Department of Health

Responding to domestic abuse

A resource for health professionals

Acknowledgements

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Foreword

Domestic abuse is appalling in its toll on the people and families affected. More than 2 million people over 16 years old in England and Wales suffer domestic abuse in some form every year. That is 1 in 4 women and 1 in 6 men. The children who are trapped seeing and hearing the abuse are also deeply affected.

We know that most often it is our health services through GPs, health visitors, midwives, emergency departments, ambulance and sexual health clinical staff who are the first point of contact for people suffering from abuse. Best estimates suggest that at the very least, domestic abuse costs the public services heavily, £4 billion each year with the NHS bearing almost half of this cost.

We also know that people experiencing domestic abuse want help but feel that they cannot speak out. Many drop hints when using health services, because they trust the staff to pick it up and probe sensitively. This trust is crucial and shows that health professionals have the opportunity to play a pivotal role in people's lives.

With proper information and tools we can help all health professionals to feel confident and supported on this crucial issue, so that routine enquiry into domestic abuse becomes a fundamental part of the skills and practice of every health professional. This Resource adds to the support we want to put in place to make sure health professionals are not afraid to ask the right questions.

If we are to end the cycle of abuse, it is also important to work with people who perpetrate domestic abuse to ensure that they get the help they need to stop.

Much has changed since the Department of Health published *Responding to domestic abuse: a handbook for health professionals* in 2005. The evidence on the impacts of domestic abuse continues to grow. NICE has also published guidance. This updated Resource also speaks to commissioners of services as well as those who manage the services. We all need to play our part, if we are to make a reality of the Government's ambitious aim in *Ending Violence against Women and Children*, and rid our society of this scourge against people.

I welcome *Responding to domestic abuse: a resource for health professionals*. I trust it will add to the practical insight and tools that health professionals need in order to work effectively with patients and clients, to improve their lives and wellbeing.

Nicola Blackwood MP

Parliamentary Under Secretary of State for Public Health
and Innovation

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Introduction

Responding to Domestic Abuse: A Resource for Health Professionals, aims to support continuing improvement in the response from health and care services and allied healthcare partners. Drawing on the NICE multiagency guideline on Domestic Violence and Abuse, this resource looks at how to support adults and young people over 16 years old who are experiencing domestic violence and abuse, and dependent children in their households. It replaces *Domestic Violence: A Resource Manual for Health Care Professionals* (2006) and *Improving Safety, Reducing Harm: Children, Young People and Domestic Violence – a Practical Toolkit for Front-line Practitioners* (2010).

The resource includes pointers to help practitioners identify potential victims, initiate sensitive routine enquiry and respond effectively to disclosures of abuse. There is a new section on dealing with perpetrators of domestic abuse and violence.

The resource is for all NHS staff, including staff in NHS commissioned services. Staff in partnership agencies who work with adults and children will also find it helpful. Commissioners will gain insight into services to support people experiencing domestic violence and abuse, and the importance of local strategic planning being joined up to deal successfully with this most common form of hidden harm to women.

Section 1: Using the resource

Domestic violence and abuse is so prevalent in our society that NHS and other provider staff will be in contact with adult and child victims (and perpetrators) across the full range of health services.

The NHS spends more time dealing with the impact of violence against women and children than almost any other agency. The NHS is often the first point of contact for women who have experienced violence.[1]

Working in a multiagency partnership is the most effective way to respond to domestic abuse at an operational and strategic level. Initial and ongoing training and organisational support and supervision are essential.

The cost of domestic abuse, in both human and economic terms, is so significant that even marginally effective interventions are cost effective.

This resource is divided into four key sections to enable users to go straight to the parts relevant to their work and interest. It is supported by more detail in the annexes. Each section is prefaced by the relevant recommendations from the National Institute for Health and Care Excellence (NICE) guidelines and quality standard on domestic violence and abuse.[2,3]

- For all users, Section 1 provides important information about the legal and policy contexts of domestic abuse in England. Valuable background information about the impact and issue of domestic violence and abuse are at Annexes A and B.
- Section 2 speaks to commissioners about how their decisions can enable the integrated care pathways necessary to deliver safe and effective responses.
- Section 3 targets the organisations and managers providing services; they have a vital role in shaping service delivery to be responsive to disclosure and subsequent support.
- Section 4 focuses on what practitioners need to know and do.
- Section 5 is dedicated both to the practitioner's response to disclosure of perpetration and what commissioners can do to ensure that the right pathway and services are in place locally.

The needs of children and young people under 18 years old as witnesses and victims of abuse, and those over 16 years old in abusive partner relationships, are covered throughout the resource.

1.1 About this resource

- The aim of this resource is to support continuing improvement in the health service response to domestic abuse.
- It includes actions to take to support adult victims and protect young people over 16 years old who are in abusive partner relationships.
- It includes actions to protect dependent children from neglect and harm that may result from parental experiences of domestic abuse.
- The resource is for all NHS staff and those providing services funded by the NHS. It may also be helpful to social care staff working with young, vulnerable or older people.
- It is designed to be used to inform health and social care professional practice as well as local commissioning and operational planning.

1.2 Definition

It is clear that victims of domestic abuse are not confined to one gender or ethnic group. The Government's definition of domestic abuse includes so-called 'honour-based' violence, female genital mutilation (FGM) and forced marriage. However, this resource does not cover FGM. There is separate national guidance on this issue.[4]

Domestic violence and abuse[5]

Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been, intimate partners or family members regardless of gender or sexuality. The abuse can encompass, but is not limited to:

- psychological, physical, sexual, financial, emotional.

Controlling behaviour

Is a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.

Coercive behaviour

Is an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish or frighten their victim.

Terms

- This resource uses the terms 'domestic abuse' and 'domestic violence' interchangeably in all cases, reflecting the fact that the abuse is not only physical.
- Where information and statistics on 'domestic violence' have been used, that terminology has been retained.
- Domestic abuse is a gendered issue largely affecting women but men and younger people also experience it.
- A study based on reports to police (taking account of context and consequences, and reflecting the view that domestic violence is a pattern of behaviour over time) found that only 5% of cases involved female perpetrators in heterosexual relationships.[6]
- Women and girls are more likely to experience repeated physical violence, a greater severity of violence, increased sexual violence, higher levels of coercive control and greater fear of their partners.
- This resource anticipates that professionals will respond according to the needs of all victims, regardless of their gender and sexual orientation, and will take appropriate, informed account of individual needs, including all human rights and equality protected characteristics.[7]

The terms 'abuser' and 'perpetrator' are used interchangeably and refer to males and females. However, most perpetrators are male.

1.3 Legal and policy context

Rights

This resource draws directly on UK legislation and policy to improve professionals' confidence that they are following the best practice in welfare terms and will be acting in accordance with UK law, including the Human Rights Act 1998 and the UN Convention on the Rights of the Child (UNCRC).[8] Article 8 of the European Convention on Human Rights (ECHR), brought into domestic law by the Human Rights Act 1998, allows the State to intervene in private and family life to protect the health, rights and freedoms of victims and prevent disorder or crime. The UNCRC directs the State to promote children's development, protect them from abuse and neglect, and promote their recovery.

Criminal law

English criminal law criminalises domestic violence through offences that also apply in non-domestic contexts such as: common assault; battery; assault occasioning actual bodily harm; wounding with intent to cause grievous bodily harm; sexual assault; rape; and harassment. Examples of offensive behaviours are given below and are also categorised at Annex A.

Some examples of behaviours that are potential offences

- constant unreasonable criticism – harassment, actual bodily harm
- throwing crockery, even if it misses the target – common assault, actual/grievous bodily harm, wounding, criminal damage, affray (fighting in a public place), threatening behaviour
- numerous phone calls to check someone's whereabouts – harassment, false imprisonment
- punching, slapping, pushing, kicking, head-butting, and hair pulling – common assault, actual/grievous bodily harm, wounding, attempted murder
- harming or neglecting a child – child cruelty
- preventing someone from having a fair share of the household money
- stopping someone from seeing friends and relatives
- repeatedly belittling to the extent of making the other person feeling worthless
- stalking.

Legislative framework for children's welfare and safeguarding vulnerable adults

The responsibilities of NHS organisations for the welfare and safeguarding of children, safeguarding adults and sharing information are set out in *Safeguarding Vulnerable People in the NHS – Accountability and Assurance Framework.*[9] For children, it reflects the guidance in *Working Together to safeguard children*.[10]

NHS policy-makers and service managers need to take account of the duty of a range of organisations, including health services, to safeguard children, promote their welfare and co-operate to improve their wellbeing.[11]

There is also a duty to safeguard vulnerable adults:

- through the actions of their staff
- in the way the organisation functions
- any services contracted to others, for example, having effective triggers for assessment, referral/care pathways, specialist services, recruitment, training and supervision of staff.

Responsibilities for safeguarding adults are set in legislation by the Care Act 2014 and through regulations. In addition, local authorities providing services to adults must promote their wellbeing. The main difference between vulnerable adults and children is that adults have a legal right to make decisions where they have the capacity to do so, even if their choices seem unwise. However, decisions that put an adult at risk of significant harm fall under safeguarding. The Care Act 2014 requires safeguarding adult boards to be established in each upper tier local authority area. The boards have a duty to make safeguarding inquiries in certain circumstances, provide for sharing information and to carry out safeguarding adult reviews in serious cases. People with care and support needs who are experiencing, or at risk of, abuse or neglect, may be unable to protect themselves. Adults who are receiving care and support from a local authority are protected by statutory safeguarding duties.[12]

Vulnerability is generally used in everyday terms to refer to the possibility of being attacked or harmed. However, the statutory definition of 'vulnerable adult' in the Protection of Freedoms Act 2012 is restricted, even more so than under the Care Act. The distinguishing feature is that the adult is receiving relevant assistance. Vulnerability in the 2012 Act means "a person aged 18 or over whose ability to protect himself or herself from violence, abuse or neglect is significantly impaired through physical or mental disability or illness, through old age or otherwise" and "to whom a regulated activity is provided… or relevant assistance is given."

Regulated activity includes health or social care. Relevant assistance is help that is offered legally, that is, through power of attorney, an independent mental health advocate or a social security payment representative. In effect, both pieces of legislation provide a means for supporting adults in different circumstances who are experiencing abuse and neglect.

Around two women are killed through domestic violence each week in England and Wales. There is a statutory requirement for domestic homicide reviews to be undertaken by the community safety partnership (CSP) and NHS organisations. General practices are also requested to co-operate.[13]

Policy

The government continues to set an ambitious vision to stop violence against women and girls through successive action plans and a refreshed strategy was published to mark International Women's Day in Spring 2016.[14,15] Much has been achieved in the past few years and the new strategy continues to provide a framework for those actions that only government can take, to enable effective local actions in the following priority areas:

- preventing violence
- providing services
- partnership working
- pursuing perpetrators.

In addition to making coercive and controlling behaviours in intimate partner relationships an offence, the government:

- brought in the Domestic Violence Disclosure Scheme ('Clare's Law') giving individuals a 'right to ask' the police about a partner's previous violent offending so that they can make informed choices about a relationship; a 'right to know' for an agency to apply for a disclosure if it believes an individual is at risk of domestic violence from their partner

- rolled out domestic violence protection orders, which prevent perpetrators from returning to their home for up to 28 days following an incident of abuse, to give victims time to consider their options
- revised the definition of domestic violence and abuse to include young people of 16 years old and over
- established a two-year fund in 2014 for the specialist sexual violence third sector to support both male and female victims
- brought legislative provision into effect for domestic homicide reviews to be carried out to understand what happened in each death to prevent and reduce risk in the future.

Government is continuing with policies to improve the public service response to victims. The 2013 Code of Practice for Victims of Crime (the Victims' Code) and the Witness Charter[16] are key elements of carrying out the strategy to transform the criminal justice system by putting victims first. The Victims' Code specifies what victims and witnesses are entitled to. The Ministry of Justice also published a Victims' Services Commissioning Framework in 2013 to help police commissioners provide appropriate services.[17]

The establishment of elected Police and Crime Commissioners in 2012 has meant that tackling violence is now on local agendas. Health and care services personnel should also note that victim service providers in the criminal justice system are monitored for how services:

- improve victims' health and wellbeing
- increase their safety and perceptions of safety
- enable victims to reintegrate.

In the health sector, NICE published a guideline on how health and social care services, and the organisations they work with, can respond effectively to domestic violence and abuse.[2] NICE also published a specification of quality standards on prevention and reduction.[3]

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Section 2: Responsibilities of commissioners and local strategic partnerships

There is a strong need to improve health commissioning of universal and specialist services to interrupt perpetrators and support victims of domestic abuse, including children who are in the household. However, integrated commissioning is essential. The NICE guideline on domestic violence and abuse makes recommendations on what local commissioners and their multiagency partnerships can do to prevent domestic abuse and how to plan and provide services for victims and perpetrators.[2] A summary of the recommendations for commissioners and strategic partners is highlighted in the diagram opposite.

2.1 Integrated commissioning

The NICE guideline builds on local commissioners' statutory responsibility to establish a joint strategic plan informed by local health needs, prioritising how they develop commissioning decisions. Clinical commissioning groups (CCGs) and local authority directors of children and adult services, directors of public health (who also have a role in reducing crime) and directors of housing, play a key role together with the Police and Crime Commissioner (PCC). Commissioners are expected to develop integrated training and referral pathways for clinical and administrative staff. The aim is to make it easier for staff to help people disclose information about domestic violence and know how to provide the necessary support.

Clinical commissioning groups

- CCGs are responsible for planning and commissioning healthcare to get the best possible health outcomes for the people they serve. The services they buy include treatment services for physical and mental health for children and adults, in hospitals and the community, urgent and emergency care and other therapeutic services that meet NHS standards, for example, from the third or independent sectors.

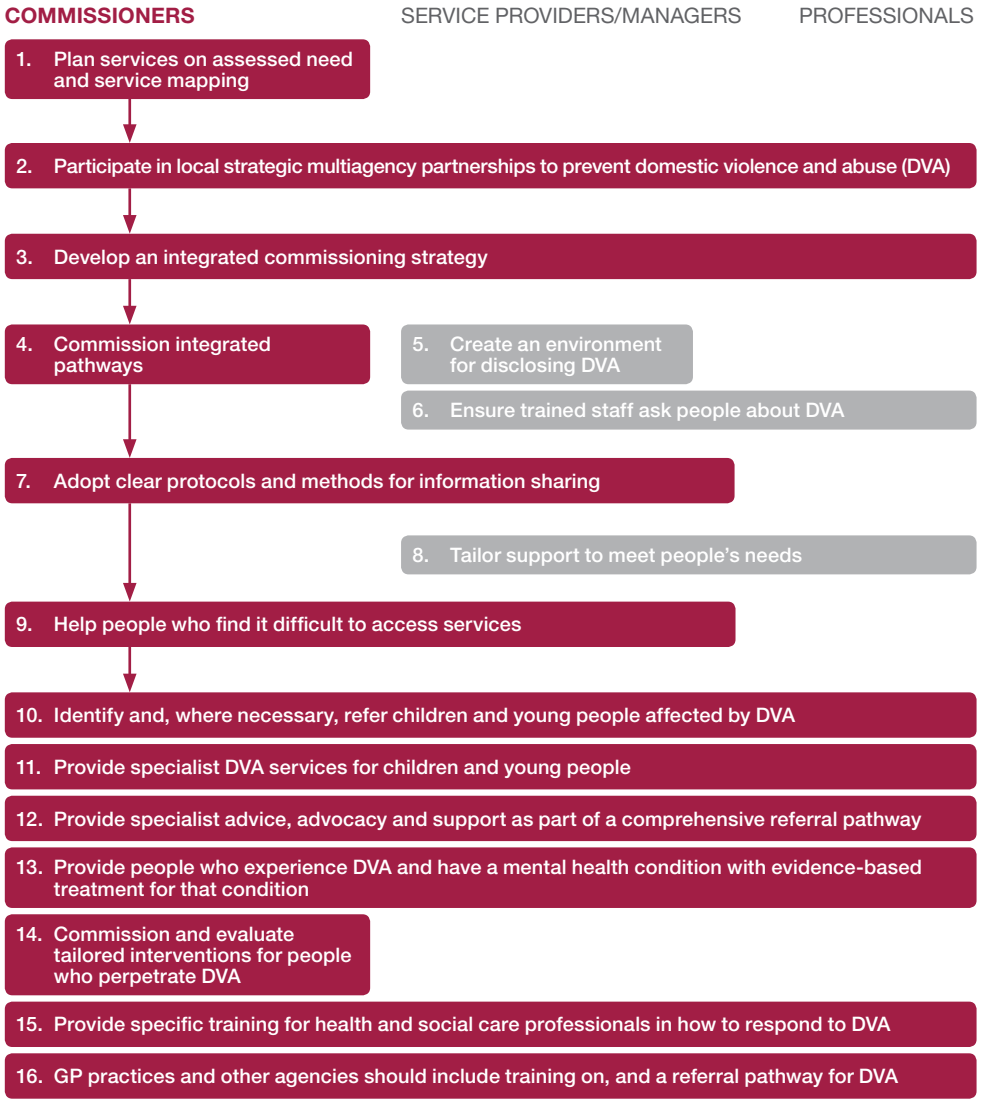

Diagram 1: NICE pathway for commissioners

- GPs also have a dual role as providers, seeing victims and perpetrators of domestic violence in their practices. GPs are in a key position for early identification in their day-to-day work, and they can act in their CCG role to improve the local multiagency response.

CCGs are required to work jointly with local authorities in their areas through the health and wellbeing board (see further below). They assess the needs of the local population and develop a strategy with priorities for commissioning. As such, CCGs can support awareness-raising campaigns, promote appropriate information sharing, contribute to multiagency interventions and commission the statutory and voluntary services needed for victim recovery or to interrupt continuing perpetration.

Local authorities and directors of public health

The upper tier council in England is responsible for improving the health of its local population. In addition to commissioning services for vulnerable children and adults, local authorities commission some mental health and public health services including: preventive mental health; substance misuse; sexual health and genitourinary medicine clinics; services for children up to 18 years old, including health visiting and school nursing; promoting community safety; violence prevention and response.

Directors of public health are the statutory chief public health officer of the local authority and the principal adviser on all health matters to elected members and officers. They have a key role in the local authority's public health commissioning as well as the health aspects of promoting community safety and violence prevention. Directors of public health need to work closely with other local authority directors on population health improvement. They need to work with CSPs, the local PCC and members of the local safeguarding children board and the health and wellbeing board to develop health improvements for children and adult victims of domestic abuse.

NHS England

NHS England is responsible for assuring that CCGs are fit for purpose and achieve health outcomes according to population need. However, NHS England itself directly commissions some health services, such as highly specialised services for rare illnesses and other services, such as for people in the justice system. The Secretary of State also delegates a range of public health services to NHS England, including sexual assault referral centres. NHS England is also a member of health and wellbeing boards in the areas where they commission services.

Police and crime commissioners

Elected PCCs represent the voice of local people on policing needs for safety. The PCC's policing and crime plan set out the policing strategy and priorities. The PCC sets the budgets for the local police force, holds the chief constable to account for effective policing and oversees local crime reduction. The PCC is also responsible for ensuring that the victim's pathway through the criminal justice system runs smoothly, and that partners work effectively to meet the personalised needs of victims with complex needs.[17] Police and crime panels, comprised of representatives from the local authorities covered by the PCC, scrutinise and challenge the actions and decisions of the PCC. Services commissioned by PCCs are expected to comply with the Victims' Code and the obligations in the EU Victims' Directive (2012) which establishes minimum standards on the rights, support and protection for victims of crime (see articles 8 and 9).[16,18] Briefing for PCCs on violence against women and girls was published in 2013.[19] It draws attention to: the government's strategic principles of prevention and early intervention; provision of support; partnership working; reducing the risks to victims, including bringing perpetrators to justice.

2.2 Multiagency partnerships

Local commissioners and their strategic partnerships on domestic violence and abuse, including clinical commissioners, local authorities and PCCs should ensure that their members have received training to understand the dynamics of domestic violence and abuse, its links to emotional wellbeing, mental health and substance misuse, and the impact on children in the household. This is necessary in order to inform an integrated commissioning strategy, based on multiagency input and including people who have experienced domestic violence and abuse, dependent children and perpetrators. Diagram 2 shows the relationships between commissioners, strategic partners and some of the main statutory and non-statutory strategic and operational arrangements for the prevention of and response to domestic abuse.

Health and wellbeing boards

- CCGs, upper tier local authorities (councillors, chief executives, directors of public health and directors of children and adult services) and the local Healthwatch, jointly lead the local health and care system, through health and wellbeing boards (HWBs) and in collaboration with their communities.
- HWBs are responsible for linking the NHS, public health and social care with a wide range of stakeholders to ensure that commissioned services meet the needs of the local population.
- The HWB undertakes the joint strategic needs assessment (JSNA) and publishes a joint health and wellbeing strategy (JHWS) on how it will address those needs. HWBs can ensure that the JSNA gathers evidence on violence and abuse and that the JHWS supports integrated commissioning of effective preventative, acute and recovery services. A practical guide is available to support HWBs on tackling violence.[20]
- As required by the public sector equality duty under the Equality Act 2010, the HWB should give due regard to the need to eliminate discrimination and advance equality of opportunity. This is especially to ensure that people with protected characteristics[21] and those who face particular barriers are able to access support services for domestic violence and abuse.

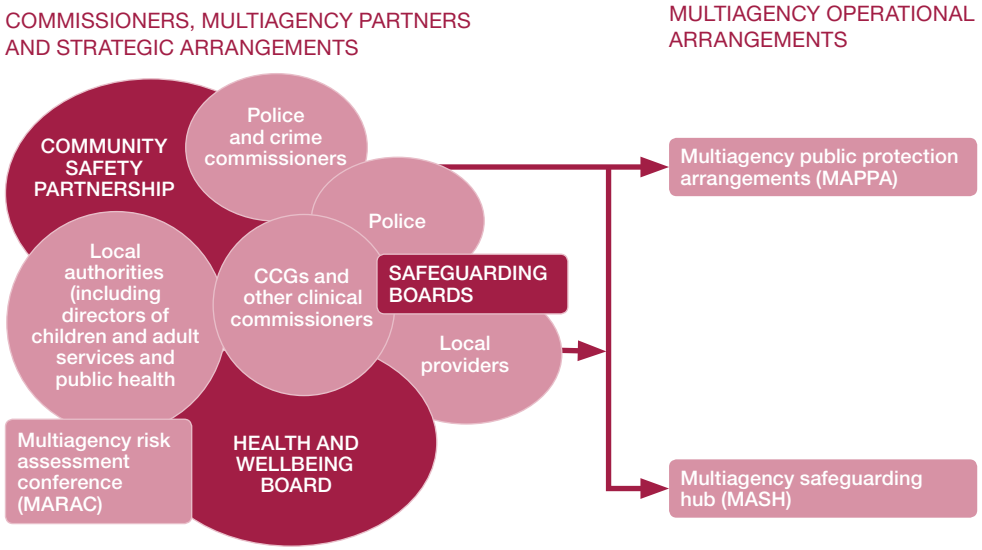

Diagram 2: Multiagency partnerships

- Local authority 'health scrutiny' holds all commissioners and providers of publicly funded healthcare and social care to account for their activities arising from the JSNA and JHWS.

Some overlapping membership with the community safety partnership (see Diagram 2) and local safeguarding adults and children boards should help to ensure that domestic abuse is appropriately prioritised by the HWB.

Local safeguarding adults boards

Safeguarding adults boards (SABs) have responsibility for co-ordinating and ensuring the effectiveness of its members' activities to help and protect any adult in its area with social care needs who is or may be at risk of, or experiencing, significant harm from abuse or neglect.[22] Activities include:

- prevention, need and service mapping
- quality assurance
- publishing local procedures for safeguarding adults
- training and contributing to service commissioning to safeguard vulnerable adults who are experiencing abuse in their intimate partner relationships.

Local safeguarding children boards

- Local safeguarding children boards (LSCBs) play a key part in promoting a good response to children living with domestic abuse and young people over 16 years old who are experiencing abuse within intimate partner relationships. Subject to the passage of the Children and Social Work Bill, LSCBs will be abolished and new multiagency arrangements will come into place for local authorities, CCGs and local police in the local authority area to take joint responsibility for making arrangements to safeguard children.
- LSCBs and (subject to legislation) their successors, can also contribute vital information to commissioning services to safeguard young people who are vulnerable and experiencing domestic abuse, and to reduce harm to children in families where there is domestic abuse.
- For young women, intimate partner abuse can be part of a more complex picture including:
  - going missing
  - sexual exploitation
  - forced marriage
  - teenage pregnancy
  - self-harm
  - substance misuse
  - gang involvement.

LSCBs are guided by *Working Together to Safeguard Children,* which is clear that 'safeguarding children is everyone's responsibility'.[10] *Working Together* sets out safeguarding accountabilities for NHS England, CCGs and individual providers of NHS-funded services.

Community safety partnerships

Community safety partnerships (CSPs) include the police, local authorities, fire and rescue authorities, probation services, CCGs and health services. They develop and carry out strategies for crime reduction. Through the community safety plan, they ensure that all agencies are operating effectively together to reduce crime and disorder, combat substance misuse, and reduce reoffending. As statutory members of the CSP, CCGs have a responsibility to work with the partnerships to tackle crime and disorder. They must:

- participate in a strategic assessment of crime and disorder, anti-social behaviour, and drug and alcohol misuse for their CSP areas
- contribute to the development of local strategies that effectively deal with the issues identified.[23]

There is also a mutual duty on PCCs and CSPs to co-operate with the policing and crime plan.

Multiagency safeguarding hubs and similar partnerships

Health and other practitioners can safeguard victims and dependent children experiencing domestic abuse effectively through a variety of multiagency arrangements. These include multiagency safeguarding hubs (MASHs) which have the benefit of being located in the same area. MASHs can provide a single referral point for an initial response and risk assessment for adults and children with safeguarding concerns. Good practice MASHs can include specialist domestic abuse services. As commissioners of services, CCGs and directors of public health should ensure that there is effective NHS and public health services representation in local MASHs or similar arrangements.

MASHs usually consist of co-located practitioners from the NHS, local police, social care and schools. Not all areas have a MASH and some develop innovative responses to overcome the multiagency challenge of protecting and responding to victims of crime. It is essential that health service managers work together with local police and partner agencies on protocols for information sharing and care planning that enable effective early intervention, through the local strategies mentioned above, which commit multiagency pathways of support to individuals.[24]

Multiagency risk assessment conferences

All police force areas in England and Wales have a multiagency risk assessment conference (MARAC). MARACs are not legal entities: they are victim-focused, co-ordinated multiagency meetings where statutory and voluntary agency representatives share information about individual high-risk victims of domestic abuse to produce a co-ordinated action plan to increase victim safety.

The agencies that attend MARACs will vary, but a suggested core membership includes local police, probation, independent domestic violence advisers (IDVAs), housing, children's services, primary care, mental health and substance misuse services. Representatives from education, other NHS services and other public services should attend according to the case.

NHS guidance says that information sharing must be compliant with Caldicott principles; this means that, if information is shared without an adult's consent, it must be on the basis of preventing or detecting serious harm or crime.[25] SafeLives data shows that, in the 12 months after a MARAC, police call-outs can decrease significantly, and cease in 40% of cases.[26]

The Themis research by SafeLives, shows that where emergency departments staff include IDVAs, disclosures are made much earlier, and by people with high levels of complex or multiple needs related to mental health, drugs and alcohol with recent abuse histories of less than six months, compared with community domestic abuse services.[27]

Multiagency public protection arrangements

Multiagency public protection arrangements (MAPPAs) ensure the successful management of violent and serious sexual offenders including, crucially, in their resettlement and rehabilitation.[28] MAPPAs are not statutory bodies, but provide a mechanism that agencies can use to co-ordinate how they discharge their statutory duty to co-operate for public protection under the Criminal Justice Act 2003, led by the location's police, prison service and probation trust. Healthcare services can usually make an important contribution where offenders have mental health problems or where they may pose a risk of harm to vulnerable children or adults. The duty to co-operate falls on NHS England, every CCG and NHS trusts in the MAPPA area.[29] CCGs need to ensure that senior representation at the MAPPA strategic management board and relevant specialists – for example, for mental health or learning disability – provide healthcare advice and support in the management, resettlement and rehabilitation of offenders in the community.

Offenders with mental health conditions

Along with the criminal justice agencies, mental health services are responsible for identifying MAPPA-eligible offenders. Managers must have robust internal management procedures to identify all MAPPA-eligible offenders under their supervision.[30] MAPPA can apply to both restricted and unrestricted patients.

Under the Mental Health Act 2007, which modified provision in the Domestic Violence, Crime and Victims Act 2004, service managers must co-operate through their trusts to discharge restricted criminal patients as safely as possible. They must also manage the discharge of unrestricted patients in line with the legislation's requirements, including:

- informing victims (if they have asked) if the patient is to be discharged, and letting victims know about any conditions relating to the patient having contact with them or their families
- inviting victims (if they have asked) to make representations about the conditions patients should be subject to if discharged conditionally or under a community treatment order
- responsible clinicians informing the Mental Health Act Office if they are considering discharging relevant unrestricted patients and their decisions relating to these patients
- responsible clinicians and approved mental health professionals considering victims' representations about conditions to be imposed on an unrestricted patient following discharge.

2.3 Local strategies

Joint health and wellbeing strategy

The JHWS is developed jointly by the local HWB as a means of collectively improving the health of local people and reducing health inequalities. The strategy is informed by the JSNA (see above) and should include abuse and violence because of their wide public health and personal impacts.[31] The JHWS helps the HWB to set priorities for commissioning effective preventative, acute and recovery services for victims, and services for perpetrators.

Troubled families

The government has prioritised supporting families to move out of troubled situations. It defines a 'troubled family' as one that has multiple and complex needs, including parents not working and children not in school, and which causes serious problems, such as anti-social behaviour and youth crime.[32] Families meeting the first three criteria (crime/anti-social behaviour, education and work) are automatically part of the local authority's programme. Authorities can choose from discretionary fourth criteria. Evidence for the impact of the Troubled Families programme is weak but reviewers are clear that local schemes are helping people to navigate problems.[33]

Promoting domestic abuse as a fourth criterion in the definition of a 'troubled family' links community safety, violence against women and children, and safeguarding vulnerable adults. It provides the potential to improve the CCG's contribution to commissioning a seamless service to this group of people in need.

Local victims' strategy

Similarly, the CCG will commission and provide psychological therapies and mental health services to meet the needs of victims of crime. This is expected to be part of a partnership strategy in collaboration with PCCs who are required to have a victim support strategy on providing emotional and practical support to victims of serious crime, and to vulnerable and intimidated victims through the third sector and social enterprises.[34] The PCC can fund local IDVAs, independent sexual violence advisers and MARAC co-ordinators. NHS clinical commissioners need to understand the commissioning and system advocacy role of PCCs. They need to involve PCCs in commissioning partnerships to meet the needs related to crime victimisation to ensure clearly joined-up care pathways.

18. EU 2012; Directive 2012/29/EU Establishing minimum standards on the rights, support and protection of victims of crime.
19. Home Office. *Ending Violence Against Women and Girls* (2013)
20. HM Government, NHS Confederation. *Violence and Health and Wellbeing Boards: A Practical Guide for Health and Wellbeing Boards* (2014)
21. The Equality Act 2010 makes it illegal to discriminate against anyone because of: age, being or becoming a transsexual person, being married or in a civil partnership, being pregnant or having a child, disability, race, including colour, nationality, ethnic or national origin, religion, lack of religion/belief, sex or sexual orientation.
22. The Care Act 2014. www.legislation.gov.uk/ukpga/2014/23/contents/enacted
23. HMSO. Health and Social Care Act 2012. Schedule 5, Paragraph 84. www.legislation.gov.uk/ukpga/2012/7/contents/enacted
24. Home Office. *Multi Agency Working and Information Sharing Project. Final Report* (2014). www.gov.uk/government/uploads/system/uploads/attachment_data/file/338875/MASH.pdf
25. Department of Health; UK Council of Caldicott Guardians. *'Striking the Balance': Practical guidance on the application of Caldicott Guardian Principles to Domestic Violence and MARACs (Multi Agency Risk Assessment Conferences)* (2012)
26. SafeLives (CAADA), *In Plain Sight: The Evidence from Children Exposed to Domestic Abuse (2014)* www.safelives.org.uk/sites/default/files/resources/In_plain_sight_the_evidence_from_children_exposed_to_domestic_abuse.pdf
27. SafeLives, *A cry for health: why we must invest in domestic abuse services in hospitals (*2016) http://www.safelives.org.uk/node/935?gclid=CK_ayM7evtACFccp0wod0PwNqQ
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29. Criminal Justice Act 2003, section 325 as amended by the Health and Social Care Act 2012, section 124. www.legislation.gov.uk/ukpga/2003/44/section/325; www.legislation.gov.uk/ukpga/2012/7/schedule/5/paragraph/124
30. Ministry of Justice, National Offender Management Service. *Guidance for Working with MAPPA and Mentally Disordered Offenders*. www.justice.gov.uk/downloads/offenders/mentally-disordered-offenders/mappa-mental.pdf
31. Bellis M., Hughes K., Perkins C., Bennett A. *Protecting People, Promoting Health: A Public Health Approach to Violence Prevention for England*. DH, NHS England (2012)
32. Department for Communities and Local Government, *Support for families* (2016). www.gov.uk/government/policies/support-for-families
33. Blades R., Day L., Erskine C. *National Evaluation of the Troubled Families Programme*. Department for Communities and Local Government (2016)
34. Home Office. *Have You Got What it Takes? Supporting Victims and Witnesses to Cope and Recover*.

Section 3: Responsibilities of service providers and service managers

Service providers and managers are in a position to shape local partnerships and what their services can add to the local response to domestic abuse. The recommendations of the NICE guideline on domestic violence and abuse[2] and quality standards[3] provide an easily navigated pathway to help managers and providers make a difference. Managers and service providers can develop a single agency response, but greater effectiveness can be gained through multiagency partnerships with agreed referral pathways. Service managers need to understand the opportunities available locally to join up their care pathways and referrals. They should take an active part in articulating the multiagency care pathway to their commissioners, who are members of the HWB. This would ensure that the local JSNA and JHWS are truly joined up to achieve greater value.

3.1 Developing the service response

Diagram 3 summarises the NICE guideline on how service providers and managers can develop their local responses (the shaded areas).[2] Partnerships are necessary to the success of local services (recommendations 2, 3, 7, 9 – 13, 15, 16). The NICE guideline recommends that providers, and the professionals they employ, should engage with commissioners to help shape local strategies and protocols. However, there are also specific actions that service providers and managers need to take (recommendation 5) and with their employees (recommendations 6, 8, 10-13). More details can be found in the guidelines and quality standards.

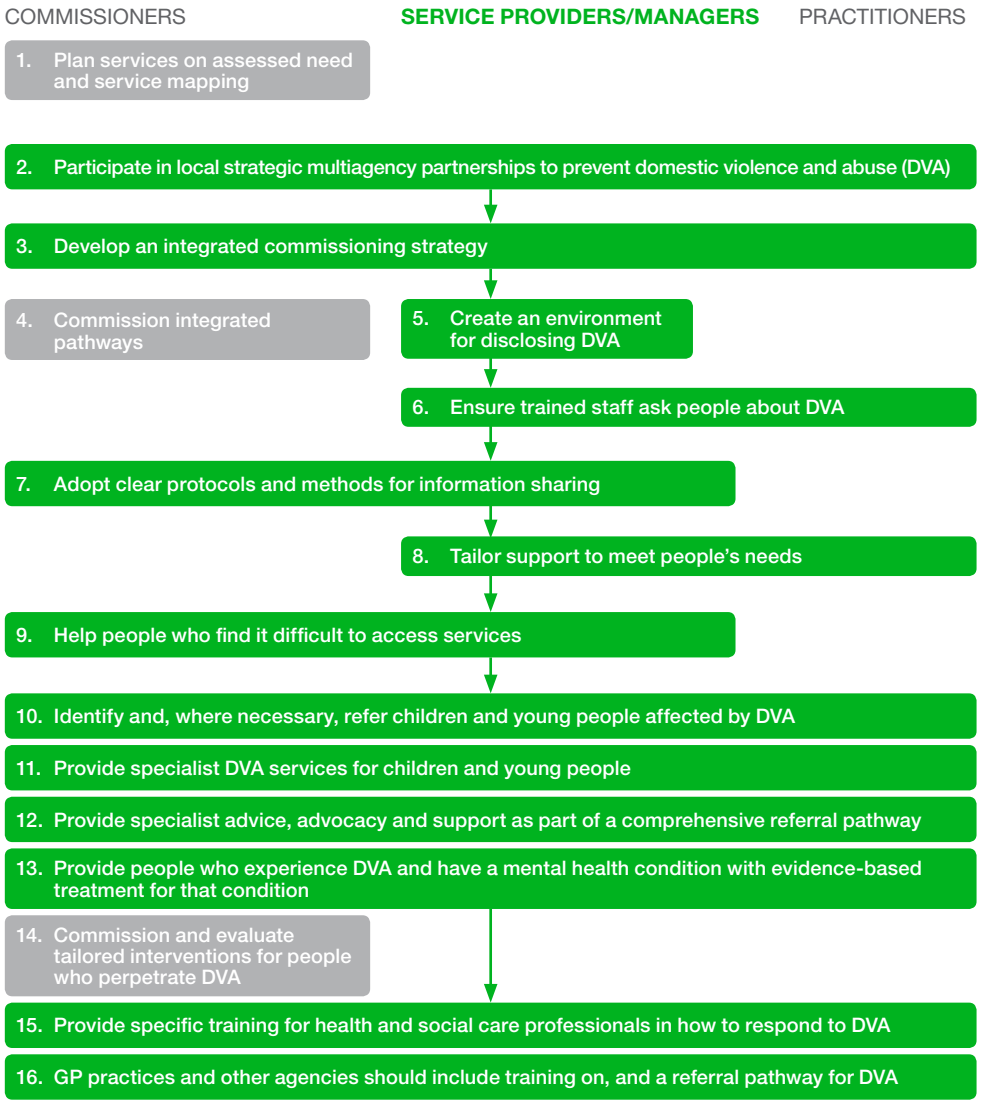

Diagram 3: NICE pathway for service providers and managers

To put Diagram 3 into practice, this section of the resource aims to help service providers and managers take up their responsibilities with commissioners or practitioners and work together. The section focuses on how service providers and managers can support the work through staff training. It also looks at the additional issue of supporting healthcare staff who have experienced domestic abuse.

3.2 Training staff

Because of the prevalence and impact of domestic abuse and other forms of interpersonal violence, health staff would be more competent and assured if professional regulators made tackling violence part of preregistration education. Both NICE and the UK's Chief Medical Officer have made similar recommendations.[2, 35] The NICE guideline asks education providers, commissioners and service managers to equip the workforce in health and social care. There is an additional emphasis on training clinicians, including those in general practices.

The guideline recommends two types of training, each with two levels and awareness raising, the latter specifically targeting commissioners and service managers, to dispel misconceptions about domestic abuse, skills and services.

To foster a universal response, training around a common core understanding of the dynamics of domestic abuse, interactions with substance misuse and mental health, the context of shame in 'honour-based violence' and the equality and diversity issues:

- Level 1: responding to disclosure with sensitivity in a way that ensures safety and being able to direct people to specialist services (for dentists, allied health professionals, ancillary staff, care assistants);
- Level 2: making routine enquiry with sensitivity and empathy, assessing safety risk and offering a referral to specialist domestic violence services (for doctors, nurses, public health nurses, midwives, social care professionals, substance misuse workers and youth workers).

To provide a specialist response from staff with more detailed understanding and skills:

- Level 3: an initial response that includes risk identification and assessment, safety planning and ongoing liaison with specialist services (for safeguarding children health professionals and social workers, MARAC and adult safeguarding representatives);
- Level 4: giving expert advice and support to people experiencing domestic abuse (specialists such as IDVAs, ISVAs, domestic violence advocates or support workers, refuge staff, counsellors and therapists for domestic violence or sexual abuse, children's workers).

Current training sources for clinicians are diverse and many involve the specialist domestic violence services sector. A number of training and organisational development tools are also available to general practice, including:

- Royal College of General Practitioners resources and e-learning tool about violence against women[36]
- Identification and Referral to Improve Safety (IRIS) system, an evidence-based model founded on training, support and a referral programme in partnership with the local specialist domestic violence sector[1]

- Researching Education to Strengthen Primary care ON Domestic violence & Safeguarding (RESPONDS)[37] training tool to bridge the knowledge and practice gap between domestic violence and protecting children.[38]

3.3 Supporting staff who experience domestic abuse

As part of the health and wellbeing of its workforce, it is important that service providers and managers support staff who may also be victims of domestic violence and abuse, to enable them to disclose information and receive support. Work on adverse experiences in childhood or adulthood shows that staff may have experienced trauma from abuse and it can have a further impact, especially when they are dealing with service users who are going through similar experiences.

This culture facilitates the personal development of staff, many of whom have identified their own ACE Scores, who then support the development of healing social networks for those served…
This is in keeping with literature highlighting the importance of preventing vicarious traumatization (Badger, Royse and Craig, 2008) and addressing self-care among helping professionals (Christopher, Christopher, Dunnagen, & Schure, 2006).[39]

NHS organisations have a duty to protect their staff from violence. The NHS has taken a strong stance against verbal or physical assaults on staff by patients or relatives. In many cases, domestic abuse is likely to take place outside the work environment. While the employer is unlikely to have a legal responsibility in these circumstances, staff should feel able to disclose information about abuse. Good employer practice should provide staff with a supportive work environment where they are able to continue to work.

Data on domestic violence and the workplace suggests that:

- 75% of domestic abuse victims are targeted at work by telephone calls and emails
- women who have left an abusive partner are especially vulnerable as perpetrators can easily identify the workplace as a place of contact
- a small-scale survey by the Cavell Nurses' Trust reported that nurses, midwives and healthcare assistants are three times more likely to have experienced domestic abuse in the last year than the average person in the UK, and are twice as likely to be in financial hardship.[40]

A sympathetic work approach is helpful to staff who have problems caused by domestic violence. NHS Employers provides NHS organisations with resources on supporting staff experiencing domestic abuse.[41] Good employment practice will include making available:

- a channel outside human resources for staff to disclose domestic abuse
- information and support, and promoting it to all staff
- time off for the victimised staff member to go to meetings associated with the incident.

This needs to be underpinned by a human resources policy for staff who are victims of domestic abuse, as well as staff who have been identified as perpetrators. The policy should include:

- a statement of commitment to provide support
- an overview of the legal basis for the policy
- what the organisation will provide for those experiencing domestic abuse
- how the organisation will respond to perpetrators
- how policy will be carried out and monitored
- what training will be made available to line managers.

The Public Health Responsibility Deal can supply a framework through its standalone chapter on domestic abuse and violence. Employers can sign up to the Deal and receive information on arrangements for voluntary support to staff affected by domestic abuse.[42] The Corporate Alliance Against Domestic Violence works with employers to reduce the impact of domestic abuse.[43]

35. DH. *Annual Report of the Chief Medical Officer, 2014. The health of the 51%: Women* (2015)

36. Royal College of General Practitioners training on Domestic Violence www.rcgp.org.uk/clinical-and-research/clinical-resources/domestic-violence.aspx

37. University of Bristol, Centre for Academic Primary Care, *Researching education to strengthen primary care on domestic violence and safeguarding (RESPONDS) study*. bristol.ac.uk/responds-study

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40. Cavell Nurses' Trust. *Skint, Shaken Yet Still Caring: But Who's Caring for our Nurses?* (2016)

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43. Corporate Alliance Against Domestic Violence (CAADV) http://thecorporatealliance.co.uk/

Section 4: Practitioners responding to victims

Domestic abuse is a serious health and criminal issue. As seen in the previous section, to enable staff to support victims effectively, service providers and managers need to create the context, including providing training, multiagency care and information-sharing protocols and suitable environments. Practitioners are in a key position to identify and help interrupt domestic abuse. They can do this by recognising the indicators of abuse and offering support and referral for protection as needed. A summary of the role of practitioners from the NICE guideline is shown in Diagram 4.

Knowing about the specific contexts and the impact of domestic abuse can be a helpful step in understanding the individual needs of victims. More information on the issues listed below – for adults and children – is provided in Annex B:

- prevalence
- typical circumstances
- impact on individuals
- understanding people affected
- the cost of domestic violence.

The NICE guideline recommends that trainers should provide four levels of training to enable professionals to respond effectively. Trainers should also raise awareness with managerial staff and enable them to support professionals effectively.[2] Practitioners will be able to provide more effective support to victims of any age, if they are trained, confident and competent in:

- their professional responsibilities
- using the local integrated care pathway

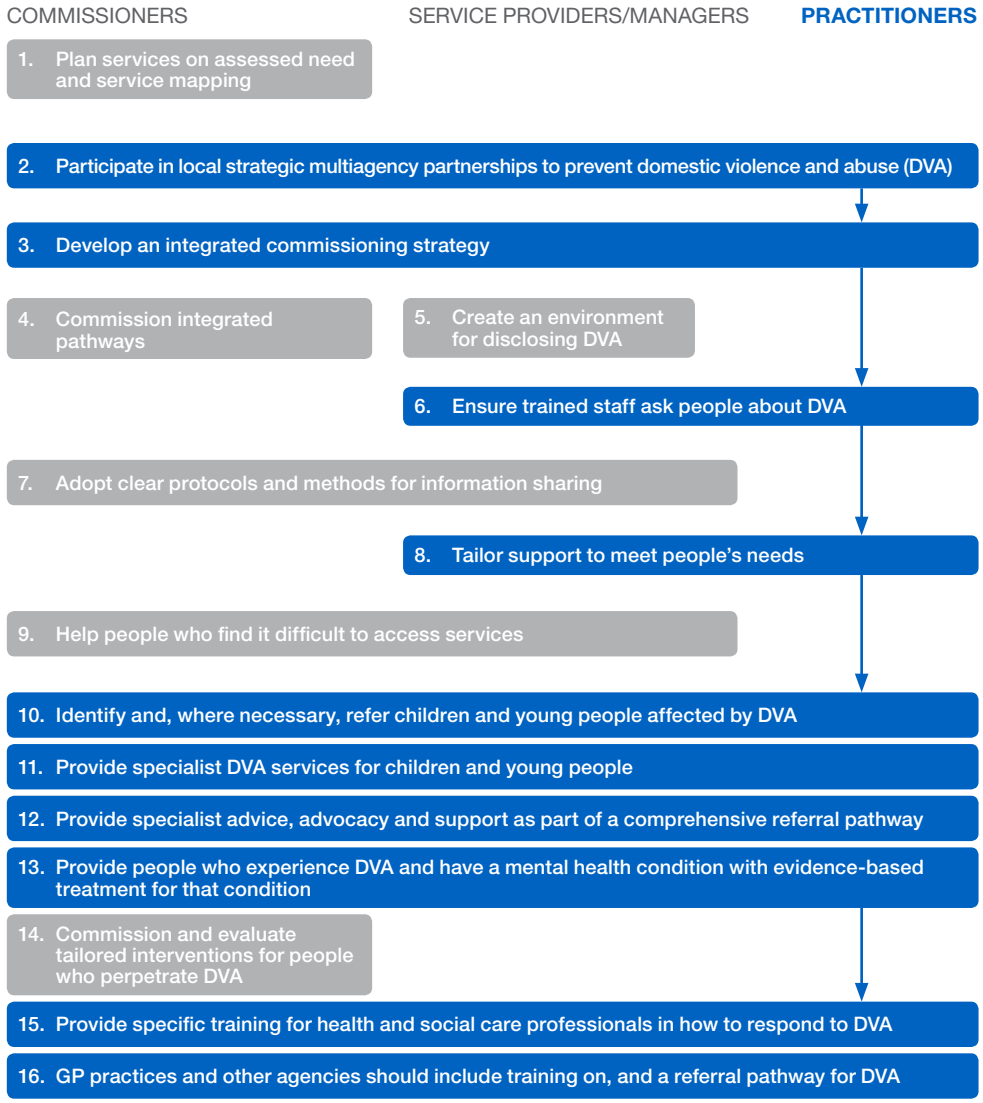

Diagram 4: NICE pathway for practitioners

- early identification
- assessment
- interventions – short term (coping) and longer term (recovery)
- gathering and recording information
- confidentiality and sharing information.

4.1 Health professionals' responsibilities

Health practitioners are in a key position to identify domestic abuse and to initiate support and safety for victims. A study of 2,500 women accessing domestic abuse services, showed that prior to receiving specialist help, just under half had attended a GP an average of 5.3 times and one in five had attended A&E as a result of the abuse.[44]

See Section 3.2 on Training of Staff, also summarised below. Your role should be matched by the level of training you have as recommended in the NICE guideline on domestic violence and abuse and should enable you to undertake a universal response or more specialist response as follows:

Universal

- Level 1: For dentists, allied health professionals, ancillary staff, care assistants - able to respond to disclosure with sensitivity and know how to direct people to specialist services
- Level 2: For doctors, nurses, public health nurses, midwives, social care professionals, substance misuse workers and youth workers – able to undertake routine enquiry, assess safety risk and offer a referral to specialist domestic violence services

Specialist

- Level 3: For safeguarding children health professionals and social workers, MARAC and adult safeguarding representatives – able to identify and assess risk, do safety planning and maintain liaison with specialist services
- Level 4: For specialists such as IDVAs, ISVAs, domestic violence advocates or support workers, refuge staff, children's workers and counsellors and therapists seeing people who experience domestic violence or sexual abuse – able to give expert advice and support to people experiencing domestic abuse.

Whatever your role, your Trust or organisation should provide information on:

- the referral pathway in your community safety partnership area
- how to access specialist advice internally and externally (such as safeguarding children and vulnerable adults)
- protocols for sharing information when you are making a referral or where you are asked to contribute information from an external agency.

You should also be able to:

- provide a trauma-informed approach that builds confidence with your client or patient
- as in any consultation, assess the level of difficulty where your client/patient may have a learning disability, cognitive problem or understand a different language, agreeing and carrying out the best method of communicating with them (never through friends or relatives).

Books Beyond Words provides a range of visual resources for health professionals to support communications with patients with cognitive difficulties or who understand a language other than English. There is a range of materials, for working with children and adults.

www.booksbeyondwords.co.uk

4.2 Using the local integrated care pathway

To fulfil your responsibilities, you need to know about the local domestic abuse care pathway and be confident in using it to respond to the needs of abused patients and dependent children. A typical local care pathway would include all elements shown in Diagram 5.

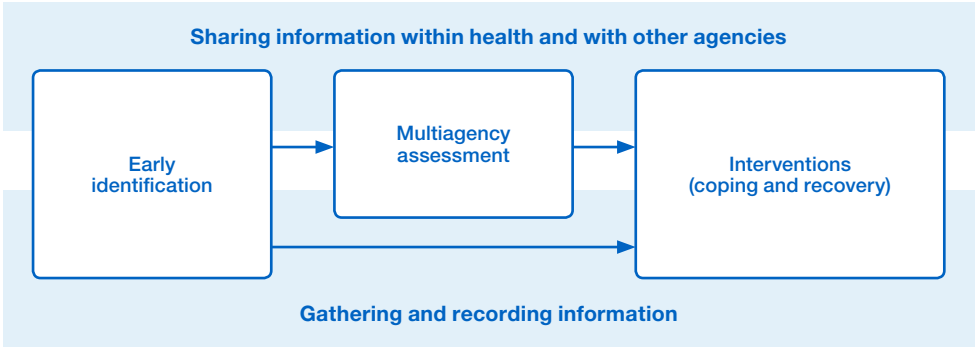

Diagram 5: Local domestic abuse integrated care pathway

4.3 Early identification

To tackle domestic abuse, it is essential that victims are identified and disclose their abuse as early as possible. People experiencing domestic abuse are more likely to come into contact with health services than other public services. As a health professional you will be a first point of contact for many. You have a responsibility to:

- know and recognise the risk factors, signs, presenting problems or conditions, including the patterns of coercive or controlling behaviour associated with domestic abuse
- facilitate disclosure in private without any third parties present; to be attentive and approachable; and use selective, routine enquiry to question what you hear and decide if the presentation of the patient warrants concern.

Sensitive enquiry

There are a whole range of indicators to warn health professionals that a patient may be experiencing domestic abuse. Some of these are quite subtle and it is important that professionals remain alert to the potential signs and respond appropriately. Some victims also drop hints in their interactions with health and care staff and their behaviours may also be telling. They rely on staff to listen, persist and enquire about signs and cues. They need staff to follow up conversations in private, record details of behaviours, feelings and injuries seen and reported, and support them to take action suitable for their organisation's systems and local pathways. Where the patient is an adult with mental capacity issues action is taken in line with their preferences and consent.

All health practitioners, whether working in emergency, acute, primary care or community health, have a professional responsibility, if you identify signs of domestic abuse or if things are not adding up, to ask patients alone and in private, whether old or young about their experience of domestic or other abuse, sensitively. Routine enquiry into domestic violence and abuse is Department of Health policy in maternity and adult mental health services.[45,46,47]

Assessments of clients using substance misuse services are also expected to take domestic abuse into account as a routine part of good clinical practice, even where there are no indicators of such violence and abuse.

Of women who have experienced domestic abuse in the last six months, 500 commit suicide every year. Almost 200 of those had attended hospital for domestic abuse on the day they died.[48]

The signs to look out for include:

Inconsistent relationship with health services

- frequent appointments for vague symptoms
- frequently missed appointments, including at antenatal clinics
- non-compliance with treatment or early discharge from hospital

Physical symptoms

- injuries inconsistent with explanation of cause or the woman tries to hide or minimise the extent of injuries
- multiple injuries at different stages of healing or repeated injury, all with vague or implausible explanations (particularly injuries to the breasts or abdomen)
- problems with the central nervous system – headaches, cognitive problems, hearing loss
- unexplained:
  - long-term gastrointestinal symptoms
  - genitourinary symptoms, including frequent bladder or kidney infections
  - long-term pain

Reproductive/sexual health issues

- unexplained reproductive symptoms, including pelvic pain and sexual dysfunction

- adverse reproductive outcomes, including multiple unintended pregnancies or terminations/miscarriages
- delayed antenatal care, history of premature labours or stillbirths
- vaginal bleeding, recurring sexually transmitted infections or recurring urinary tract infections

Emotional or psychological symptoms

- symptoms of depression, fear, anxiety, post-traumatic stress disorder (PTSD), sleep disorders
- self-harming or suicidal tendencies
- alcohol or drug misuse

Intrusive 'other person' in consultations

- partner or spouse, parent, grandparent (or, for elder abuse, a partner or family member) always attends appointments unnecessarily
- the patient is submissive or afraid to speak in front of the partner or relative, escort or spouse. The escort is aggressive, dominant or over attentive, talking for the patient or refusing to leave the room.

None of these signs automatically indicates domestic abuse, but even if the patient chooses not to disclose at this time, knowing that you are aware of the issues and are supportive builds trust and lays the foundations for them to choose to approach you or another practitioner at a later time.

Young women

Young women can have additional signs such as indicators of sexual exploitation (see the *Health Working Group Report on Child Sexual Exploitation*, Annex C, page 77)[49], going missing and gang involvement.

Privacy and direct questions

Privacy

Many health settings are busy places, with people passing in and out of cubicles and offices, and this will not be conducive to revealing vulnerability or talking about feelings.

"I thought about saying something to the nurse, because she was quite friendly to me. But she kept getting called away – you know how it is with nurses – and she looked stressed. I didn't want to add to that."[50]

Only ever raise the issue of domestic abuse with a patient when you are alone with them in private and, if not, ask the escort to wait elsewhere.

"When I went to hospital, he would always come with me. The only time he left me was in X-ray. Can't the nurses see he is not leaving me? Can't they be trained to spot this? Why can't they take me into another room and ask this?"[51]

Even if a patient is accompanied by someone of the same gender, that person could be related to the abuser or could be the abuser.

"I was admitted to A&E twice. Each time my daughter was with me. When they asked if anything had happened to cause these severe panic attacks she was there, so what could I say? The third time I was seen at home by a locum GP, he asked her to wait outside the room… I told him."[52]

Ask direct questions

Women who have been abused say they were glad when a health practitioner asked them about their relationships.

"If you keep going back and you have bruises or injuries, or if there's different things wrong, like you're not sleeping, or you're depressed or anxious, they need to approach you about why you have all these bruises or broken bones, or pick up on what's causing the depression. It's common sense. Why don't they just ask about it, find out what's going on, and tell us where there's help available?"[53]

Young women also want people to ask. Talking about school nurses one young woman said:

"Even if they don't report it, they should at least ask you about it [signs and symptoms of abuse]. Because at the end of the day, why is it there?"[52]

Explain that you are concerned (or, if it is a routine enquiry, that you ask everyone), and respectfully ask direct questions, such as:

- Has anyone ever hit you? Who was it? What happened? When? What help did you seek?
- Are you ever afraid at home or in your relationship?
- Have you been pressured or made to do anything sexually that you did not want to?

Where you have contact with **children**, give your attention to every child and talk sensitively and directly to each one to create opportunities for a disclosure.

- There are children who do not want to talk at all. Others disclose indirectly, not sharing the details without being prompted. Or they disclose in a roundabout way, for example: "Sometimes my step-dad upsets my mum".
- The child is hoping that you will take up the hint they are offering. Many children are unsure because the abuser is someone they love. School nurses are in a good position to identify children experiencing harm.

"I don't feel safe at school 'cos my dad says he's going to come and take me away. I just try and stay with friends, near teachers and near buildings where teachers are."[26]

Do not interrogate the child. Ask simple questions, such as:

- Is there something you're sad or worried about?

Reassure the child, but only so far as is honest and reliable – that is, do not say: "Everything will be all right now". You could say:

- I believe you
- I am glad you came to me
- I am sorry this has happened
- You're not to blame
- We are going to do something together to get help – this will ensure that the child will not be surprised that you share the information.

Seen and Heard is a training resource for healthcare professionals to help recognise the signs of abuse. It includes ways to listen to children who may have things on their mind that they want to talk to professionals about.[54]

"People tend to protect children and young people. For me, this translated into ignoring my need to be informed and involved. My life was affected anyway … I needed good, age-specific information about my mother's [situation]. And I needed someone to talk to who would listen in confidence and help me to express and explore the complex feelings and situations I was dealing with."[55]

Using an interpreter

Never use a relative or friend of the victim as an interpreter. Always use a professional interpreter, who has had domestic abuse training or an advocate from the local specialist domestic abuse agency. The interpreter needs to be the same gender as the victim and should sign a confidentiality agreement. Look at your patient and speak directly to them – not to the interpreter.

4.4 Multiagency assessment

Multiagency input is essential. A person being abused will only be able to tell you about the things they know about. However, there are other services, for example, the police, probation, youth justice, substance misuse, mental health and other health services, that may have additional information about the perpetrator. Friends and family of a victim can often provide helpful information. There are also professionals who know more about the impact of neglect and trauma on children than a mother could be expected to know. Health professionals must take this into account and actively seek additional information from the multiagency network rather than expect the victim to accurately assess the risk of harm in their situation. The effect of abuse and violence can reduce a victim's ability to analyse situations clearly and come to appropriate decisions.

The typical process from risk assessment through to providing interventions is shown in Diagram 6. Most local safeguarding arrangements have customised processes that reflect local multiagency processes and the availability of local services.

Terms used in Diagram 6 are explained in the Glossary at the end of this resource.

Once domestic abuse is identified, an assessment should be undertaken to evaluate the risk of further harm to the person and to children in the household.

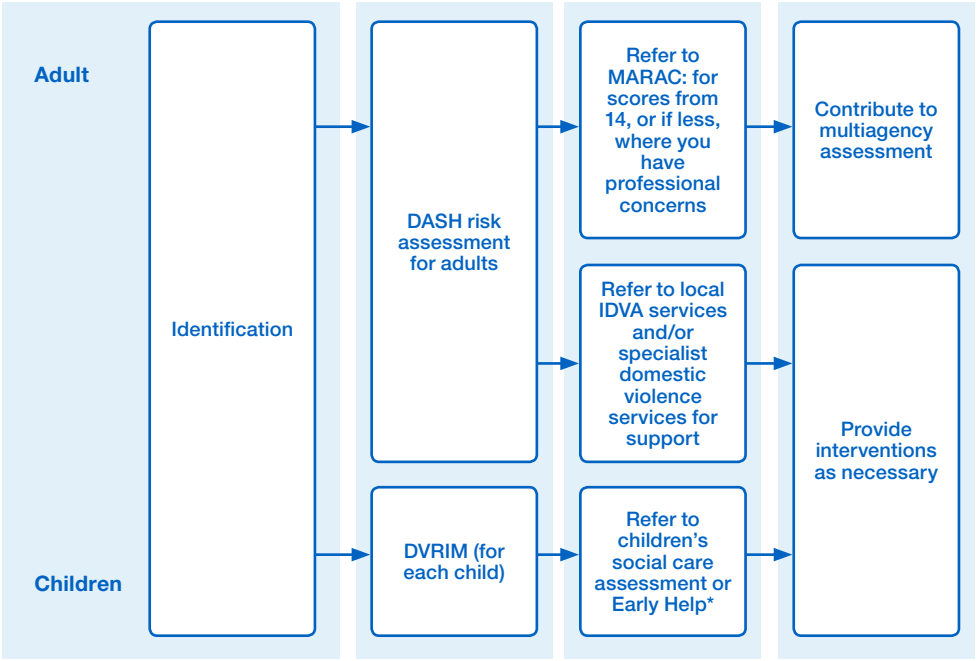

Diagram 6: Risk assessment process

- You should involve a colleague who is trained at least to Level 2, as recommended in the NICE guideline, if you are at Level 1, or your named safeguarding professional. Assessment is of your client/patient's immediate safety. For example, for an adult or person over 16 years old, determine whether it is safe to go home (see Annex D for sample safety plans).
- Assessment identifies the risks facing the abused person and informs safety planning, referrals to specialist support services and to aid any police investigation.
- The Safe Lives Domestic Abuse, Stalking and Honour Based Violence (DASH) risk assessment tool is a reliable method for your initial risk assessment (see Annexes E and F). Additional advice is also available to support risk assessment of different groups such as older people, disabled people or children.
- This structured, score-based approach helps decide the high-risk cases (score of 14 or more or for lower scores, where you have professional concerns) that you will need to refer to the MARAC for a multiagency assessment. It provides a record for any subsequent case management or review and contributes to making decisions based on evidence. You should read the full practice guidance and frequently asked questions before completing the form.
- Based on findings from domestic homicide reviews, the top six risk indicators are:
  - victim's pregnancy
  - stalking/harassment
  - separation/child contact
  - sexual abuse
  - escalation of abuse
  - victim isolation.
- You will need the consent of a competent adult victim to refer them to a MARAC, unless the public interest test is engaged with the high threshold risk.[56,57] A MARAC referral will go to the police and an independent domestic violence adviser (IDVA) will contact the victim discretely, initially by telephone where available. While consent is not needed for children, it is best to engage with the person if it is their child, or if they themselves are under 18 years old.
- If you think that an abused adult may lack capacity to make any decision related to or arising as a result of the suspected abuse, with advice from your named or designated safeguarding professional, you will need to consult guidance on the Mental Capacity Act 2005.[58] Under the Act, where the vulnerable adult has no family or friend who can speak on their behalf, or where such networks are suspected as potential abusers, you need to consider whether to appoint an independent mental capacity advocate.
- If you are responding to an adult who is experiencing abuse and neglect, you will need to follow your local procedure on safeguarding adults. This should reflect the statutory guidance on care and support of adults who may need safeguarding.[12] Under the guidance, safeguarding adults has to be part of promoting their wellbeing, recognising that adults can have complex interpersonal relationships and may be ambivalent, unclear or unrealistic about their personal circumstances. The practitioner must take into account what being safe means to an adult experiencing domestic violence, and work with them to establish solutions. The Care Act safeguarding duties apply to an adult who:

  - has needs for care and support (whether or not the local authority is meeting any of those needs)
  - is experiencing, or is at risk of, abuse or neglect
  - as a result of those care and support needs, is unable to protect themselves from either the risk of, or the experience of abuse or neglect.

- Undertaking a risk assessment for each dependent child in the family, and listening and speaking to each child present carefully, provides a record of evidence and information on which to base a referral to social services. You may use the Barnardo's Domestic Violence Risk Identification Matrix (DVRIM) or the Safe Lives DASH risk assessment checklist for young people. You can find an outline of these at Annexes E and F.
- If the initial assessment and advice from your named/designated safeguarding professional indicates that the risk is not critical, then the child may be referred to a local Early Help Assessment[10] (see Glossary). It is the lead professional's responsibility to co-ordinate this assessment. They can come from any agency. No consent is needed for referring a child, but it is important to set out what you are doing.
- Before making the referral, discuss the case with your named/designated safeguarding professional and consider what immediate actions you and your agency need to take to support the victim, and children involved, to increase their safety (see 4.5 Interventions below).

Additional factors in responding well to children

The law requires you and your organisation to provide health services in a way that safeguards children and promotes their welfare. This includes co-operating effectively with local partner agencies as needed.

- Follow safeguarding procedures for all children aged 0-18 years who are at risk of neglect and/or abuse.
- Safeguarding procedures can be combined (not replaced) with case management by a young person's independent domestic violence adviser (IDVA) taking the case to the local multiagency risk assessment conference (MARAC).

Only half of all children referred to specialist domestic abuse services are known to children's social care, so identification and referral by a health professional may be their only chance of being protected from harm.[26] You should:

- work on the basis that, if there is a child involved, their safety and wellbeing needs to be secured
- be guided by your local authority's Threshold of Need guidance, which should provide information about assessment, referrals and services available for children and their families at different levels of need
- identify children's and families' strengths/protective factors because increased resilience can reduce the risk of harm.[60] Key components of resilience are self-esteem and confidence, adapting to change and having a repertoire of social problem-solving skills.

Like direct physical harm, witnessing domestic abuse can have adverse emotional, behavioural and traumatic impacts on children.[59]

- Though resilient to trauma, many children go on to develop clinically-significant emotional and behavioural problems. Be clear about all the impacts on physical, emotional and mental health and record the actions you will take to address them.[60]

Additional factors in responding well to adults

Responding well to older people and people with disabilities

Your response to an older person, or a person with disability, should be the same as for younger people, but with an added awareness that people in vulnerable circumstances face greater barriers to disclosing abuse or accepting support. Fear of unknown intervention can feel more risky than the known fear of abuse, especially where perpetrators might be depended on as carers and also as relatives or friends.[61] It is not unusual for vulnerable people in such circumstances to deny that there is a problem, even in very serious cases.

Responding well to stalking

Any allegation of stalking, online or in person, should be taken very seriously as it is synonymous with increased risk of serious harm or death. Stalking by partners or ex-partners is one of the most predictive factors of both further assault and of murder, even in cases where there is no history of physical violence. Stalkers will often combine physical, emotional and sexual intimidation. They may also broaden their targets to family and friends in a bid to exert control over the person's life.

Responding well to women from black and ethnic minority communities

The under-reporting of domestic abuse by women, especially from black and ethnic minority communities is because they can face additional barriers to disclosure. Help women overcome the following potential barriers:

- language barriers
- family or the group's honour, shame and stigma
- fear of confidentiality being broken
- immigration status and no recourse to public funding
- racism – perceived or actual
- cultural beliefs and practices
- fear of rejection by their community
- misunderstandings of forced marriage and FGM
- more than one perpetrator in the family or community
- fear of honour-based violence.[61]

Do not underestimate that perpetrators of honour-based violence can kill close relatives and/or others for what might seem a cultural transgression. If you are unsure of how to proceed, call the following helplines for advice:

Karma Nirvana – 0800 5999247 or 01332 604098

Iranian and Kurdish Women's Rights Organisation – 0207 920 6460

HALO Project (for honour-based violence) Emergencies – 08081 788 424 (free phone) or for advice 01642 683 045

Forced Marriage Unit – 0207 008 0151

4.5 Interventions

'Coping' and 'recovery' are the terms used by the police Victims' Services Commissioning Framework,[17] referring to interventions that help the victim cope with any immediate impacts of abuse, and to support recovery from the longer-term harm to personal wellbeing that the abuse may have caused.[62]

People who are experiencing domestic abuse are likely to need help and support in more than one aspect of their lives. Diagram 7 is adapted from the assessment framework used for children in need to help practitioners identify categories of victims' support needs.

Health professionals have a responsibility to address the health impacts on people directly or indirectly affected by domestic abuse. They also have a duty to ensure that other agencies are engaged to address the social, environmental and wider impacts. People experiencing domestic abuse may choose to disclose to health professionals, including GPs.

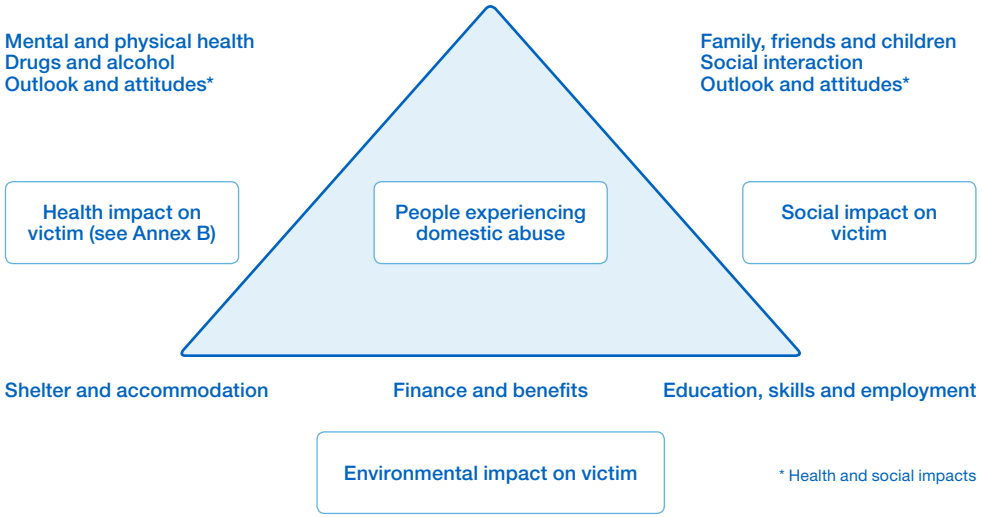

Diagram 7: Adapted framework for categorising support needs

Do not advise a victim to leave their partner without all the support in place, including police involvement, because they are at high risk of injury or murder when they leave a violent and abusive partner.

If a person discloses that they are suffering domestic violence or abuse, an initial risk assessment can inform a number of options to address the immediate and longer-term health, social and environmental impacts. Some of the options are represented in Diagram 8. There is some interdependency between the social and environmental options.

Short-term Interventions		
Health	**Social**	**Environmental**
Acknowledge the disclosure. Being believed is very important. Address presenting physical injuries and refer for more serious injuries. Undertake a comprehensive physical and mental health assessment. Refer to appropriate health services as relevant, for example: • maternity services • Sexual Assault Referral Centre (SARC) in the case of sexual abuse.[63] • substance misuse services • trauma-focused mental health treatment. If you are not the GP, refer to a GP for a psychological or mental health assessment for a decision on suitable therapy.	Refer people under 18 years old to children's social care services, including early years services. Refer to safeguarding adults groups/boards.	Initial safety plan. If below MARAC threshold, and there are no other concerns, help the person contact local specialist domestic violence services for help such as: changing locks; advice on legal routes, e.g. restraining orders or injunctions; emergency refuge accommodation; IDVA advocacy and support.[64, 65, 66] Make a MARAC referral if at threshold. Report to police if immediate risk is very serious, with consent if it is about a competent adult. If no consent, consider public interest test.[56, 57]
Longer-term Interventions		
NHS psychological therapy, physical or mental health treatment.	Safeguarding measures in place for vulnerable adults. Child protection plan for children.	Support the person to develop resilience and seek help through local specialist services for domestic abuse.

Diagram 8: Options for addressing the health, social and environmental impact

"The mental health service also should have a big role in responding to violence against women. It's after the abuse that women mostly need the support."[53]

"The service here at SERICC [South Essex Rape and Incest Crisis Centre] is my lifeline. Without the service here and without the support of my GP, I wouldn't survive. Because when things have happened to you, you become vulnerable and you find it impossible to cope without support."[53]

There are support programmes to improve the wellbeing of children exposed to domestic abuse.[67] Some of the interventions in North America have been tested rigorously, but there is less evidence on the impact of those being used in the UK. Recent research by the National Institute for Health Research has called for more evaluation programmes of interventions in the UK.[68]

4.6 Gathering and recording information

You should record sufficiently detailed, accurate and clear notes to show the concerns you have and indicate the harm that domestic abuse may have caused. Records can be used in:

- criminal proceedings if a perpetrator faces charges
- obtaining an injunction or court order against a perpetrator
- immigration and deportation cases
- housing provision
- civil procedures in family courts to assess the risks associated with granting an abusive parent contact with children
- serious case reviews, safeguarding adult reviews and domestic homicide reviews.

"The solicitors said there just wasn't enough evidence on my health records. Nothing to suggest my ex was to blame for my injuries. I was so let down. I thought my doctor had written down everything I said."[69]

Always keep a detailed record of what you have discussed with a patient – even if your suspicions of domestic abuse have not led to disclosure. The patient might disclose information in the future.

- For confidentiality ensure that the record can only be accessed by those directly involved in the victim's care.
- Domestic abuse should never be recorded in hand-held notes, such as maternity notes.
- A patient's permission is not required for you to record a disclosure of domestic abuse or the findings of an examination. Make it clear to a person or child that, as a duty of care, you have a responsibility to keep a record of their disclosure and injuries.[70, 71, 72]
- Data protection regulations exempt information from being released as a result of an access request which "would be likely to cause serious harm to the physical or mental health or condition of the data subject or any other person".[73]
- Even if an abuser was able to sustain a right of subject access, information provided by their wife/partner about the abuse could still be withheld on the grounds that it would be likely to result in further abusive behaviour causing serious physical or mental harm to the wife/partner.

When recording information, you should:

- describe exactly what happened. For example, patient states "my husband kicked me twice in stomach" rather than "patient assaulted". Diagnostic codes for domestic violence will be included in electronic patient records
- use the patient's own words (with quotation marks) rather than your own

- document injuries in as much detail as possible, using body maps to show injuries, and record whether an injury and a victim's explanation for it are consistent. For example, "patient has four small two-pence-sized bruises on her upper arm 2cm apart. Patient reported 'I fell down, I can't really remember what happened'"
- take photographs (sign and date them) as proof of injuries.

In general practice, domestic abuse records should be seen in the context of the whole health record to get a clear understanding of repeat consultations for health problems connected to the abuse. However, practices that encourage hand-held records should record abuse separately.

- You should record concern or disclosure of domestic abuse on the records of dependent children.
- If your organisation has computerised records, ensure that nothing about domestic abuse is visible on the opening screen (which could be seen by a perpetrator or another member of staff).
- Where there selective or routine enquiry is practised, devise a code to indicate whether the question has been asked and information provided, when it was carried out and what the outcome was – to alert staff to potential risks.

What to include in notes

Your notes on domestic abuse should include:

- suspicion of domestic abuse which has led/not led to disclosure
- whether routine or selective enquiry has been undertaken and the response
- relationship to perpetrator, name of perpetrator
- whether the woman is pregnant
- the presence of children in the household and their ages
- nature of psychological and/or physical abuse and any injuries
- description of the types of domestic abuse/any other abuse experienced and reference to specific incidents
- whether this is the first episode, or how long regular abuse has been going on
- presence of increased risk factors
- results of completed Domestic Abuse, Stalking and Honour Based Violence (DASH) risk assessment for the adult and a Domestic Violence Risk Identification Matrix (DVRIM) or DASH assessments for each child, if relevant
- indication of information provided on local sources of help
- indication of action taken (for example, direct referrals)

4.7 Confidentiality and sharing information

Confidentiality

It is vital that information on domestic abuse is kept confidential to protect victims from injury or death. However, in some instances, failure to share information can put victims at risk. When sharing information about adult patients, breaking confidentiality has to be based on consent, unless there is a public interest or other legal justification. *Confidentiality: NHS Code of Practice* sets out the standards required for confidentiality of patient information and consent.[57]

The General Medical Council and other professional regulators also provide members with helpful guidance on confidentiality and consent.[74, 75, 76]

Be particularly careful in situations where confidentiality could accidentally be broken and cause harm, such as:

- in general practice, where health professionals might treat other members of a victim's family – including the perpetrator of the domestic abuse. The perpetrator may punish their victim for disclosing the abuse or use the GP surgery as a source of information to track down a victim who has moved away
- if a child who is staying at a refuge spends time in hospital and the perpetrator of the domestic abuse visits the child, you should take care that records on display do not include a contact address or any other information that could help a perpetrator track down people he has abused

Gina McCarthy's husband had been refused contact with his baby son following their separation. The courts had ordered Gina to send her husband monthly progress reports via social services. Using the information from the monthly reports, Gina's husband identified her home, tracked her down and killed her in front of their son, who he then abducted.[77]

Sharing information

Sharing anonymised data does not need individual consent. Consent should be sought to share personal information. Although, if the information was provided on the understanding that it would be shared with a limited range of people or for limited purposes, then sharing accordingly will not be a breach of confidence.

Where consent cannot be obtained or is refused, or where seeking it is likely to undermine the prevention or interruption of a crime, professionals may lawfully share information if this can be justified in the public interest, such as:

- where there is a risk of harm to the victim, any children involved or somebody else if information is not passed on as a referral
- to inform a risk assessment (where the definition of 'harm' to a child includes impairment caused by seeing or hearing the abuse of another person)[78]
- when the courts request information about a specific case.

If you do pass on information without permission, you should be completely sure that your decision does not place somebody at risk of greater violence. Record your reasons to be able to justify your decision and subsequently, record confirmation that the information you passed on has been received and understood.[79]

Always follow local single and multiagency guidelines for sharing information. These should comply with the Data Protection Act 1998[25, 80], Caldicott principles and safeguarding guidance for children or adults.[81, 82] The guidelines should define the range of information that can be shared and with whom (including information on a perpetrator's criminal history). You may also seek advice from the Caldicott guardian if you are working in an NHS organisation.

Mark Goddard was convicted for the murder of his wife, Patricia. In the five months before Patricia's death, her employer and six different agencies (including health, housing and police services) were aware of her problems and abuse. None of the agencies informed anyone else about their concerns. We don't know that information sharing could have saved Patricia's life, but it would have at least enabled a comprehensive risk assessment to be carried out.[77]

Sometimes failure to share information can be as dangerous as breaking confidentiality. For instance, the definition of 'harm' to a child as a result of domestic abuse includes impairment suffered from seeing or hearing ill treatment of another person.[83] Only ever consider giving information to reputable agencies – never to individuals making enquiries about a victim's circumstances.

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Section 5: Commissioning services and responding to perpetrators of domestic abuse

The primary goal of all work with perpetrators of abuse is to ensure the safety of victims and their children. Perpetrators are ordinary users of the health service, which means health professionals are in a key position to identify them and assist in the interruption of their harmful behaviours.[84] An exploratory study of intimate partner homicides suggests that depression, mental health and suicide risk are indicators of high-risk perpetrators.[85] The majority of domestic violence and abuse perpetrators are male, but health professionals also need to understand the markers of perpetration by females.

This section covers commissioning services and the response from professionals.

The aims are to be able to help perpetrators as follows:

- commissioners support specialist services for perpetrators with local referral pathways
- service providers work with integrated local referral pathways to improve victim safety
- health professionals understand perpetration and refer to local specialist services
- health professionals are confident and competent in:
  - identifying abusers
  - asking questions and responding to perpetrator disclosures
  - making referrals to local specialist services
  - recording and sharing information.

5.1 Commissioning services for perpetrators of domestic abuse

The NICE multiagency guideline on domestic violence and abuse found insufficient evidence of the cost effectiveness of interventions with perpetrators. However, NICE agreed that interventions were a necessary part of tackling the domestic abuse.[2] NICE therefore recommends that HWBs and commissioners that provide services for perpetrators should ensure that:

- commissioning is informed by a robust evaluation of services
- commissioned, tailored interventions for perpetrators of domestic violence align with national standards and local needs assessments
- the primary aim of perpetrator services is to increase safety for victims
- for the perpetrator, individual attitudinal change, accountability for violence and willingness to engage with the services should be monitored and reported to demonstrate patient outcomes and service effectiveness
- they identify and link the services working with or available to perpetrators of abuse
- services to victims and perpetrators are linked to enable timely exchange of information, for example, in ongoing risk assessments of the perpetrator, with safety planning for victims
- services commissioned for perpetrators are available in different languages and are suitable for those with additional needs such as physical, sensory or learning disabilities.

NICE Quality Statement 4 sets out a quality standard for referring people over 16 years old who disclose that they are perpetrators.[3] The standard seeks to drive the improvements needed in patient safety, patient experience and clinical effectiveness. Commissioners will need to:

- drive local arrangements to ensure that specialist services are available
- ensure that local referral pathways are in place.

The simple measure of progress recommended by NICE is the proportion of perpetrators who disclose and are referred to specialist services. This can be taken from local data, collected by service providers and shared with commissioners.

5.2 Providing services for perpetrators of domestic abuse

Both specialist and universal services have a role to play in rehabilitating perpetrators' abusive behaviours.

Specialist services

A range of specialist services for perpetrators may be available locally or regionally based on a number of different therapy approaches, including:

- a structured domestic violence perpetrator programme (DVPP) offering a series of weekly sessions using education and challenge, and examining the individual's behaviours and beliefs about gender and relationships to change their behaviour. In the UK, perpetrator services are run by prisons and the criminal justice system or as community-based programmes, usually by third sector organisations. DVPPs aim to increase the safety of victims by supporting perpetrators to end their use of violent and abusive behaviours.

DVPPs should be accredited, or working towards accreditation by the national organisation, Respect.

- DVPPs are primarily designed for abusive men in heterosexual relationships, but some can work for female abusers in heterosexual relationships and people in same-sex relationships:

Through the *Drive Partnership*, police and crime commissioners in Essex, Sussex and South West Wales are working with Safe Lives and Social Finance to support and challenge high-risk male and female perpetrators (above the MARAC line) who are over 16 years old, to change their abusive behaviours. The three-year pilot started in February 2016 and is expected to work with 900 high-risk perpetrators.[86]

Strength to Change is a confidential service led by NHS Hull for men who are concerned about their violence and abuse in their intimate relationships. The primary aim of the service is to improve the safety of women and children while giving men an opportunity to change their behaviour. It offers support to male perpetrators, professionals who come into contact with them and victims, friends and family members wanting to find out what help is available for perpetrators.[87]

- While the evidence is not confirmed, some programmes for perpetrators appear to indicate that domestic abuse is also a relationship and family issue rather than a power dynamic malfunction.

Working with the Tavistock Centre for Couple Relationships, Harrow Council has made a service available for couples living in the borough who are violent to each other. Based on a model from the USA, couples are engaged individually before being brought together in family therapy, with wider social care support for them and their children.[88]

The Good Lives Model of Offender Rehabilitation developed in New Zealand is a strength-based rehabilitation model that focuses on the child or young person's interests, abilities and aspirations and provides a framework for healthy human functioning and an effective approach for therapy.[89] It is also applicable to adult perpetrators. English and Welsh youth justice inspectorates recommend approaches that incorporate or replicate the model.[90]

The Caledonian System designed in Scotland draws from the Good Lives Model and combines challenges to reduce harm with the recognition that offenders want better lives. It is accredited by the Scottish Accreditation Panel for Offender Programmes and the Equality Unit of the Scottish Government.

The Caledonian System works with men convicted of offences related to domestic violence to reduce reoffending. It is integrated with a women's service to provide safety planning, information, advice and emotional support to partners and ex-partners and with a children's service to meet the needs and rights of the children involved with the offender.[91]

Following the expanded definition of domestic violence to include 16- to 18-year-olds, the Department for Education sponsored SafeLives and partners to offer training support and advice to young people's advocates. The programme showed that specialist domestic abuse services can provide effective help for young people who harm others. Of the young people supported through the programme in 2014, 20% were perpetrators.[92] There was a reported 50% reduction in the number of cases where the young people's behaviour remained a concern. SafeLives are continuing to develop training and other resources for the advocates.

Universal services

Mental health problems and substance misuse may be factors in abusive behaviour but are not the sole causes of perpetrators' behaviour. For example, some perpetrators may have issues relating to past traumatic experiences. A referral pathway that does not include specialist domestic abuse perpetrator programmes risks dealing with such health issues alone and may allow the perpetrator to avoid responsibility for their domestic abuse behaviours with increased risk of harming. Substance misuse and mental health services should not work in isolation from perpetrator services. Therefore universal and specialist services both need to be built into local referral pathways.

5.3 Health professionals responding to perpetrators of domestic abuse

Identifying an abuser

You may encounter perpetrators of domestic abuse as direct service users. You may also encounter them through partners or children you know or suspect are affected by domestic abuse. Your approach will depend on whether the perpetrator directly acknowledges their domestic abuse behaviour as a problem, seeks help for a related problem, or has been identified by others as abusive. This section provides information for all health professionals who come into direct contact with patients who may be perpetrating domestic violence and abuse. However, after anonymous helplines, GPs are the main source of support accessed by perpetrators.[93]

"I actually punched the wife … we have our arguments but after doing that it was something I never want to do again, so she went to her sister's and I went to the doctor and asked where I could go for help."[94]
People who perpetrate domestic abuse are not a homogenous group. The discussion below should not be considered stereotypical.

'The main findings from this examination of the criminogenic needs of DV [domestic violence] offenders on probation or referred for a pre-sentence report in England were that they are not a homogeneous group in terms of characteristics and criminogenic need. Two types of DV offenders were identified:

- *borderline/emotionally dependent offenders, who were primarily characterised by high levels of interpersonal dependency, high levels of anger and low self-esteem;*
- *antisocial/narcissistic offenders, who were primarily characterised by hostile attitudes towards women, low empathy and had the highest rate of alcohol dependence and previous convictions.'*[95]

Abusive people as service users

Some people may identify their abusive behaviour directly and ask for help to deal with their violence. This is usually prompted by a crisis such as a particularly serious assault, an arrest or ultimatum from the abused partner.

Even though abusers may have come voluntarily, they are unlikely to admit responsibility for the seriousness or extent of the abuse, and may try to 'explain' the abuse or blame other people or factors.

They may present with other related problems such as alcohol, stress or depression, and may not refer directly to the abuse.

They present themselves as victims. They may do this because their victim has defended themselves or retaliated with violence or because they are seeking to control and isolate the victim – who may then not have access to the right type of services they need because they could be seen as 'the perpetrator'. This pattern is sometimes observed among female perpetrators. Without resolving counter-allegations you will not be able accurately to understand the likely risks to both parties and to any children.

Abusive young people

A 2009 study by the National Society for the Prevention of Cruelty to Children (NSPCC) found that up to three-quarters of teenage girls and up to half of teenage boys reported emotional, physical and/or sexual violence in their intimate partner relationships, with girls experiencing more severe violence.[96]

Of the young people receiving help from the Department for Education's National Young People's Violence Advocacy Programme, 20% have been causing harm, most frequently to a current or ex-girlfriend, or a parent.[97] This prevalence means that a number of the young men you come into contact with as patients will be coercive and violent towards their partners.

Foshee et al, cited in the NSPCC research, found that more than half of boys perceived violence as a 'playful and accepted' aspect of relationship behaviour.[98]

Partner abuse by young men can also be part of a more complex picture of gang-related abuse – with the peer group often appearing to support it.[99, 100]

Abusive people as partners of service users

You may encounter people who insist on accompanying their partners to appointments or who want to speak for their partners. Likewise for adult children accompanying their older parent. These escorts may appear to be caring and protective and very plausible; some may be carers of partners or parents with long-term health conditions. However, controlling their relative's access to you is part of the abuse. Always find a way to see your patient on their own and only use professional interpreters where needed.

Directly engaging with an abuser who is not your service user may be difficult, given the normal standards of service user confidentiality and the overriding need to avoid acting in a way that might increase the risk of harm to their relative.

Abusive parents of young service users

There are clear links between domestic abuse and child abuse (as high as 40% in some cases)[101, 102] and much evidence about the detrimental impact of domestic abuse and violence on children (See Annex B). If you have any suspicions, information or a disclosure that an adult may be an abuser, you should:

- establish if there are children in the household, the number of children and their ages
- explain that children are always affected by domestic abuse
- explain the limits of confidentiality and your safeguarding responsibilities.

Responding to female perpetrators

There is increasing recognition of abusive females in heterosexual relationships and in same-sex relationships.

- A critical review found emotional abuse to be most common, followed by physical and sexual violence.[103]
- A growing critique asserts that the same power dynamic of abuse may be at play for both male and female abusers. Behaviour change needs to affirm both individual and social responsibilities and mutual respect for equality.[104]
- There is a counter-critique that females are the gender who are most abused – repeatedly and more severely. Crown Prosecution Service data for 2014/15 reported that 92% of defendants in domestic abuse cases were male and the proportion of female victims was consistently around 84%.[105]

- Evidence suggests that some females who abuse may be motivated by defence, fear, control or retribution.[106]

Practitioners need to be able to apply their understanding of domestic abuse to identify and provide early support to all the victims they see in their services, irrespective of gender or sexuality of the victim or the perpetrator.

Asking questions

Health professionals' responses to any disclosure of abuse could be significant in encouraging responsibility and motivating a perpetrator to change. However, before seeking or enabling a disclosure from a person you suspect may be a perpetrator of domestic abuse, you should be confident. You should also consider your own safety and that of the victim and any children.

Use motivational interviewing approaches to be persuasive but supportive. Use incisive moments to intervene.[107, 108, 109] A simple set of skills is needed for this approach, but the key principles are:

- express empathy through reflective listening
- identify discrepancy between the client's goals or values and their current behaviour and explore it further
- avoid argument and direct confrontation
- adjust to the client's resistance rather than opposing it directly
- support self-efficacy and optimism.

If the patient presents with a problem such as drinking, carer issues, stress or depression, but does not refer to their abusive behaviour, these are useful questions to ask:

- How is this drinking/stress at work/depression affecting how you are with your family and spouse?
- When you feel like that, what do you do?
- When you feel like that, how do you behave?
- Do you find yourself shouting/smashing things?
- Do you ever feel violent towards a particular person?
- It sounds like you want to make some changes for your benefit and for your partner/family. What choices do you have? What can you do about it? What help would you like to make these changes?

If the patient has stated that domestic abuse is an issue and they are not the victim, these are useful questions to ask:

- How does your behaviour make you feel?
- How does your behaviour affect people close to you?
- How do alcohol/drugs affect your behaviour?
- What do you think will help you change your behaviour?

If the patient responds openly to these prompting questions, more direct questions relating to heightened risk factors may be appropriate:

- Do you feel unhappy about your partner seeing friends or family – do you ever try to stop them?
- Have you assaulted your partner in front of the children?
- Have you ever assaulted or threatened your partner with a knife or other weapon?
- Did your behaviour change towards your partner during pregnancy?

Making referrals to local specialist services

You should be aware of local referral pathways and offer patients perpetrating domestic abuse referrals to specialist services.[3] The information you have gathered from the patient will be the basis for doing so. The first step is to manage the risk to the victim and any children. The second is to address the perpetrator's behaviour and other health needs.

Young people between 16 and 18 years old who are harming their partner, siblings, parents or other adult family members should be referred for support through child protection procedures. Children who harm others are likely to have considerable needs themselves.[100]

You can go to a number of sources if you need more advice, including:

- the designated safeguarding professional in your organisation
- community perpetrator programme services. Many CSPs include what is available in their area on their website. Alternatively you could contact the PCC's office to ask about what is available in the local area
- the Respect national phone line for domestic violence perpetrators (see below)

Respect Phone Line: 0808 802 4040 or email at info@respectphoneline.org.uk. Respect is a membership association for providers of domestic violence perpetrator programmes and associated support services, such as information and advice to frontline workers, including providing contact details for local perpetrator programmes.

Recording and sharing information

It is vital to keep detailed records if a patient discloses abusive behaviour. This important information will enable continuity of care and may also help in any future legal proceedings, serious case reviews, safeguarding adult reviews, domestic homicide reviews or other inquiries.

Record the information and file it in the perpetrator's case notes. While these records are strictly confidential, if there is a risk of death to an adult or a risk of significant harm to a child, this will override any requirement to keep information confidential.[57] See also sections 4.6 and 4.7.

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Glossary

Caldicott Guardian – the senior person responsible for protecting the confidentiality of patient and service-user information and enabling appropriate information sharing. The Guardian plays a key role in ensuring that the NHS, councils with social services responsibilities and partner organisations satisfy the highest practical standards for handling patient identifiable information; actively supports work to enable information sharing where it is appropriate to share and; advises on options for lawful and ethical processing of information; represents and champions issues related to information sharing at board or management team level.

Caldicott principles – in 1997, a review committee under the chairmanship of Dame Fiona Caldicott investigated ways in which patient information is used in the NHS. The Caldicott Report highlighted six key principles (to which a seventh was subsequently added):

- justify the purpose(s) of using confidential information
- do not use patient-identifiable information unless it is necessary
- use the minimum necessary patient-identifiable information
- access to patient-identifiable information should be on a strict need-to-know basis
- everyone with access to patient-identifiable information should be aware of their responsibilities
- understand and comply with the law
- the duty to share information can be as important as the duty to protect patient confidentiality.

These principles have been subsumed into the NHS confidentiality code of practice.

Clinical commissioning group (CCG) – CCGs were created by the Health and Social Care Act 2012, replacing Primary Care Trusts. CCGs are clinically-led NHS bodies responsible for the planning and commissioning of health care services for their local area.

Code of Practice for Victims of Crime (the Victims' Code) – forms a key part of the wider Government strategy to transform the criminal justice system by putting victims first, making the system more responsive and easier to navigate. The Code sets out the services that must be provided to victims of crime by organisations in England and Wales. Victims of crime should be treated in a respectful, sensitive, tailored and professional manner without discrimination of any kind. They should receive appropriate support to help them, as far as possible, to cope and recover and be protected from revictimisation. It is important that victims of crime know what information and support is available to them after reporting a crime and who to request help from if they are not getting it.

Community safety partnership (CSP) – a statutory partnership of local organisations which work together to create strategies and practical interventions to reduce crime and disorder in their local area. CCGs are the health partners – strategies are likely to overlap with local health priorities including reducing health inequalities, improving the quality of life and independence of vulnerable older people and improving the life chances of children.

Community treatment order – allows a person who has been detained in hospital for treatment to leave hospital (discharged from detention) and get treatment in the community.

Designated safeguarding professional – a clinical expert and strategic leader, who takes a lead on all aspects of the health service contribution to safeguarding children across an area, providing leadership, advice, support and supervision to named safeguarding health professionals, social workers, Local Safeguarding Children Boards and NHS England. Designated professionals also provide advice to subcontracting agencies, independent providers and privately funded establishments within the health economy.

Domestic Abuse, Stalking and 'Honour'-Based Violence (DASH) RISK – a risk identification, assessment and management model that was implemented across all police services and partner agencies in the UK from March 2009. SafeLives has produced a DASH risk identification checklist for use by IDVAs and other non-police agencies to identify risks when domestic abuse, 'honour'- based violence and/or stalking are disclosed.

Domestic homicide review (DHR) – Community safety partnerships (CSPs) are responsible for undertaking DHRs where the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by a relative, household member or someone with whom he or she has been in an intimate relationship. The purpose is to learn lessons regarding the way in which local professionals and organisations work individually and together to safeguard victims, and to change practice, policies or procedures as necessary.

Domestic Violence Disclosure Scheme (DVDS) – often referred to as "Clare's law", the DVDS was rolled out across England and Wales from March 2014. An individual can ask the police to check whether a new or existing partner has a violent past ("right to ask"). If police checks show that a person may be at risk of domestic violence from their partner, the police will consider disclosing the information ("right to know").

Domestic violence prevention programme or domestic violence perpetrator programme (DVPP) – behaviour-change programmes for people who use violence and abuse towards their (ex)partners. Normally offered over a series of weekly sessions using education and challenge, and examining the individual's behaviours and beliefs about gender and relationships to help to change their behaviour. In the UK, perpetrator services are run by prisons and the criminal justice system or, as community-based programmes, usually by third sector organisations.

Domestic Violence Protection Order (DVPO) – DVPOs were rolled out across England and Wales from March 2014. Under the DVPO scheme, the police and magistrates can, in the immediate aftermath of a domestic violence incident, ban a perpetrator from returning to their home and from having contact with the victim for up to 28 days. An initial temporary notice (Domestic Violence Protection Notice, DVPN) can be authorised by a senior police officer and issued to the perpetrator by the police, followed by a DVPO that can last from 14 to 28 days, imposed at the magistrates' court. DVPOs are designed to help victims who may otherwise have had to flee their home, giving them the space and time to access support and consider their options. They can be issued for all forms of domestic abuse, including coercive control.

Domestic Violence Risk Identification Matrix (DVRIM) – a tool, freely available from Barnardo's, the children's support charity, for assessing the risks to children from domestic abuse.

Fraser guidelines and Gillick competence – refer to a legal case which looked specifically at whether doctors should be able to give contraceptive advice or treatment to under 16-year-olds without parental consent. However, since then, they have been more widely used to help assess whether a child has the maturity to make their own decisions on health care and to understand the implications of those decisions.

Health and Wellbeing Board (HWB) – a statutory strategy committee covering an upper tier local authority area. Hosted by the local authority, the HWB has key representation from across the health and care system. By undertaking a joint strategic needs assessment (JSNA), the HWB formulated a joint health and wellbeing strategy (JHWS), which should inform the commissioning activities of its members.

Identification and Referral to Improve Safety (IRIS) – an evidence-based model founded on training, support and a referral programme for general practice teams to identify and support female victims of domestic abuse. Core areas of the programme are training and education, clinical enquiry, care pathways and an improved referral pathway to local specialist domestic violence services in the third sector. An advocate educator who is based in a local specialist domestic violence and abuse service is linked to the general practice, and works with the clinical lead jointly to provide training and document referral pathways. IRIS also signposts to perpetrator services.

Independent domestic violence adviser (IDVA) – addresses the safety of victims at high risk of harm from intimate partners, ex-partners or family members to secure their safety and that of affected family members. Serving as a victim's primary point of contact, an IDVA is proactive in implementing safety plans, which address immediate safety, including practical steps to protect victims and their families, as well as longer-term solutions. IDVAs should receive specialist accredited training and hold a nationally recognised qualification.

Independent mental capacity advocate (IMCA) – a statutory form of advocacy that was introduced in April 2007 in line with the Mental Capacity Act 2005. The aim of the IMCA service is to provide independent safeguards for people who lack capacity to make certain important decisions regarding a change of accommodation, serious medical treatment, care reviews and adult protection investigations.

Independent sexual violence adviser (ISVA) – provides a similar service to an IDVA, to victims of rape and sexual assault. Sexual assault can be implicated in intimate partner abuse. Like IDVAs, an ISVA normally works through local agencies providing specialist services to survivors of rape and sexual abuse, including NHS services such as Sexual Assault Referral Centres, as well as third sector providers.

Joint health and wellbeing strategy (JHWS) – a local strategy, produced by the health and wellbeing board (which brings together representatives of the local authority and CCGs), that explains what priorities have been set in order to tackle the needs identified in the JSNA.

Joint strategic needs assessment (JSNA) – an assessment of the current and future health and social care needs of the local community, produced by the health and wellbeing board.

Local Safeguarding Children Board (LSCB) – the Children Act 2004 requires each local authority to establish an LSCB for their area and specifies the organisations and individuals that should be represented on it. LSCBs co-ordinate local work undertaken by all agencies and individuals to safeguard and promote the welfare of children and young people and ensure the effectiveness of that work. They play a key part in promoting a good response to dependent children living with domestic abuse and young people over 16 years old who are experiencing abuse within intimate partner relationships. Subject to the passage of the Children and Social Work Bill in 2017, LSCBs will be replaced by new local multi-agency arrangements for safeguarding children, to be established jointly by local authorities, police and CCGs.

Multi-Agency Public Protection Arrangement (MAPPA) – the process through which the police, probation and prison services work together with other agencies to manage the risks posed by violent and sexual offenders living in the community, in order to protect the public.

Multi-Agency Risk Assessment Conference (MARAC) – all police force areas in England and Wales have a MARAC. MARACs are victim-focused, co-ordinated multi-agency meetings where statutory and voluntary agency representatives share information about individual high-risk victims of domestic abuse, in order to produce a co-ordinated action plan to increase the victim's safety.

Multi-Agency Safeguarding Hub (MASH) – brings together practitioners, still employed by their individual agencies but usually co-located in one office. The MASH operates on the basis of a 'sealed' intelligence hub, with clear information sharing protocols, to combine the information held by the full range of agencies working with a child or family. This allows practitioners to build up a fuller picture of an individual child's circumstances and history before deciding the most appropriate course of action to keep them safe.

Named safeguarding professional – each health provider must have a named nurse and named doctor (and a named midwife, if the agency provides midwifery services) for safeguarding children, to support all activities necessary to ensure that the organisation meets its responsibilities to safeguard and protect children and young people. Named professionals promote good professional practice within their organisation, provide advice and expertise to fellow professionals, and ensure safeguarding training is in place.

NHS Code of Practice on Confidentiality – sets out standards required for NHS and NHS funded organisations concerning patient confidentiality.

National Institute for Health and Care Excellence (NICE) – an executive non-departmental public body of the Department of Health, which provides national guidance and advice to improve health and social care.

Police and Crime Commissioner (PCC) – an elected representative who oversees how crime is tackled in a police force area. The aim of PCCs is to cut crime and to ensure the police are effective. The decisions and actions of the PCC are scrutinised and challenged by the police and crime panel. The panel reviews the PCC's draft police and crime plan and scrutinises the PCC's annual report.

Safeguarding Adults Board (SAB) – people with care and support needs who are experiencing, or at risk of, abuse or neglect, may be unable to protect themselves. The Care Act 2014 requires an SAB to be established in each local area. The SAB has a duty to make safeguarding inquiries in certain circumstances, provide for sharing information and to carry out safeguarding adult reviews in serious cases.

Serious case review (SCR) – LSCBs are required to undertake an SCR after a child dies or is seriously injured and abuse or neglect is thought to be involved. It looks at lessons for all the professionals and agencies involved, that can help prevent similar incidents from happening in the future. Similarly, an adult SCR will consider the circumstances that led to, for example, a death from domestic violence and identify where responses to the situation could have been improved.

Sexual Assault Referral Centre (SARC) – a "one stop" location where victims of sexual assault can receive medical care and counselling, whilst at the same time having the opportunity to assist the police investigation of alleged offences. It includes facilities for a high standard of forensic examination.

Specialist domestic violence service (SDVS) – provided by the voluntary and community sector, and funded through commissioning by local authorities, CCGs and PCCs and from fundraising. These services provide support, advocacy, advice and sometimes counselling to local victims of domestic abuse. They employ IDVAs to work with victims at significant risk of harm. The SDVS may offer each woman a keyworker or IDVA support (normally if they reach or are above the MARAC referral threshold), advocacy support with housing, attending court, accessing education and training, finding a job, referrals to other agencies, accessing children's services and building self-esteem, self-confidence and independence.

Annexes

Annex A – Examples of domestic abuse behaviours

Annex B – The statistics and impact

Annex C – Care Pathways - Overview of NICE recommendations

Annex D – Sample safety plans

Annex E – Risk identification tools for adults and dependent children, and young people

Annex F – Extract: Risk identification process by health professionals

Annex G – Useful contacts

Annex A – Examples of domestic abuse behaviours

Physical

Shaking, smacking, punching, kicking, presence of finger or bite marks, starving, tying up, stabbing, strangulation, suffocation, throwing things, using objects as weapons, female genital mutilation, 'honour violence'.

Physical effects are often inflicted on areas of the body that are covered by clothing, for example, breasts and abdomen.

Sexual

Forced sex, forced prostitution (both rape), ignoring religious prohibitions about sex, refusal to practice safe sex, sexual insults, passing on sexually transmitted diseases, preventing breastfeeding.

Psychological

Intimidation, harassment and stalking, insulting, isolating a woman from friends and family, criticising, denying the abuse, treating her as an inferior, threatening to harm children or take them away, forced marriage.

Financial

Not letting a woman work, undermining efforts to find work or study, refusing to give money, asking for an explanation of how every penny is spent, making her beg for money, gambling, not paying bills.

Emotional

Swearing, undermining confidence, making racist or sexist remarks, making a woman feel unattractive, calling her stupid or useless, eroding her independence, threatening to 'out' a victims sexual orientation or gender identity to friends, family or work colleagues.

Annex B – The statistics and impact

Health professionals are in a key position to identify and help interrupt domestic abuse, by recognising the indicators of abuse and offering support and referral for protection as needed. To achieve this, each practitioner needs to be aware of, and be able to use, information about:

- the cost and burden of domestic abuse to society
- prevalence
- typical circumstances
- impact on individuals
- understanding the people affected
- understanding abused men

B.1 The cost to society

The public service burden of violence is considerable. Within that, domestic abuse is underestimated because it is under-reported.[110] A high proportion of women attending A&E departments, primary care, family planning, reproductive and sexual health settings are likely to have experienced domestic violence and abuse in their lives. [27, 111, 112] Between 25% and 56% of female psychiatric patients report experiencing domestic violence and abuse in their lifetime.[113] Analysis of the population survey for the Adult Psychiatric Morbidity Survey found that around one-third (27% to 37%) of people who had experienced abuse ranging from physical to extensive physical abuse/coercion had a common mental illness, such as anxiety or depression.[114]

A conservative estimate of the financial cost of domestic abuse in England and Wales was in the region of £16 billion.[115] The largest share was the human and emotional cost of £10 billion, followed by an estimated £4 billion cost to public services, of which the NHS shouldered almost half of it at £2 billion (an underestimate as it only covered hospital and GP services and did not include the impact on children). £2 billion was for lost economic output.

B.2 Prevalence

Domestic abuse is so prevalent in our society that NHS and other provider staff across the full range of public services will be in contact with adults and children who are affected. Some staff may themselves be affected.

Many cases go unreported as it is difficult and often dangerous for victims to tell somebody that they are being abused by someone close to them.

Abuse of adults

The Crime Survey for England and Wales covers the ages of 16-59 years old. Figures for the year ending March 2015 continue to show that domestic abuse is suffered by both women and men, but its prevalence is higher in women.[116, 117] Women are twice more likely than men to have experienced any domestic abuse since the age of 16 years old (4.5 million females, 2.2 million males).

Further findings on prevalence in the last year showed that:

- Women are twice more likely than men to have been victims of domestic abuse in the last year (1.3 million females, 0.6 million males). Together, this represents 6% of the adult population and shows a continuing downward trend in domestic abuse (compared to 11.5% in March 2007)
- women who were separated had the highest prevalence of any domestic abuse (20%) compared to other marital status such as married/civil partnership (4%) or cohabiting (7%)
- both women and men in lower household income brackets (under £10,000) are more likely to experience domestic abuse compared to those in higher income ranges (over £50,000); however the prevalence for women in low income households is three times higher (16%) than those in better earning households (5%)
- there are deprivation differentials. Domestic abuse prevalence is higher in both women and men living in the 20% most deprived areas of England and Wales
- the 3 year dataset analysis from end March 2013 to end March 2015 shows that partner abuse is the most common for all victims. 72% of victims experienced one type of abuse. Women were predominant in the 28% of people with more than one type of abuse, the commonest combination being partner abuse and stalking
- of the type of partner abuse, both women and men are more likely to experience non-physical abuse such as emotional and financial abuse and threats than physical force. 63%. 29% and 45% respectively amongst females, 56%, 37% and 31% amongst males
- both women and men report 'mental or emotional problems' as a consequence of the domestic abuse (47% females, 30% males), followed by difficulties in trusting people or in other relationships
- on average two women over 16 years old are killed by domestic homicide in England and Wales each year. Analysis of the Crime Survey 3 years dataset to end March 2015 shows that:[118]
  - 77% of female domestic homicide victims were killed by a partner or ex-partner. This compares with 51% for male victims (and 49% killed by other family members)
  - the majority of domestic homicide victims were killed by male suspects (97% for women and around 66% for men)
  - male victims of domestic homicide were more likely to be white than male victims of non-domestic homicides. Female victims of domestic homicide were less likely to be white compared to female homicides and were also more likely to be of Asian origin.

Sexual violence in domestic abuse

Domestic abuse often includes coercive control, physical assault and sexual assault – including sexual activity that is inflicted on someone without their consent. Partners, former partners and people in the same household may use force or threats (including threats to post images online). Partners or former partners may taunt or use degrading treatment related to sexuality, force the use of pornography or force their partners to have sex with other people.

The issue of consent to sexual activity is not well understood in the general public. The Crown Prosecution Service has produced simple material to help understand consent to sex among adults.[119] Consider one young woman's experience of the rape of her friend by her friend's boyfriend and two of his mates.

"He asked if she liked it and she said yeah, even though in her head she didn't. She should have said 'no' but there were three of them. So even if she'd wanted to fight back, she couldn't, could she? She couldn't exactly say 'no'."[120]

Abuse of older adults[121]

- At least 342,000 older people (aged 66 and older) living in England in private households reported experiencing maltreatment from a family member, close friend or care worker in 2007.
- Maltreatment included neglect and psychological, physical, sexual and financial abuse.
- Of those experiencing maltreatment:
  - 51% experienced it from a partner
  - 49% from another family member
  - 5% from a close friend
  - 13% from a care worker
  - Women were more likely to experience maltreatment than men (3.8% of women and 1.1% of men in the past year); men were more often the perpetrators except in financial abuse, where the gender ratios were similar.

Abuse of young women

Analysis of the self-completion module of the Crime Survey for the year ending March 2015 reports that:[117]

- prevalence of domestic abuse is highest among younger age groups (13% in 16-19 year olds and 9% in 20-24 year olds) and falls with increasing age (5% in 55-59 year olds)
- on attitudes to partner abuse, respondents in the younger age groups are most likely to think it acceptable to be hit or slapped by a partner for having an affair (13% for 16-19 year olds; 13% for 20-24 year olds) compared to older people (5% for 55 – 59 year olds)
- though physical injuries affect 49% of all adult victims between 16-59 years old (in the 3 year combined data to March 2015), 16-24 year olds are more likely to experience non-physical abuse and sexual assault or stalking; and are less likely to seek medical attention for injuries or help from people in official positions or support organisations.

Findings from a study providing a detailed picture of the incidence and impact of teenage partner violence showed that:[96]

- 25% of girls and almost 20% of boys reported some form of physical partner violence
- nearly 75% of girls and 50% of boys reported some form of emotional partner violence
- 33% of girls and 16% of boys reported some form of sexual partner violence
- girls experienced more repeated abuse, at the same level of severity or worse

- girls with a 'much older' partner experienced significantly more serious abuse
- for young women, intimate partner abuse can increase vulnerability and be part of a more complex picture of sexual exploitation, going missing and gang involvement
- having a same-sex partner was also associated with increased incidence rates for all forms of partner violence.

Abuse of women and children with long-term conditions or disabilities

The 2016 Crime Survey for England and Wales found that:[117]

- women and men with a long-term illness or disability are more likely to experience domestic abuse than those without, but almost twice as many women than men (16% females, 9% males).

Previous studies on disability or having a long-term condition confirm these as risk factors in being a victim of domestic abuse:

- Women with disabilities are twice as likely as other women to experience domestic abuse.[122]
- Women with disabilities are likely to endure abuse for longer because they experience additional barriers in situations where they are reliant on their abuser (often their partner) for personal assistance with daily, and perhaps, personal care tasks, making them more vulnerable and unsafe.[123]
- Children with disabilities are more than three times more likely to be abused or neglected than non-disabled children.[124] This is important for dependent children and also because the risk of having an abusive relationship increases for female teenagers who have learning disabilities.[125]

Neglect and abuse of dependent children

There is a strong link between child physical abuse and domestic violence. Even if not physically harmed, children's emotions and behaviour can be adversely affected by witnessing domestic abuse as well as experiencing the toxic environment of a family in violence.[59]

- NSPCC figures from 2011 suggest that broadly the same proportions of children younger than 11 years old (3.3%) and 11- to 17-years-old (2.9%) had witnessed at least one incident of domestic violence in the past 12 months.[96, 126]
- This rises to 12% and 18.4% respectively when both domestic violence and abuse are included. Combining this with another study in 2009 which had a larger sample group, concludes that about 4.5% of children and young people in the UK would have witnessed severe domestic violence with a parent being kicked, choked or beaten.[127]
- Parents experiencing domestic abuse often have difficulty organising day-to-day living. As a result, their parenting may be neglectful, unpredictable and inconsistent. Severely maltreated children are up to three times more likely to have witnessed family violence.[127]
- The NSPCC study also found that children younger than 11 who were physically abused by a parent or carer were almost five times more likely to have witnessed family violence.[96]
- Nearly two-thirds (63%) of serious case reviews of child abuse in England were found to have domestic abuse as a risk factor,[130] a finding that is supported by a study in which a similar proportion of children (62%) exposed to domestic abuse were also directly harmed, in almost all the cases (91%), by the same perpetrator of the parental domestic abuse.[26]

Abuse of parents by children

The prevalence of abuse of parents by their children under 18 years old is very difficult to ascertain and *"still lies in a veil of secrecy"*.[129] It is *"a pattern of behaviour that uses verbal, financial, physical or emotional means to practise power and exert control over a parent."*[130] It is more commonly experienced by mothers than fathers – and is more common among single parents. A large proportion of the children and young people inflicting the abuse will themselves have been physically or sexually abused or have witnessed abuse.

Abuse in black and ethnic minority communities

Black and ethnic minority women and girls are disproportionately affected by different forms of abuse, for example, forced marriage, dowry abuse, honour-based violence, sexual exploitation through trafficking and FGM. They are more likely to experience threats of deportation and abandonment, isolation, entrapment, multiple perpetrators and violence that may be indirectly condoned by family and community, for instance, for reasons of culture or perceived dishonour.

Abuse in lesbian, gay, bisexual and transgender (LGBT) communities

It is thought that the prevalence of domestic abuse in lesbian and gay relationships is about the same as experienced by heterosexual women.[131] LGBT victims can be reluctant to seek help for domestic abuse because they would need to disclose their sexual orientation and fear a homophobic response from service providers. This is compounded by the fact that health (and other) practitioners may not be confident to identify LGBT domestic abuse.

Abuse of men

Domestic violence is largely perpetrated by men on women but variations are also evident, although women remain the main victim group. Nonetheless, men can be abused by other men or women in an intimate partner relationship. Prevalence studies can be confusing. However, the Crime Survey for England and Wales has provided some consistent rates for men which are set out earlier in this annex. The 2016 Crime Survey reports that 0.6 million males experienced domestic abuse in the last year to March 2015 and for the lifetime experience for males aged 16-59 as 2.2 million. The Survey figures also show a similar abuse pattern in men and women, i.e. in partner abuse being the most common, and in ranking, emotional and financial abuse are foremost, followed by physical force and threats.

More research is needed on the psychological impacts on male victims of domestic violence and abuse, including internalising symptoms and externalising behaviours. However, it is thought that, although less prevalent, some abused men may suffer from severe physical assault. Associations with post-traumatic stress disorder (PTSD), depression and suicide have also been documented.[132]

Advice for male victims is available on the NHS Choices website and also through advice lines such as:

- Men's Advice Line: 0808 801 0327 Monday to Friday 9am–5pm; email info@mensadviceline.org.uk
- Mankind Initiative: 01823 334244
- Refuge through the National Domestic Violence Helpline: free phone 0808 2000 247

B.3 Typical circumstances

Health service professionals need to know that:

- domestic abuse occurs across the whole of society, regardless of race, ethnicity, gender, religion, age, class and income or where people live
- domestic abuse doesn't always occur at home. Young people, some women and older people who experience abuse have never lived with the abuser. In the case of some older people, the abuser is 'like family', for example, a close friend, lodger, neighbour, carer or trusted acquaintance
- domestic violence can take multiple forms for the same victim. Some young people might be experiencing intimate partner violence, gang or group abuse and sexual abuse/rape at the same time
- approximately a third of cases of parental mental ill health and substance misuse (alcohol and/or drugs) are concurrent with domestic abuse[26]

"So many people don't understand what violence against women is about. It's not all about being beaten up, it's also not allowing you to see your friends; not allowing you your own money; it's controlling your life in every possible way; no one can see it."[53]

- Any family member can be a perpetrator – but in the vast majority of cases the abuser is male.
- Repeat victimisation is common. The abuse usually gets worse and more frequent over time: 44% are victimised more than once, and almost one in five (18%) are victimised three or more times.[133]
- In a study of South Asian women, one-fifth had experienced forced marriage – though only one of these had applied for a forced marriage protection order under the Forced Marriage (Civil Protection) Act 2007.[134]
- More than 40% of South Asian women had been in the violent relationship for five years or more and, for most of these women, the abuse was frequent, often from multiple perpetrators;[134]
- Women in cultures which subordinate women are more vulnerable, as are women whose first language is not English, who are transient, of low socioeconomic status and/or who have mental ill health or learning disabilities.
- Women who experience discrimination struggle disproportionately to access help.

The risk of domestic abuse increases:

- during pregnancy, when a third of cases of domestic violence start;[135, 136]
- at the point of separation or after leaving a violent partner, when women are at greatest risk to homicide;[137]
- when children are handed over for contact, women and children are at risk of threats or harassment.[138]

B.4 Impact on individuals

Health consequences of domestic abuse for women

Domestic abuse has serious consequences for the victim's physical and mental health.

Examples of the impact on women

Physical impact

- bruising
- recurrent sexually transmitted infections
- sexual dysfunction
- broken bones
- burns or stab wounds
- death
- gynaecological problems
- tiredness
- general poor health
- poor nutrition
- Long-term pain
- miscarriage
- maternal death
- premature birth
- babies with low birthweight/ stillbirth/injury/death
- self-inflicted injuries

Psychological impact

- fear
- increasing likelihood of misusing drugs, alcohol or prescribed anti-depressants
- depression/poor mental health
- self-harming
- wanting to commit or attempting suicide
- sleep disturbances
- PTSD
- anger
- guilt
- loss of self-esteem and confidence
- feelings of dependency
- loss of hope
- feelings of isolation
- panic or anxiety
- eating disorders

Examples of the impact on men

Apart from the gender-specific impacts on females, such as gynaecological problems, teenage pregnancy, premature birth, and others, the impacts for men and women are similar. However, for men there is less severe physical violence and more severe depression, especially in older men.

Examples of the impact on children

Physical impact

- bruising
- broken bones
- burns or stab wounds
- death
- neurological complications
- tiredness and sleep disturbance
- general poor health
- stress-related illness (asthma, bronchitis or skin conditions)
- enuresis or encopresis
- running away, leading to potential homelessness
- eating difficulties
- damage following self-harm
- teenage pregnancy
- gynaecological problems
- self-harm
- damage to the unborn child during pregnancy

Psychological impact

- fear, panic, guilt and anxiety
- depression/poor mental health
- introversion or withdrawal
- thoughts of suicide or running away
- PTSD
- anger, aggressive behaviour and delinquency
- substance misuse
- loss of self-confidence
- assumes a parental role
- hyperactivity
- tension
- low self-esteem
- sexual problems or sexual precocity
- suicide
- eating disorders
- difficulty in making and sustaining friendships
- truancy and other difficulties at school

There is an extremely strong relationship between partner violence and mental illness which has received very little attention in clinical practice.[139]

Strong association with mental illness

1,052 mothers participated in the Environmental Risk (E-Risk) Longitudinal Twin Study over 10 years. Only subjects with no previous history of depression were considered for the study. More than one-third of the women reported suffering violence from their spouses (for example, being pushed or hit with an object). They were twice as likely to suffer from depression, even when the sample was controlled for the impact of childhood abuse. Domestic violence had an impact, not just on mood, but on other mental health aspects as well. The risk for these women developing schizophrenia-like psychotic symptoms was three times higher than for other women. This risk doubled for women who were also victims of childhood abuse.

- A latent class analysis of the Adult Psychiatric Morbidity Survey found that over half of one of the groups, representing 1 in 25 of the population (around 1.5 million adults) for their experience of extensive forms of physical and sexual violence, including childhood abuse, had a common mental disorder. A further group, representing one in 50 of the population who experienced extensive physical violence and coercive control by a partner (but not by other kinds of abuse), had very high levels of common mental disorder (three or more). Women were more likely than men to be in every abuse group. Suicide attempts and self-harm rates were also high.[114]

Unmet mental health need

"There is a high level of unmet mental health need among survivors of extensive violence and abuse which needs to be addressed. Despite being 15 times more likely to have three or more mental disorders they were only four times more likely to discuss their mental health with a GP." [114]

- Victims of domestic abuse are at increased risk of experiencing mental health problems[140, 141, 142, 143] such as depression, anxiety disorders including PTSD, eating disorders, bipolar disorders (I and II), psychotic disorders, antenatal and postnatal mental health disorders, and alcohol and substance misuse.[144, 145, 146, 147]
- The severity of the victim's mental health appears to be directly related to the severity and duration of physical intimate partner violence.[144, 148]
- Even after controlling for physical violence, injuries and sexual coercion, psychological abuse (and stalking) is found to be predictive of post traumatic stress disorder and depression.[149]
- Domestic abuse commonly results in self-harm and attempted suicide, including for pregnant women: one-third of women attending emergency departments for self-harm were domestic abuse survivors; abused women are five times more likely to attempt suicide; and one-third of all female suicide attempts can be attributed to current or past experience of domestic violence.[140,150]

- Suicide rates in England and Wales have always been higher in men than women. However, Office for National Statistics data for 2013/14 does not break down causes to experience of violence. Specialist domestic violence support groups have reported that, on average, three women take their lives each week to escape domestic abuse.[151]

There are strong associations between domestic abuse and substance misuse. Of 223 men being treated for drug or substance misuse or both, 77% had perpetrated any form of intimate partner violence. Almost all reported it being mutually perpetrated between partners (75%) and having witnessed violence between their parents in their childhood (76%). 71% of the men had experienced physical and/or sexual abuse in childhood.[152] Only half of the men who perpetrated physical violence thought it to be a criminal act.

Substance misuse by victims of violence is well documented, including alcohol as a coping mechanism or 'self- medication'.[153]

Domestic abuse is:

- a major factor leading to death in, or related to, pregnancy and childbirth[135, 154]
- experienced by between 5–10% of women during their pregnancies and/or after the birth[155]
- a prime cause of miscarriage or stillbirth[156]

Victim coping strategies

Many women go to great lengths to protect themselves and try to shield their children from the violence.[157] However, women are not always aware of how they and their children are being affected by the abuse (and by the neglect that children can experience when their mother is preoccupied with maintaining her safety). Even when aware of the harm, women are often unable to protect themselves and their children. Other women can be in denial about the severity of the abuse in order to cope with it, sometimes also denying the harm it is doing to their children.

Health consequences of domestic abuse for children

Domestic abuse significantly affects the quality of the relationship between a woman and her children. A woman coping with abuse is hampered in being able to give her children the attention, care and protection they need. Children living in households where there is domestic abuse can be significantly harmed by neglect that may result, as well as witnessing or being involved in the abuse.

The age of the child is critical in terms of the impact on their development. There are two periods where children are particularly vulnerable: the first is in the first three years of life;[158] and the second is as the child approaches their early teenage years, between 13 and 17 years old. Rapid brain developments in these two periods suggest heightened vulnerability to trauma in that good experiences can have a positive impact on the child's development, and poor support and experiences can create lifelong deficits.[159]

A child in a household is likely to be affected in one or more of the following ways:

- experiencing emotional abuse as a result of witnessing the violence/abuse directed at their parent
- experiencing neglect as a result of the violence or abuse
- becoming inadvertently involved in the violence/abuse, for example, being accidentally caught up in an assault or being used as part of emotional blackmail by the perpetrator

- intervening to stop the violence/abuse directed at their parent
- being a direct target for physical, emotional and/or sexual violence or abuse from the perpetrator, in addition to abuse of the mother and other children.

"I feel upset at the way my dad treats mum. I feel sad because she goes off for days and drinks. I want someone to stop them arguing. I'd like someone to help my mum, like a doctor. I haven't told anyone what's happening. I like to keep it a secret."[160]

In a 2014 study of children with experience of domestic abuse, 52% had behavioural problems, over a third (39%) had difficulties adjusting at school and almost two-thirds (60%) felt responsible or to blame for negative events. A quarter of the children (of either gender) exhibited (usually physically) abusive behaviours, mostly towards their mother (62%) or siblings (52%). These children were usually at least 15 years old and were no longer living with the abuse.[26]

The younger the child is, the more serious the impact of being in a household of domestic abuse. Other factors include:

- the levels of physical and psychological/emotional violence
- the length of time the abuse continues
- whether the child is abused directly
- the extent of neglect or witnessed violence
- how much support the child receives from other people.

Living with domestic violence and abuse can pose a serious threat to children's emotional, psychological and physical wellbeing, particularly if the violence is persistent over the long term.

- Children witnessing domestic violence show significantly poorer outcomes on a range of developmental and behavioural dimensions than those living without violence. The outcomes are similar to those of children who were directly physically abused.[161, 162]
- Children in homes where there is domestic abuse, even if they do not witness the abuse directly, are more likely to have behavioural problems and suffer from anxiety, depression, post-traumatic stress disorder and educational problems. Compared with their peers who were not in homes, when grown up children from abusive homes are also more likely to have problems with mental health, be unemployed and experience or perpetrate domestic abuse.[68]
- Studies show that domestic abuse between adults, and overlap with the direct sexual and physical abuse of children, is as high as 40% in some cases.[163, 164]
- Children may learn that it is acceptable to exert control or relieve stress by using violence, or that violence appears to be linked to expressions of intimacy and affection. These negative lessons can have a powerful adverse effect on children in social situations and relationships throughout childhood and in later life[165] (see teenage intimate partner abuse below).
- Children may also have to cope with the disruption of temporary homelessness, change of physical location and schools, loss of friends, pets and personal belongings, continued harassment by the perpetrator and the stress of making new relationships.[161]
- Children living with domestic abuse are likely to suffer neglect, in some cases this is exacerbated by parental drug, alcohol or mental health problems, that is, 'the toxic trio'.

- Maltreatment and neglect can have serious short-term and long-term effects on children's brain development and can lead to cognitive impairment and risk-taking behaviours that harm the child's mental and physical wellbeing, including perpetrating abuse on others.[166, 167]
- Stressful events that happen in childhood or 'adverse childhood experiences' are shown to have a continuing impact throughout life, with adversity including a household where there is domestic violence, among other factors such as the 'toxic trio' of parental drug, alcohol and substance misuse.[110]

Teenage intimate partner abuse

There is a significant difference in psychological maturity between the ages of 13 and 17 years. Partner violence can begin with a girl's first boyfriend relationship (even before the age of 16) and become a continuing pattern of re-victimisation, more obviously noted when she reaches 16 years old.

A study of 13- to 17-year-old girls in 2009 revealed that 90% of them had been in an intimate relationship.[96] The same study revealed the following on relationships:

Physical partner violence

- 25% of girls and 18% of boys reported some form of physical partner violence
- 11% of girls and 4% of boys reported severe physical violence
- 75% of girls and 14% of boys stated that the physical violence had a negative effect on their welfare.

Emotional partner violence

- Nearly 75% of girls and 50% of boys reported some form of emotional partner violence
- 33% of girls and 6% of boys stated that the emotional violence had a negative effect on their wellbeing

Sexual partner violence

- 33% of girls and 16% of boys reported some form of sexual partner violence
- 70% of girls and 13% of boys stated that the sexual violence had a negative effect on their welfare.

The Crime Survey for England and Wales ending in March 2015 found that 16 year-olds were the group most likely to suffer abuse from a partner but the least likely to seek help or medical attention.[117]

Multiple risks

The Department for Education's National Young People's Violence Advocacy Programme reports that young people needing specialist domestic abuse services are experiencing multiple types of abuse and are at high risk of serious harm:[97]

- over 50% were victims of emotional abuse, jealous and controlling behaviours and physical abuse
- 20% were victims of current sexual abuse
- 37% had experienced, or were at risk of experiencing, online intimate partner abuse

- in addition to experiencing abuse in their own relationship, many of the young people were also at risk at home:
  - 47% were exposed to domestic abuse within the family home
  - 29% were experiencing, or at risk of, child sexual exploitation
  - 27% were vulnerable as a result of their parents' mental health
  - 26% were experiencing financial abuse.

"I never got on with my step-dad – there was a lot of physical abuse of my mum. I think I must have run away 30 or 40 times from home. Social care were involved but they never did anything about it. He wouldn't feed us for days and locked us up in our bedrooms. I never had any support from social care. It was only when I got pregnant that they, kind of, helped me."[168]

Teenage pregnancy

The National Young People's Violence Advocacy Programme reports that 21% of the young women seeking help from them had children of their own (on average, one child each).[97] While sexual health and teenage pregnancy teams may be best placed to identify circumstances where young women could be experiencing intimate partner abuse, including sexual assault and rape, all health practitioners need to be alert. Young women often do not recognise when they are being abused:

"If you're doing that [coerced sex] to someone random, it's rape. But if you're doing that with your girlfriend, that's not rape."[169]

It is critical that as health professionals, you understand and know when to apply the different types of consent in assessing potential risk and harm:

- the legal age of consent to sex is 16 years old; children under 13 years old are deemed legally to not have the capacity to consent to sexual activity[170]
- the medical model of consent relates to the ability to consent to treatment (Gillick competence) and to request contraception (Fraser guidelines)[171]
- the social model of consent to sexual activity – that is, consent that occurs within a social context of peer pressure, violence and control, financial need or professional negligence, may negate the possibility of individual consent.[172]

"I think it's a given now that you are expected if you ever go out with a guy or whatever, it's expected that you are supposed to be having sex with him. Even when you are little [young]."[169]

B.5 Understanding the people affected

Why don't they just leave an abuser?

"That attitude of 'why don't you just leave?' I got from my doctor really isn't helpful; abusers grind you down over time so you really believe you can't cope without them. Where do you go? He's telling you he will kill you if you go."[53]

Women and girls want the abuse to end, but they do not always want the relationship to end.

- They might be afraid of the abuser, and the abuse often escalates and continues after separation.

- They could be financially dependent on the abuser, afraid to be alone, have lost their self-esteem and confidence to leave, still love or feel a 'trauma bond' with their abuser (often referred to as 'hostage syndrome').[173]
- They may want their children's father to be around when they are growing up and/or to remain within or near their family, social networks and community.
- They may be suffering long-term post-traumatic stress and be unable to make critical decisions.
- For young women fear and financial constraints make leaving an abusive partner impossible, especially where there are lifelong social circles, such as from being in the same education establishment or local gang. For many, living with their parents with no financial independence is untenable.

"We live in a violent society and everyone hardly bats an eyelid when anything happens, like a girl getting hit by her boyfriend. People just think she must have done something to deserve it. Schools should be teaching students and parents, because most of the students learn their aggression from their families."[174]

Why don't they just tell someone?

Women/young women

- Women may not disclose because they are afraid of the abuser and they worry that nobody will believe them, particularly if there are no physical injuries.
- Some women don't tell because they are not asked, sometimes because they are not left alone with anyone they could tell.
- Some may not recognise their experience as abuse; others feel ashamed.
- There might be cultural or religious barriers. They might be worried about their immigration status. Many women are worried about losing their children if Children's Social Care become involved.

Older women

- Older women do not disclose because of low self-confidence and self-esteem, experience of bereavement, physical frailty and a perception that the mistreatment is not serious enough to merit taking action.
- They also fear alienating family and friends and becoming isolated; they don't want to be seen to be 'making a fuss'.
- They fear being blamed, embarrassment and shame; they have concerns for what the consequences could be for their family and significant others.
- They are scared the abuse will escalate and, if they are the carer of the perpetrator, they may be worried about his health and wellbeing.

In 2007 2.5% of people aged 66 and over living in private households reported that they had experienced mistreatment (psychological, physical, sexual, financial abuse and/or neglect) involving a family member, close friend or care worker during the past year – which equates to about 227,000 older people across the UK.[175]

Financial abuse can take the form of misappropriation of benefits and/or use of the person's money by other members of the household. It includes fraud or intimidation in connection with wills, property or other assets.

As with younger women, older women often do not know where to go for help. They do not know whether it is appropriate to report their experiences to the police or other statutory services, sometimes worrying that their case may not be seen as serious enough. They think services have no or limited ability to take effective action on their behalf. They lack awareness of their legal rights and some, due to illness, may not have the mental capacity to take action.

B.6 Understanding abused men[176, 177, 178]

Why don't they just leave?

Reasons for both men and women can be similar:

- men may feel that they will not be believed
- they may be ashamed by the abuse and feel they have failed in the traditional perception of their masculinity
- fathers may fear that losing custody of children and think that mothers are more likely to be believed
- they may be concerned that leaving will put their children at risk of abuse
- if the relationship is same-gender or transgender, it may not be public knowledge and there could be a fear of isolation
- finance may play a part where men may lack resources to be able to set up another home and/or support their children if they move out
- they may feel able to change the relationship by staying.

Why don't they tell someone?

The reasons why men and women do not disclose domestic abuse can be similar, relating to fear of being believed, the stigma and loss of self-confidence and self-esteem. Even when men want to disclose, there is less certainty about where to go for help and how to access advocacy and support.

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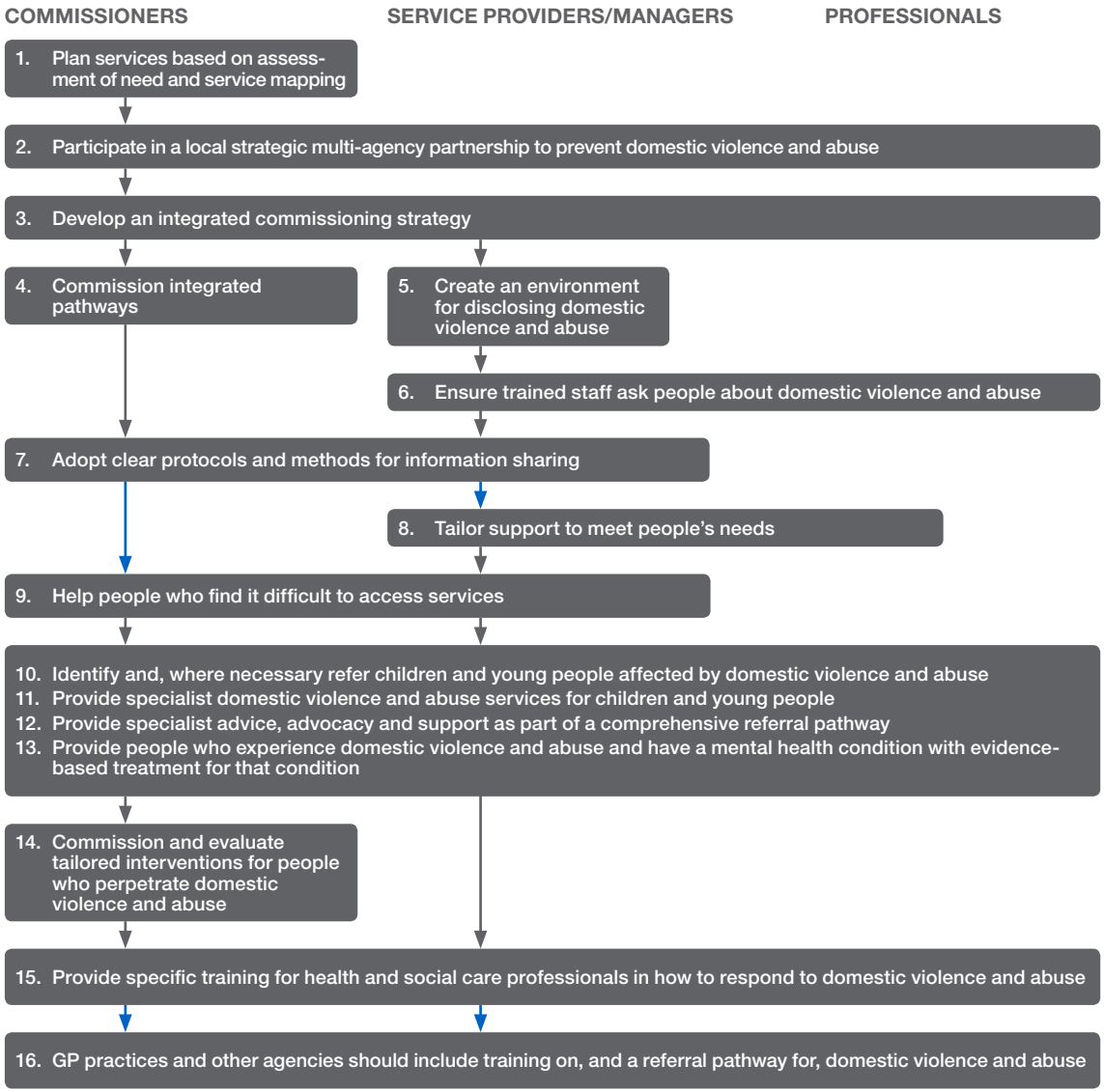
Annex C – Care pathways – overview of NICE recommendations



Annex D – Sample safety plans

An adult safety plan should cover these areas:

Safety in the relationship

- places to avoid when abuse starts (such as the kitchen, where there are many potential weapons)
- people a woman can turn to for help when they are in danger
- asking neighbours or friends to call 999 if they hear anything to suggest that a woman or her children are in danger
- places to hide important phone numbers, such as helplines
- how to keep the children safe when abuse starts
- teaching the children to find safety or get help, perhaps by dialling 999
- keeping important personal documents in one place so that they can be taken if a woman needs to leave suddenly
- letting someone know about the abuse so it can be recorded (for example, this is important for cases that go to court or immigration applications)

Leaving in an emergency

- packing an emergency bag and hiding it in a safe place in case a woman needs to leave in an emergency
- plans for who to call and where to go (such as a domestic violence refuge)
- things to remember to take: documents, medication, keys or a photo of the abuser (useful for serving court documents)
- access to a phone
- access to money or credit/debit cards that a woman might have put aside
- transport plans
- plans for taking clothes, toiletries and toys for the children
- taking any proof of the abuse, such as photos, notes or details of people who know about it

Safety when a relationship is over

- contact details for professionals who can advise or give vital support
- changing landline and mobile phone numbers
- how to keep her location secret from her partner if she has left home (by not telling mutual friends where she is, for example)
- getting a non-molestation, exclusion or restraining order
- plans for talking to children about the importance of staying safe
- asking an employer for help with safety while at work

A dependent young child's safety plan should cover these areas:

Where the plan is kept

- This safety plan should not be kept by the child.
- Professionals should give the child no written material except telephone numbers. Children can use mobile phone and text messaging to seek help.
- The child needs to rehearse the safety plan with you as part of safety planning intervention.

Getting out of the way when there's abuse going on

- I can't stop it
- Find a safe place in my house

Getting help when it's safe to do so

- Ringing the Police on 999
- Giving contact details (my name, address)
- Telling what's happening (e.g. someone is hurting my mum)

Other sources of help

- E.g. next door
- Who to tell if am hurt

Saying how I feel

- It's OK to feel e.g. sad, scared, angry

Who knows about the plan

- Non-abusing parent

A dependent older child's safety plan should cover these areas:

Where the plan is kept

- This safety plan should not be kept by the child.
- Professionals should give the child no written material except telephone numbers. Children can use mobile phone and text messaging to seek help.
- The child needs to rehearse the safety plan with you as part of safety planning intervention.
- Getting out of the way when there's abuse going on
- I can't stop it
- To protect myself, I can break rules, like: say no, shout, kick and scream if you need help, also
- Get out of the room where the violence is happening
- Find a secure place in my house

Getting help when it's safe to do so

- Use my mobile, if you have one
- Ring the Police on 999
- Give contact details (my name, address)
- Tell what's happening (e.g. someone is hurting my mum)

Other sources of help

- E.g. next door
- Text/call someone I can trust in an emergency e.g. with a pre-agreed code word on what they should do

Siblings at home

- Each has a safety plan
- We know about each's other's safety plan
- My role in their safety plans
- If we have to leave the house
- A bag of clothes ready
- Where I'd like to go

Checking how I feel

- It's OK to feel e.g. sad, scared, angry
- Who I can talk to about it/contact details

Who knows about my plan

- Non-abusing parent
- Teacher; school nurse; social worker; other relative etc.

Annex E – Risk identification tools for adults and dependent children, and young people

Risk identification is critical first step in ensuring that people are made safe. It helps you, as a health professional with:

- a framework for processing the information you have to make a professional judgement about levels of risk;
- the reasons for referral to appropriate support and safeguarding;
- a record that can be used to support future case management;
- a common tool and a shared language and understanding of risk with the other agencies that will need to work with the victim.

This Annex draws on three risk identification tools as follows

You can use any of them for your risk identification. Training in undertaking routine enquiry sensitively would be helpful beforehand. Knowledge of local safeguarding processes and referral pathways are essential for an effective decision on what to do next.

1. SafeLives – Responding to domestic abuse [adults] – guidance for general practitioners

A tool to help general practice with disclosure and what to do next. It can be adapted for use in other health settings.

www.safelives.org.uk/practice-support/resources-other-professionals (see Annex F)

2. SafeLives Young People DASH Risk Identification and guidance

To help frontline practitioners identify risk in cases of domestic abuse, stalking or 'honour'-based violence within young people's relationships and take appropriate action.

www.safelives.org.uk/practice-support/resources-identifying-risk-victims-face

3. Barnardo's Domestic Violence Risk Identification Matrix (DVRIM)

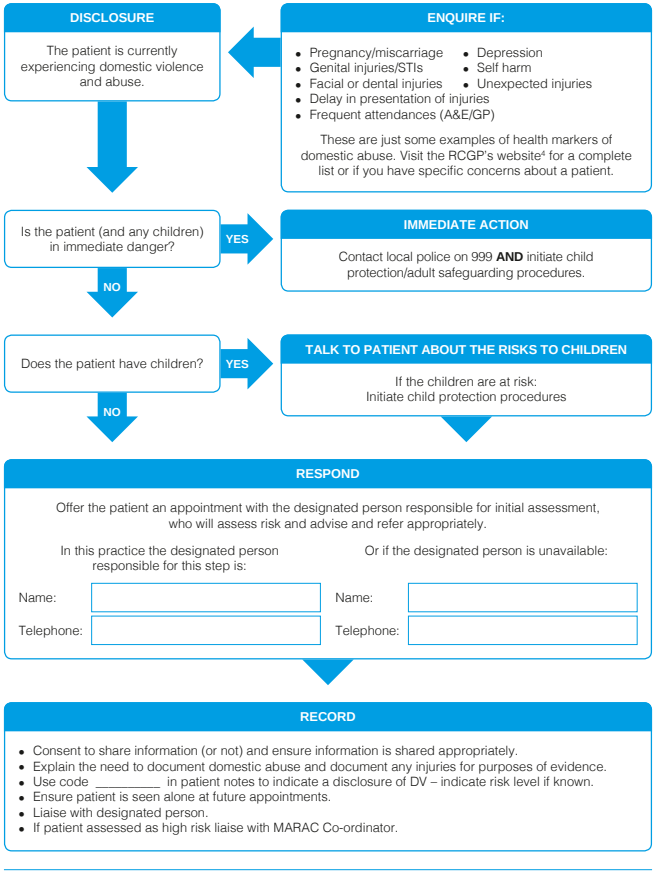
A tool for identifying risk to dependent children in households where there is male to female domestic abuse.

www.barnardos.org.uk/Barnardos_Domestic_Violence_Risk_Identification_Matrix.pdf

Annex F – Extract : Risk identification process by health professionals

(by SafeLives and IRIS)

Resource: Process for responding to domestic abuse



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Responding to domestic abuse: Guidance for general practices
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SafeLives – registered charity number 1106864. www.safelives.org.uk www.irisdomesticviolence.org

Annex G – Useful contacts

This section provides some contact details for the main organisations and resources that might be useful when supporting women, men and children who are experiencing, or who have experienced, domestic abuse.

In an emergency always ring 999

1. National helplines

Domestic Abuse

Free 24 hour National Domestic Violence Helpline: for support, help and information wherever the caller is, in the UK; translation service for people for whom English is nor a first language or for people with hearing problems. Managed by Refuge and Women's Aid. Free phone: 0808 2000 247;

helpline@womensaid.org.uk;
www.nationaldomesticviolencehelpline.org.uk/

Stalking

Free National Stalking Helpline: practical advice and information, including information on being safe, the law; how to report stalking and gather evidence. Managed by the Suzy Lamplugh Trust. It is not a 24 hour service. Free phone: 0808 802 0300; advice@stalkinghelpline.org; www.stalkinghelpline.org

General support

Samaritans: a free phone 24 hour listening service. Free phone: 116 123; jo@samaritans.org; www.samaritans.org.uk

2. Specialist national support organisations for violence and abuse

Refuge: support women and children on any given day through a range of services, including refuges, independent advocacy, community outreach and culturally specific services; The free phone national Domestic Violence Helpline: 0808 2000 247; helpline@refuge.org.uk; www.refuge.org.uk

General enquiries to: 0207 395 7700; info@refuge.org.uk

Women's Aid: supports abused women, children and young people (runs the National Domestic Violence Helpline with Refuge). The free phone national Domestic Violence Helpline: 0808 2000 247; www.womensaid.org.uk/

Self-help: Women's Aid Survivors Forum www.survivorsforum.womensaid.org.uk/

General inquiries: 0117 944 4411; info@womensaid.org.uk

The Survivor's Trust: provides advice and specialist support to men, women and children who have experienced rape or sexual abuse. 01758 550554; www.thesurvivorstrust.org

Where to find local support www.thesurvivorstrust.org/find-support/

Rape Crisis England and Wales: specialist service for women and girls who have been raped or experienced any form of sexual abuse. Free phone 0808 802 9999 (not a 24 hour service); www.rapecrisis.org.uk

Where to find local support rapecrisis.org.uk/centres.php

General enquiries rcewinfo@rapecrisis.org.uk

National Association for People Abused in Childhood: supports adults to recover from childhood abuse

Free phone helpline 0808 801 0331; http://napac.org.uk/contact/; www.napac.org.uk

Victim support: help for survivors of crime or traumatic events, including information on rights. Free phone: 0808 16 89 111; www.victimsupport.org.uk

3. Legal support

National Centre for Domestic Violence: provides a fast, free injunction service to all victims of domestic abuse regardless of their financial circumstances, race, gender or sexual orientation. Free phone: 0800 970 2070; www.ncdv.org.uk

Rights of Women: provides information and advice to women on all aspects of the law. www.row.org.uk

Family Law 0207 251 6577; Criminal Law 0207 251 8887; Immigration and Asylum Law 0207 251 6577; For women in London: 0207 608 1137 info@row.org.uk

Asylum Aid: free confidential, independent legal advice for people seeking asylum in the UK. 0207 354 9264 (Tuesdays 1-4pm) www.asylumaid.org.uk

4. Specific support services

Shelter: a housing and homelessness charity providing free advice; Free phone: 0808 800 4444; www.shelter.org.uk

Woman's Trust: counselling and support service; 0207 034 0303; admin@womanstrust.org.uk

www.womanstrust.org.uk

Advocacy After Fatal Domestic Abuse: for bereaved friends and family; 07768 386922;

info@aafda.org.uk, www.aafda.org.uk

Gingerbread: expert advice and practical support for single parents; 0808 802 0925; info@gingerbread.org.uk; www.gingerbread.org.uk

Mothers Apart from Their Children (MATCH): Support and information to mother apart from children or with little contact; 0808 800 2222; enquiries@matchmothers.org; www.matchmothers.org

Action on Elder Abuse: provide advice, guidance and casework to older victims and their families and friends (whether in own home, sheltered housing, care homes and hospitals); to practitioners through the helpline; and an Elder Abuse Recovery Services (EARS) to assist victims with recovery. Free weekday helpline: 0808 8088 141; enquiries@elderabuse.org.uk; www.elderabuse.org.uk

5. Support for women and children from minority ethnic communities

Foreign and Commonwealth Office Forced Marriage Unit: 020 7008 0151 www.gov.uk/forced-marriage

Karma Nirvana: preventing forced marriage & honour based abuse: Free phone helpline: 0800 599 9247 www.karmanirvana.org.uk

Iranian & Kurdish Women's Rights Organisation: support, information and help to Middle Eastern and Afghan girls and women on a range of issues including domestic abuse and forced marriage; 0207 920 6460; Emergencies outside office hours: 07846 275 246 www.ikwro.org.uk

Muslim Women's Network UK: providing advice, information, support and social networking on a range of issues for Muslim women, including violence, faith and spirituality, relationships and homelessness. Free phone 0800 999 5786; 24 hour text service 07415 206 936 http://www.mwnhelpline.co.uk/

Muslim Community Helpline: a listening helpline for women, men, children and young people aiming to provide emotional support. 0208 904 8193/0208 908 6715 www.muslimcommunityhelpline.org.uk

Jewish Women's Aid Helpline: a helpline for Jewish women and children who are/have experienced domestic abuse. Freephone: 0808 801 0500 www.jwa.org.uk

Chinese Information and Advice Centre: support to women and families in distress; advice and support to female victims of domestic abuse and advice on a range of issues including housing and health. Phone: 0300 201 1868 www.ciac.co.uk

Refugee Council: works with refugees and asylum seekers and supports them to rebuild their lives. www.refugeecouncil.org.uk; a range of online portals for help at: http://www.refugeecouncil.org.uk/how_can_we_help_you

Southall Black Sisters: provides advice to black women (Asian, African-Caribbean) to empower them to escape domestic violence, forced marriage, honour based violence and inequalities. Will not turn women of any background away. Operates from London but has a national reach on its campaigning work. Helpline: 0208 571 0800; http://www.southallblacksisters.org.uk/

6. Support for children and young people

NSPCC Childline: Help, advice and counselling for children and young people: 0800 1111: www.childline.org.uk

NSPCC: Help for adults concerned about a child: 0808 800 5000: www.nspcc.org.uk

The Mix: advice and support on lifestyle issues and abuse to people between 13 and 25 years old. Free phone): 0808 808 4994: www.themix.org.uk/

7. Support for lesbian, gay, bisexual, transsexual people

Galop: supporting "*lesbian, gay, bi, trans and queer people*" who experience hate crime, sexual or domestic abuse. National LGBT Domestic Abuse Helpline: 0800 999 5428; help@galop.org.uk; London casework service: 020 7704 2040, referrals@galop.org.uk; www.galop.org.uk/

8. Support for men experiencing domestic violence

Men's Advice Line: Free phone: 0808 801 0327; info@mensadviceline.org.uk; www.mensadviceline.org.uk

NHS Choices: Domestic abuse against men. www.nhs.uk/Livewell/abuse/Pages/domestic-violence-against-men.aspx

Mankind Initiative: helping men escape from domestic abuse. Phone: 01823 334244; www.new.mankind.org.uk/

Mankind UK: advice and counselling to men experience violence. Phone: 01273 911680; admin@mankindcounselling.org.uk; www.mankindcounselling.org.uk

9. Support for perpetrators

Respect: a UK membership organisation working with domestic violence perpetrators, male victims and young people. Free phone for perpetrators: 0808 802 4040, Free phone: Men's Advice line for male victims Free phone: 0808 801 0327; www.respect.uk.net

10. Support to specific occupational groups

Cavell Trust: helping registered nurses, midwives and healthcare assistants with difficulties in their lives.

Phone: 01527 595 999; www.cavellnursestrust.org/talk-to-us; www.cavelltrust.org

Royal Medical Benevolent Fund: provides help and support to doctors, medical students and their dependents in need. Phone: 0208 540 9194; help@rmbf.org ; www.rmbf.org/pages/whatwedo.html

The Charity for Civil Servants: supports past and present employees of UK Government departments and organisations sponsored by such departments, who are in need, including domestic abuse.

Free phone: 0800 056 2424; info@foryoubyyou.org.uk

Royal College of Nursing: raising health care professionals understanding of how domestic violence and abuse impacts on lives and providing toolkits: https://www.rcn.org.uk/clinical-topics/domestic-violence-and-abuse