for example being asked about feeling 'useful' (see Appendix 21 for full details). The child version (SWEMWBS) was seen as including inaccessible language which would be a barrier to use. (This is in line with previous research suggesting it should be used with children over the age of 11). [19]

In addition, the survivor advisory group felt strongly that any measurement tools should have comment boxes so that service users could explain their responses, should they wish to do so. Comment boxes were judged as useful for several reasons: 1) they provide a more meaningful record of the context of responses; 2) narrative responses are more useful when looking back at change over time; 3) they could help explain why an item was scored a certain way. The third point was seen as especially relevant if data from the tool were to be used in court cases.

Finally, both tools were critiqued for their inaccessibility for children or adults who may have additional needs including cognitive difficulties, learning disabilities, no or low levels of literacy, nonverbal communication requirements, or English as an additional language. It is clear further adaptations are needed; however, the SWEMWBS has been used in populations with autism spectrum disorder (ASD) and attention deficit hyperactive disorder (ADHD)/ attention deficit disorder (ADD). [28] In addition, the WEMWBS has been cross-culturally validated in minority ethnic groups living within the UK. [25] More detail on comments and concerns about these two tools can be found in Appendix 21.

Partially-recommended tools

The four partially-recommended tools (based on steering group and practitioner group discussions) were reviewed by the survivor advisory group and their main concerns are summarised below. See Appendix 21 for full details.

Measure	Survivor advisory group
Outcomes Rating Scale (Caregiver emotional health and wellbeing)	+ Covers important aspects of wellbeing - Measurement scale unclear - Visually daunting

Adult Wellbeing Scale (Caregiver emotional health and wellbeing)	- Too repetitive and too much text - Clinical, pathologizes anger and dismisses feelings - Concerns about how information would be used in court
MOVERS (Feelings of safety)	- Negatively worded and very complex - First question around safety is triggering - Places responsibility/blame on individual
Rainbow Dial (Multiple outcomes)	+ Colour and visual aspect good - Scale is confusing - Statements are too broad - Unvalidated tool

Table 5. Survivor advisory group feedback on the tools that were partially-recommended by the steering and practitioner groups

Additional measurement tools assessed as usable by victims and survivors

Following discussions with the survivor advisory group about their ideal outcome tools, three key factors were highlighted as important, but currently lacking in the available tools:

- Free text options, to allow narrative data collection.
- Use of understandable language or emojis that are child-friendly and can support individuals with low levels of literacy or English as an additional language.
- Questions that link outcomes to service delivery e.g. 'I feel safe because of the intervention' rather than just 'I feel safe'.

The three tools meeting these criteria were service-specific measurement tools that did not score highly enough on the checklists to be reviewed. Instead, we presented them to the survivor advisory group as additional tools for comments. These tools did not meet the threshold for review for various reasons, including: 1) lack of cultural applicability assessments, 2) lack of availability in other languages, 3) proprietary restrictions, and 4) no assessments of reliability or validity.

- Asian Women's Resource Centre evaluation form (related to 'caregiver emotional health and wellbeing' and 'feelings of safety').

- IRIS service user feedback form (related to 'caregiver emotional health and wellbeing' and 'feelings of safety').

- POWeR forms (Women's Aid) (related to 'caregiver emotional health and wellbeing' and 'feelings of safety').

The survivor advisory group rated all three tools positively, providing some minor feedback. In terms of psychometric validation, the Asian Women's Resource Centre evaluation form and the IRIS service user feedback form have not been validated. The POWeR form is based, in part, on the WEMWBS; thus, validation studies from the WEMWBS are relevant. Further details on these three tools can be found in Appendix 22.

Summary of practitioner commentary

Practitioners emphasised their need for tools to be useful in the context of a therapeutic session, and not just to measure outcomes. Usable tools were those with a balance between quantitative information and narrative, and tools that were both clear and visually appealing. The group emphasised that different versions of the tools might be needed at different times (e.g., during a crisis vs. one year after abuse has ended) and for people with different needs (e.g., cognitive difficulties, learning disabilities, no or low levels of literacy, nonverbal communication requirements, or English as an additional language). There was concern about whether tools were relevant for minoritized groups and whether adaptations or entirely different tools would be needed in those circumstances

Practitioners stressed the importance of measurement tools that are easy to use and have clear practical guidelines. They also highlighted the importance of ongoing support and supervision for practitioners using tools in the context of their session with victims and survivors because they are part of the therapeutic process. Discussions highlighted that some victims and survivors wish to access practitioners outside of their community for confidentiality reasons, and this also applies to completing outcome measures with practitioners. Furthermore, some practitioners might be put at risk if victims and survivors are disclosing to them in unstable or politically charged contexts such as war zones. These wider considerations would need to be part of any manual or guide.

Practitioners expressed concerns about the use of tools that are not sensitive to the dynamics of abuse or that inadvertently place responsibility for abuse on the child or non-abusive partner through question wording. There was some debate about the use of risk assessments to measure the outcome of 'feelings of safety'. Whilst practitioners emphatically approved of risk assessments, such assessments were not felt to be suitable to measure the impact of an intervention.

The call for evidence survey identified general challenges around outcome tools, emphasising the burden for service providers and victim and survivors – namely, the time needed to complete tools and the time needed to analyse the results. Practitioners explained that they preferred self-designed tools that reflected the nuances of specific interventions because standardised tools may not always reflect holistic ways of working. Practitioners favoured tools that could demonstrate individual distance travelled and the specific type of support provided, and they emphasised the need for diverse forms of monitoring to meet the diverse needs of their clients. Finally, some practitioners discussed the difficulties arising when stasis (i.e., a lack of change in outcomes) was in fact due to problems with other services or external factors.

Detailed comments can be found in Appendices 18, 19 and 23.

Conclusions

This review is a first step towards determining measurement tools by consensus for the DVA-COS. We have identified practitioner and victim and survivor priorities (and the differences between them) as well as one measurement tool that is acceptable to both practitioners and victims and survivors.

Types of tools used in practice

This review has identified two types of outcome measurement tools currently used in DA practice:

- DA-specific, in-house designed tools. These do not tend to be psychometrically validated, but they often include service feedback in addition to individual outcome questions.

- Broader health and wellbeing tools. These are more likely to be psychometrically validated, however they have not generally been designed for the DA context. Their integration into the DA sector needs to be carefully considered alongside the possibility of increasing the risk of harm, including the potential to trigger a trauma response.

There were 55 tools that mapped to the DVA-COS, however, few of these were assessed as usable by practitioners in a therapeutic context. Those tools that were psychometrically valid and reliable were less likely to be judged as acceptable by both victim and survivors and practitioners.

Recommended tools

The only measurement tools recommended as usable and acceptable from this adapted consensus process are the Warwick-Edinburgh Mental Wellbeing Scale and the Short Warwick-Edinburgh Mental Wellbeing Scale which map on to the caregiver and child emotional health and wellbeing core outcomes respectively. There were no recommended tools for the remaining three core outcomes.

There were four measurement tools that were partially recommended as usable and acceptable, and three measurement tools identified as fulfilling victim and survivor priorities. These measurement tools may benefit from further refinement and validation; however, we would not suggest using resources to do this before a complete review of measurement tools has occurred (i.e., including those used in research and related trauma-informed interventions).

Summary of key features for measurement tools

Through consultation with practitioners and victims and survivors, there are four key features that need to be considered for future development or refinement of measurement tools. Full details of all recommendations and commentary can found in Appendix 23.

Trauma-informed

Victims and survivors highlighted the challenges they face using tools that have not been designed by victims and survivors or for the DA context. Victims and survivors explained that until they are in places of relative safety, it can be very difficult to complete questionnaires or answer questions about health or wellbeing. This needs to be considered when outcomes are measured at a time when victim and survivors are still in situations of danger (and even afterwards too).

It was clear that many mainstream tools have inaccessible wording, or wording that could trigger a trauma response. Victims and survivors indicate that clear and positive wording is important, as is the order of the questions. In addition, victims and survivors suggest that the first item should not assess difficult topics, and the last item should point towards self-care or other support avenues. Any items that might lead to safeguarding concerns (e.g., around harm to self or others) need to be highlighted so that victims and survivors can decide whether to answer. There needs to be transparent communication and processes that are safe and developmentally appropriate, about what happens if adults or children choose to answer safeguarding-related items.

The survivor advisory group also suggested that measurement tools might need adapting for different points in the victim and survivor journey, for example if someone is still living with the perpetrator or co-parenting with the perpetrator. Sensitivity needs to be used by practitioners using measurement tools that refer to children if women have lost children (either through miscarriage or the family courts) and similarly practitioners might need to adapt tools when victims and survivors are going through court processes.

DA definitions need to be kept up to date as broader understanding in the field of DA expands and as legislation changes. For example, coercive control is now a recognized feature of DA and should be incorporated into definitions and related measurement tools. Knowledge about the dynamics of abuse is crucial to the development and implementation of any relationship-based measure. The key criticism of relationship tools was that they were inappropriate, and potentially harmful, because they had been developed for marriage counselling or to resolve relationship conflict.

The possibility that outcomes data may be shared, particularly in court processes, was flagged as critical for victims and survivors. Victims and survivors need to know exactly how outcome data will be used and by whom, including whether/how personal and special category data will be pseudonymised or anonymised before use. Finally, both victims and survivors, and practitioners emphasised that staff using trauma-informed

measurement tools inappropriately can still cause harm to victims and survivors. Staff need appropriate training and support to ensure they do not inadvertently cause distress.

Space for narrative

Practitioners and victims and survivors both felt that any tool that incorporates ratings or scores should include space for comments. Comments would enable victims and survivors to record relevant details about their context, which was felt to be very important in the DA sector. These comments could also be used to understand any change that had taken place over time. Narrative was regarded as a more meaningful way to capture this for individuals than ratings scales. Whilst practitioners were keen to input their own observations, victims and survivors expressed a wish for this to be done collaboratively with them to safeguard against any misinterpretations that could later be used against them in court. This highlights the importance of mixed methods (i.e., qualitative, and quantitative) measurement of outcomes.

Accessibility

Victims and survivors and practitioners emphasised that different versions of tools need to be developed that are accessible to: children of different ages; adults and children with varying levels of literacy, adults and children with nonverbal communication requirements and/or cognitive difficulties; adults and children with disabilities; and adults and children speaking different languages. Translation was not seen as sufficient; concepts in any outcome tool need to be assessed for potential cultural adaptation. Finally, both victim and survivors, and practitioners wanted tools to have options for both self-reporting and practitioner delivery.

Linking outcomes to service delivery

The survivor advisory group felt strongly that individual outcomes should be linked to service delivery or the intervention (i.e., questionnaire statements might be ‘I feel safe because of the intervention’ rather than just ‘I feel safe’). Although there are validated patient satisfaction questionnaires in use in healthcare settings, none of the DA tools we reviewed that measured satisfaction with services were validated. In terms of validated tools more generally, there tends to be a separation between Patient Recorded Outcome Measures (PROMs) and Patient Recorded Experience Measures (PREMs).

Practitioners highlighted that a standardised service feedback tool linking outcomes and experience could be problematic for two main reasons: 1) it might not capture the nuances of different services; 2) for interventions that connect victims and survivors with wider services or that are effective as part of a wider system, linking outcomes with single service delivery might not reflect the complexity of how the intervention works. This requires further exploration; however, a recent evaluation of domestic abuse services asked victims and survivors whether they attributed their change to the service, so this might be a useful approach. [29]

Recommendations

1) We recommend the use of WEMWEBS and SWEMWEBS for capturing caregiver and child emotional health and wellbeing outcomes.

    - This measurement tool is widely used in practice by Women's Aid and in a recent evaluation of Women's Aid and SafeLives, [29] so it is already familiar to the sector.

    - A comment box can easily be added, and this would improve acceptability for victims and survivors, and practitioners.

    - Victims and survivors recommended minor changes in wording; these could perhaps be used by practitioners implementing the tool and a study could be funded to see whether these changes affect the tool psychometrics.

    - Further work is needed to adapt this tool for children under 11 years old.

2) In the long term we recommend the funding of a comprehensive review of tools, and the full COSMIN process, to develop a set of recommended tools for the DVA-COS, in particular for the remaining three outcomes, and for younger children's emotional health and wellbeing.

    - This would involve reviewing measurement tools used in research (in addition to those used here), and potentially measurement tools used in related areas of trauma-informed practice. Broadening the scope would hopefully enable tools to be found that could be refined or adapted.

    - As part of this process, in-house tools that are acceptable to practitioners and victims and survivors could be validated and tested for reliability; this would bridge the gap between acceptability and validation. From this review, Asian Women's Resource Centre evaluation forms, IRIS and POWeR forms, and Project Mirabal interview schedules seem promising, although these would need to be reconsidered within a wider review of measurement tools.

3) Until a full suite of DVA-COS tools is developed, we suggest that future funded interventions collect outcomes from the DVA-COS and measure them using their own existing tools (apart from where WEMWEBS and SWEMWEBS can be used).

    Interventions could be asked to report the details of the measurement tools they have used and their advantages and disadvantages in a standardised template. This data could be used in future development of consensus around measurement tools for the DVA-COS.

4) Future and current tools should be developed or improved from a trauma-informed perspective. Ideally, development, validation, and evaluation processes would be a collaborative process with victims and survivors, and practitioners. Tools should:

   - Be evaluated for their acceptability, feasibility, and psychometric robustness.

   - Have multiple versions, allowing for data collection from children and adults with a range of cognitive, developmental, and language abilities.

   - Be reviewed and developed with and for minoritised groups, including but not limited to: families living in poverty, ethnic minority families, and families with insecure immigration status.

   - Be selected in agreement with victims and survivors, and practitioners, given their differing perceptions of 'usability' and the extent to which many measurement tools currently do not meet victim and survivor, or practitioner needs.

5) Any measurement tools in use need periodic review and updating to ensure they reflect the current state of knowledge, understanding, and legal status of DA.

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