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Domestic Violence:

A Resource Manual for Health Care Professionals

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Contents

Foreword by Yvette Cooper

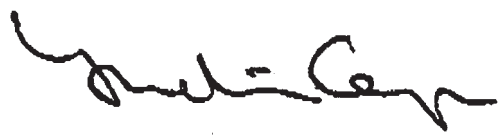
It is mainly women who experience domestic violence and it is largely men who perpetrate such violence. Frequently the children are caught up somewhere in the middle. For many women, and their families, the effects will be catastrophic, and the impact on their physical and mental health and well-being deeply damaging, and sometimes fatal. The sheer scale of the violence and abuse has many dreadful consequences not only for the individuals directly involved, but for their wider families and the whole community.

This Government is not prepared to tolerate domestic violence, nor to regard it as less serious than other forms of violent crime. That is why domestic violence has been placed firmly within the Government's Crime Reduction Programme and resources allocated to reducing its incidence. We know that domestic violence is rarely a one-off episode - more often the experience is one of repeated and intensifying assault. There are also likely to be multiple victims: if a woman is being abused, her children are more likely to be at risk. It is therefore essential that public agencies take every opportunity to identify those who may be subject to such violence, and by offering appropriate practical and emotional support, help prevent the situation deteriorating.

The NHS has a particular contribution to make because it is the one service that almost all victims of domestic violence will come into contact with at some point in their lives. There can be few health care professionals who have not seen patients whom they suspect are being abused at home, but have not known what to do about it. Particularly if the patient is attempting to conceal what has happened to them, and provides alternative explanations for injuries, it can be very difficult to raise the question of domestic violence. Equally many survivors describe how desperately they wanted someone to ask them what was happening at home, and to give them a chance to talk about it in safety and confidence. This resource manual has been developed to help all those health care professionals who come into contact with the victims of domestic violence, and to equip them with the skills, knowledge and confidence to identify domestic violence, and to respond appropriately so as to help break the cycle.

The health service is not working on its own in this area. Indeed, it is particularly important that the NHS should develop effective multi-agency partnerships with other statutory and voluntary sector agencies. The focus for much of this work should be the local Domestic Violence Forum, the Crime and Disorder Partnership and the Area Child Protection Committee. Different Health Authorities, Trusts and Primary Care Groups need to share their experiences and to identify policies and practices which are of proven value. There is considerable good practice in responding to domestic violence, but the challenge is to ensure that this becomes more widespread both within and across agencies.

This manual offers a foundation for local work, it provides factual information to help raise awareness about domestic violence, and offers a good practice approach for dealing with domestic violence which should be adopted and supported by managers throughout the health service in hospital, community and primary care settings.



Yvette Cooper
Parliamentary Under Secretary of State for Public Health

Executive Summary

1 The term 'Domestic Violence' describes a continuum of behaviour ranging from verbal abuse, through threats and intimidation, manipulative behaviour, physical and sexual assault, to rape and even homicide. The vast majority of such violence, and the most severe and chronic incidents, are perpetrated by men against women and their children. Those who experience domestic violence often keep it to themselves - shamed and embarrassed by what is happening to them; unsure of where they can go and what help they can get, and fearful of doing anything which might make the situation worse.

2 The health service has a particular contribution to make in the Government's drive to tackle domestic violence. The impact of domestic violence on individuals' health and well being is substantial: psychological and psychiatric problems such as depression, anxiety, despair, post traumatic stress disorder, suicide attempts etc are higher among those who have been abused, compared with those who have not. Physical injuries are also common and include bruises and abrasions, fractured bones, lost teeth, internal injuries, gynaecological problems and miscarriages. Whether in general practice, dentistry, health visiting, nursing, maternity services, psychiatry and mental health care, general medicine and surgery, or in Accident and Emergency care, health care professionals have daily contact with patients whose health is damaged by domestic violence, and who often face risks of further and more extreme injury.

3 How should health care professionals respond? It is not acceptable to simply assume that someone else - such as social services, or the police - will be doing something. This may not be the case. Those who experience domestic violence will often have told no one what is happening to them, and may be particularly wary of statutory services becoming involved. It is estimated, for example, that women on average experience 35 episodes of domestic violence before seeking help. They may be concerned that their children will be taken away from them, or they may not want to see their partner prosecuted, they simply want the abuse to end. The NHS is less likely to be seen as stigmatising than are some other statutory services, and this creates a unique opportunity for health professionals to respond to people

experiencing domestic violence. Women who do eventually disclose their abuse to someone typically describe a history of long-standing and escalating violence, and also remark on how much they wanted to be able to talk about what was going on, *if only someone had asked them*.

4 The purpose of this resource manual is to increase the knowledge and understanding of health care professionals (whether in acute, community, or primary based care settings) about the nature of domestic violence, and how it is likely to be evident among the patients they care for. It is not enough to improve detection of domestic violence without also putting in place appropriate policies and protocols to guide response. Health service managers should be instrumental in ensuring this is achieved. The NHS response must not be seen simply in terms of treating the *consequences* of abuse, without also addressing the underlying causes. This responsibility rests with *all* health care professionals who have contact with patients - including those who have an on-going relationship such as through General Practice, Health Visiting, or Midwifery, and those who may have only a fleeting contact with someone in crisis, such as in Accident and Emergency departments. Detecting domestic violence and taking appropriate action (such as giving advice about local helplines or refuge services) has the potential to break the cycle, and to prevent a violent situation becoming one of repeated and intensifying victimisation. Such preventive intervention is important for the individual experiencing domestic violence, but also for the NHS which can reduce the continuing need for palliative support.

5 For health professionals to be able to respond effectively, it is essential that they are supported by their clinical supervisors, managers and other colleagues. The commitment of agencies - from the level of Chief Executive down - should be reflected in clearly stated policies and protocols. These need to be underpinned by sound monitoring and information gathering processes to ensure progress can be reviewed against stated aims and objectives, and services tailored to meet local needs.

6 In all contacts with those who have disclosed domestic violence, or where it is suspected that there may be experience of domestic violence, health professionals must ask the question “will my intervention leave this patient and her children in greater safety or greater danger?” This requires health professionals to:

- ensure that the safety of the person (and of any dependent children) is the paramount consideration in deciding on a particular intervention,;

- treat people with respect and dignity; listen to what they are saying, and not be judgmental;
- seek to empower people to make informed choices about their lives, and not try to make decisions on their behalf;
- respect confidentiality, especially in minority ethnic communities, and recognise the real dangers which may be created if this is breached;
- recognise the skills and contributions which other agencies are able to make, and co-operate with them appropriately;
- ensure that they do not place themselves or their colleagues at risk in a potentially violent situation.

These key principles should underpin local policies and protocols developed by Health Authorities, Trusts and Primary Care Groups (PCGs).

7 In addition these protocols and policies, backed up by appropriate training, supervision and support, need to address and take account of:

- awareness raising about the nature and prevalence of domestic violence;
- supporting staff in their personal reactions to encountering domestic violence, and helping them to deal with issues when they have personal experience of being abused;
- demonstrating zero tolerance for perpetrators of violence in the workplace of the NHS;
- how information gathered from individual record keeping should be aggregated and monitored, and feedback provided to inform practice and help shape local service provision;
- the need to clearly identify responsibilities for inter-agency working (such as through Domestic Violence Fora), and promote co-operation;
- all available local resources and services to support victims of domestic violence, and to address treatment of perpetrators.

8 This manual is - as its title indicates - to be used as a *resource*. It provides a starting point for Health Authorities and Trusts to review their own policies and practices for responding to actual and suspected domestic violence. It is intended that the document should be supplemented with information and data which will support local implementation. At various stages, suggestions are offered for the inclusion of such local material (see the end of Sections 2, 3 and 4). The loose leaf format has been developed to facilitate this approach, and it is important that local material is regularly reviewed and up-dated. The manual builds on and consolidates the separate guidelines which have been issued by various Royal Colleges in recent years. In synthesising different guidelines into a single set which can be used across all areas of health care, it is intended to provide greater clarity which will stimulate and inform the development of good practice throughout the health service.

9 Section 1 explores the background and context to the subject. The Government is committed to tackling and reducing the incidence of domestic violence, not least within the framework of local Crime Reduction and Community Safety Strategies. Indeed, the requirements of the Crime and Disorder Act provide valuable reinforcement to other work to reduce domestic violence; in undertaking audits and developing crime reduction strategies police and local authorities, in partnership with other agencies including health, are *already expected to identify the level of domestic violence in their area*. It is in the interests of all local agencies which come together within the Domestic Violence Forum to see how best they can contribute to the local strategy.

10 Section 2 presents the core facts and figures about the prevalence and nature of domestic violence. It is apparent that domestic violence is widespread; around one woman in four is likely to experience such abuse at some time in her life. Moreover, there are strong associations between domestic violence and child abuse - wherever one or other is in evidence, there is a likelihood that the other abuse will also be taking place, and health professionals need to be alert to this possibility. While domestic violence is found across all age groups and social strata, it is clear that there are certain risk factors which increase the likelihood of domestic violence. The prime risk factor is being female - women are far more likely than men both to be victims of domestic violence, and to be physically and emotionally damaged by their experiences. Other risks include: being young; the presence of dependent children; pregnancy; relationship breakdown and separation; financial pressures; drug and alcohol abuse; and disability or ill-health.

11 Section 3 considers the role of the health professional in recognising domestic violence. It explores the difficulties which surround asking about domestic violence; establishes the principles which should *always* guide practice, and sets out the approach which should be followed in developing policies and protocols both in asking questions routinely, and in circumstances where there are good reasons to suspect domestic violence.

12 Section 3 also considers the action to be taken following disclosure in terms of: respect and validation; response and risk assessment; record keeping; information giving; information sharing and confidentiality; and support and follow up. Consistent record keeping is of particular importance, and a possible minimum data set for recording domestic violence is outlined. Managers have a key role to play in monitoring and utilising the information which is collected. The aggregation of data collected at the level of the individual will contribute to an assessment of local prevalence, the adequacy or otherwise of existing services, and deficits to be addressed.

13 Section 4 addresses the importance of multi-agency work between health and other agencies, particularly that which is focused through local Domestic Violence Fora. Such fora need to co-ordinate the work of the key agencies and professional groups involved in tackling domestic violence. There need to be clearly defined links between Domestic Violence Fora and Area Child Protection Committees in order to ensure joint working on areas of overlapping interest. To date health care professionals have been relatively absent from Domestic Violence Fora, but it is essential that they are adequately represented and involved in this work.

14 Section 5 considers some of the education and training implications of putting domestic violence on the NHS agenda. Those responsible for pre and post registration professional education are urged to address the implications within their courses. In addition, there are opportunities for continuing local training and education in response to local circumstances. As a matter of course, such training should be organised in full co-operation with the key agencies which have established their expertise in this area (such as the Women's Aid Federation, and Refuge). Training and education need to address different requirements, beginning with information and awareness raising about the issue of domestic violence, and moving to specific training on identifying and responding to domestic violence in practical situations.

15 It needs to be recognised that training will often raise personal issues for staff having to confront their own responses to domestic violence. The NHS has responsibilities as an employer to provide appropriate support, and to encourage an environment in which staff are enabled to access confidential help. At the same time, the NHS needs to demonstrate its zero tolerance of violence in the workplace.

16 Finally, Appendices 1 and 2 address some of the context which health care professionals need to understand: the general legal framework in respect of domestic violence, and the specific requirements in respect of the protection of children and of vulnerable adults. Appendix 3 provides a listing of national agencies involved in responding to domestic violence, and sources of additional information.

1 Introduction

Background & Context

1.1 Domestic violence is a term which refers to a wide range of physical, sexual, emotional and financial abuse of people who are, or have been, intimate partners - whether or not they are married or cohabiting. Although domestic violence can take place in any intimate relationship, including gay and lesbian partnerships, and abuse of men by female partners does occur, *the great majority of domestic violence, and the most severe and chronic incidents, are perpetrated by men against women and their children.* In recognition of this reality, the document refers throughout to the victims of domestic violence as women.[i]

1.2 Domestic violence is a serious criminal, social and medical problem, with serious consequences. It infringes fundamental human rights, and causes far reaching damage to people's lives and development. The Government is committed to tackling domestic violence with vigour and its strategy on reducing domestic violence is a major component of the agenda for promoting equality and opportunity for women, and for tackling crime in general.[1] The publication in 1999 of *Living Without Fear*[2] by the Cabinet Office (Women's Unit) and Home Office presented the Government's strategic framework in relation to violence against women. The report emphasised the development of effective multi-agency partnerships as the key to good practice, and signalled the Government's readiness to allocate resources to and support innovative projects under the Crime Reduction Programme to reduce the incidence of domestic violence, rape and sexual assault. The importance of developing a co-ordinated response at both central and local levels has been underlined by the establishment of a Home Office-led Interdepartmental Official Group on Violence Against Women to take forward this agenda, and by the publication of multi-agency guidance for addressing domestic violence.[3] Moreover, the Crime and Disorder Act 1998 placed a requirement on local authorities and the police, in partnership with

i The document also adopts the term domestic violence in recognition of its common usage, but it must be emphasised that this is neither different from, nor less serious than, other forms of violent behaviour, nor is it used to imply that the perpetrator can share responsibility for his violent behaviour towards his partner.

other agencies including health, to establish local Crime and Disorder Partnerships. These will be expected to identify the level of domestic violence in their area, and to develop a strategy for addressing it as part of their wider community safety strategy.

Domestic Violence: A health care issue

1.3 Domestic violence cannot be addressed by the police and criminal justice system alone. The consequences for the well-being of those who experience domestic violence are of such magnitude as to constitute a major public health issue. In his Annual Report of 1997 the Chief Medical Officer highlighted the implications of domestic violence for the NHS:

> *"Domestic violence has considerable implications for the NHS - particularly in accident and emergency departments, primary care and in specialist settings such as maternity services and child and adolescent mental health services. Health care costs incurred are considerable; personal costs even more so - perhaps especially if not acknowledged or recognised."* [4]

1.4 The health service is in a unique position to contribute to helping people who suffer violence at home get the support they need. Health services have a pivotal role to play in the identification, assessment and response to domestic violence, not only because of the impact of domestic violence on health, but crucially because the health services may often be the only contact point with professionals who could recognise and intervene in the situation. Virtually every woman in Britain uses the health care system at some point in her life - whether for routine health care, pregnancy and childbirth, illness, injury, or in the role of carer for children or older people. The health service may literally be a lifeline for women whose contact with the outside world is restricted by a violent partner, or who may not wish to become involved with the police or the criminal justice system.

1.5 If the NHS is to respond appropriately and effectively, the issue of domestic violence must be addressed on a number of levels:

- Raising awareness among staff;
- Creating an environment which encourages disclosure by those experiencing domestic violence;
- Developing protocols for women and children where there are suspicions of domestic violence;

- Ensuring appropriate referral channels as part of a multi-agency response.

1.6 It is not acceptable for health care professionals to assume that domestic violence is the sole responsibility of social services, or of the police and courts. *All* health care professionals have the opportunity and responsibility to identify people who are experiencing domestic violence, and to take steps to empower those women to get help and support. Early intervention can prevent an abusive situation becoming worse and the level of violence becoming more intense.

Health impact of domestic violence

1.7 The effects of domestic violence can range from psychological, to sexual abuse and rape, physical injury and death. The effects can also impact on people who may be indirectly involved, for example where children are witnesses to domestic violence, or where they may also be at risk of assault or abuse (see Appendix 1), and may be frightened, distressed and disturbed by the behaviour which they have witnessed.

1.8 It is important to recognise that domestic violence is not only about physical assault, but can also involve psychological and emotional abuse. Such abusive behaviour can include, for example:

- constant criticism and belittling comments;
- verbal abuse and threats (including threats to harm the children);
- isolation and control of contact with family and friends;
- restrictions on entry/exit from home;
- intimidation;
- controlling and coercive behaviour;
- denial of privacy;
- oppressive control of finances;
- destruction of personal property and valued possessions.[5]

1.9 The stresses and anxiety which many people experience in abusive relationships can be reflected in a range of emotional and psychiatric problems (see Box 1). Women who experience domestic violence are more likely than non-abused women to use mental health services, or to report depressive symptoms.[6]

Box 1
The Psychological Impact of Domestic Violence

"…domestic violence can also have psychological effects including depression, anxiety, Post Traumatic Stress Disorder (PTSD) and suicide. Women may also feel anxious, helpless, afraid, demoralised, ashamed and angry and may experience panic attacks. Battered Women Syndrome (BWS) is a psychological condition that is characterised by psychological, emotional and behavioural deficits arising from chronic and persistent violence. The central features of BWS include 'learned helplessness', passivity and paralysis (…) In relation to domestic violence, common features associated with PTSD include anxiety, fear, experiencing flashbacks or persistently re-experiencing the event, nightmares, sleeplessness, exaggerated startle responses, difficulty in concentrating, feelings of shame, despair and hopelessness. There is little doubt that psychiatric illness, particularly PTSD, depression and anxiety is greater among women who have experienced domestic violence compared to those who have not."

British Medical Association (1998), *Domestic Violence: A health care issue?*, pp30-31.

1.10 Physical assaults typically involve slapping, punching, kicking, biting, hitting with objects, hair pulling etc. The physical injuries which may result from assaults include: bruises, cuts and abrasions (particularly facial injuries), fractured bones, lost teeth, internal injuries and miscarriages[7]. Pregnancy can be a trigger for domestic violence to begin or intensify, and injuries are particularly likely to the breasts, chest and abdomen. Both the woman and her unborn child are at risk from such violence, and indeed it has been argued that foetal morbidity from violence is more prevalent than from gestational diabetes or pre-eclampsia.[8]

1.11 It is important that there is recognition of different effects of domestic violence. While some consequences are highly visible in physical trauma, others are more hidden, and people may be reluctant to reveal the cause of their injuries. Sexual abuse, including rape, can be a further dimension of domestic violence.

Box 2
Why Mothers Die

"Murder by a partner or ex-partner are the extreme end of the spectrum of domestic violence. This is a very important, but often overlooked, cause of maternal and child morbidity and mortality."

Why Mothers Die. Report on Confidential Enquiries into Maternal Deaths in the United Kingdom 1994-1996, Department of Health, 1998, P 159.

1.12 The report on *Confidential Enquiries into Maternal Deaths 1994-96,* included a detailed assessment of deaths resulting from domestic violence. Such deaths had not previously been considered by the Enquiry.[9] The report made a number of recommendations endorsing those made by a report from the Royal College of Obstetricians and Gynaecologists[10] and by guidelines from the Royal College of Midwives.[11] In particular, the Enquiry report recommended that local trusts and community teams should develop inter-agency guidelines for the identification of vulnerable women and the provision of support for them and their families[12]. It also recommended that "a sensitive enquiry about domestic violence should be routinely included when taking a social history" during pregnancy[13] (guidance on how to approach such enquiry is set out in Section 3). The key findings and recommendations were subsequently endorsed in Health Services Circular 1998/211, with the statement that "wherever possible, all the recommendations should be implemented as part of local care and audit plans".[14]

1.13 Because of the nature of physical injuries and the psychological effects of domestic violence, some specialties are more likely to come into contact with domestic violence than others. In particular, people who are subject to physical domestic violence are likely to seek treatment through Accident and Emergency Departments, or from their general practitioner or dentist. Midwives, health visitors, obstetricians and gynaecologists, psychiatrists and psychologists are

also more likely to encounter women who have been injured and abused. However, this document is *not* directed solely towards these areas of practice. Other areas, such as paediatrics – injuries to children can be indicators of domestic violence – and general medicine and surgery, may also encounter symptoms which can be associated with domestic violence, but which can be easily overlooked (for example, irritable bowel syndrome, chronic pain, failure to recover from procedures). It is imperative that there is an increased awareness across *all* sectors of health care, both among those who have on-going contact with particular patients, as well as those whose contact may be occasional or one-off. Recognising and responding appropriately to domestic violence has to be the business of everyone working within the NHS.

Purpose of this document

1.14 In recent years different Royal Colleges have developed their own guidelines on domestic violence. The Royal College of General Practitioners,[15] the Royal College of Midwives (RCM),[16] and the British Association for Accident and Emergency Medicine[17], for example, have issued guidelines, and the Royal College of Nursing has published a position paper on domestic violence[18]. The Community Practitioners and Health Visitors Association[19], the British Medical Association,[20] and the Royal College of Obstetricians and Gynaecologists (RCOG)[21] have similarly produced publications which have done much to highlight the importance of domestic violence as a health care issue, and to propose ways forward. Local research projects, such as Camden Multi-Agency Domestic Violence Pilot Project, have also been undertaken to test out the introduction of training and guidelines for health professionals.

1.15 This resource manual has been developed in order to produce a synthesis of existing guidelines, and to build on local initiatives, to stimulate and inform the development of good practice throughout the NHS. It can be used in a variety of ways:

- It provides information for health care professionals about the nature and prevalence of domestic violence (Sections 1 and 2);
- It addresses what steps need to be taken in developing policies and protocols for identifying domestic violence, and the actions which need to follow disclosure (Section 3);

- It encourages the adoption of an inter-agency response at local level (Section 4);

- It explores some of the education and training implications (Section 5);

- It outlines the relevant provisions of the law and the implications of these for health personnel (Appendices 1 & 2).

1.16 Where good practice already exists in responding to domestic violence, it is important that this is shared within the NHS and with partner agencies, in order to spread such practice and to develop the evidence base. Opportunities for doing this already exist, for example via the NHS Learning Zone which can be accessed through the NHS intranet web site, or using the address: http://194.189.27.190/doh/learn/learnzone.nsf?OpenDatabase. Health care professionals are encouraged to use this resource as a means of sharing what works in domestic violence through improvements to service delivery, organisation and management of patients.

2 Domestic Violence : The Facts

2.1 This section of the document presents some of the core facts and figures about the prevalence and nature of domestic violence. Such information is important in raising awareness and in countering some widespread misconceptions. It is important to define what is meant by the term 'domestic violence', and in particular, different agencies working together need to ensure that they are using the same shared and agreed definition. The definition set out in paragraph 1.1 is derived from that adopted by the Home Office, and since April 1999 by all police forces across England and Wales:

> *"The term 'domestic violence' shall be understood to mean any violence between current or former partners in an intimate relationship, wherever and whenever the violence occurs. The violence may include physical, sexual, emotional or financial abuse."*[22]

2.2 Sometimes people use the term 'domestic violence' to refer to all forms of violence and abuse within the home, including, for example, abuse of children, and abuse of older people or other vulnerable adults. It is important to be aware of the relationships between these different forms of abuse. For example, where child abuse is identified, it is likely that wider domestic violence is also present. Similarly, there is evidence that where a woman is abused, the children are also more likely to experience abuse, and health care professionals must be alert to these possibilities.[23] However, whilst these forms of abuse take place, they are not the prime focus of this document. Reference to Child Protection Procedures, and protocols for the protection of other groups, appear at Appendix 1.

2.3 Domestic violence varies in both frequency and intensity. People may experience a violent or abusive attack as a one-off or rare episode, or - more commonly - it can be part of a regular pattern of violence of increasing intensity. Given that the pattern of domestic violence is one of escalation, *there is no level of abuse which should be viewed as acceptable or insignificant*. Indeed, intervening at an early stage has the potential to prevent abuse intensifying.

2.4 Information on the prevalence of significant domestic violence is based on the findings from various local studies, from self-reported sources, and from criminal statistics, and the *British Crime Survey*. Findings from surveys are likely to *under-estimate* rather than exaggerate the scale of domestic violence for the following reasons:

- Domestic violence is both under-reported to the police, and under-recorded, and therefore remains a hidden crime;
- People may choose not to disclose their experiences to a survey, particularly if it is not conducted in private and the presence of others may act as a deterrent;
- Many victims[ii] of domestic violence may not perceive themselves in these terms, and may justify or explain abusive behaviour;
- Surveys sometimes focus on particular populations - such as women using a refuge, and may therefore overlook women who do not seek help from services.

Prevalence of domestic violence

2.5 The British Crime Survey (BCS) provides a periodic estimate of the number of incidents of domestic violence. However, because the survey uses face to face interviewing, it has been recognised that this is likely to produce an under-estimate. The 1996 survey included the use of a computer assisted self-interviewing (CASI) questionnaire, designed to maximise confidentiality and anonymity, and therefore to give the most reliable findings to date on experience of domestic violence committed by partners and ex-partners against men and women aged 16 to 59. The CASI questionnaire was not restricted to asking about experiences which had been reported as crimes, but asked about physical assaults and serious threats involving partners, ex-partners, household members and other relatives, both in terms of life time and last year experiences. The findings indicate the following[24]:

At some time in their lives:

- Almost one in four (23%) of women aged 16-59, and around one in seven (15%) men have been physically assaulted by a current or former partner.

ii The use of terminology to describe those subject to domestic violence is controversial. To use the term 'victim' is thought by some to be unhelpful, and there is some preference for reference to 'survivors' of domestic violence. Throughout this document neutral terms are used wherever possible.

- More than one in four women (26%) and almost one in six men (17%) have experienced physical *or* non-physical domestic violence from a partner.

- The highest incidence of domestic violence was reported by women aged 20-24, 28% had experienced assault, and one third had experienced assault or threats.

Within the past year:

- 4.2% of both men and women aged 16 to 59 said they had been assaulted by a current or former partner.

- The likelihood of domestic assault appears to decrease with age for both men and women; around 1% of those aged over 45 reported being assaulted in the previous year, compared with over 10% of women aged 16 to 19, and 9% of men aged 20 to 24.

- Half of those who had experienced violence from a partner or former partner in the previous year were living with children under 16, and 29% reported that the children had been aware of what was happening. However, where women experienced repeated violence, 45% reported that their children had been aware of the latest incident.

- Women who are separated from a partner are at greatest risk: 29% of separated women had experienced threats or domestic assault from a previous partner in the previous year, compared with only 5% of separated males.

Nature of violence:

- Pushing, shoving and grabbing were the most common forms of assault (reported in two thirds of incidents), and kicking, slapping or punching by the assailant was reported in almost half the incidents (47%).

- Injuries resulted in 41% of incidents, and women were more likely to be injured than men (47% compared with 31%). Women who experienced a chronic pattern of violence were particularly likely to have been injured in the last incident (58%).

- Emotional distress was reported by 90% of women experiencing chronic domestic violence, and three quarters of women whose experience was of intermittent violence reported being very upset. Women were also very fearful: 80% of chronic female victims, and 52% of intermittent victims reported being very frightened during the incident (compared with only 11% of chronic male victims, and 5% of intermittent male victims).

2.6 The BCS CASI questionnaire estimated the extent of domestic violence incidents involving physical assault, as well as the prevalence of serious threats. Those responsible for the survey conclude the estimates are "reasonably accurate", and "given the high quality and size of the sample, will give the most reliable estimates for England and Wales".[25] The evidence indicates that domestic violence is widespread.

2.7 Although on first sight, the CASI questionnaire findings might appear to suggest that men are equally likely as women to experience domestic violence, closer examination indicates that experiences differ both in prevalence and intensity. ***Incidents reported by men tended to be less serious than those reported by women. Men were also less upset or frightened by their experience, less often injured, and less likely to seek or to need medical help.*** However, when men *are* the focus of domestic violence there are considerable social and cultural pressures which may prevent them disclosing their experiences or seeking help, and these need to be handled with great sensitivity, and services need to be available and accessible for men who *have* been abused.

Box 3
Women and Domestic Violence

"The government recognises that women are more likely to experience domestic violence at some point in their lives, more likely to experience repeat victimisation, more likely to be injured and to seek medical help, more likely to experience frightening threats, and more likely to be frightened and upset."

Home Office (1998), *Government Policy Around Domestic Violence.*

2.8 Despite some exceptions, the general pattern *is* one of male violence. Certainly men are much less likely to be killed by women: while 45% of female homicide victims are killed by present or former male partners, only 8% of male victims are killed by current or former female partners.[26] Moreover, women who use violence typically do so to defend themselves, while men are more likely to use violence to control other people. The idea that women are at least as abusive as men is both wrong and dangerous, and can lead to the belief that there is no need to provide dedicated services to protect women and their children against domestic violence.

Other evidence indicates:

- Every week in the UK two women are killed by current or former partners.[27]
- Domestic violence accounts for one quarter of all violent crime.[28]
- Domestic violence often starts or intensifies during pregnancy.[29 30]
- On average a woman will be assaulted by her partner or ex-partner 35 times before reporting it to the police.[31]
- Violence can begin or intensify following separation from an abusive partner.[32]
- Domestic violence occurs at similar prevalence among people at all income levels, and among people from all white, black and minority ethnic backgrounds.[33]

Box 4
Risk Factors

"Certainly domestic violence is not the prerogative of certain social classes, family circumstances, or localities. It can, and does, occur in households of all types. Nevertheless, certain groups of people do seem to be at particularly high risk at any one time. The most significant factor is age, with young people most at risk. Although the BCS cannot definitely state the causes of domestic violence, the factors identified indicate the importance of relationships under particular social or economic strain. Key indicators include: marital separation; young children; financial pressures; drug/alcohol abuse; disability/ill health."

Home Office (1999), *Domestic Violence: Findings from a new British Crime Survey self-completion questionnaire.* P 62.

2.9 Being female is the greatest risk factor for experiencing domestic violence. Any woman can experience domestic violence, and one in four will do so. Domestic violence takes place among all social groups although women from professional backgrounds may be less likely to report violence to the police or other authorities, and more likely to speak to friends and relatives about their experiences. Such women are also more likely than women from non-professional backgrounds to have the options and resources to make choices without recourse to statutory services. A study in Islington in London found 25% of women from professional backgrounds reporting that they had experienced domestic violence at some time in their lives (and 7% during the previous year), compared with 30% of working class women, 10% of whom had experienced violence during the last 12 months.[34] Similar proportions of professional and working class males in the survey admitted they had hit their partners.

2.10 Studies on domestic violence and poverty indicate that there is not a *causal* relationship between these factors, although poverty can be a contributory, or exacerbating, factor. Moreover, women with few financial or other resources face particular difficulties in finding protection which may be reflected in the greater reporting of incidents to the police.

2.11 Women belonging to black and other minority ethnic groups may also face greater difficulties in seeking protection against domestic violence. Experience of racism can have a powerful effect in deterring people from seeking help from services about which they may have low expectations. Services and information need to be culturally sensitive and appropriate. The assumptions and attitudes of some people working in health agencies towards the cultural norms of different ethnic groups may also create further difficulties for women being abused.[35] Erroneous assumptions, for example, about the acceptability of domestic violence within some cultures or the mechanisms which exist to deal with it, or stereotyped assumptions about the roles of men and women within these cultures, may contribute to poor recognition - or acknowledgement - of domestic violence. Women from all black and minority ethnic groups should be entitled to exactly the same protection from domestic violence as all other women.[iii]

2.12 It is often assumed that domestic violence is a reflection of a cycle of violence which is transmitted across generations. However, the evidence on whether people who have grown up with violence, go on to be abused or be abusive in their adult relationships, is inconclusive.[36]

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iii The Working Group on Forced Marriages, established by Home Office Minister Mike O'Brien in August 1999, is working towards a strategy to protect women who are forced to marry against their will. This is an issue which affects a small, but significant, minority of women in the UK. It can happen to anyone, but experience shows it is an issue particularly for women with a cultural background in the Indian sub-continent. This work will be undertaken in the broader context of the Government's policy to address domestic violence, family breakdown and social exclusion. A report from the Working Group, which will include some examples of good practice, is expected in the early part of 2000. Health care professionals and managers will need to take account of that report when developing their local protocols for dealing with domestic violence. Inquiries should be directed to the Constitutional and Community Policy Directorate of the Home Office (Tel: 020 7273 4000).

The Local Facts

It is suggested that a local profile of facts and figures is collected and inserted in this manual. This can be especially helpful in local training sessions directed at raising awareness and understanding of domestic violence. Without an understanding of the local prevalence and nature of domestic violence it is not possible to make judgements about how well services are responding, or what strategic development is required.

Health Authorities, Trusts and Primary Care Groups will wish to determine their own local data requirements and to consider any implications for information technology and the designation of appropriate diagnostic coding, but at a minimum it might be helpful to include:

- Number of recorded, and repeated, incidents of domestic violence in locality in last year (and breakdown of figures by age, sex and ethnicity). This information should be collected as a component of local Crime and Disorder strategies, and there is an opportunity to make use of this data on a multi-agency basis;

- Proportion of local child protection cases involving domestic violence;

- Findings from any local research initiatives on detecting/ responding to domestic violence;

- Copy of local child protection guidelines and protocols.

A helpful guide for agencies on collecting and managing data has been produced as part of the Crime Reduction Programme - Reducing Violence Against Women Initiative. The guidance, called Measuring Up, includes a self-assessment diagnostic section which agencies can use to assess their current data collection methods. Linked to this is information about how to obtain and manage data that draws on practical case studies, including collecting domestic violence data within an A&E department. The guidance is available for downloading on the Home Office Website at http://www.homeoffice.gov.UK/violenceagainstwomen/crp.htp or by contacting the Government offices for the Regions or the National Assembly for Wales.

3 Recognising Domestic Violence The role of the health care professional

Box 5
A woman's view

"I wish I'd been asked about what had happened. I was so ashamed but I really wanted to tell them. They didn't ask me though and I didn't have the courage to tell them myself. Even though he wasn't there I lied for him just like I always did. They just gave me some painkillers and sent me home."

Quoted in Langley H (1997), 'The health professionals an overview', in Bewley S; Friend J and Mezey G (Eds), *Violence Against Women*, Royal College of Obstetricians & Gynaecologists. P 151.

3.1 All health care professionals who have contact with patients need to be aware of the risks of all forms of domestic violence, and alert to possible indicators that it is taking place. This section explores some of the difficulties in asking about domestic violence; establishes the principles which ought to guide practice; considers situations in which there should be routine enquiry about the possibility of domestic violence, and identifies the signs which can suggest abuse is taking place.

3.2 The duration and type of patient contact varies between different health care professionals. Where there is on-going contact because of the nature of the care provided (such as in maternity care, psychiatric services or in health visiting and other primary care) there can be repeated opportunities to observe a situation or to ask about domestic violence. Women often need to be asked on a number of different occasions before they are able to disclose abuse; and it is important not to assume that because abuse has been denied in the past, the possibility can be discounted. In situations of more limited and brief contact, such as in Accident and Emergency departments, it can be especially important that warning signs are identified and picked up. Failure to do so could be the loss of the only opportunity to offer help.

Difficulties in asking about domestic violence

3.3 Health workers may sometimes be reluctant to acknowledge domestic violence or to seek evidence of it for a number of reasons[37]. These include:

- fear of taking the lid off something which will get out of control;
- fear of not knowing what to do next;
- fear of causing offence;
- belief that this is not the province of the NHS;
- personal identification with abuse either as a victim or perpetrator.

3.4 Sometimes reluctance may be a reflection of particular beliefs or prejudices about domestic violence. It may be believed, for example:

- that domestic violence is not a serious issue, or that it is essentially a private matter between partners;
- that women provoke violence or 'ask for it';
- that some women deliberately choose violent men.

Such assumptions must be challenged in the course of education, training and guidance for all health care professionals (see Section 5).

3.5 The guidelines below should help health care workers to address these concerns by helping them develop a better understanding of domestic violence, and of the importance of establishing protocols to deal with detection and response.

3.6 People who have experienced domestic violence may similarly be reluctant to disclose what has happened to them. Reasons for reluctance include:

- fear of an unsympathetic response;

- fear of reprisals and serious escalation of violence from their partner if they get outsiders involved;
- shame and embarrassment over what has happened to them;
- fear that their children will be taken into care;
- lack of awareness that help might be obtained from health professionals;
- fear of the police or other authorities being contacted and - for some black and ethnic minority women - fear of deportation.

3.7 It is therefore vital that health care professionals are sensitive to clues and indications which might suggest domestic violence. While women may be reluctant to disclose what is happening to them, often they are also hoping that someone will realise that something is wrong and ask them about it.

Principles in asking about domestic violence

3.8 In all contact with women who may have experienced domestic violence, it is vital that health professionals ask the question "will my intervention leave this woman and her children in greater safety or greater danger?" Box 6 summarises the principles which should guide all interaction. In asking women if they have been abused, it is important that this is done in a sympathetic manner in which the woman can feel safe. Abused women feel ashamed, humiliated, frightened, and are prone to blaming themselves. In this state, even the slightest hint that a doctor or nurse is sceptical about their story, or feels that she is in some way responsible for the situation, can drive the woman back to isolation and a violent setting.

Box 6
Principles of Conduct

- Ensure that the safety of the woman (and of any dependent children) is the paramount consideration.
- Treat people with respect and dignity at all times; listen to what they are saying and do not be judgmental, establish empathy and trust.
- Seek to empower people to make informed decisions and choices about their lives, and do not try to make decisions on their behalf.
- Respect confidentiality and privacy, and recognise the real dangers which may be created if this is breached.
- Recognise the skills and contributions which other agencies are able to make, and co-operate with them.
- Ensure that you do not place yourself or your colleagues at risk in a potentially violent situation.

3.9 In addition to the general principles outlined in Box 6, the following aspects of good practice should be followed.

- **See the woman on her own.** The presence of a partner or a relative may constrain discussion of domestic violence because, regrettably carers are often perpetrators, and could place the woman in greater danger. Discussion should also not take place in the presence of children. Seeing a patient on their own may sometimes be difficult without arousing the suspicions of a partner, but it can be stressed that this is routine practice, or a reason can be found to divert the partner elsewhere (such as asking them to help fill in documentation).[38] In maternity services there is an increasing emphasis on seeing the woman and her partner together, and the requirement to see the woman alone may be felt to undermine this principle. However, health professionals should understand the importance of seeing the woman alone at least once.

- **Consider the need for an interpreter.** Some people may need someone else to be present (preferably of the same gender) either as an interpreter (for different spoken languages, or as sign language interpreters), or as advocates (particularly if the person has a learning disability), or for moral support. The person who is used as an interpreter should be independent and a professional interpreter; it is unacceptable to use family members or friends in this role, or to use staff who happen to have these skills but are not employed (or trained) to use them.

- **Ensure privacy.** The consultation should take place in a room in which confidentiality can be assured, and where the patient cannot be overheard or seen from outside the room, and where there will not be disturbance or interruption of the interview.

- **Emphasise confidentiality**, but be clear about its limits, and explain these to the woman (for example, if there are reasons to believe that a child may be at risk - see Appendix 1).

- **Consider the welfare of any children.** Whenever there is any suspicion of domestic violence, there should be awareness of the potential risks to any children. Children who have witnessed or experienced a violent episode may also need an immediate response to address their own needs and fears.

Who should be asked?

3.10 Local policies and protocols need to be developed to address *who* should be asked about the possibility of domestic violence, *under what circumstances, and by whom*. There are likely to be two main situations. First, circumstances in which enquiry about the possibility of domestic violence is adopted with all patients as a matter of routine, and second, situations in which such enquiry follows only when there are reasons to assume that domestic violence might be taking place. Approaches to both situations are outlined below.

a) Routine Enquiry

3.11 Routine enquiry refers to asking about the experience of domestic violence of all people within certain parameters (e.g women aged over 16), *regardless of whether or not there are signs of abuse, or whether domestic violence is suspected.*[39] As noted in Section 1, Health Services Circular HSC 1998/211, which followed the 1998 report on the

Confidential Enquiries into Maternal Deaths, underlined the need for *routine questioning in ante-natal care, and sensitive enquiry about domestic violence being included in taking a social history*, because of the prima facie evidence that pregnant women and their unborn children are at increased risk of domestic violence. This strategy has also been endorsed by the Royal College of Obstetricians and Gynaecologists.[40] Evidence from practice where this has been followed suggests that most women do not mind being asked when it is explained that the same inquiry is being made of *all* women because domestic violence is widespread and often hidden.[41] A study in detecting domestic violence in an emergency department found 96% of women respondents supported being asked about violence at triage.[42]

3.12 In endorsing routine enquiry about domestic violence for all women in ante-natal care, the report on maternal deaths also emphasised the need for supporting protocols and strategies (see Box 7). This is essential, and it is vital to recognise that the adoption of routine questioning about domestic violence *must* be accompanied by appropriate protocols, and training and support for all staff involved.

Box 7
Local strategies and routine enquiry

"If routine enquiry is introduced, this must be accompanied by the development of local strategies for referral, which should be accompanied by an educational programme for professionals in consultation with local groups, and preferably delivered by those already working in this area."

Why Mothers Die: Report on the Confidential Enquiries into Maternal Deaths in the United Kingdom 1994-1996, Department of Health, 1998. P. 166.

3.13 Approaches to routine enquiry should employ validated screening questions and methodologies. Such tools have been developed in the United States, but have not generally been tested in the UK (although there are some exceptions). Some local research initiatives are taking place, and work in Camden and Islington, for example, has developed and tested a three question screening tool derived from the Abuse Assessment Screen (see Box 8). Routine enquiry should not be treated as a one-off episode. Repeat questioning, for example, at different stages of pregnancy, can be worthwhile. As women establish

a greater rapport with health professionals they may be more likely to disclose experiences than if they are only asked at the beginning of their maternity care. There is evidence that repeated enquiry at various intervals increases the likelihood of disclosure.[43]

Box 8
A Possible Approach to Routine Enquiry

Guidelines for use in Obstetrics and Gynaecology, and in Accident & Emergency, developed by Camden Multi-Agency Domestic Violence Forum, adopt the following approach:

Suggested opening:
We are sorry if you have been asked these questions before. According to recent research 1 in 4 women face violence in their home during their lifetime, so we are now routinely asking every woman about domestic violence.

- *As an adult, have you ever been emotionally or physically abused by your partner or someone important to you?*
- *Within the last year have you been hit, slapped, kicked or otherwise physically hurt by someone?*
- *(If applicable) Since you have been pregnant, have you been hit, slapped, kicked or otherwise physically hurt by someone?*

Camden Multi-Agency Domestic Violence Forum, *Domestic Violence: A training pack for health professionals.*

3.14 The introduction of routine enquiry must be handled with care: staff *must* be properly trained in how to recognise domestic violence, in the use of enquiry tools and interview techniques, and to be able to respond skilfully and confidently. This necessitates careful planning, preparation and resourcing. Accompanying guidelines must also be developed, and referral processes and necessary support services be in place.[44] The introduction of routine enquiries without the necessary protocols and guidelines is not only poor practice, it can be dangerous. Questioning by untrained staff, however well-intentioned, can be damaging and leave the woman vulnerable to further violence.

3.15 There has been some debate about the introduction of routine enquiries in health care settings other than ante-natal care. A review of approaches to asking women about domestic violence in health care settings concluded that routine questioning is likely to be superior to case finding approaches: identifying women suffering domestic violence can best be done by universal screening rather than by selective screening based on risk factors.[45] The arguments against routine questioning typically identify the time constraints in clinical practice (for example where the service response is crisis-led as in Accident and Emergency departments), which create barriers to implementation. Other concerns question the value of routine enquiry without consensus about what to do with the information generated, or what steps to take in responding to the needs of the individual. Again, this is a reason for emphasising the importance of routine enquiry only being introduced with supporting guidelines, protocols and necessary training in their use. Moreover, the extension of routine questioning to other health settings also requires further development and research validation prior to wholesale introduction.

b) An index of suspicion: being alert to the possible signs of domestic violence

3.16 If a decision is made against routine enquiry in some health care settings, it is especially important that health staff have an awareness of the possibility of domestic violence, and of the signs which might suggest this is taking place. It is important to bear in mind, however, that abused women may react very differently to domestic violence - while some will seem depressed and withdrawn, others may be agitated and angry. Similarly, perpetrators of domestic violence will not necessarily fit stereotypes - while some will be overtly aggressive and domineering, others may appear concerned, attentive and charming. Despite these considerations, the following circumstances have been identified as likely indicators which should arouse suspicion,[46] and are based on existing guidelines for good practice.

- Does the woman make frequent appointments for vague complaints or symptoms?
- Are appointments often missed?
- Are there injuries which seem inconsistent with the explanations of accidental causation (such as falls, or walking into doors etc), and are these injuries to the face, head and neck, chest, breast and abdomen?

- Is there evidence of multiple injuries (e.g burns, bruises, areas of erythema consistent with slap injuries) at different stages of healing?

- Does the woman try to minimise the extent of injuries, or try to keep them concealed by clothing?

- Does the woman appear frightened, excessively anxious and depressed or distressed?

- Is there a history of psychiatric illness and alcohol/drug dependency?

- Is the woman always accompanied by a partner or other family member when they attend a consultation?

- If so, do they seem to be passive or afraid of the partner?

- Does the partner appear aggressive and overly-dominant and reluctant to allow the woman to speak for herself?

In addition, in obstetric practice consider:

- Are there injuries to the breasts or abdomen?

- Is there a history of repeated miscarriages, termination of pregnancies/still births or pre-term labour?

If any of the above are present, the patient should be asked about the possibility of domestic violence.

Box 9
Markers for Domestic Violence in Women

The 'markers' or indicators for undisclosed domestic violence have not been fully determined. However, research indicates particular injury patterns which are significantly associated with disclosed domestic violence. A recent study identified the following markers which should alert Accident and Emergency departments to the possibility of undisclosed domestic violence in assault cases:

- Delay in presentation
- Referral by a General Practitioner
- Pregnancy
- History of loss of consciousness
- Multiple injuries
- Abdominal injuries
- Injuries to the face and hands
- Fractures

Spedding R L., McWilliams M., McNicholl R P., Dearden C H (1999), 'Markers for domestic violence in women', *Journal of Accident and Emergency Medicine*, 1999; 16: 400-402.

Asking the Questions

3.17 It is not easy to ask, or be asked, about domestic violence. It is important, therefore, that initial comments or questions attempt to put the patient at ease and help them to feel comfortable about disclosing their experiences. If health professionals focus only on treating injuries or distress, without asking about their causes, they will do little to help the person experiencing domestic violence.

3.18 **Indirect Questions**

Particularly if the abuse has been happening over a long period of time, the woman is likely to feel depressed, insecure and lacking in confidence and self-esteem. She may be extremely afraid of the situation, and that fear may include a fear of talking to anyone about what has been taking place. Women who experience domestic violence often try to explain it to themselves, and others, by seeing it as their responsibility or fault, and the response of others to their situation may have reinforced this view. Before asking direct questions, it may help to begin with some indirect ones to help in establishing a relationship with the patient and developing empathy[47], for example:

- Is everything alright at home?
- Are you being looked after properly/is your partner taking care of you?
- Do you get on well with your partner?

Box 10
Disclosure to Questions

"Disclosures of violence require privacy, confidentiality and sensitive questioning by non-judgmental staff. Women may not disclose violence unless asked directly."

Bewley S, Friend J and Mezey *G (Eds) (1997), Violence Against Women,* Royal College of Obstetricians and Gynaecologists. Section 10, Recommendations. P 326.

3.19 **Direct Questions**

The following questions are intended as prompts; it will not always be necessary or appropriate to ask all of these. In particular, the questions tend to focus on evidence of physical assault and injury, but many women who routinely access health care services and who are experiencing domestic violence, will not have physical evidence of injuries at the time. The questions are ones which have been recommended in guidelines in the UK [48], which have been based on models developed in the USA.[49]

Explain why you are asking the questions. For example:

> *"I am sorry if someone has already asked you about this, and I don't wish to cause you any offence, but we know that throughout the country 1 in 4 women experiences violence at home at some time during their life. I noticed that you have a number of bruises/cuts/burns (as appropriate)".*[50]

1 Could you tell me how you got those injuries?

2 Do you ever feel frightened of your partner, or other people at home?

3 Have you ever been slapped, kicked or punched by your partner?

4 Have you ever been in a relationship where you have been hit or hurt in some way?

5 Are you currently in a relationship where this is happening to you?

6 Does your partner often lose their temper with you? If he/she does, what happens?

7 Has your partner ever:

- destroyed or broken things you care about?
- threatened or hurt your children?
- forced sex on you, or made you have sex in a way you did not want?
- withheld sex or rejected you in a punishing way?[51]

8 Does your partner get jealous of you seeing friends, talking to other people or going out? If so, what happens?

9 Your partner seems very concerned and anxious about you. Sometimes people react like that when they feel guilty, was he responsible for your injuries?

10 Does your partner use drugs or alcohol excessively? If so, how does he behave at this time?

Whose responsibility is it to ask about domestic violence?

3.20 Local guidelines and protocols need to make clear where primary responsibility for domestic violence enquiry should lie. There is a risk that in emphasising that it should be the business of everybody in health care, no one takes specific responsibility. In general, the onus should rest on whoever has main responsibility for a person's care. In a consultation with the GP, for example, this will be the GP. In other situations, it could be the midwife, or health visitor etc. Anyone who is likely to have individual responsibility for the care of a person should be trained in following local guidelines. Staff who are more junior should also be aware of local procedures, including local support agency helpline numbers, and alert to the possibility of domestic violence, and how to respond with sensitivity. There should also be local guidelines which address what staff should do if they suspect domestic violence, and who they should alert to undertake an assessment.

Action Following Disclosure

3.21 The BMA[52] followed the approach of the Royal College of General Practitioners[53] in suggesting a number of stages to the detection of domestic violence and action following disclosure. These have been expanded below to address:

- Respect and validation
- Response and risk assessment
- Record keeping
- Information giving
- Information sharing and confidentiality
- Support and follow up.

Respect and validation

3.22 Work by the Camden Multi-Agency Domestic Violence Forum has highlighted the importance to victims of domestic violence of:

- being asked
- being believed

- being treated with respect
- being given time
- being given information

3.23 All health care professionals must recognise that their response to a woman experiencing domestic violence is of great importance. It may have taken a woman many months or years to reach the point at which she is able to disclose her abuse. How she is treated will be significant in determining whether she is able to disclose more and seek help, or whether she mistrusts professionals and is left to face continued violence alone. The fear of not being believed, or of being blamed for what has happened, may stop women from talking about their experience of violence. When a disclosure *has* been made, it is essential that the response of health professionals is sympathetic, supportive and non-judgemental. It is important to emphasise confidentiality to the woman.

3.24 Central to a position of respect and validation must be support to a woman in whatever decisions she makes. This must include avoiding criticism of women who choose to remain with an abusive partner. There may be many reasons why such a decision is made.

Response and risk assessment

3.25 Immediate response to physical injuries may be necessary, and referral for further assessment, treatment, specialist advice or counselling may also be necessary. Once or whilst any response to the immediate needs of the person has been made, an **assessment of safety** should be undertaken. This needs to consider the immediate risks which may face someone in a domestic violence situation, and whether they are in danger of serious injury or even death. Going through such an assessment with the victim may help them to think through their situation and make decisions about what they need to do. A safety assessment should address:

1 History of abuse (physical, emotional, or sexual) of the woman and her children. Has violence increased in intensity, frequency and severity? (One way of evaluating escalation may be to ask about first, worst, and last episodes of abuse).

2 Is the abuser:

- Making verbal threats?
- Frightening/disturbing/threatening friends and neighbours?
- Threatening to harm or abduct the children?
- Actually harming the children?
- Frequently intoxicated (drugs/alcohol), and more violent when in this state?

3 Victim's current fear of the situation, and her beliefs about the immediate danger.

4 Self-harm or suicide threats/attempt by the abused person.

5 Attempts to get help (e.g. from police, courts, refuges etc) during past 12 months.

6 Availability of emotional and practical support (e.g. friends, family).

7 Availability of a 'safe haven' of alternative accommodation if they do not wish to return home, bearing in mind the woman's own preferences.

3.26 The person who is experiencing the violence is ultimately the only one who can reliably predict the risks she faces and the likelihood of further violence. In considering the likely risks the principal responsibility of the health professional is to support the woman in the decisions and choices she wishes to make.

3.27 If it is believed that children are at risk, Child Protection Guidelines *must* be adhered to, and the need to follow these procedures should be discussed with the patient, and their consent obtained if possible. However, the interests of the child are paramount, and initiating child protection procedures is not conditional on obtaining consent. It is essential that there is an understanding of the inter-relationship which frequently exists between domestic violence and the abuse and neglect of children. As the guidance on safeguarding children states:

"Where there is evidence of domestic violence, the implications for any children in the household should be considered, including the possibility that the children may themselves be subject to violence or other harm. Conversely, where it is believed that a child is being abused, those involved with the child and family should be alert to the possibility of domestic violence within the family."[54]

3.28 In undertaking a risk assessment, health care professionals need also to take account of their own safety and that of their colleagues, and must minimise the risks which they may face from the perpetrator of domestic violence. [iv]

Record Keeping

3.29 Documentation and record keeping have an important role in responding to domestic violence. The BMA has stressed the need for evidence, particularly in the event of the perpetrator of violence being charged with assault. Evidence can also be important in helping an abused woman to obtain protection through an injunction or court order, in opposing an immigration/deportation case, and can be used by the family courts to assess possible risks in granting access to children to a violent parent.

3.30 Extreme care needs to be taken with documenting domestic violence. In order to maintain confidentiality, any record of domestic violence should be kept separately from notes which may be held by the patient or which the perpetrator could have access to. Confidentiality should be discussed with the patient and their consent should be obtained if information needs to be shared with other health care professionals, or with other agencies in accordance with locally agreed protocols (see also paragraphs 3.38 to 3.43).

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iv The NHS Executive has produced a *Manager's Guide to Stopping Violence Against Staff Working in the NHS*. The Zero Tolerance Zone is a nation-wide campaign to tackle violence against staff in the NHS. In addition to the manager's guide, a series of resource sheets and posters are available.

Box 11
Documenting Domestic Violence

"Injuries should be documented in as much detail as possible: body maps are recommended to illustrate injuries, although many GPs will not have these available. Photographs can be helpful and this could be suggested to the woman. GP records may also be helpful in confirming other effects of the violent situation such as mental health problems. All information should be documented clearly and the context of violent episodes recorded, particularly with regard to the perpetrator."

British Medical Association (1998), *Domestic Violence: A health care issue?*, P 48.

3.31 The principle of recording domestic violence information separately from any patient held records is generally recognised as good practice, but it *can* be more problematic in some health care settings.

- In Accident and Emergency care, for example, patient's records should be indexed with their unique hospital number. It may be necessary for medical legal reasons to identify by name any individual alleged to be responsible for an assault leading to their treatment in A & E.

- In maternity services, women usually hold their own records and particular care needs to be taken to ensure that information about domestic violence is *not* included on this record. With the knowledge and consent of the woman concerned, the information should be recorded separately. This is a similar approach to that which is followed, for example, in relation to HIV status, which is not recorded on the hand-held record.

- In General Practice it may be particularly important that any record of domestic violence can be seen within the context of the whole record, since this may be needed to understand, for example, a wider pattern of repeated consultations for depression, or of multiple problems, which may be connected to the violence. However, care must be taken to maintain the confidentiality of the record, and in any practices which encourage patient held records, there would need to be separate recording of such information.

3.32 Many acute, community and primary care trusts will have developed their own documentation for recording domestic violence. What is important is that documentation is locally agreed and tested in order that there is ownership and commitment to its use. If documentation is onerous there will be disincentives for health professionals to identify cases of domestic violence. Paperwork should be the minimum necessary for the purpose, and this will vary between specialties. In situations in which forensic evidence may be required, liaison should take place with the police Domestic Violence Unit which will have established procedures.

3.33 A possible data set might include the following:
In addition to the patient reference number

1. Date of birth
2. Ethnicity
3. Response to screening questions
4. Relationship to perpetrator
5. Whether woman is pregnant
6. Whether there are any other children in the household
7. Nature of abuse and - if physical - type of injuries
8. Brief description of all forms of domestic violence experienced
9. Whether this is the first episode, and if not - what frequency over what period
10. Safety assessment
11. Indication of information provided on local sources of help
12. Indication of any action taken (e.g. referral through multi-agency forum).

3.34 Information recording and the development of a case history is an important part of the health service intervention around domestic violence. Managers have a key role to play in monitoring and utilising information collected. The aggregation of anonymous

information from individual records will enable a picture to be built up which describes:

- the nature of the NHS workload associated with domestic violence,

- the adequacy of the existing service response, and obvious deficits to be addressed.

Regular feedback of such information is important for health care professionals in reinforcing their good practice and ensuring the relevance of record keeping and data collection.

Providing Information

3.35 It is not the job of the health care practitioner to give *advice* to someone experiencing domestic violence on what direct action they should take. Indeed, ill-informed (however well-intentioned) advice - such as to leave the abusive relationship - can be positively dangerous. Women who leave their partners can face an *increased* risk of assault.[55]

3.36 However, at a minimum the health practitioner should provide the woman with information about where she can go for help, and how to contact local services including the local Women's Aid group; the Police Community Safety Unit; Victim Support; Refuge; Rape Crisis etc. (see Appendix 3). The nature and type of help should be in direct response to the woman's identified needs and preferences. Health care professionals should consider offering help in making contact with other agencies on behalf of the woman. The availability of information leaflets and cards, and display of posters, within surgeries, Accident and Emergency departments, Outpatients departments, and other health service premises can be useful, and signals to women that they *can* talk to health workers about such issues. A copy of the Home Office *Break the Chain* leaflet and poster is contained in the back of this resource pack.

3.37 Leaflets should be available in the range of languages which are appropriate for the local area, and should provide information about local support services and contact details. Ensuring these are made available in the toilets (and in changing cubicles) can help both with confidentiality and with situations in which women are otherwise constantly accompanied by a partner. Details about help available should include help for perpetrators of domestic violence, as well as

for victims. On occasions some people may seek help from their GP because they recognise they have a problem with their abusive behaviour. It is important that the GP (or anyone else) is able to respond to this in a non-judgemental way, and without breaching any confidentiality concerning disclosures about violence.

Information Sharing and Confidentiality

3.38 Confidentiality is essential in enabling victims of domestic violence to disclose their experiences. Their physical safety can be dependent on confidentiality being maintained. Where a health professional such as a GP might also have contact with the perpetrator of domestic violence, it is vital that they do not disclose confidential information. However, all health care workers must understand, and be honest about, the limits to confidentiality. It has been pointed out earlier in this document that when there are reasons to believe that children are at risk, protection must take precedence over confidentiality, and Child Protection Guidelines and protocols must be followed.

3.39 Questions of ethics, confidentiality and accountability can be complex. Different health care professionals may subscribe to different objectives, and unless there is careful and shared consideration of domestic violence, it is possible that confidentiality can inadvertently be breached. For example, a child who has been living in a refuge with her mother may need to be admitted to hospital. If the father visits the child, it is clearly essential that records on display do not indicate addresses or contain any other information which could place the mother and child in greater danger.

3.40 It is not only in the area of child protection that confidentiality may need to be balanced against the interests of disclosure. Where a health care professional is aware that someone has been the target of domestic violence, and is believed to be at risk of serious harm, the decision might be made to pass this information to other parties and agencies in line with locally agreed multi-agency guidelines and protocols on domestic violence which address how such information is to be used and safeguarded. This decision must be discussed with the person concerned, an explanation of the reason for sharing information should be given, and their consent should be obtained. The only information which should be shared is that which is judged to be necessary for securing the best interests of the woman and/or her children.

3.41 Guidance by the General Medical Council on confidentiality makes it clear that disclosure *can* exceptionally be made in the public interest, and without the patient's consent, when it is believed that failure to pass information to an appropriate authority may expose the patient, or others, to risk of death or serious harm.[56] Similarly the United Kingdom Central Council (UKCC) Code of Professional Conduct states that nurses or midwives should protect all confidential information, and make disclosures without consent only where required by order of a court, or *where disclosure can be justified in the wider public interest.* In deciding whether there is a public interest consideration which outweighs the duty of confidentiality, health care workers will often be working in a grey ethical area, and will need to be able to justify the decision reached on a case by case basis.[57] Whatever decision is made, the health care worker must be confident that their action will not place someone at greater risk of violence.

3.42 It is important that health professionals are not isolated or burdened in making such decisions. The majority of health professionals work in teams where they should have access to clinical supervision, allowing a case to be discussed in general terms *without disclosing an individual's identity*. Trusts and other NHS employers should develop policies to ensure that discussion about the appropriateness of disclosure can take place, and that responsibility does not fall exclusively on individual professionals.

3.43 The Crime and Disorder Act 1998 also allows for the disclosure of information to the police, local authority, health authority, or probation committee where it is believed to be necessary for the purposes of that Act. However, this *does not* over-ride existing controls on the use of personal information in terms of confidentiality or data protection legislation. The sharing of *anonymised information* between domestic violence service providers is of great importance in identifying gaps in service provision for example (See Section 4).

Support & Follow Up

3.44 It is often the case that the person to whom domestic violence has been disclosed will have ongoing contact with the patient (for example, the GP, Midwife, Health Visitor etc.), and continuity of care can be very important in further building trust. This allows opportunities for monitoring the situation and being alert to signs of escalating violence and increasing risk.

3.45 Some professional guidelines on domestic violence (for example RCGP[58] and CPHVA[59]) emphasise the importance of developing a safety plan, or emergency action plan, as part of the support to an abused person. Such contingency arrangements have been developed within practice guidelines in the US[60], and address the preparations which should be made in case a person has to leave their home in a hurry. The responsibility of health care professionals should be to support women in making decisions and in advising them about what services they can contact for particular advice and help. Specialist services such as Women's Aid, or Refuge, have the appropriate skills and training to address these issues.

3.46 A further important aspect of support is that of support to individual health care professionals engaged in work around domestic violence. Health Authorities, Trusts and Primary Care Groups should all address how best they can offer support to staff who may be distressed by the impact of domestic violence on those they are caring for. A supportive workplace environment should also support staff who may themselves need to disclose their own experience of domestic violence. UNISON has developed helpful guidelines on developing workplace policies on domestic violence.[61]

Local Approaches

Acute and Community Trusts, Primary Care Groups and others may find it helpful to insert the following local information into this section of the ring binder:

- **Local Information and Resources**
  A list of local addresses and telephone helpline numbers for agencies involved in responding to domestic violence and local refuge projects. Copies of information leaflets which are available for local use should also be included.

- **Policies and Protocols for Domestic Violence**
  These should reflect the approach outlined in Section 3, and should be developed and tested in consultation with different stakeholder groups. The Royal College of Midwives recommends, for example, that 'a systematic and structured framework be developed to facilitate the midwife's role by introducing policies and guidelines within maternity units.' Policies and protocols should address clearly those areas in which there is to be routine enquiry (at minimum *all* pregnant women should be routinely asked about domestic violence), and those which are to be approached through a case finding approach. They should also identify who is responsible for asking the questions.

- **Practice Guidelines**
  Practice guidelines should address: interview technique and principles to be followed; and action following disclosure.

4 Developing a Multi-Agency approach

4.1 The importance of multi-agency work between health and other agencies has been increasingly emphasised by the Government. There are already initiatives in which there is scope for including work on domestic violence, in particular:

- **Crime and Disorder Act partnerships** which require local authorities and the police, in co-operation with other agencies (including NHS Trusts and Health Authorities) to audit the levels of crime within their boundaries and to formulate and implement a local crime and disorder reduction strategy. Violence, including domestic violence, creates a significant cost burden for the NHS. However, since much of this violence is unknown to the police - and therefore they cannot take action to deal with it - NHS managers have an important role through partnership working to maximise the contribution the NHS can make to reducing crime and releasing hard pressed resources.

- The Government introduced a new statutory duty for Health Authorities to improve the health of their populations, and to do so in partnership with local authorities.[62] The **Health Improvement Programme** is the local strategy for improving health and healthcare. Clearly, domestic violence is a key public health issue which can be addressed within such strategies.

- Two waves of **Health Action Zones (HAZs)** have been established. Eleven were set up in 1998, and a further 15 in 1999. HAZs bring together health and other agencies to develop local strategies for improving the health of local people. A number are focusing on domestic violence as an explicit component of their strategy (including, for example: Sandwell; Plymouth; South Yorks Coalfields; Bradford; Tyne and Wear; North Cumbria; Walsall; Wolverhampton; Leicester; Nottingham; Camden and Islington; Merseyside; and Cornwall & the Isles of Scilly.

- Further partnership opportunities exist through **Sure Start** - a programme of support aimed at families with children aged under four, and targeted at some of the most disadvantaged areas of the country. 250 Sure Start programmes in England will bring together early education, health services and family support, in order to break the cycle of poverty, dysfunctional families, and social exclusion.

4.2 In addition to these and other developments in partnership, the majority of local multi-agency working to address domestic violence is of a strategic and co-ordinating nature, typically focused on the local Domestic Violence Forum. A wide range of agencies and professional groups are required to address the complex issue of domestic violence. The most constructive approach to ensuring that approaches are properly coordinated is the development of a multi-agency approach. More detailed guidance on multi-agency working to address domestic violence has been issued by the Home Office.[63]

4.3 The first multi-agency domestic violence projects were established in the UK in the 1980s. Evaluation of this approach has identified the strengths of the model, as well as the practical difficulties which can arise.[64] Multi-agency work in general (as well as in the specific case of work in relation to domestic violence) can work well and can enhance the coordination and coherence of policy and practice. However, it is also understood that multi-agency work is most successful when it is focused on a specific task or tasks, rather than operating as a general talking shop with few concrete objectives or achievements.[65]

4.4 Multi-agency working must be recognised as a means to an end, *not* as an end in itself. Accordingly, Domestic Violence Fora need to establish clear aims, objectives and plans against which their progress can be assessed. As the Home Office guidance emphasises, the purpose of a forum is to improve the overall approach to addressing domestic violence, and the level of service provided to survivors. All agencies involved in the forum need to have specific domestic violence policies and practices which can be co-ordinated through the forum**. Each Domestic Violence Forum and local Area Child Protection Committee (see Appendix 1) should have clearly defined links, including some cross-membership in order to improve working together on areas of overlapping interest.**

4.5 The Interdepartmental Group on Domestic Violence was set up in 1992 to bring together key interests and coordinate response across

government. In 1995 an inter-agency circular was published. This has been enhanced by the latest Home Office guidance. The Government supports the development of inter-agency Domestic Violence Fora.[66] Inter-agency work on domestic violence is increasingly being seen within the wider context of local crime reduction partnerships established under the Crime and Disorder Act. The Government wishes to see effective partnerships developing to address domestic violence.[67] Initial audits carried out under the Crime and Disorder Act have indicated the paucity of existing local data on domestic violence, and this is an area where urgent improvements are required and where the Domestic Violence Forum has a key role.

Models of Domestic Violence Fora

4.6 Inter-agency work is already well established in the field of domestic violence (more than 200 such fora exist in England and Wales), although the BMA points out that, despite some notable exceptions, to-date health care professionals have only played a small part in these developments.[68] Fora are therefore at different stages in their development, and while some will be well advanced, others are in need of considerable revision. A national study of multi-agency responses to domestic violence found a wide range of approaches.[69]

Box 12
Involvement of Health Service Professionals in Domestic Violence Fora

"Health service professionals participate in some domestic violence forums although, during the mapping study, their absence was noted far more frequently than their presence."

Hague G., Malos E., & Dear W (1999), *Multi-Agency Work and Domestic Violence*, Joseph Rowntree Foundation, Para 4.11

4.7 Because of the statutory responsibilities on local authorities and police for establishing local Crime and Disorder Partnerships, many Domestic Violence Fora will be led by one or other of these agencies. Care must be taken to ensure that this does not lead to the marginalisation or exclusion of key voluntary sector groups which have a particular expertise in the field of domestic violence, including those concerned with black and minority ethnic groups. The police have often taken the initiative in establishing Domestic Violence

Fora. This can arise directly from their work with Police Domestic Violence Units, Community Safety Units, or local equivalent bodies. The national study of inter-agency initiatives concluded that there was evidence that police-initiated projects work best where the police refrain from taking too much of a dominant role. [70] It is also essential that representatives on inter-agency fora are drawn from appropriate levels of senior policy making and commissioning, and are not simply people who are interested in the issues but who lack the seniority to speak on behalf of their authority. If senior managers are not personally represented it should be clear that staff who attend have the full support and commitment of their managers.

4.8 Reasons why health care professionals may have been relatively absent from multi-agency fora are unclear. However, there may be concerns both about the additional burden of work which may be generated, and over the implications for confidentiality of becoming involved in discussion with other agencies. As the review by Hague *et al* identified, there is a wide range of activities which fora can be engaged in which are concerned with domestic violence as an issue, and which will not compromise patient confidentiality.

4.9 There isn't a standard model for inter-agency working, and different models operate in different localities. Essentially, inter-agency fora bring together both statutory and voluntary sector agencies to share information, and to coordinate activities in response to domestic violence. While the range of agencies involved can be extensive, the full and effective involvement of the local voluntary sector is vital, and relevant bodies include:

- Women's Aid, Refuge, and other local representatives of refuges, helplines, advocacy, support and outreach services, and legal advisers.
- Specialist domestic violence services, including those for women and children from ethnic minorities, and for women with disabilities.
- Rape Crisis centres.
- Child contact centres
- Victim Support

- Community organisations, including groups representing survivors of domestic violence.

4.10 In addition, a wide range of statutory bodies need to be represented, these include: the Police and Probation services; the Crown Prosecution Service; Local Authority Departments (including housing, education and social services), and appropriate Health Authority, Trust and Primary Care Group representation. The involvement of a large number of different organisations in inter-agency working to tackle domestic violence should *not* lead to unwieldy and cumbersome structures, nor does it imply the involvement of all members in lengthy and detailed case conferences. There are a variety of ways in which Domestic Violence Fora can operate, but their responsibilities are essentially strategic.

The Work of Fora

4.11 The national study identified a number of ways in which fora can operate, including:

- Liaison and networking
- Co-ordinating local services
- Improving local service delivery
- Initiating domestic violence training for agencies
- Engaging in public education
- Establishing direct services for women and children
- Educative and preventative projects.[71]

4.12 The national study concluded that the networking and liaison stage of development is typically a transitional one. It serves a valuable purpose in enabling people to get to know one another and understand the contribution of different agencies. Beyond this, most fora evolve into more focused approaches to developing specific pieces of work. If practical changes are to result, it is essential that this more action-oriented phase develops.

Box 13
Moving Beyond the Talking Shop

"...while networking is important, in good multi-agency practice, forums move beyond this stage in order to engage, on some level at least, in action to increase safety and protection against domestic violence. There is nothing magic or prescriptive about the multi-agency approach. If it does not appear to be resulting in concrete, observable changes and remains a talking shop in the long-term, then it is better for those involved to do something else instead."

Hague G (2000), 'Multi Agency Initiatives as a Response to Domestic Violence', in Taylor-Browne J (Ed), *Reducing Domestic Violence: What Works?* Home Office.

4.13 The majority of inter-agency initiatives were concerned with co-ordination of local services and practices in domestic violence, and with a range of educative or awareness raising initiatives, rather than with setting up direct service provision.[72]

4.14 Improved co-ordination can include addressing referral systems between agencies (such as between A&E Departments and refuges). It can also take the form of producing material to improve local liaison, such as the development of local resource directories. Improving local practice and service delivery may include work on developing and implementing practice guidelines - either for use by all agencies, or specific ones for use by particular groups. Training in domestic violence awareness, and on specific policies and practice, is another area in which the national study found many inter-agency fora were engaged. Public education includes the development and distribution of leaflets, posters etc aimed at women and children experiencing domestic violence. Educational and preventative projects can also be concerned with the development of training materials for use in schools and other settings. Some multi-agency fora are also involved in programmes directed at the male perpetrators of domestic violence. Usually such programmes are connected to the probation service, although some take referrals from other channels.

4.15 The Home Office guidance indicates that fora should ensure *at the very least* that the following are available:

- Forum's statement of policy.
- Information for survivors of domestic violence.
- Resource pack, including detailed guidance for service deliverers.
- Training for service deliverers in meeting the needs of victims.[73]

Monitoring and Evaluation

4.16 The work of fora needs to be monitored in order to ensure that it *is* improving the safety of abused women and their children. The Home Office guidance suggests the following criteria might be adopted:

- Improvements in safety.
- Improvements in take-up and delivery of services.
- Improvements in service provision.
- Concrete changes in policy and practice.
- Service user consultation and satisfaction.
- Development and take-up of comprehensive domestic violence strategies.

4.17 These are illustrative criteria, and different evaluation will be appropriate in different localities depending on the specific goals and objectives adopted by fora. However, what is essential in making judgements about progress is that members of fora share appropriate information. As noted previously, the sharing of information *must* observe protocols which ensure confidentiality is protected. This can be achieved by anonymising data, while tracking trends in referrals and workloads which enable gaps in services to be identified. All the agencies involved in dealing with domestic violence need to be able to:

- describe the work they are doing;

- measure the services they provide;
- detail how their services are being used; and
- how their existing resources are being spent.

In sharing information, agencies will need to ensure data are comparable, and this can be greatly helped by signing up to a shared working definition of domestic violence. This need not rule out the use of more than one definition if agencies wish to collect *additional* information over and above the multi-agency core data set, for their own purposes.

Local Information

Acute, community and primary care Trusts might include local information on multi-agency working on domestic violence at this point in the ring binder.

This might include:

- **Local Domestic Violence Forum/Fora**
  Contact details and membership information

- **Copies of terms of reference/objectives and current priorities**

- **Indication of data collection and monitoring requirements for individual agencies.**

Agencies will also find it helpful to consult the Home Office guidance on collecting and managing data on domestic violence which includes attention to how data should contribute not only to the needs of individual agencies, but also to those of the multi-agency forum, see:
http://www.homeoffice.gov.UK/violenceagainstwomen/crp.htm.

5 Education and Training

5.1 The Social Services Inspectorate observed that perhaps the most useful contribution of domestic violence fora is in training, and that "a goal for the future must be to include domestic violence as a subject in the core training of all health and social work professionals.[74] Education and training *must* be addressed by the health service. *All* health professionals should be given basic information and taught about the nature and prevalence of domestic violence, and the steps which need to be taken to support disclosure and prevent further violence. This needs to begin at undergraduate/pre-registration level, and continue in specialist training and continuing professional development. Responsibility for professional education rests with the respective Colleges and with the English National Boards and the UK Central Council. These bodies should review their existing training and examination approaches to ensure that domestic violence is incorporated wherever relevant, and forms part of the basic training for all health care professionals in understanding human and family relationships.

5.2 Although there are some common basic training and education requirements in respect of domestic violence across all health care specialties, there are also distinctive needs in respect of the particular skills and knowledge required in different health care settings. Additionally, there is a need to develop educational opportunities at a higher level which allow health care professionals to specialise. The professional bodies responsible for developing and validating courses at pre- and post-registration levels are encouraged to address such requirements. It is through the development of such recognised specialisation that the status of this area of work can be enhanced, research and professional networking can be developed, and good practice can be expanded.

The purpose of training

5.3 In addition to professional education programmes, there is a need for local training and education on aspects of domestic violence to be developed in response to local situations and requirements. Such

training should, as a matter of course, involve and work alongside key voluntary sector agencies involved in working against domestic violence (such as the Women's Aid Federation, and Refuge), many of which have developed great expertise in training. Refuge, for example, has established protocols for training in domestic violence awareness for different health care professionals including: General Practitioners; staff in Accident and Emergency Units, and those engaged in Psychological and Psychiatric services.[75] The local Domestic Violence Forum will often be able to advise on how best to access these skills. Training about domestic violence can have a number of objectives, including:

- Improving awareness and understanding.
- Increasing sensitivity to potential signs of domestic violence.
- Ensuring appropriate response to identified abuse (including documentation and record keeping).
- Establishing core principles on how to respond to people experiencing domestic violence and recognising the need for flexible approaches in dealing with women from majority and minority ethnic communities.
- Increasing confidence among health workers in their ability to provide support.[76]
- Developing communication skills to improve empathetic responses to those experiencing domestic violence.[77]
- Improving communication and information sharing between key professionals.
- Ensuring a co-ordinated service response at both strategic and individual levels.
- Ensuring awareness of local specialist services and resources available.

5.4 Training should include all health care professionals who have direct contact with patients including junior and administration staff, and receptionists who usually have first contact with patients. The development of any local policies and protocols on the health service response to domestic violence *must* be accompanied by a training strategy, and new approaches must not be introduced until staff have been appropriately trained. Training must be relevant to the situation, and should address the context within which health professionals are operating.[v]

5.5 Domestic violence can raise painful and emotive issues for staff. Training will sometimes be the trigger for confronting personal difficulties which are the result of direct or indirect experience of domestic violence in their own lives. Experienced trainers will be alert to these reactions, and able to provide appropriate support. The NHS must also recognise that it has responsibilities as an employer, and should be clear that it will support employees who are experiencing domestic violence, and will encourage an environment which enables staff to access confidential help. At the same time, as an employer the NHS should demonstrate 'zero tolerance' for perpetrators of domestic violence in the workplace. [78]

5.6 Multi-agency working can be greatly enhanced by joint education and training programmes which bring together different professional groups involved, or potentially involved, in responding to domestic violence. This can promote a common and shared understanding not only of the issues, but also of the respective roles and responsibilities of different professionals, and can contribute to more effective working relationships.

v. A training and resource pack, *Making an Impact*, commissioned by the Department of Health was launched in June 1998. Focusing particularly on children and domestic violence in families, the pack aims to equip front-line staff with the skills to identify victims of abuse and to provide support.

Appendix 1: Protection of children and of vulnerable adults

a) Child Protection Procedures

Guidance issued by the Department of Health in 1999[79] provides a national framework within which agencies at local level must agree ways of working together to safeguard children.

An **Area Child Protection Committee (ACPC)** has to cover every local authority area. Where boundaries between local authorities, health authorities and the Police are not coterminous, it can be helpful for an ACPC to cover more than one local authority area, or for adjacent ACPCs to collaborate in establishing common procedures, protocols and inter-agency training. The ACPC is a multi-agency forum which brings together the different agencies and professionals responsible for safeguarding children. Social Services Departments have lead responsibility for the establishment and operation of ACPCs. Membership of ACPCs is determined locally, but as a minimum should include representation from:

- local authorities (education and social services)
- health services (both managerial and professional expertise and responsibility)
- the police
- the probation service
- NSPCC (when active in the area)
- the Domestic Violence Forum
- the armed services (where appropriate, and especially where there is a large service base in the area).[80]

ACPCs are expected to establish working groups or sub-committees to address specific tasks (such as in respect of inter-agency training needs), or in providing specialist advice (for example in relation to work with specific

ethnic or cultural groups, or with disabled children and parents), or in representing a particular geographical area within an ACPC.

Where a child is suspected to be suffering from, or likely to suffer significant harm, the local authority Social Services Department (SSD) is required under **Section 47** of the **Children Act 1989** to make enquiries and decide whether any action is required. An **initial assessment** should be undertaken, using the *Framework for Assessment of Children in need and their families*, which addresses:

- What are the needs of the child?
- Are the parents able to respond appropriately to the child's needs?
- Is the child being adequately safeguarded from significant harm, and are the parents able to promote the child's health and development?
- Is action required to safeguard the child's welfare?[81]

When emergency action is needed to protect a child, it is the responsibility of the local authority. This action should be followed by **Section 47 enquiries** which bring together the agencies involved with the child and the family to assess the circumstances. The objective of such enquiries is to determine what, if any, action is needed to promote and safeguard the welfare of the child or children. Enquiries can lead to a number of possible outcomes:

- concerns are not substantiated;
- concerns are substantiated, but the child is not judged to be at continuing risk of significant harm;
- concerns are substantiated *and* the child is judged to be at continuing risk of significant harm.

In the latter case, the Social Services Department should convene a **Child Protection Conference** which brings together family members, the child (where appropriate) and the professionals most involved with the child and family in order to:

- bring together and analyse in an inter-agency setting the information which has been obtained about the child's health,

development and functioning, and the parents' or carers' capacity to ensure the child's safety and promote the child's health and development;

- make judgements about the likelihood of a child suffering significant harm in future; and

- decide what future action is needed to safeguard the child and promote his or her welfare, how that action will be taken forward, and with what intended outcomes.

If the child *is* judged to be at continuing risk of significant harm, inter-agency help and intervention is organised through a formal **child protection plan**, and registration on the **child protection register**. When a child's name is placed on the register, a named key worker is designated to be responsible for the case. A child is registered under one or more categories of risk in terms of physical, emotional, or sexual abuse, or neglect. The categories used for registration help indicate to those using the register the nature of presenting concerns.

A first **child protection review conference** should be held within three months of the initial child protection conference, and further reviews should be held at intervals of no more than six months, for as long as the child's name remains on the register. A child whose name is removed from the child protection register may nonetheless still require support and services, and de-registration should never lead to the automatic withdrawal of help.

B) Protection of Vulnerable Adults

A 'Vulnerable Adult' is defined as those aged over 18 with learning disabilities, mental health problems, older people, and people with a disability or impairment. Abuse of a vulnerable adult is physical, psychological, or an act of neglect, or occurs where a vulnerable person is persuaded to enter into a financial or sexual transaction to which they have not, or cannot, consent. Abuse can occur in any relationship and may result in significant harm to, or exploitation of, the individual.[82]

Abuse can therefore be perpetrated by people including relatives and family members, professional staff, paid care workers, volunteers, other service users, neighbours, friends and associates, people who deliberately exploit vulnerable people, and strangers. Health and social care agencies commissioning or providing services have a duty of care to adults who are vulnerable and at risk.

There are not equivalent arrangements for the protection of vulnerable adults as there are in respect of children. However, guidance issued by the Department of Health addresses a framework for action including:

- the development of a local inter-agency policy
- the development and implementation of a strategy
- the development of procedures for dealing with cases of abuse
- the establishment of inter-agency procedures.

Just as it is important that there are close links between ACPCs and Domestic Violence Fora, so it is also important that there is close liaison between these two agencies and those responsible for policy and practice in respect of vulnerable adults.

Appendix 2: Domestic Violence and the Law

The legal framework which provides protection against domestic violence involves both the civil law and the criminal justice system. Anyone requiring specific legal advice should be advised to seek it from the appropriate professionals. It is certainly *not* the role of health care professionals to offer legal advice, but they should know where such advice is available locally, and what information can be passed to people needing help and information (details of national organisations such as Women's Aid, Victim Support, and Refuge are listed in Appendix 3).

Health care professionals should also have a general knowledge and understanding of the law in relation to domestic violence for the following reasons:

- specific statutory provisions exist for the protection of children (notably under Section 47 of the Children Act, 1989) , and of vulnerable adults, and these have implications for multi-agency working and appropriate referral processes between health and other agencies (see Appendix 1).

- protection against domestic violence is available in certain circumstances under both the criminal law and the civil law (including provisions under the Family Law Act, 1996; the Housing Act, 1996; and the Protection from Harassment Act, 1997);

- in some situations medical records of domestic violence may be required as evidence to support a prosecution, or applications for injunctions against a perpetrator of domestic violence, or as evidence in immigration cases. [vi]

There has been an increasing recognition in recent years that domestic violence should not be regarded as a private matter which takes place behind closed doors. This has been reflected in new requirements for police

vi A concession to the one year rule allows applicants whose relationships have broken down as a result of domestic violence to remain in the UK. Evidence required is an injunction, non-molestation or other protection order against the partner, a relevant court injunction or full details of a relevant police caution.

practice (following Home Office Circular 60/90 issued in 1990), leading to the establishment of domestic violence policies, and Domestic Violence Units. The primary duty of police called to domestic violence incidents is the protection of the victim and any children, and then to consider what action should be taken against the offender. Immediate steps to ensure protection can include referral to a refuge, and liaison with statutory and voluntary agencies.

The police have the discretion to decide to intervene, arrest, caution or charge someone being abusive. Domestic violence can be dealt with under the common law the same way as any other assault or offence. When a perpetrator of domestic violence is arrested and charged, the file is passed to the Crown Prosecution Service (CPS) which then decides whether or not to proceed. This decision is guided by whether there is sufficient evidence to continue, and whether it is in the public interest to do so. The judgement of sufficient evidence is likely to depend on independent evidence of the crime (e.g. witnesses, forensic evidence - including medical records - etc.), and on whether the victim is willing to be a witness for the prosecution.

The Family Law Act, 1996

The Family Law Act replaces previous legislation in this area and consolidates civil protection against domestic violence. Part IV of the Act provides a set of remedies available in all family courts, and introduces two types of orders:

- **occupation orders** which concern the right to occupy the family home; and
- **non-molestation orders** providing protection against violence and abuse.

Eligibility for orders under the Act depends on the nature of the relationship between the applicant and the respondent. The following persons are included, those who:

- are or have been married to each other;
- are or have been cohabitants (i.e. a man and woman living as husband and wife);
- have lived in the same household (other than as tenant, lodger, boarder or employee) - this includes those in gay and lesbian relationships, and those sharing a house;

- are relatives;
- have agreed to marry;
- are both parents of or have parental responsibility for a child/children.

Those excluded from eligibility are therefore people in a close relationship who have not lived together, and where there is no child for whom they are both parents or have parental responsibility. However, Part IV of the Act *does* extend access to protective remedies to a much larger group of people than previous legislation. Powers of arrest can also be attached to all orders whenever physical violence has been used or threatened against the applicant or any relevant child.

Protection from Harassment Act, 1997

The so-called 'stalking legislation' introduced in 1997 provides further protection against abuse through establishing two new criminal offences: that of **criminal harassment**, and a more serious **offence involving fear of violence**. Harassment is defined as behaviour which would be regarded as harassment by a 'reasonable person'. A perpetrator is guilty of the offence of causing fear of violence when they know or ought to know that their course of conduct will cause the other so to fear (on at least two occasions). This offence is seen as useful in allowing the courts to take action *before* serious psychological or physical harm occurs. Other advantages of the new law have also been identified:[83]

- it strengthens the use of police protection and the criminal law against men who continue to harass women after their relationship with them has ended;
- it provides protection for women without children and not living with their abusers who cannot apply for injunctions under Part IV of the Family Law Act;
- restraining orders can be issued following a conviction, and these provide the same protection as injunctions under the civil law, although with stronger penalties attached.

Housing Act, 1996

Women experiencing domestic violence might also seek help through the local authority with its responsibilities for providing priority accommodation to homeless people. Under the **Housing Act, 1996**, people experiencing domestic violence (defined as violence or threats of violence from a person associated with the person under threat) are defined as homeless. Priority need for accommodation is given to those who are pregnant, have dependent children, are vulnerable, or threatened with homelessness because of an emergency.

This brief account of the legal framework has outlined the major areas of the law under which victims of domestic violence may have recourse to legal protection. It should be emphasised once more that this *is not intended as a definitive account of the law in this complex area*.[vii] The key issues for health care professionals can be summarised:

- It is *not* the role of health care professionals to offer women legal advice about domestic violence, but it is appropriate to refer them to agencies who *can* provide such help.

- Aspects of domestic violence are recognised under both the criminal and civil law, and there are remedies available which can offer protection to women and their children. Seeking help under the law may require supporting evidence of domestic violence such as that contained in individual medical records.

- Health care professionals should not assume that women will automatically wish to proceed with prosecution of their abuser, and should not routinely encourage them to follow legal proceedings. There are many reasons why women will choose not to seek legal redress, including: reluctance to give evidence against someone they still love or care for; fear of family or community ostracism (particularly for black and ethnic minority women); fear of antagonising the situation and violence worsening as a result; and reluctance to endure court proceedings.

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vii A helpful and detailed summary of the legal context can be found in: Marianne Hester, Chris Pearson and Nicola Harwin (1998), *Making an Impact: Children and Domestic Violence. A Reader.* Department of Health; School for Policy Studies, University of Bristol; NSPCC; Barnardos.

Appendix 3: Useful National contacts

WOMEN'S AID

Women's Aid Federation of England
PO Box 391
Bristol BS99 7WS
Tel: 0117 944 4411 (office)
08457 023468 (helpline)

Welsh Women's Aid
38-48 Crwys Road
Cardiff CF24 4NN
Tel: 029 2039 0874

Refuge
2-8 Meltravers Street
London WC2R 3EE
Tel: 020 7395 7700 (office)
Fax: 020 7395 7721
24 hour national helpline:
0870 599 5443

Zero Tolerance Helpline
Tel: 0800 028 3398
0800 028 3397 (Textphone)

ETHNIC MINORITY WOMEN'S GROUPS

Black Association of Women Step Out (BAWSO)
109 St Mary Street
Cardiff CF1 1DX
Tel: 01222 343154

Newham Asian Women's Project
661 Barking Road
London E13 9EX
Tel: 020 8472 0528
020 8552 5524 (advice line)

Southall Black Sisters
52 Norwood Road
Southall
Middlesex UB2 4DW
Tel: 020 8571 9595
Fax: 020 8574 6781

VICTIM SUPPORT

Victim Support National Office
Cranmer House, 39 Brixton Road
London SW9 6DZ
Tel: 020 7735 9166 (enquiries)

Victim Support Line
PO Box 11431
London SW9 62H
Tel: 0845 3030900

ADVICE & LEGAL ADVICE

NACAB (National Association of Citizens Advice Bureaux)
Middleton House
115-123 Pentonville Road
London N1 9LZ
Tel: 020 7833 2181

Rape Crisis
PO Box 69
London WC1X 9NJ
Tel: 020 7837 1600 (24 hour helpline)

Cardiff Rape Crisis Line
PO Box 338
Cardiff CF2 4XH
Tel: 029 2037 3181

Rights of Women
52-54 Featherstone Street
London EC1Y 8RT
Tel: 020 7251 6575 (office)
Tel: 020 7251 6577 (advice)

Immigration Advisory Service
Tel: 020 7378 9191

Immigration and Joint Council for Welfare of Immigrants
Tel: 020 7251 8706

Lesbian and Gay Switchboard
Tel: 020 7837 7324

AGENCIES FOR PARENTS & CHILDREN

AMICA (Aid for Mothers Involved in Contact Action)
C/O Rights of Women
52-54 Featherstone Street
London EC1Y 8RT
Tel: 020 7251 6575

Childline
Freepost 1111
London N1 0BR
Tel: 020 7239 1000 (office)
0800 1111 (freephone helpline for children & young people)

Childline (Wales)
9th Floor
Alexander House
Alexander Road
Swansea SA1 5ED
Tel: 01792 480111 (office)
0800 1111 (freephone helpline for children & young people)

National Society for the Prevention of Cruelty to Children (NSPCC)
Tel: 0800 800500 (national freephone child protection helpline)

NSPCC (Wales)
Maes y ffynnon
Penrhosgarnedd
Bangor
Gwynedd
LL57 2DW
Tel: 0808 1002524 (child protection helpline)
0808 1001033 (textphone)

Reunite (for parents of abducted children)
International Child Abduction Centre
PO Box 24875
London E1 6FR
Tel: 020 7375 3440 (advice line)

AL-ANON Family Groups
UK & Eire
(a national network of self help groups for families and friends to people whose drinking is causing concern)
61 Great Dover Street,
London SE1 4YF
Tel:: 020 7403 0888

OTHER CONTACTS

Gingerbread
16-17 Clerkenwell Close
London EC1R 0AN
Tel: 020 7336 8183
0800 0184318 (freephone helpline)

Miscarriage Association
C/O Clayton Hospital
Northgate
Wakefield
West Yorks WF1 3JS
Tel: 01924 200799 (national helpline)

Action on Elder Abuse
Astral House
1268 London Road
London SW16 4ER
Tel: 0808 808 8141 (Helpline)

Alcoholics Anonymous
Tel: 020 7833 0022

Alcohol Concern
Waterbridge House
32-36 Loman Street
London SE1 0EE
Tel: 020 7928 7377

MIND (The National Association for Mental Health)
Granta House, 15-19 Broadway
Stratford
London E15 4BQ
Tel: 020 8519 2122
0208 522 1728 (London helpline)
0845 7660163 (National helpline)

MIND
23 St Mary Street
Cardiff CF1 2AA
Information Line: 0345 660163

Samaritans
Tel: 0345 909090

USEFUL WEBSITES

http://www.domesticviolencedata.org

The **Domestic Violence Data Source** is an information co-ordinating system providing up to date material about domestic violence in England, Wales, Scotland, Northern Ireland and the Republic of Ireland.

Although targeted mainly at practitioners, researchers and other academics, the site is also sensitive to the needs of those who have experienced violence.

http://www.womensaid.org.uk

Website of Women's Aid, providing information and help and local refuge contact details and sources of help for women experiencing domestic violence, as well as information about domestic violence, and links to other useful websites.

http://www.homeoffice.gov.uk/domesticviolence

Sets out the Government's policy around domestic violence; lists relevant publications and provides links to other sites.

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